

# **PROVIDER AGREEMENT**

## **To Participate in the South Dakota Medical Assistance Program**

The following agreement to participate in the South Dakota Medical Assistance Program is entered into between \_\_\_\_\_ hereinafter called Provider, and the State of South Dakota, acting by and through its Department of Social Services, Division of Medical Services, hereinafter called Medical Services.

### **A. PROVIDER AGREES TO THE FOLLOWING**

1. Provider is currently licensed to practice and in good standing in the State of South Dakota or in Provider's resident State.
2. Provider agrees to promptly notify Medical Services if there is a change in Provider's name or address, if there is a change of ownership or corporate entity of Provider, or if Provider's license is revoked or suspended. Provider further agrees to supply all documentation necessary for the reimbursement of any outstanding claims upon termination from the medical assistance program.
3. Provider agrees to comply with all Federal and State laws, regulations and rules applicable to Provider's participation in the medical assistance program. Provider also agrees to abide by regulations and rules adopted during the term of the provider agreement pursuant to SDCL Chapter 1-26 or 5 USC §553.
4. Provider agrees to provide medically necessary goods and services as required by the recipient and only in the amount required by the recipient without discrimination on the grounds of age, race, color, sex, national origin, physical or mental disability, marital or economic status.
5. Provider agrees to keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services rendered and billings made under the medical assistance program, and agrees to furnish Medical Services and/or Medicaid Fraud Control Unit (MFCU) and/or Department of Health & Human Services (HHS), upon request, such information regarding any payments claimed for providing these services. Provider agrees to obtain a written waiver of the physician-patient privilege and release of medical records from each patient for the purposes of allowing access to the pertinent patient records and facilities by Medical Services, MFCU and/or HHS. Access includes, but is not limited to, the examination, inspection, photocopying and/or auditing of any requested records. Provider understands that failure to submit or failure to retain adequate documentation for all services billed to the medical assistance program may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of Provider from participation in the medical assistance program, and may result in civil or criminal liability.
6. Provider acknowledges that by submitting a claim to the medical assistance program, Provider certifies that the services were medically necessary, were rendered prior to the submission of the claim to the medical assistance program and that the services were rendered by Provider or incident to Provider's professional service by an employee, and in the case of an individual practitioner, under Provider's immediate personal supervision as permitted by the medical assistance program.
7. Provider agrees to allow Medical Services and/or MFCU and/or HHS access to any and all materials which may be deemed confidential by any regulatory or licensing agency, board or commission.
8. Provider agrees to submit claims in accordance with billing instructions and as required under any and all state regulations.
9. Provider agrees to submit claims that are true, accurate, and complete. Provider acknowledges by Provider's signature on this agreement that Provider understands that payment and satisfaction of each claim will be from Federal and State funds and that any false claims, statements or documents, or concealment of material fact, may be prosecuted under applicable Federal and State law.
10. Provider agrees to be individually responsible and accountable for the completion, accuracy, and validity of all claims submitted, including claims submitted for Provider by other parties. Provider further agrees to not make or cause to be made a claim, knowing the claim to be false, in whole or in part, by commission or omission or in any other respect contrary to the provisions of SDCL ch.22-45.
11. Provider agrees that claims for services and supplies rendered to medical assistance recipients shall not exceed the usual and customary charges by Provider to the general public for the same services and supplies. Provider further agrees to provide Medical Services and/or MFCU and/or HHS access to Provider's usual and customary billing practices.
12. Provider agrees to accept as payment in full the amounts paid in accordance with the reimbursement rates established by Medical Services, including any authorized cost sharing as allowed by Medical Services.
13. Provider acknowledges that Medical Services is the payer of last resort (subject to certain exceptions) and acknowledges its obligation to pursue payment from all other liable parties. Provider further agrees that in the event Provider receives payment from the medical assistance program in error or in excess of the amount properly due under the applicable rules and procedures, Provider will promptly notify Medical Services and arrange for the return of any excess money so received.

14. Provider agrees that failure to comply with any portion of this Provider Agreement will be good cause for termination of this agreement.
15. Provider agrees that any improper submission of claims, or actions deemed an abuse of the medical assistance program, or actions involving medical assistance program abuse which result in administrative, civil or criminal liability, will be good cause for termination of this agreement.
16. This agreement will be automatically terminated if Provider is convicted (including any form of suspended sentence) of any crime determined to be detrimental to the best interests of the Medical Assistance Program, if Provider has been suspended or terminated from participation in Medicare, or if Provider's license is surrendered, lapsed, suspended, or revoked.
17. Provider agrees to accept payment from the medical assistance program via electronic funds transfer.

**B. MEDICAL SERVICES AGREES TO THE FOLLOWING**

1. Provide eligible recipients with a medical assistance identification card indicating the current period of eligibility.
2. Reimburse Provider for medically necessary covered medical assistance services rendered to medical assistance recipients in accordance with the provisions of State law implementing Title XIX of the Social Security Act, as amended, and State rules and standards, as amended.
3. Notify the above named Provider of any changes in the provider manual as they occur.

**C. GENERAL PROVISIONS**

1. Provider agreement is binding upon enrollment effective date.
2. Provider agreement will be automatically renewed for one year on July 1 if neither party gives notice requesting termination, except that the duration of this agreement may be limited pursuant to Section 13 or by action of Medical Services in excluding a provider for fraud or abuse pursuant to 42 CFR Part 1002. This agreement may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party.

**D. CERTIFICATION REGARDING SUSPENSION, DEBARMENT, OR EXCLUSION**

Provider certifies that Provider, Provider's principals, and/or any person or entity with any "ownership interest," is not currently, and has never been, suspended, debarred, proposed for debarment, declared ineligible, or voluntarily or otherwise excluded from participation in this transaction by any Federal department or agency. Further, the Provider agrees to notify the South Dakota Medical Assistance Program by certified mail within ten (10) days should the Provider or any of its employees, agents, contractors, or any person or entity with any "ownership interest" become debarred, suspended, proposed for debarment, declared ineligible, or voluntarily or otherwise excluded during the term of this Agreement. Provider further certifies by signing this Agreement that Provider, Provider's principals, and/or any person or entity with any "ownership interest," has never been convicted (including any form of suspended sentence or settlement in lieu of conviction for fraud or abuse) of any crime determined to be detrimental to the best interests of the Medical Assistance Program.

**ELECTRONIC MEDIA PROVIDER PROVISIONS  
HOSPITAL, NURSING HOME/LTC, CMS 1500, PHARMACY AND DIRECT DATA ENTRY**

The purpose of this section of the agreement is to enable the Provider to submit claims to the South Dakota Medical Assistance Program Agency with the use of electronic media.

**A. RESPONSIBILITY OF THE PROVIDER/BILLING AGENT**

1. Claims submitted by electronic media must comply with the format specifications defined by the South Dakota Medical Assistance Program. Failure to comply with the format specifications will result in the electronic claim being rejected.
2. The provider will notify the South Dakota Medical Assistance Program if the provider changes software providers or billing agents.

**B. RESPONSIBILITIES OF THE SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM**

If the above mentioned requirements are met the South Dakota Medical Assistance Program shall be responsible for the following:

1. The South Dakota Medical Assistance Program will process and reimburse the Provider in a timely manner for all covered services submitted via electronic media.
2. The South Dakota Medical Assistance Program will notify the Provider/Billing Agent of any changes that may occur in the format specifications.

If Provider is a legal entity other than a person, the person signing the provider agreement on behalf of the Provider warrants that he/she has legal authority to bind Provider.

**TO BE COMPLETED BY PROVIDER**

I declare and affirm under the penalties of perjury that this Agreement has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further declare and affirm under the penalties of perjury that any claim to be submitted pursuant to this Agreement will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct.

PROVIDER NAME: \_\_\_\_\_

APPLICATION ID: \_\_\_\_\_

BY: \_\_\_\_\_

Authorized Signature

BILLING NPI: \_\_\_\_\_

BILLING NPI: \_\_\_\_\_

NAME/TITLE: \_\_\_\_\_

BILLING NPI: \_\_\_\_\_

DATE: \_\_\_\_\_

SERVICING NPI: \_\_\_\_\_

**TO BE COMPLETED BY MEDICAL SERVICES**

APPROVED BY: \_\_\_\_\_

PROVIDER NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_

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MAIL APPLICATION COVER SHEET, SIGNED AGREEMENT, AND OTHER APPLICABLE DOCUMENTATION TO:

**DEPARTMENT OF SOCIAL SERVICES**  
DIVISION OF MEDICAL SERVICES  
700 GOVERNORS DRIVE  
PIERRE, SD 57501-2291

QUESTIONS:  
1-800- 452-7691 (In State Providers)  
(605) 773-3495 (Out of State Providers)