pennsylvania
DEPARTMENT OF HUMAN SERVICES

Application Tracking Number (ATN): [redacted] **Type:** New Enrollment **Start Date:** 05/09/2019 **Completion By:** 06/19/2019

Application Comments Provided by Pennsylvania Department of Human Services (DHS) Medical Assistance (MA)

In order to provide Tobacco Cessation services, you must complete the TC Webinar and get pre-approved from the Department of Health,. Please follow the appropriate steps: Access the PA Department of Health site ? www.health.pa.gov; Select title ?My Health? then ?Healthy Living? from the populated list; Select ?Smoke Free/Tobacco? link; Tobacco Prevention and Control? page select ?Pre Approved Tobacco Cessation Registry? under Quick links; Proceed to the ESET (Every Smoker Every Time) Webinar site, and go where to: ?Click this link to begin Webinar?. Begin the Webinar to receive Certification and become Pre-Approved with DOH.

Provider Information

Program Type Pennsylvania Medical Assistance (PA MA)
Provider Type 37 - Tobacco Cessation
Enrollment Type Individual with SSN
Last Name [redacted] **First Name** [redacted] **Middle Initial** r

Social Security Number (SSN) [redacted]

Are you a Medicare participating Provider? No

Contact Information

Last Name [redacted] **First Name** [redacted] **Title** pharmD
Phone Number [redacted] **Extension**
Toll Free Number **Extension**
Fax Number [redacted]
Email [redacted]

Service Location

Street 250 MOUNT LEBANON BLVD **Room/Suite**
City PITTSBURGH **State** PA - Pennsylvania
Zip+4 15234-1252 **County** Allegheny
Email [redacted]
Phone Number [redacted] **Extension**
Fax Number [redacted]

Co-location Providers

Are you sharing space with another provider? No

General & Historical Questions

Are you only enrolling as an ordering, referring or prescribing provider? No

Does the office have exterior steps leading to the main entrance doorway? No

Does the office have interior steps leading to the main entrance doorway? No

Is this address an active Rural Health Clinic or FQHC? No

Has screening been performed at this location for this provider within the last 12 months by:

Medicare? No

Children's Health Insurance Program (CHIP)? No

Another state's Medicaid? No

Other Addresses

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information: http://www.dhs.pa.gov/provider/electronicfundstransferdirectdepositinformation/index.htm (http://www.dhs.pa.gov/provider/electronicfundstransferdirectdepositinformation/index.htm)

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

Would you like to receive E-Mail notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used. Yes

☐ **Mail-To Address :** *Same As Service Location*

☐ **Pay-To Address :** *Same As Service Location*

☐ **Home-Office Address :** *Same As Service Location*

Specialties

Primary Specialty	Sub-Specialty	Primary
370 - Tobacco Cessation		Yes

ProviderType 37 - Tobacco Cessation
Specialty 370 - Tobacco Cessation **Sub-Specialty**

Provider Eligibility Program (PEP)

Requested Effective Date

Is a requested effective date prior to the application submission date required for this enrollment? No

Associated PEPs

Provider Eligibility Program (PEP)

☑ Fee For Service

Provider Identification

Provider IRS/Legal Name and Address

Last Name [redacted] **First Name** [redacted] **Middle Name**
Street [redacted] **Room/Suite**
City [redacted] **State** PA - Pennsylvania
Zip+4 [redacted]

Contact IRS/Legal Name and Address

Last Name [redacted] **First Name** [redacted] **Title** pharmD
Phone Number [redacted] **Extension**
Toll Free Number **Extension**
Fax Number [redacted]
Email [redacted]

Individual Provider

Birth Date [redacted] **Gender** F

Title/Degree PharmD

Are you a U.S. citizen who was born in the United States, or whose birth parents are U.S. citizens? Yes

If you are a U.S. citizen, but were not born in the U.S. you must provide a copy of your U.S. Permanent Resident Card or your U.S. issued Passport. If you are not a U.S. citizen you must provide a copy of your I-797B Notice of Action issued by the Department of Homeland Security, U.S. Citizenship and Immigration Services.

Are you Board Certified? Yes

I had initially uploaded my pharmacist license and included issue and current exp of PA licensure, so may try issue date of smoking cessation certificate, as there is no expiration date on it

Issuing Date 2005-01-20 **Expiration Date** 2020-09-30

NPI

NPI [redacted]

Taxonomy

☑ 174H00000X - Other Service Providers : Health Educator : Default Specialty Code

Do you want Medicare claims to crossover to this location? No

Drug Enforcement Administration (DEA) Number

Is a Drug Enforcement Administration (DEA) Number associated with this provider? No

Additional Information

Enrollment Languages

In addition to English, do you or your staff communicate with patients in another language? No

Fee Determination

Provider Disclosures

Have you ever:

Had clinical privileges or hospital privileges denied, suspended, restricted, revoked, or not renewed; either voluntarily or involuntarily for an agreed to definite or indefinite period of time? No

Had any judgments entered against you or settlements been agreed to in any professional liability cases? No

Are there any professional liability lawsuits pending against you at the present time? No

Do you have physical or mental health condition(s) which in any way impairs your ability to practice your profession, with or without accommodations? No

Do you have any physical or mental health condition(s) which in any way poses a risk of harm to your patients? No

Are you currently using, or have you used in the past five years, drugs or any other chemical substance that has or may impair your ability to practice your profession? No

Have you or anyone in your employ ever:

Been terminated, excluded, precluded, suspended, debarred from or had your participation in any federal or state health care program or hospital privileges limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time? No

Been the subject of a disciplinary proceeding by any licensing or certifying agency, had your license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? No

Had a controlled drug license withdrawn? No

Been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? No

Been convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? No

Been convicted of interference with or obstruction of any investigation? No

In connection with the delivery of a health care item or service, or with respect to any act or omission in a heath care program, been convicted of any criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? No

Been in default on repayments of scholarship obligations or loans in connection with your education as a health professional? No

Been subject to a civil penalty or assessment for any act or omission related to Medicare, Medicaid, or a state health care program? No

Ownership / Managing Individuals

Managing Employee or Agent Disclosure

Does the enrolling individual practitioner have any Managing Employees or Agents? No

Direct Or Indirect Ownership

Are there any subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more? No

Criminal Offense

Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? No

Significant Business Transactions

Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? No

Attachments

Provider

Required Attachment	Uploaded File Name
Copy of the Provider's Board Certification	[redacted].DOH smoking cessation certificate 4.29.19.pdf

Upload your DOH smoking cessation email certificate for the copy of provider's board certification

Agreements

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

Provider Agreement for Outpatient Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and [redacted] (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.

2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.

3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania Medical Assistance Program.

4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.

5. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.

6. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:

    A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12–month period ending on the date of the request; and

    B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5–year period ending on the date of the request.

7. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.

8. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.

9. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider that has

been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).

10. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.
11. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

Please sign by typing your full name here: [redacted] **Today's Date: 05/22/2019**

Submission Details

I have reviewed the information in this enrollment application and affirm that the information submitted in or with this application is true, accurate and complete.

I understand that I am responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if I become aware that any of the information is not true, accurate or complete.

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities.

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of my enrollment in the Pennsylvania Medical Assistance (PA MA).

Please sign by typing your full name here: [redacted] Date of Submission: **5/22/2019**

⚠ Prepared on 5/22/2019 by the PA Department of Human Services Provider Enrollment On-line Application.