TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Tuberculosis and Hansen's Disease Branch
Medicaid Provider Application

This application is intended for providers who have an existing legal, financial, or contractual relationship with Texas Department of State Health Services (DSHS), and are performing comprehensive tuberculosis clinical care services. All other providers may apply directly to Texas Medicaid and Healthcare Partnership (TMHP).

Section A: PROVIDER BACKGROUND

Provider Name:			
Mailing Address:			
	(P.O. Box or Street Address)	City	Zip Code
Billing Address:			
	(P.O. Box or Street Address)	City	Zip Code
Phone Number:		Fax Number:	
Contact Person:		Title:	
E-mail Address:			

Section B: PROVIDER TYPE

Please check type of provider:

DSHS clinic
City/County Health Department
Non-Hospital Based Private Provider

Section C: PROVIDER SERVICES

Under the approved Medicaid State Plan Amendment, the following tuberculosis (TB) related clinic services may be covered for reimbursement. Approved providers must have the facilities and resources available to provide any or all services required under the State Plan Amendment. Please indicate which services your clinic/facility presently provides by checking the box which represents the service. Providers may be required to provide documentation of service delivery methodology upon request.

☐ Physician and non-physician examination, consultation and evaluation, treatment and prevention services including counseling and education for preventative and curative treatment of TB disease or TB infection, transmission, and risk factors.

☐ X-ray, diagnostic and evaluation services/procedures which:
   a. permit the presumptive diagnosis of TB disease;
   b. confirm the presence of TB infection or TB disease;
   c. monitor and assess client response to treatment for TB disease or TB infection

☐ Health history, evaluation, assessment, and record maintenance.

☐ Prescribed medications.

☐ Monitor client compliance and completion of regimes of prescribed drugs, including direct observation of client intake of prescribed drugs.

Section D: ADDITIONAL PROVIDERS

Please list additional tuberculosis clinics operating under the applying provider's jurisdiction. These clinics will be assigned a performing provider identifier to be used in conjunction with TB-unique provider codes.

Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code
Clinic Name:		Phone Number:	
Address:			
	Street	City	Zip Code

Section E: PROVIDER INFORMATION

Please list all physicians licensed to practice medicine by the State Board of Medical Examiners for the State of Texas (M.D., D.O.) who assume professional responsibility for clients treated in TB clinics under the applying provider's jurisdiction.

Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	
Provider Name:			☐ M.D. ☐ D.O.
Provider License Number:		Provider Medicaid Number:	

Section F: STATE PLAN AMENDMENT & ENROLLMENT REQUIREMENTS

If approved as a provider to bill Medicaid under the Tuberculosis State Plan Amendment, I, on behalf of myself and any and all practitioners associated with this provider, ensure the following is true:

1. Provider is not an administrative, organizational, or financial part of a hospital.
2. Provider is organized and operated to provide TB related services, which include but are not limited to any or all of the services listed in Section C of this application.

3. Approved providers must have the facilities and resources available to provide all services required under the Texas Title XIX State Plan Amendment which adds coverage and reimbursement provisions for tuberculosis related clinic services.
4. Services will be provided to clients only when deemed medically necessary.
5. Providers receiving tuberculosis medications from the Texas Department of State Health Services (DSHS) or another source at no cost will not bill Medicaid for those drugs.
6. Provider will comply with all applicable federal, state, and local laws and regulations.
7. Provider employs or has a contractual agreement/formal arrangement with a licensed provider (M.D., D.O.) who is responsible for providing medical direction and supervision over all services provided to the clinic's clients.
8. Provider will comply with any TB related guidelines issued by the Department of State Health Services and ensure that services are consistent with published recommendations of the Standing Delegation Orders (SDO) and Standing Medical Orders for TB Prevention and Control, American Thoracic Society and the Centers for Disease Control and Prevention.
9. Provider will maintain complete and accurate medical records of client's care and treatment, and will accurately document all services provided, including medical necessity for those services.
10. Appropriate documentation will be sent to the primary care physician (PCP) of clients receiving treatment through a managed care organization (i.e., a copy of clients Form TB-400).
11. Provider must be qualified, approved and enrolled for participation in the Texas Medical Assistance Program (Medicaid) and sign a written Medicaid Provider Agreement with the department or its designee.
12. Provider agrees to comply with all other provisions and requirements contained in the current Texas Medicaid Provider Procedures Manual and as updated on a bimonthly basis by the Medicaid Bulletin.
13. Provider will submit claims for services using the claims filing procedures established by the department or its designee. All claims are subject to review for medical necessity.
14. Once services are billed under a TB clinic Medicaid provider number, the same services will not be billed dually under other Medicaid provider numbers (i.e., Physician Medicaid Number).

Authorized Signature _____ Title_____

Print Name_____ Date_____

SUBMIT

<table>
<tr><td colspan="3">DSHS Central Office Use Only</td></tr>
<tr><td>Application

☐ Approved ☐ Disapproved</td><td colspan="2" rowspan="2">Comments/Reasons for disapproval:</td></tr>
<tr><td>Application Review By:</td></tr>
<tr><td colspan="2">Tuberculosis and Hansen's Disease Branch Manager Signature:</td><td>Date:</td></tr>
</table>