GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Puerto Rico Medicaid Provider Enrollment Checklist

Provider Type – Hospital (01)

Specialty – General Hospital (901)

Specialty – Critical Access Hospital (250)

Specialty – Psychiatric Hospital (251)

Specialty – Rehabilitation Hospital (252)

Specialty – Rural Hospital (253)

Specialty – Stabilizing Room (139)

Specialty – Partial Hospitalization (141)

Specialty – Mental Health Transitional (142)

Specialty – Detoxification Treatment Services (143)

Enrollment Type: Facility

Application Information:

The following is an overview of the primary information needed to complete an application for the provider type and specialties listed above. Please note that all service locations where Medicaid beneficiaries are rendered services must be enrolled.

- ☐ **General information** including provider type, enrollment effective date, legal name, employer identification number (EIN), national provider identifier (NPI), and contact information.
- ☐ **Specialty and taxonomy information** including effective dates.
- ☐ **Address information** including service location address of all locations at which services are rendered to Medicaid beneficiaries, mail to, and pay to addresses.
- ☐ **Tax classification information** including organization type (e.g., non-profit, for profit).
- ☐ **License information** including license number, issuing state, and effective and end dates; and Medicare enrollment (if applicable), including Medicare number, Medicare type, effective and end dates, and other state Medicaid enrollment information (if applicable).
- ☐ **ASSMCA license information** including license number, issuing state, issuing board, and effective and end date. This license is required when enrolling the following specialties.
    - Psychiatric Hospital (251)
    - Stabilizing Room (139)
    - Partial Hospitalization (141)
    - Mental Health Transitional (142)
    - Detoxification Treatment Services (143)
- ☐ **Certification information** (if applicable) including specialty, certificate type, and effective and end dates.
- ☐ **Drug Enforcement Administration (DEA) information** including DEA number, and effective and end dates.
- ☐ **Controlled Substance Certificate (Puerto Rico) information** including registration number, effective and end dates (if provider dispenses or prescribes controlled substances).
- ☐ **Clinical Laboratory Improvement Amendments (CLIA) information** (if applicable) including CLIA number, CLIA certification type, and effective and end dates.
- ☐ **Accreditation information** (if applicable) including accrediting organization and expiration date.
- ☐ **Malpractice Insurance information** such as type of carrier, name of carrier, coverage amount, policy number, and effective and end dates.
- ☐ **Bed Information** including bed type, number of beds, and effective and end dates.
- ☐ **Level of Maternal Care** (if applicable) including effective and end dates.
- ☐ **Self-disclosure information** including actions taken against or changes to your license/certification, enrollment terminations, actions taken against a federal or state controlled substance certificate, actions taken against you during participation in a

governmental healthcare program, investigations, actions taken against your professional liability coverage, and contact information for audit purposes (42 CFR § 455.100-106).

- ☐ **Subcontractor disclosure information** for any entity/individual with which you have had any business transactions totaling more than $25,000 during the preceding 12-month period. If applicable, you will be required to provide subcontractor information such as name, address, effective and end dates, and control interest. If control interest is reported, additional ownership details such as % interest, name, SSN, DOB, and address will also be required (42 CFR § 455.100-106).

- ☐ **Ownership and control interest information** in the disclosing entity (individual or corporation). For entities having ownership/control interest in the disclosing entity, information such as ownership/control interest in any other provider, fiscal agent or managed care entity, criminal convictions in other government programs, other state Medicaid participation, program terminations, outstanding debts with other government programs, adverse legal actions, and relationships to the entity having ownership/control interest in the provider will be required (42 CFR § 455.100-106).
  Note: A person with an ownership or control interest means a person or corporation that has a direct or indirect ownership totaling 5% or more in the provider, is an officer or director of a provider organized as a corporation or non-profit or is a partner in a provider organized as a partnership.

- ☐ **Managing employee information** such as name, SSN, DOB, address, email, effective and end dates, criminal convictions in other government programs, other state Medicaid participation, program terminations, outstanding debts with other government programs, adverse legal actions, and relationship to the provider (42 CFR § 455.100-106).
  Note: One form must be completed for each managing employee. Per 42 CFR § 455.101, a managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of an institution, organization, or agency.

- ☐ **Business transactions** with any wholly-owned supplier or subcontractor. Information required includes name, tax ID, DOB (for individuals), effective date and end dates, and address (42 CFR § 455.105).
  Note: One form must be completed for each wholly-owned supplier or subcontractor.

- ☐ **Application fee** will be required if you have not already paid the fee to Medicare or another state's Medicaid program (42 CFR § 455.460).
  Note: You can upload proof of payment as an attachment to your application if you have already paid the fee to Medicare or another state's Medicaid program. Proof of payment is a receipt or formal notification from Medicare or another state Medicaid program specifically indicating payment of the application fee.

Required Documents:

The following is a list of required enrollment documents for the provider type and specialties listed at the beginning of this document. A copy of each document listed below must be

uploaded with your online application to the Provider Enrollment Portal (PEP). Exceptions to the required documents are noted as applicable.

- ☐ Documentation showing taxpayer identification number (TIN) (signed W-9)
- ☐ Current Hospital state licensure as required in the state in which the facility is located
- ☐ Current ASSMCA license including license number, license classification, and effective and end date
  Note: If you are enrolling the following specialties, and have provided ASSMCA information on the License panel, please attach a copy of your current ASSMCA license.
  - Psychiatric Hospital (251)
  - Stabilizing Room (139)
  - Partial Hospitalization (141)
  - Mental Health Transitional (142)
  - Detoxification Treatment Services (143)
- ☐ Current Drug Enforcement Administration (DEA) certification
- ☐ Current Malpractice/liability insurance
- ☐ CMS Medicare certification or accreditation
  Note: You may provide a copy of one of the following accreditations in lieu of the CMS Certification letter: American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), The Joint Commission (JC) or Det Norske Veritas (DNV) CMS-recognized deemed status certifications

Optional Documents:

The following is a list of optional enrollment documents for the provider type and specialties listed above.

- ☐ Current Controlled Substance Dispensing/Prescribing Certificate of Registration (Puerto Rico)
  Note: If you provided information on the Controlled Substances panel, please attach copy of your current Controlled Substance Certificate Registration (Puerto Rico).
- ☐ Current Clinical Laboratory Improvement Amendment (CLIA) certificate
  Note: If you provided CLIA information on the CLIA panel, please attach a copy of your current CLIA certificate.

You do not need to submit this checklist with your enrollment/revalidation documents.

If you have questions regarding your enrollment in the Puerto Rico Medicaid Program (PRMP), please submit your inquiry by email to prmp-pep@salud.pr.gov.