



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

Dear Health Care Provider:

The Center for Cancer Prevention and Control at the Maryland State Department of Health and Mental Hygiene would like you to consider participation in the Breast and Cervical Cancer Diagnosis and Treatment Program. It is designed to help low-income, Medicaid ineligible, women and men in Maryland who qualify for the program, to receive diagnosis and treatment for breast and cervical cancer.

Access to state-of-the-art treatment is a critical element needed to reduce mortality from either of these cancers. Funding to pay for diagnosis and treatment was made available starting in fiscal year 1993. The Center for Cancer Prevention and Control developed regulations governing the Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment and was charged with the responsibility for their administration. The success of this Program is dependent upon the participation of all providers involved in the diagnosis and treatment of breast and cervical cancer. If you are interested in providing services for this underserved population, have questions concerning the Program and/or would like a copy of the regulations please contact Patricia Harvey at (410) 767-6787.

Sincerely,

Courtney Lewis, M.P.H., C.H.E.S.
Director
Center for Cancer Prevention & Control

INSTRUCTIONS FOR COMPLETING THE PROVIDER APPLICATION

(ALL INFORMATION MUST BE PRINTED LEGIBLY OR TYPED)

CONTRACT

PAGE 1: "The Provider" – means the individual provider as solo practitioner or the organization/group.

- **Individual Provider** – print or type provider name on the first line, leave next line blank
- **Organization or Group** – print or type organization or group name on the first line and the name of the person authorized to sign for the organization or group on the next line.

I. PLEASE READ CAREFULLY AND NOTE :

- The reimbursement rates
- The Program is payer of last resort.
- Accept as payment in full the amount reimbursed by the Program and/or the patient's health insurance, if applicable. Do not to seek additional payment from the patient. Billing the patient for account balances is a violation of this agreement.

PAGE 2: II. PLEASE READ CAREFULLY AND NOTE:

- Termination requires a 30 day notice in writing and notification of patients prior to rendering additional services of your withdrawal from the Program. This provides patients the opportunity to transfer to a participating provider.
- Please obtain appropriate signature

DEMOGRAPHIC INFORMATION

PAGE 1: INDIVIDUAL PRACTICE – Any individual M.D in solo practice

GROUP PRACTICE/ORGANIZATION –Please provide a list of all individuals and ALL of their office locations.

BILLING ADDRESS – PLEASE ATTACH A COPY OF THE W-9

- **Tax ID number** – This is the ID number used. If the tax ID is used by another organization (e.g., hospital, corporate pharmacy, etc.) a suffix must be added to the Tax ID number. This suffix identifies your organization separately for payment and must appear on all claims. The billing address must match exactly that which appears in Box 33 of the CMS 1500. Any changes must be reported immediately to the central office in order to prevent a delay in payment. Please identify the Tax ID# as SSN or EIN.
- Please provide a BLANK **copy of a CMS 1500 or UB 04** with your billing name and address in Box 33 (OBTAIN FROM YOUR BILLING OFFICE).
- **Contact Person** – Please provide the name and telephone number of the person to contact in case of problems. This should be the office manager or billing supervisor.
- Please provide a list of all office locations and the contact person for each. This information is helpful to our patients.

PAGE 2: NPI NUMBER – Please provide your **National Provider Identifier** number on the appropriate line.

LICENSE NUMBERS – Please provide copies of all applicable licenses. Your office will be asked to update this information periodically. For physicians, please attach a copy of each individual's current medical license.

All Provider types except Pharmacies Attach the following:

1. W-9
2. Sample CMS 1500 or UB04 with billing address completed as on an actual claim
3. A list of all providers in the practice-include for each:
 - Copy of License
 - NPI Number
 - Certificate of Insurance

Pharmacies attach the following:

1. W-9
2. A list of all pharmacy locations

*Provider Agreement for Participation in the
Breast and Cervical Cancer Diagnosis and Treatment Program*

BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM
Maryland State Department of Health and Mental Hygiene
Prevention and Health Promotion Administration

This agreement is entered into between the Maryland State Department of Health and Mental Hygiene (“the Department”) and _____ (“the Provider”) by _____, the Provider’s duly authorized representative (in the case of a group, institutional, or corporate provider), to provide covered services for breast and/or cervical cancer diagnosis and treatment to Program eligible individuals in accordance with COMAR 10.14.02. The provider is advised that the applicable regulations may differ significantly from those of other third-party payor programs.

I. THE PROVIDER AGREES:

- A. To comply with all applicable requirements or the Breast and Cervical Cancer Diagnosis and Treatment Program as well as any other applicable regulations, transmittals, and guidelines issued by the Department. The provider acknowledges his responsibility to become familiar with those requirements.
- B. To maintain adequate records which fully describe the nature and extent of all goods and services provided and rendered.
- C. To provide covered breast and/or cervical cancer diagnostic and/or treatment services for uninsured patients at the current Medical Assistance reimbursement rate or, if the provider is a hospital, at 94% of the current HSCRC rate.
- D. To provide breast and/or cervical cancer diagnostic and/or treatment services for insured patients at the rate approved by the patient’s health insurer. The Program will reimburse the patient contribution amount and deductible for all insured patients.
- E. That if the provider is a pharmacy, the Program shall reimburse the patient contribution amounts (deductible and co-payment) for insured patients.
- F. That if the provider is a home health agency, the Program shall reimburse at the rate per visit set by Maryland Medicaid.
- G. That if the patient has insurance, to seek reimbursement from that source first. If reimbursement is made by both the Program and the insurer, the provider shall refund to the Department, within 60 days of receipt, the amount reimbursed by the Program or the insurer, whichever is less.
- H. To accept as payment in full the amount reimbursed by the Program and/or the patient’s health insurer for the service rendered and not seek additional payment from the patient. To accept responsibility for the accuracy of all claims submitted to the Program.
- I. To attest that all claims submitted under the provider number shall be for services rendered for breast and/or cervical cancer diagnosis and/or treatment.
- J. To assume liability for the procedures and/or services rendered.

State of Maryland
Provider Agreement for Participation in the
Breast and Cervical Cancer Diagnosis and Treatment Program
(Page 2 of 2)

II. THE DEPARTMENT AGREES:

- A. To pay the provider for services for breast and/or cervical cancer diagnosis and/or treatment provided to uninsured or insured, low-income patients in accordance with all Program regulations by reference in the Code of Maryland regulations.
- B. To provide notice of changes in the Program regulations through publication in the *Maryland Register* in accordance with their publication schedule.

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

- A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this agreement by giving a thirty (30) day notice in writing to the other party. The Provider shall notify patients, prior to rendering additional services, of withdrawal from the Program.
- B. That the effective date of this agreement shall be the date on which it is signed by the Provider. This agreement shall remain in effect until such time as it is terminated by either party pursuant to the terms of this agreement. Termination of this agreement shall not discharge the obligation of the Provider with respect to services or items furnished prior to termination, including retention of records and restitution of overpayments.
- C. That this agreement shall not be transferable or assignable.
- D. That payment shall be contingent upon the availability of funds per State Finance Procurement Article, §§7-234 and 7-235, annotated Code of Maryland.

Provider Signature

Date

Provider Name (Please type or print)

This agreement cannot be processed until all the information in the Provider Application Form (see attached) is completed and received by the Center for Cancer Prevention and Control

PLEASE RETURN PROVIDER AGREEMENT AND COMPLETED APPLICATION TO:

Maryland Department of Health and Mental Hygiene
Prevention and Health Promotion Administration
Center for Cancer Prevention and Control
P.O. Box 13528
Baltimore, Maryland 21203-2399

For questions, please call (410) 767-6787

Provider Application

BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM
Maryland State Department of Health and Mental Hygiene
Prevention and Health Promotion Administration

PLEASE TYPE OR PRINT LEGIBLY

INDIVIDUAL PRACTICE	GROUP PRACTICE/ORGANIZATION
Name of Individual Provider:	Name of Group/Organization:
_____ Last	If there is more than one provider in this group/or organization, please attach a list of all providers, a copy of their medical license, NPI number and certificate of insurance.
_____ First MI	

BILLING NAME AND ADDRESS :

Federal Tax Number: Suffix: SSN EIN

Name _____
Street _____ Suite _____ FL _____ BLDG _____
City _____ State _____ Zip code _____
Phone: Ext:
FAX: E-Mail: _____

<u>CONTACT PERSON</u>
Name: _____
Phone: _____
Ext: _____

The "Billing Information" provided here must be an EXACT match to the "Billing Information" given on the CMS 1500 or the UB 04. Any inconsistency of information will be interpreted as an error by the system and result in a rejection of the claim.

LOCATION ADDRESS:

Name _____ TOTAL # OF SITES:

Street _____ Suite _____ FL _____ BLDG _____

City _____ State _____ Zip Code _____

County _____

Phone: Ext:
FAX: E-Mail: _____

<u>CONTACT PERSON</u>
Name: _____
Phone: _____
Ext: _____

(If there is more than one location in this practice, group or organization, please attach names of all locations, full addresses, and contact information.)

Health Care Provider Billing Procedures

BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM

Maryland State Department of Health and Mental Hygiene
Prevention and Health Promotion Administration

THE CENTER FOR CANCER PREVENTION AND CONTROL IS THE PAYOR OF LAST RESORT

Patients with NO INSURANCE:

1. Complete CMS 1500 (for physician, physical therapy, radiology, DME, and laboratory).
2. Complete UB 04 (for hospital, home health and free standing ambulatory surgical centers).
3. Submit the required claim form to the Breast and Cervical Cancer Diagnosis and Treatment Program.

Patients with MEDICARE OR INSURANCE:

1. Complete CMS 1500 (for physician, physical therapy, radiology, DME, and laboratory).
2. Complete UB 04 (for hospital, home health and free standing ambulatory surgical centers).
3. Send the required claim form to MHIP or Medicare.
 - Do not charge patient for any co-payment/co-insurance.
 - Do not charge patient for any deductible.
4. Obtain explanation of benefits (EOB) from Medicare.
5. Accept the Insurance payment.
6. Bill the Breast and Cervical Cancer Diagnosis and Treatment Program for the following:
 - Denied claims
 - Reimbursement is less than the Medical Assistance rates
 - Co-Payment/Co-Insurance
 - Deductible
7. Submit the required claim form and the EOB to the Breast and Cervical Cancer Diagnosis and Treatment Program.

PLEASE SEND REQUIRED DOCUMENTATION TO:

**Center for Cancer Prevention and Control
Maryland Department of Health and Mental Hygiene
Prevention and Health Promotion Administration
P.O. Box 13528
Baltimore, Maryland 21203-2399**

Allowed benefits will be paid to the provider by the Center for Cancer Prevention and Control,
Maryland State Department of Health and Mental Hygiene

For questions, please call (410) 767-6787

Health Care Provider Billing Procedures for Pharmacy Services

BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM

Maryland State Department of Health and Mental Hygiene
Prevention and Health Promotion Administration

THE CENTER FOR CANCER PREVENTION AND CONTROL
IS THE PAYOR OF LAST RESORT

HEALTHCARE PROVIDER BILLING PROCEDURES FOR
MEDICAL SUPPLIES AND EQUIPMENT ONLY

Patients with NO INSURANCE:

1. Complete CMS 1500 for medical supplies and/or equipment.
2. Submit the required form to the Breast and Cervical Cancer Diagnosis and Treatment Program.

Patients with INSURANCE:

1. Complete CMS 1500 for medical supplies and/or equipment.
2. Send claim to the patient's primary insurance and/or secondary insurance.
 - **Do not charge patient for any deductible or Co-pay/Co-insurance.**
3. Obtain explanation of benefits (EOB) from insurance carrier.
4. Accept insurance payment, including Medicare.
5. Bill the Breast and Cervical Cancer Diagnosis and Treatment Program for the following:
 - Denied claims
 - Reimbursement is less than the Medical Assistance Rates
 - Co-pay/Co-insurance
 - Deductible
6. Submit the claim and the EOB to the Breast and Cervical Cancer Diagnosis and Treatment Program.

PLEASE SEND REQUIRED DOCUMENTATION TO:

**Center for Cancer Prevention and Control
Maryland Department of Health and Mental Hygiene
Prevention and Health Promotion Administration
P.O. Box 13528
Baltimore, Maryland 21203-2399**

Allowed benefits will be paid to the provider by the Center for Cancer Prevention and Control,
Maryland State Department of Health and Mental Hygiene

For questions, please call (410) 767-6787