COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Ordering, Referring or Prescribing Provider (ORP)

VIRGINIA MEDICAID PROVIDER ENROLLMENT PACKAGE

Thank you for your interest in becoming a participating provider with the Virginia Medicaid program. Upon receipt of your completed Virginia Medicaid / Family Access to Medical Insurance Security Plan (FAMIS) enrollment application and any required documents, your application will be processed. Processing of your application may take up to ten business days. Completed paper enrollment applications can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax number or address.

Toll free Fax 1-888-335-8476

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803

If you have any questions regarding your paper enrollment application you can contact Provider Enrollment Services at toll-free 1-888-829-5373 or local 1-804-270-5105.

Contents:

- Enrollment Form Instructions - Please read all instructions to ensure your enrollment application is complete and that all necessary documentation has been attached prior to submission.
- Enrollment Application - Please make sure all required fields are complete prior to submission.
- Participation Agreement - This must be signed by the provider.

ENROLLMENT FORM INSTRUCTIONS

If you are already an active Virginia Medicaid Provider, it is NOT necessary to enroll as an Ordering, Referring and Prescribing (ORP) provider.

As part of the Affordable Care Act, providers who provide Ordering, Referring and Prescribing (ORP) services to Medicaid Members must be enrolled as Virginia Medicaid Providers.

- If you are already an active Virginia Medicaid Provider, it is NOT necessary to enroll as an Ordering, Referring and Prescribing (ORP) provider.
- If you are not and do not plan to be a Virginia Medicaid Provider for other services, you must enroll as an Ordering Referring and Prescribing (ORP) provider.
- The organization for which you are providing ORP services will enter your NPI on the claim submitted to Virginia Medicaid.
- Your NPI will be entered in the claim field as the Ordering, Referring and Prescribing provider of record.
- You will not be paid for these claims, but the information is required to be submitted if ORP services are rendered to a Virginia Medicaid member.

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. National Provider Identifier (NPI) (Required)

Enter your organization's 10 digit NPI (Required). To participate as a provider of medical or health services for the Virginia Department of Medical Assistance Services (DMAS), you are required to obtain an NPI. DMAS has adopted the NPI as the standard for identifying all providers on all transactions, including paper claims. More information about the NPI and how to obtain one can be found at http://www.cms.gov under Regulations and Guidance, HIPAA Administrative Simplification, National Provider Identifier Standard (NPI).

2. Individual Provider Name (Required)

Enter your first name, middle initial, last name, suffix, and title.

3. Primary Servicing Address (Required)

Enter your Primary Servicing address in this section.

- A Post Office Box address is not acceptable as a service location.
- Only one Primary Servicing Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ from the Primary Servicing and Correspondence address.

4. Correspondence Address (Required)

Enter the address to which you would like correspondence (Medicaid Manual updates, Medicaid memos, etc.) sent.

- A Post Office Box is acceptable for this type of address.
- Only one Correspondence Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ from the Primary Servicing and Correspondence address.
- If the Correspondence Address is the same as the Primary Servicing Address, write SAME on the attention line.

Indicate if you want to receive mailed Medicaid correspondence at this address. If you select 'No' then all mailed Medicaid correspondence associated with your enrollment will be suppressed.

5. Social Security Number (SSN) and Date of Birth (Required)

Enter the Social Security Number (SSN) and date of birth of the individual provider.

ENROLLMENT FORM INSTRUCTIONS

6. Requested Effective Date of Enrollment (Required)

Enter the date that you are requesting your enrollment to begin.

- Effective date cannot be more than one year past the current date.
- Effective date will never be before the effective date of your license.

7. Ordering, Referring and Prescribing Provider Type Requirements (Required)

As an Ordering, Referring and Prescribing provider you will not receive any payment from Virginia Medicaid for any services rendered to a Virginia Medicaid Member.

Select your provider type. These provider types are the only eligible providers to be enrolled as an Ordering, Referring and Prescribing provider.

- Audiologist
- Baby Care
- Certified Professional Midwife
- Chiropractor
- Clinical Nurse Specialist
- Clinical Psychologist
- Dentist
- Licensed Clinical Social Worker
- License Marriage and Family Therapist
- Licensed Professional Counselor
- Licensed Psychologist
- Licensed School Psychologist
- Licensed Substance Abuse Treatment Practitioners
- ORP Other (See Below)
- Non-Medicaid TDO
- Nurse Anesthetist
- Nurse Practitioner
- Occupational Therapist
- Optician
- Optometrist
- Out of State Physician
- Out of State Psychiatrist
- Physical Therapist
- Physician
- Podiatrist
- Psychiatrist
- Speech/Language Pathologist

If ORP Other is chosen as a provider type, you must select one of the Provider Classifications below.

- Intern
- Physical Assistant
- Other

8. License Board (Required)

Enter license number, state, effective and end dates for your license to practice.

9. Adverse Legal Actions (Required by 42 C.F.R. §455.106)

Check Yes if the applicant has had any adverse legal actions imposed by:

- Medicare
- Medicaid
- Federal agency or program
- Any state agency or program
- Any licensing or certification agency

If Yes, attach a copy of the final disposition.

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. National Provider Identifier (NPI) (Required) ____________________

2. Individual Provider Name (Required)

First ________ Middle Initial ____ Last ________ Suffix ________ Title ________

3. Primary Servicing Address (Required)

Address ____________________ ________ ________ ________
Street City State Zip

Office Phone **(Required)** ________ Ext. ____ 24 Hour Phone ________

TDD Phone ________ Fax Number ________ Email **(Required)** ________

Contact Name ________ Contact Phone ________

4. Correspondence Address (Required)

Attention ____________________

Address ____________________ ________ ________ ________
Street City State Zip

Office Phone ________ Ext. ____

TDD Phone ________ Fax Number ________ Email **(Required)** ________

Do you want to receive mailed Medicaid correspondence sent to this address? ☐ Yes or ☐ No

5. Social Security Number (SSN) and Date of Birth (Required)

SSN ________ Date of Birth ________

6. Requested Effective Date of Enrollment (Required) ________

7. Ordering Referring and Prescribing Provider Type (Required)

- ☐ Audiologist
- ☐ Baby Care
- ☐ Certified Professional Midwife
- ☐ Chiropractor
- ☐ Clinical Nurse Specialist
- ☐ Clinical Psychologist
- ☐ Dentist
- ☐ Licensed Clinical Social Worker
- ☐ License Marriage and Family Therapist
- ☐ Licensed Professional Counselor
- ☐ Licensed Psychologist
- ☐ Licensed School Psychologist
- ☐ Licensed Substance Abuse Treatment Practitioners
- ☐ ORP Other (See Below)
- ☐ Non-Medicaid TDO
- ☐ Nurse Anesthetist
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Optician
- ☐ Optometrist
- ☐ Out of State Physician
- ☐ Out of State Psychiatrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Podiatrist
- ☐ Psychiatrist
- ☐ Speech/Language Pathologist

If ORP Other is chosen as a provider type, you must select one of the Provider Classifications below.

☐ Intern

☐ Physician Assistant

☐ Other ______________________________

8. License Board (Required)

State where you hold a license to practice ______________________________

License Number ______________ Begin Date ______________ End Date ______________

Attach copy if your license cannot be validated through an Internet search.

9. Adverse Legal Actions (Required by 42 C.F.R. §455.106)

Indicate if the applicant has ever had any adverse legal actions imposed by Medicare, Medicaid, any other federal or state agency or program, or any licensing or certification board.

☐ No ☐ Yes If Yes, attach a copy of any final disposition documentation.

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services
Medical Assistance Program

Ordering, Referring or Prescribing Provider (ORP) Participation Agreement

This is to certify:

NPI ____

Provider Name ____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.
3. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
4. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
5. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
6. Except as otherwise provided by applicable state or federal law, all disputes regarding termination or denial of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
7. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
8. This agreement shall commence upon the approval date of your enrollment application. Your effective date of participation is listed on your approval letter which is sent to your correspondence address upon approval of your application. The provider shall retain a copy of this approval letter as part of the Participation Agreement. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For Virginia Medicaid use only
Director, Division of Program Operations Date

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Original Signature of Provider Date