PrimeWest HEALTH™

Home and Community Based Waivered Services Provider Enrollment Application

Please type or block print the requested information as completely as possible. If any field is not applicable, please enter N/A. An incomplete application may delay approval. Detailed instructions for completion of this application are included.
Please complete Satellite location pages for any additional locations.

1. Legal name (as shown on your income tax return) _____
2. Doing Business As (DBA) name (if different from above) _____
3. Physical address _____
4. City _____ State _____ Zip _____
5. Federal Employer Identification Number (FEIN) _____
6. Taxpayer name (if FEIN indicated) _____
7. Social Security Number (SSN) _____ 8. Minnesota tax ID _____
9. Fiscal year end (default is Dec. 31) _____ 10. Office phone (_____) _____
11. Office fax (_____) _____ 12. NPI/UMPI _____
13. Are you currently enrolled as a Medicare provider with the Centers for Medicare & Medicaid Services (CMS)? ☐ Yes ☐ No
13a. If "yes," provide your Medicare number _____
14. Website _____
15. Language(s) spoken (list all applicable) _____
16. Meets cultural competency standards ☐ Yes ☐ No 17. Service accessibility ☐ Yes ☐ No
18. Service limitations _____
19. Types of services (check all that apply). For all services identified, indicate the county(ies) where the service will be provided. Services must take place in at least one of the counties listed below.

- Beltrami
- Big Stone
- Chippewa
- Clearwater
- Cottonwood
- Douglas
- Grant
- Hubbard
- Jackson
- Kandiyohi
- Lac qui Parle
- Lincoln
- Lyon
- McLeod
- Meeker
- Nobles
- Pipestone
- Pope
- Redwood
- Renville
- Stevens
- Swift
- Traverse
- Yellow Medicine

☐ 24-Hour Emergency Equipment (PERS) _____
☐ Adult Day Care Services _____
☐ Adult Companion Services _____
☐ Adult Foster Care Services _____
☐ Assistive Technology Equipment _____
☐ Case Management _____
☐ Chore Services _____
☐ Common Carrier Transportation Services _____
☐ Consumer Directed Community Support Services _____
☐ Customized Living _____
☐ 24-Hour Customized Living _____
☐ Elderly Waiver Foster Care _____
☐ Environmental Accessibility Adaptations – Home _____
☐ Environmental Accessibility Adaptations – Vehicle _____
☐ Extended Home Health Care Services _____
☐ Extended Home Care Nursing _____
☐ Extended Nursing and Home Health Aide _____
☐ Extended Personal Care Services _____
☐ Family Caregiver Coaching and Counseling _____
☐ Family Caregiver Training and Education _____

- ☐ Home Delivered Meals _____
- ☐ Homemaker Services _____
- ☐ Individual Community Living Support (ICLS) _____
- ☐ Non-Emergency Medical Transportation _____
- ☐ Residential Care Services _____
- ☐ Respite Care _____
- ☐ Specialized Medical Supplies & Equipment _____
- ☐ Specialized Transportation _____
- ☐ Transitional Support _____
- ☐ Transportation _____

20. Ownership code _____

21. Alternate addresses

Address 2 _____ PO Box _____
City _____ State _____ Zip _____

Address 3 _____ PO Box _____
City _____ State _____ Zip _____

Indicate to which of the addresses listed (physical address [Address 1], Address 2, or Address 3) each of the following should be sent.

_____ Claims payment
_____ Provider correspondence
_____ Enrollment status
_____ Prior authorization notice

22. All providers: complete the following license information. *Enclose a copy of current license.*

License number	*Original license date*	*End date*	*Type of license*	*State*

23. Contact information

Title	*Name*	*Telephone*	*Email address*
Administrator/facility site manager			
Business/billing office manager			
Director of nursing/nursing supervisor			

24. Hours of operation

Regular office hours				
Monday		to		☐ Closed
Tuesday		to		☐ Closed
Wednesday		to		☐ Closed
Thursday		to		☐ Closed
Friday		to		☐ Closed
Saturday		to		☐ Closed
Sunday		to		☐ Closed

Holiday hours				
New Year's Day		to		☐ Closed
Martin Luther King Day		to		☐ Closed
President's Day		to		☐ Closed
Memorial Day		to		☐ Closed
Independence Day		to		☐ Closed
Labor Day		to		☐ Closed
Thanksgiving		to		☐ Closed
Christmas Day		to		☐ Closed
Other:		to		☐ Closed

25. Contract signer statement

I certify that the information provided on this form is true and correct. I will notify PrimeWest Health of any additions/ changes to the information.

Provider name (please print) _____ Title _____

Contract signer signature _____ Date _____

Name of person completing this form _____ Phone _____

Email address _____

Satellite Location(s)

Copy pages 4 – 5 and complete for each additional practice location associated with the primary facility.

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Director of nursing/nursing supervisor			

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Tuesday		to		☐ Closed
Wednesday		to		☐ Closed
Thursday		to		☐ Closed
Friday		to		☐ Closed
Saturday		to		☐ Closed
Sunday		to		☐ Closed

Holiday hours				
New Year's Day		to		☐ Closed
Martin Luther King Day		to		☐ Closed
President's Day		to		☐ Closed
Memorial Day		to		☐ Closed
Independence Day		to		☐ Closed
Labor Day		to		☐ Closed
Thanksgiving		to		☐ Closed
Christmas Day		to		☐ Closed
Other:		to		☐ Closed

PrimeWest HEALTH

Instructions for completing your Home and Community Based Waivered Services Provider Enrollment Application

Field number	Instructions
1. Legal name	If you are a business or organization, use this space to enter your company name. Individual providers should enter your name as it appears on your state-issued identification (e.g., driver's license).
3. Physical address	Enter the street address where you practice or do business. This is the physical location of your place of business. **A post office box is not considered a business address.**
5. Federal Employer Identification (ID) Number	If you or the business have a Federal Employer Identification Number (FEIN), you must supply it.
6. Taxpayer name	If you indicate an FEIN on the application, use the name as it appears on your tax forms.
7. Social Security Number (SSN)	If the FEIN and the Social Security Number (SSN) are both entered, the FEIN will be used for tax purposes, and the SSN will be used for identification purposes only.
8. Minnesota (MN) tax ID	The MN Department of Revenue requires a business to have a MN tax ID if any of the following apply: a. It collects sales tax on retail sales in MN b. It has employees and collects withholding taxes c. It is a corporation doing business in MN and files a tax return with the MN Department of Revenue To obtain a MN tax ID, call the MN Department of Revenue at **1-651-296-6181**.
9. Fiscal year end	Enter your business's or organization's fiscal year end date. If left blank, the date will default to December 31.
12. National Provider Identifier (NPI)/Unique Minnesota Provider Identifier (UMPI)	Enter the NPI or the UMPI Medicaid number assigned to you by the MN Department of Human Services (DHS).
15. Language(s) spoken	Enter all applicable languages spoken by the provider from the following list of languages: English, Spanish, Hmong, Vietnamese, Khmer (Cambodian), Laotian, Russian, Somali, American Sign Language, Amharic, Arabic, Bosnian/Serbo-Croatian, Oromo, Tigrinya, Burmese, Cantonese, French, Mandarin, Swahili, Yoruba, Korean, Karen, and Other. (Please indicate language if "Other.")
16. Meets cultural competency standards	This is determined by the capability of providers to engage diverse individuals and communities in ways that both promote and improve their health and well-being and reduce disparities in health outcomes between these groups and mainstream populations.
17. Service accessibility	Check "Yes" if your facility is Americans with Disabilities Act (ADA)-accessible.
18. Service limitations	Provide information about service limitations (e.g., geriatric or pediatric patients only).
19. Types of services	Check the box(es) of the service(s) you wish to provide and indicate the county(ies) where you will provide the services.
20. Ownership code	Enter the appropriate one-digit code to indicate the nature of ownership of your business. Choose one of the following codes: 1. Nonprofit 2. Sole owner 3. Hospital based 4. State 5. Public 6. Partnership 7. Corporation 8. HMO 9. Professional association

21. Alternate addresses	PrimeWest Health offers the opportunity to receive various types of information at one of three addresses of your choice. The address you indicate in field #3 is considered Address #1. If you want us to send one or more of the types of information listed to a different address, please indicate up to two alternative addresses in the spaces provided. Indicate which of the three addresses provided should be used for each type of correspondence. If no alternative address is provided or no choices are made, PrimeWest Health will mail all correspondence and other materials to Address #1. Enter 1, 2, or 3 (if applicable) for each item.
22. License/certification/permit/ registration	Complete this section indicating your license, certification, registration, or permit number; the original date issued; the expiration date; type of license, certification, registration, or permit; and issuing state. We will verify this information. Enclose a copy of each license, certification, registration, or permit.
25. Contract signer statement	Read this statement. Print the name and title of the person who will sign and date the application. Indicate a contact person, telephone number, and email address.