STATE OF NEW MEXICO
MEDICAL ASSISTANCE DIVISION
PROVISIONAL PROVIDER PARTICIPATION AGREEMENT
INDIVIDUAL APPLICANT WITHIN GROUP

THIS AGREEMENT IS FOR INDIVIDUAL APPLICANTS WHO PERFORM SERVICES WITHIN A GROUP OR OTHER ORGANIZATION. PAYMENTS WILL BE MADE ONLY TO THE GROUP OR ORGANIZATION. NO PAYMENTS WILL BE MADE DIRECTLY TO THE INDIVIDUAL IF THE APPLICANT WILL BE PROVIDING SERVICES FOR WHICH PAYMENTS ARE TO BE MADE DIRECTLY TO THE APPLICANT, THIS FORM SHOULD NOT BE USED. USE MAD 335 PROVISIONAL INSTEAD.

Return completed application to:
New Mexico Medicaid Project
Conduent
P.O. Box 27460
Albuquerque, NM 87125-7460

(1) NM Medicaid Number (if previously assigned)	(2) National Provider Identifier (NPI)	(3) Primary Taxonomy NOT REQUIRED

(4) Applicant Name (for individuals – must match license name)
First Name | Middle Initial | Last Name | Professional Title (MD, DDS, etc)

(5) Physical Street Address where services are rendered (PO BOX NOT ACCEPTED) | City | State | Zip Code | County

(6) Billing Office Address(MAY BE PO BOX) NOT REQUIRED	City NOT REQUIRED	State NOT REQUIRED	Zip Code NOT REQUIRED

(7) Mailing Address for official correspondence (MAY BE PO BOX) | City | State | Zip Code

(8) Fax Number NOT REQUIRED	(9) Billing Office Phone NOT REQUIRED	(10) Location Phone (REQUIRED)
(11) Mailing Email Address	(12) Billing Office Email Address NOT REQUIRED	(13) Location / Provider Email Address

(14) Provider Type (see attached list)	(15) Provider Specialty (see attached list)	(16) License Information Number / State / Expiration Date NOT REQUIRED / NOT REQUIRED / NOT REQUIRED	(17) (REQUIRED) Individual Provider's : Social Security Number / Date of Birth

(18) Individual's Medicare Provider Number *(Attach Medicare letter)* NOT REQUIRED	(19) Are federal tax payments current? If not, attach an explanation. ☐ YES ☐ NO
(20) DEA Number (attach copy)	(21) HMO Affiliation? ☐ YES ☐ NO NOT REQUIRED Name of Plan(s) in which you participate: NOT REQUIRED

(22) Do you have admitting privileges at a hospital? ☐ YES ☐ NO
If yes, list name of hospital(s): NOT REQUIRED NOT REQUIRED

(23) To be completed by physicians (provider type 301 or 302) only: (If *Certified*, attach copy of certificate; if *Not Certified* or if *Eligible for Certification*, attach proof of residency completion / training in your specialty area)
Board certified in the provider specialty listed in box 15? ☐ Certified ☐ Eligible for certification ☐ Not certified

(24) Identify the groups or organization(s) to which payments will be made for your Medicaid services: (Please attach separate page if additional space is needed)

Organization or Group Name	Prov. Type	Specialty	NM Medicaid Prov. No.	NPI	Medicare Number

(25) If services have already been rendered to a NM Medicaid recipient, please enter Date of Service and attach copy of claim:
DOS: NOT REQUIRED

(26) To be completed by out-of-state providers only:
Home State Medicaid Provider Number: NOT REQUIRED

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

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Name of Individual	SSN	NPI

A) Have you ever had a license revoked, suspended or denied in any state? ___YES ___NO Initial_____

B) Have you ever been convicted of any criminal offense? ___YES ___NO Initial_____

C) Have you ever been excluded or suspended from participation in Title XVIII (Medicare), Title XIX (Medicaid) or any other health care program? ___YES ___NO Initial_____

If YES to any of the above three questions, attach a brief statement of situation; date; city, county and professional association or court which handled the matter; any precinct case identification, and the adjudication or other result.

Initial to Confirm the following:

_____ The provider is covered by malpractice, professional, medical, or other liability insurance. Coverage will remain in place for all dates of service

Initial One:

_____ I am licensed in NM and do not otherwise participate as a NM Medicaid provider. I will provide only COVID19 testing and related service

_____ In accordance with the NM licensure authority for my professional license, I am authorized to practice in NM based on my federal, temporary, emergency, or other license (copies attached)

Initial All That Apply:

_____ I am currently enrolled as a Medicare provider. My Medicare provider ID is _____

_____ I am currently enrolled in my home state's Medicaid program. My home state Medicaid provider ID is _____

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and telephone number.

Contact Person: _____ ***Telephone Number:*** _____

_____

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Original signature required. Please use blue ink only.

INDIVIDUAL PROVIDER:

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Individual Practitioner: _____

Signature of Individual Practitioner: _____ **Date** _____

FOR STATE PURPOSES ONLY:

HEALTH CARE AUTHORITY APPROVAL

☐ APPROVED ☐ NOT APPROVED

Reasons Not Approved:

Dates of Agreement: From: _____

Authorized Signature	Date