STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE & ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

ICF/Level I Nursing Home Providers

In response to your interest in participating in the Tennessee TennCare/Medicaid Program, we are providing the necessary documents for enrollment.

Tennessee TennCare/Medicaid Providers must have completed application forms on file before claims can be processed for payment. Please complete all documents and return to:

Department of Finance and Administration
Bureau of TennCare
Provider Enrollment Unit
310 Great Circle Road
Nashville, TN 37243 – 1700

All incomplete applications and requested documents not included will be returned to the pay-to address on your application.

All documents must have original signatures.

Completed Applications will be assigned a Tennessee Medicaid Provider Number. You will be notified in writing of your assigned Provider Number. Please file all future claims only after you receive the notification as your provider number must be stated on all claim forms. Providers who have rendered a service to a TennCare only recipient will be required to enroll with the TennCare Managed Care Organization the recipient has chosen to manage his/her healthcare. The state Medicaid ID number assigned by this office should be presented to the MCO upon enrolling. You will be assigned a billing number by the MCO for reimbursement.

Should you have any questions regarding your number assignment, please contact: 1-800-342-3145, or (615) 741-6669.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 GREAT CIRCLE ROAD
NASHVILLE, TENNESSEE 37243 – 1700

CHECKLIST

This check list will assist you in completing and returning the correct forms along with this document. Enrollment Packets must include the following:

ICF/Level I Nursing Home Providers

Medicare Provider Number _ _ _ _ _ _

NPI Number _ _ _ _ _ _ _ _ _ _

NPI Collection Form _____

CMS Medicare Approval Letter
New _____
Change Of Ownership _____

Disclosure of Ownership _____

(2) HIPAA Agreements _____

(1) No. 3 Group Practice Application
New _____
Change Of Ownership _____

Substitute W-9 Form _____

(2) Contracts Signed by Provider: _____

For Office Use Only

Contracts**:** Signed by Assistant Commissioner _____
(date)

Executed Contracts Returned to Provider _____
(date)

File Completed Yes _____ No _____ _____
(date)

_____
(INITIAL)

Instructions and General Information
Pertaining to Criminal Attestation and
Disclosure of Ownership and Control Interest Statement

Federal Regulations in 42 USCA 1396a(p) and 42 C.F.R. §438 require that the State plan monitor the payments of Medicaid funds to providers. The Tennessee State plan has chosen to implement this provision by use of this form which is designed to collect the information required in 42 C.F.R. §455. CMS has approved the use of this method of monitoring provider receipt of Medicaid monies. A full and accurate disclosure of ownership and financial interest is required. Direct or indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Failure to submit requested information may result in a refusal by the State agency to enter into contract with any such institution or in termination of existing contracts. This form must be submitted at the time a provider is re-accredited by the managed care organization (MCO), or whenever there is a material change in the information required by this form

GENERAL INSTRUCTIONS

If you are part of a provider group or corporation with 50 or more practitioners, who are employees of the provider, do not use this form. There is a special form you can obtain from TennCare which is designed to reduce the administrative burden of providing this information for very large practices with many practitioner employees. If you have 50 or more practitioners who are not employees of a common provider (for example doctors are self employed but share overhead and administrative staff), then each practitioner must complete the form. Please contact MCO Provider Relations for a copy of the special form.

There are two ways in which this form is being used. Firstly, individual providers need to fill out the appropriate parts of this form about themselves. Secondly, an authorized individual needs to fill out the form for groups of practitioners or disclosing entities. This authorized individual is providing information, not for the individual providers, but for the business entity i.e. the corporation or partnership, under which the providers are organized. The purpose of this form is to capture information about non-provider employees, i.e. business managers, as well as officers, members of the Board of Directors, and owners of the business entity.

THEREFORE before you fill out the form make sure you know if you are filling it out for yourself as a provider or on behalf of the business entity. Direct any questions to the MCC with which you are or will be contracted.

Please see the detailed instructions *for your particular type* of practice. For example, individuals would follow the instructions listed as "Instructions for Individuals".

If you are a **governmental entity** fill out Items I and IV. See instructions and definition for disclosing entity.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. (For example: Item II. (a) continued.)

Completely answer the questions that are applicable to your organization/business. Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

Return the original to the MCO. Please retain a copy for your files.

DETAILED INSTRUCTIONS FOR INDIVIDUALS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. **Definitions are underlined and bolded**.

Provider means an institution, facility, physician, or other health care practitioner that is licensed or otherwise authorized to provide and receive payment for any covered service furnished to TennCare enrollees. There are three categories of providers: 1) individual practitioners; 2) group of practitioners; and 3) disclosing entity.

ITEM I **(a)** Check the entity type for "Individual"

(b) Identifying Information: Specify name of your organization/business. Do not include a name of a contact person.

(c) Enter DBA name. This may be the same as (b) above.

(d) Enter address.

(e) Federal Tax Identification Number: Enter provider's nine-digit federal tax identification number.

(f) If your organization is chain affiliated you must complete Item II(a).

DO NOT FILL OUT ITEM II.

ITEM III **(a)** A provider must submit, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) Any significant business transactions between the provider and any subcontractor, or wholly owned supplier, during the 5-year period ending on the date of the request. 42 C.F.R. §455.105.

Subcontractor means any organization or person who provides any function or service for an individual, group of practitioners, or disclosing entity specifically related to securing or fulfilling the individual's, group of practitioner's, or disclosing entity's obligations, to TennCare. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement. 42 C.F.R. §455.101.

ITEM IV **(a)** Answer Yes or No in the boxes provided

(b) If your practice is incorporated in some fashion provide the relevant information.

(c) Answer if your practice is incorporated

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. 42 C.F.R. §455.101.

Managing employee means an individual who exercises operational or managerial control over, or who conducts the day-to-day operation of an institution, organization, or agency. For example, general manager, administrator, or director may be considered a managing employee. The individual provider may be considered a managing employee if he/she performs these tasks. 42 C.F.R. §455.101.

DO NOT FILL OUT ITEM V .

DO NOT FILL OUT ITEM VI

SIGN & DATE FORM

Signature The signature on this form must be the written signature of the individual provider. Signature stamps are not acceptable.

DETAILED INSTRUCTIONS FOR A GROUP OF PRACTITIONERS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. **Definitions are underlined and bolded.**

The group of practitioners should submit one form for the group practice.

Authorized representative means an individual with designated authority to act on behalf of the group of practitioners. The authorized representative must be a partner, president, or secretary of the group of practitioners.

Provider means an institution, facility, physician, or other health care practitioner that is licensed or otherwise authorized to provide and receive payment for any covered service furnished to TennCare enrollees. There are three categories of providers: 1) individual practitioners; 2) group of practitioners; and 3) disclosing entity.

Group of Practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment). 42 C.F.R. §455.101.

Common location means an interconnected area or location that may consist of more than one building or office that is used for an assortment of purposes.

ITEM I **(a)** Check Group of Practitioners

(b) Identifying Information: Specify name of your organization/business. Do not include a name of a contact person.

(c) Enter DBA name. May be the same as (b) above.

(d) Enter address.

(e) Federal Tax Identification Number: Enter provider's nine-digit federal tax identification number.

(f) If your organization is chain affiliated you must complete Item II (a).

DO NOT FILL OUT ITEM II.

ITEM III **(a)** The group practice must submit, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) Any significant business transactions between the group practice and any subcontractor or wholly owned supplier, during the 5-year period ending on the date of the request. 42 C.F.R. §455.105.

The information in this section only applies to business transactions that the group of practitioners has entered into as a group practice.

Subcontractor means any organization or person who provides any function or service for an individual, group of practitioners, or disclosing entity specifically related to securing or fulfilling the individual's, group of practitioner's, or disclosing entity's obligations to TennCare. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement. 42 C.F.R. §455.101.

ITEM IV Answer IV (B)

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. 42 C.F.R. §455.101.

Managing employee means an individual who exercises operational or managerial control over, or who conducts the day-to-day operation of an institution, organization, or agency. For example, general manager, administrator, or director may be considered a managing employee. A provider may be considered a managing employee if he/she carries out these administrative or managerial type functions. 42 C.F.R. §455.101.

DO NOT ANSWER ITEM V .

ITEM VI List the name, title, personal address, social security number, and percentage of interest for each member of the Board of Directors or the Board of Governors of the provider.

SIGN & DATE FORM

Signature The signature on this form must be the written signature of an authorized representative and not a signature stamp.

DETAILED INSTRUCTIONS FOR DISCLOSING ENTITY

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. **Definitions are underlined and bolded**

Disclosing entity means a Medicaid provider or a fiscal agent other than an individual practitioner or group of practitioners. 42 C.F.R. §455.101. This includes both quasi-governmental and state and local governmental entities. State and Local governmental entities need only fill out Part I and Part IV of the form. Quasi Governmental entities need to fill out all parts of the form.

ITEM I **(a)** Check Disclosing Entity.

(b) Identifying Information: Specify name of your organization/business. Do not include a name of a contact person.

(c) Enter DBA name. May be same as (b) above

(d) Enter address.

(e) Federal Tax Identification Number: Enter provider's nine-digit federal tax identification number.

(f) If your organization is chain affiliated you must complete Item II(a).

A **chain affiliate** means a freestanding health care facility that is owned or operated under lease or contract by an organization of two or more freestanding health care facilities that is under the ownership or control of a common party. Chain affiliates facilities may be public, private, charitable, or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered to be chain affiliates. **List the name, address, and FEIN of the Corporation.**

ITEM II (a) **Who owns you?** List the name, title, personal address, and social security number of each office and/or individual, or the TIN for an organization, having any ownership or controlling interest, that amounts to an ownership interest of 5 percent or more in the disclosing entity (your company) submitting this Provider Contract. 42 C.F.R. §455.100; 42 C.F.R. §455.104.

Indirect ownership means an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. 42 C.F.R. §455.101.

Direct ownership interest means the possession of stock, equity in capital or any interest in the profits of the disclosing entity. 42 C.F.R. §455.101.

The amount of indirect ownership in the disclosing entity that is held by another entity is determined by multiplying the percentage of ownership interest at each level. For example, if Dr. Abby owns 10 percent of the stock in Blue Health Corporation that owns 80 percent of the stock of Medical Plus, a disclosing entity, Dr. Abby's interest equates to an 8 percent indirect ownership and must be reported. Conversely, if Dr. Bob owns 80 percent of the stock of Red Health Corporation that owns 5 percent of the stock of Medi-Pulse, a disclosing entity, Dr. Bob's interest equates to a 4 percent indirect ownership interest in Medi-Pulse and need not be reported. 42 C.F. R. §455.102.

Controlling interest means the management of a disclosing entity that has the ability or authority: to change the corporate identity; to nominate or name members of the Board of Directors or Trustees; to change the by-laws or constitution; to control the sale of any or all of the assets; to mortgage assets; to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control. 42 C.F.R. §455.101.

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if Dr. Smith owns 10 percent of a mortgage secured by 60 percent of Dr. Murray's assets, Dr. Smith's interest in Dr. Murray's assets equates to 6 percent and must be reported. Conversely, if Dr. Brad owns 40 percent of a mortgage secured by 10 percent of Dr. Jolie's assets, Dr. Brad's interest in Dr. Jolie's assets equates to 4 percent and need not be reported. 42 C.F.R. §455.102.

ITEM II (b) List those persons named in Item II (a) that are related to each other (spouse, parent, child, or sibling). 42 C.F.R. §455.104.

ITEM II (c) Who do you own? List the name, title, address, and social security number of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more. 42 C.F.R. §455.104.

Subcontractor means any organization or person who provides any function or service for an individual, group of practitioners, or disclosing entity specifically related to securing or fulfilling the individual's, group of practitioner's, or disclosing entity's obligations to TennCare. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement. 42 C.F.R. §455.101.

ITEM II (d) Who do you own? List the name, personal address, and TIN of any other disclosing entity, in which a person with an ownership or controlling interest in the disclosing entity (your company) also has an ownership or control interest of at least 5 percent or more. 42 C.F.R. §455.104.

Other disclosing entity means another entity that is required to disclose ownership and control information because of participation in any Title V, XVIII, or XX of the Act. For example, hospitals, skilled nursing facilities, home health agencies that participate in Medicare (Title XVIII) and any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for the health related services for which it claims payment under Title V or Title XX of the Act. 42 C.F.R. §420.201.

ITEM III (a) The disclosing entity must submit, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) Any significant business transactions between the disclosing entity and any subcontractor, during the 5-year period ending on the date of the request. 42 C.F.R. §455.105.

ITEM IV Answer (C)

ITEM V **(a)** If there has been a change in ownership within the last year, or a change is anticipated, indicate the date in the appropriate space.

(b) If this facility is operated by a management company or leased in whole or part by another organization, list the name or the management firm and federal tax identification number or the leasing organization.

Management company means any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

(c) If you have increased your bed capacity by 10% or more or by 10 beds, whichever is greater within the last year, list the actual number of beds in the facility now and the previous number. If this doesn't apply to your type of entity check N/A.

(d) Identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include the name of the NEW Administrator, Director of Nursing, or Medical Director.

(e) List the date of any bankruptcy, if applicable.

(f) If your entity is or was a chain affiliate complete this section.

ITEM VI List the name, title, personal address, social security number, and percentage of interest for each member of the Board of Directors or the Board of Governors of the provider.

SIGN & DATE FORM

Signature The signature on this form must be the written signature of an authorized representative and not a signature stamp.

Authorized representative means an individual with designated authority to act on behalf of the individual provider.

DISCLOSURE OF OWNERSHIP
AND
CONTROL INTEREST STATEMENT

This form must be completed by an Authorized Representative, who is defined as an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity. The signature on this form must be the written signature of the authorized representative and not a signature stamp.

Item I. Identifying Information

(a) Do you practice as: ☐ individual ☐ group of practitioners at a common location ☐ a disclosing entity *Quasi-government and governmental entities see instructions.

(b) Name of Individual, Facility or Organization:

(c) DBA Name:

(d) Address:

(e) Federal Tax Identification Number (TIN) OR Social Security Number:

(f) Is this entity chain affiliated? ☐ No ☐ Yes If yes, complete Item II.

Item II. Ownership and Control Information. 42 C.F.R. §455.100; 42 C.F.R. §455.104.

(a) List the name, title, address, and SSN for each **office and/or individual** who has any ownership or controlling interest in this provider entity. The office/individual's ownership or controlling interest is an ownership interest of 5% or more of this provider entity. List the name, Tax ID (TIN), and address of any **organization, corporation, or entity** having any ownership or controlling interest in this provider entity. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity. Attach additional pages as necessary to list all officers, owners, management, and ownership entities.

Name	Title	Address	SSN/TIN	Percentage

(b) List those persons named in Item II (a) that are related to each other (spouse, parent, child, or sibling). 42 C.F.R. §455.104.

Name	Relationship	SSN

(c) List the name, title, address, and social security number of each person with an ownership or control interest in any subcontractor that this disclosing entity has direct or indirect ownership of 5% or more. 42 C.F.R. §455.104.

Name	Title	Address	SSN	Percentage

(d) List the name, address, and TIN of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more. 42 C.F.R. §455.104.

Name	Title	Address	SSN	Percentage

Item III. Business Transaction Information. 42 C.F.R. §455.105.

(a) List the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous 12-month period. 42 C.F.R. §455.105.

(b) List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. 42 C.F.R. §455.105.

Item IV. Criminal Offenses. 42 C.F.R. §455.100; 42 C.F.R. §455.106.

(A) If you are filling out this form as an individual provider, giving information about yourself, please answer the following questions:

1) (a) Have you personally been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? ☐ No ☐ Yes

(b) Has someone connected with your practice (i.e. an office manager) been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? ☐ No ☐ Yes

If you answered yes above please provide the following information for the individual with the criminal conviction.

Name	Address	Title	SSN(or TIN if an organization)

2) If you answered **Item I(a)** at the beginning of this form as an individual **AND** your practice is incorporated please list the names and addresses of the corporations Officers and Board of Directors in the spaces below.

Name	Address	Title	SSN(or TIN if an organization)

B) If you are filling this form out as an **authorized representative** of a **Group of Practitioners,** providing information about the **business entity,** please answer the following question:

1) Have you or any Director, Officer, Agent or managing employee of this Group of Providers been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs?
☐ No ☐ Yes

2) If yes please list the information requested below for each person convicted of a criminal offense

Name	Address	Title	SSN (or TIN if an organization)

C)) If you are filling this form out as an **authorized representative** of a **Disclosing Entity,** providing information about the **business entity,** please answer the following question:

Have you or any other individual or organization who has ownership or a control interest in this provider been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? ☐ No ☐ Yes) If yes please list the information requested below for each person convicted of a criminal offense

Name	Address	Title	SSN (or TIN if an organization)

Item V. Status Changes - For Disclosing Entities Only

(a) Has there been a change in ownership or control within the last year or is a change of ownership or control anticipated within the year?

☐ No ☐ Yes

(b) Is this facility operated by a management company or leased in whole or party by another organization?

☐ No ☐ Yes

If "Yes", list date of change in operations:

(c) Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last year?

☐ No ☐ Yes ☐ N/A

If "Yes", when?

Previous No. of Beds_____ Current No. of Beds_____ Date of change:_____

(d) Has there been a change in administrator, Director of Nursing, or Medical Director within the last year?

If "Yes", please check box below and list date.

☐ Administrator ☐ Director of Nursing ☐ Medical Director Date:_____

Name of new Administrator, Director of Nursing, or Medical Director:

(e) Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?

☐ No ☐ Yes

If "Yes", when?

(f) 1. Is this facility chain affiliated? If yes list name, address of parent corporation and EIN # ☐ No ☐ Yes

Name EIN#

Address

2. If you answered 1. above "no" was this facility ever affiliated with a chain? If yes list names address of parent corporation and EIN # ☐ No ☐ Yes

Name EIN#

Item VI. Board of Directors or Board of Governors

List the name, title, address, social security number, and percentage of interest for each of the Board of Directors or Board of Governors of this provider.

Name	Title	Address	SSN	Percentage

The State agency or secretary may refuse to enter into, renew, or terminate an agreement with this provider if it is determined that this provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. §455.106.

Authorized representative means an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity.

Name of Authorized Representative (Typed)	**Title**

Written Signature	**Date**

HIPAA BUSINESS ASSOCIATE AGREEMENT

IN COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is between **The State of Tennessee, Department of Finance and Administration, Bureau of TennCare (TennCare),** 310 Great Circle Road, Nashville, TN 37243 ("Covered Entity") and _____**(**"Business Associate"), located at _____, including all office locations and other business locations at which Provider Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

If Business Associate provides services to Covered Entity pursuant to one or more contractual relationships, said Agreements are detailed below and hereinafter referred to as "Service Agreements."

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT

All State of Tennessee, Department of Finance & Administration, (Bureau of TennCare), Provider Agreements between the above parties

In the course of executing Service requests, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI") (defined in Section 1 below). Said Service Agreements are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, and E, which require Covered Entity to have a written memorandum with each of its internal Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI and, therefore, execute this Agreement.

1. DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.304, 164.504 and 164.501.

1.2 "Breach of the Security of the [Business Associate's Information] System" shall mean the unauthorized acquisition, including, but not limited to, access to, use, disclosure, modification or destruction, of unencrypted computerized data that materially compromises the security, confidentiality, or integrity of personal information maintained by or on behalf of the Covered Entity under the terms of Tenn. Code Ann. § 47-18-2107 and this Agreement.

1.3 "Commercial Use" means obtaining protected health information with the intent to sell, transfer or use it for commercial, or personal gain, or malicious harm; sale to third party for consumption, resale, or processing for resale; application or conversion of data to make a profit or obtain a benefit contrary to the spirit of this Agreement, including but not limited to presentation of data or examples of data in a conference or meeting setting where the ultimate goal is to obtain or gain new business.

1.4 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Electronic Protected Health Information" (ePHI) shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 "Encryption" means the process using publicly known algorithms to convert plain text and other data into a form intended to protect the data from being able to be converted back to the original plain text by known technological means.

1.7 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 "Marketing" means the act or process of promoting, selling, leasing or licensing any information or data for profit without the express written permission of Covered Entity.

1.10 "Privacy Officer" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1). The Privacy officer is the official designated by a Covered Entity or Business Associate to be responsible for compliance with HIPAA regulations.

1.11 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.12 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or

received by Business Associate from or on behalf of Covered Entity. PHI includes information in any format, including but not limited to electronic or paper.

1.13 "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

1.14 "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 "Security Event" shall mean an immediately reportable subset of security incidents which incident would include:

a) a suspected penetration of Business Associate's information system of which the Business Associate becomes aware but for which it is not able to verify within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS (of the time the Business Associate became aware of the suspected incident) that enrollee PHI or other confidential TennCare data was not accessed, stolen, used, disclosed, modified, or destroyed;

b) any indication, evidence, or other security documentation that the Business Associate's network resources, including, but not limited to, software, network routers, firewalls, database and application servers, intrusion detection systems or other security appliances, may have been damaged, modified, taken over by proxy, or otherwise compromised, for which Business Associate cannot refute the indication within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of the time the Business Associate became aware of such indication;

c) a breach of the security of the Business Associate's information system(s)(see definition 1.2 above), by unauthorized acquisition, including, but not limited to, access to or use, disclosure, modification or destruction, of unencrypted computerized data and which incident materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI; and/or

d) the unauthorized acquisition, including but not limited to access to or use, disclosure, modification or destruction, of unencrypted TennCare enrollee PHI or other confidential information of the Covered Entity by an employee or authorized user of Business Associate's system(s) which materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI or other confidential information of the Covered Entity.

If data acquired (including but not limited to access to or use, disclosure, modification or destruction of such data) is in encrypted format but the decryption key which would allow the decoding of the data is also taken, the parties shall treat the acquisition as a breach for purposes of determining appropriate response.

1.16 “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information” at 45 CFR Parts 160 and 164, Subparts A and C.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Compliance with the Privacy Rule. Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Agreements, or as Required By Law. In case of any conflict between this Agreement and the Service Agreements, this Agreement shall govern.

2.2 Privacy Safeguards and Policies. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as Required By Law. This includes the implementation of administrative, physical, and technical safeguards to reasonably and appropriately protect the Covered Entity’s PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its workforce.

2.3 Business Associate Contracts. Business Associate shall require any agent, including a subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity, or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential TennCare information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.4 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.5 Reporting of Violations in Use and Disclosure of PHI. Business Associate agrees to require its employees, agents, and subcontractors to promptly report to Business Associate any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

2.6 Access of Individual to PHI and other Requests to Business Associate. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 CFR § 164.524. If Business Associate receives a request from an Individual for a copy of the individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested

copies to the individual in a timely manner. If Business Associate receives a request for PHI not in its possession and in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity. Business Associate shall then assist Covered Entity as necessary in responding to the request in a timely manner. If a Business Associate provides copies of PHI to the individual, it may charge a reasonable fee for the copies as the regulations shall permit.

2.7 Requests to Covered Entity for Access to PHI. The Covered Entity shall forward to the Business Associate in a timely manner any Individual's request for access to or a copy of their PHI that shall require Business Associate's participation, after which the Business Associate shall provide access to or deliver such information as follows:

a) The Parties understand that if either Party receives a request for access to or copies of PHI from an Individual which the Party may complete with only its own onsite information, the time for such response shall be thirty (30) days, with notification to the Covered Entity upon completion.

b) If Covered Entity does not have the requested PHI onsite and directs Business Associate to provide access to or a copy of his/her PHI directly to the Individual, the Business associate shall have sixty (60) days from the date of the Individual's request to provide access to PHI or deliver a copy of such information to the Individual. The Business Associate shall notify the Covered Entity when it completes the response.

c) If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall have thirty (30) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day requirement of 45 CFR § 164.524.

d) If the Party designated above responding to the Individual's request is unable to complete the response to the request in the time provided, that Party shall provide the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Party may extend the response time once for no more than thirty (30) additional days.

2.8 Individuals' Request to Amend PHI. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, regarding an Individual's request to amend PHI. The Business Associate shall make the amendment promptly in the time and manner designated by Covered Entity, but shall have thirty (30) days notice from Covered Entity to complete the amendment to the Individual's PHI and to notify the Covered Entity upon completion.

2.9 Recording of Designated Disclosures of PHI. Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be

required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

2.10 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. The Covered Entity shall forward the Individual's request requiring the participation of the Business Associate to the Business Associate in a timely manner, after which the Business Associate shall provide such information as follows:

a) If Covered Entity directs Business Associate to provide accounting of disclosures of the Individual's PHI directly to the Individual, the Business Associate shall have sixty (60) days from the date of the Individual's request to provide access to or deliver such information to the Individual. The Covered Entity shall provide notice to the Business Associate in time to allow the Business Associate a minimum of thirty (30) days to timely complete the Individual's request.

b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate shall have thirty (30) days from date of Covered Entity's notice of request to provide information for the Accounting to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day period.

c) If either of the Parties is unable to complete the response to the request in the times provided above, that Party shall notify the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Parties may extend the response time once for no more than thirty (30) additional days.

d) The accounting of disclosures shall include at least the following information: (1) date of the disclosure; (2) name of the third party to whom the PHI was disclosed, (3) if known, the address of the third party; (4) brief description of the disclosed information; and (5) brief explanation of the purpose and basis for such disclosure.

e) The Parties shall provide one (1) accounting in any twelve (12) months to the Individual without charge. The Parties may charge a reasonable, cost-based fee, for each subsequent request for an accounting by the same Individual if he/she is provided notice and the opportunity to modify his/her request. Such charges shall not exceed any applicable State statutes or rules.

2.11 Minimum Necessary. Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.11.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.11.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.11.3 Business Associate agrees to adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.12 Privacy Compliance Review upon Request. Business Associate agrees to make its internal practices, books and records, including policies, procedures, and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.13 Cooperation in Privacy Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Compliance with Security Rule. Business Associate agrees to fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Security Safeguards and Policies. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

3.3 Security Provisions in Business Associate Contracts. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI

received from, maintained, or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, shall execute a bilateral contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, incorporating the same restrictions and conditions in this Agreement with Business Associate regarding PHI.

3.4 Tennessee Consumer Notice of System Breach. Business Associate understands that the Covered Entity is an "information holder" (as may be Business Associate) under the terms of Tenn. Code Ann. § 47-18-2107, and that in the event of a breach of the Business Associate's security system as defined by that statute and Definition 1.2 of this agreement, the Business Associate shall indemnify and hold the Covered Entity harmless for expenses and/or damages related to the breach. Such obligation shall include, but is not limited to, the mailed notification to any Tennessee resident whose personal information is reasonably believed to have been acquired by an unauthorized individual. In the event that the Business Associate discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, the person shall also notify, without unreasonable delay, all consumer reporting agencies and credit bureaus that compile and maintain files on consumers on a nationwide basis, as defined by 15 U.S.C. § 1681a, of the timing, distribution and content of the notices. Substitute notice, as defined by Tenn. Code Ann. § 47-18-2107(e)(2) and (3), shall not be permitted except as approved in writing in advance by the Covered Entity. The parties agree that PHI includes data elements in addition to those included by "personal information" under Tenn. Code Ann. § 47-18-2107, and agree that Business Associate's responsibilities under this paragraph shall include all PHI.

3.5 Reporting of Security Incidents. The Business Associate shall track all security incidents as defined by HIPAA and shall periodically report such security incidents in summary fashion as may be requested by the Covered Entity, but not less than annually within sixty (60) days of the anniversary of this Agreement. The Covered Entity shall not consider as security incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the "footprinting" of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate's operations. However, the Business Associate shall expediently notify the Covered Entity's Privacy Officer of any Security Incident which would constitute a Security Event as defined by this Agreement, including any "breach of the security of the system" under Tenn Code Ann. § 47-18-2107, within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware. The Business Associate shall likewise notify the Covered Entity within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

3.5.1 Business Associate shall identify in writing key contact persons for administration, data processing, Marketing, Information Systems and Audit Reporting

within thirty (30) days of execution of this Agreement. Business Associate shall notify Covered Entity of any reduction of in-house staff persons during the term of this Agreement in writing within ten (10) business days.

3.6 Contact for Security Event Notice. Notification for the purposes of Sections 2.5, 3.4 and 3.5 shall be in writing made by certified mail or overnight parcel within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

Privacy Officer
Bureau of TennCare
310 Great Circle Rd.
Nashville Tennessee
Phone: (615) 507-6830
Facsimile: (615) 532-7322

3.7 Security Compliance Review upon Request. Business Associate agrees to make its internal practices, books, and records, including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.8 Cooperation in Security Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Security Rule.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Use of PHI for Operations on Behalf of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services (i.e., treatment, payment or health care operations) for, or on behalf of, Covered Entity as specified in Service Agreements, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Other Uses of PHI. Except as otherwise limited in this Agreement, Business Associate may use PHI within its workforce as required for Business Associate's proper management and administration, not to include Marketing or Commercial Use, or to carry out the legal responsibilities of the Business Associate.

4.3 Third Party Disclosure Confidentiality. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or, if permitted by law, this Agreement, and the Service Agreement, provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business

Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

4.4 Data Aggregation Services. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation Services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(I)(B).

4.5 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS [BUSINESS ASSOCIATE] AGREEMENT & HIPAA REQUIREMENTS" on page one of this Agreement.

4.6 Covered Entity Authorization for Additional Uses. Any use of PHI or other confidential TennCare information by Business Associate, its affiliate or Contractor, other than those purposes of this Agreement, shall require express written authorization by the Covered Entity, and a Business Associate agreement or amendment as necessary. Activities which are prohibited include, but not are not limited to, Marketing, as defined by 45 CFR § 164.503 or the sharing for Commercial Use or any purpose construed by Covered Entity as Marketing or Commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws.

4.7 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Business Associate to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the Covered Entity.

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and disclose a Limited Data Set that Business Associate creates for Research, public health activity, or Health Care Operations, provided that Business Associate complies with the obligations below. Business Associate may not make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of this Agreement.

4.9 Limitation on Permitted Uses and Disclosures. Business Associate will limit the uses and disclosures it makes of the Limited Data Set to the following: Research, public health activity, or Health Care Operations, to the extent such activities are related to covered functions**,** including business planning and development such as conducting cost-management and planning-related analysis related to managing and operating Business Associates functions, formulary development and administration, development and improvement of methods of payment or coverage policies, customer service, including the provision of data analysis for policy holders, plan sponsors, or other customers, to the

extent such activities are related to covered functions, provided that PHI is not disclosed and disclosure is not prohibited pursuant to any other provisions in this Agreement related to Marketing or Commercial use.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of Privacy Practices produced by Covered Entity in accordance with 45 CFR § 164.520, as well as any changes to such notice.

5.2 Notice of Changes in Individual's Access or PHI. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Notice of Restriction in Individual's Access or PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

5.4 Reciprocity for Requests Received by Business Associate. The Parties agree that this Section (Section 5) is reciprocal to the extent Business Associate is notified or receives an inquiry from any individual within Covered Entity's covered population.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Requests Permissible under HIPAA. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and shall terminate when all PHI which has been provided, regardless of form, by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if the Parties agree that it is unfeasible to return or destroy PHI, subsection 7.3.5 below shall apply.

7.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Agreement in the event Business Associate fails to comply with, or violates a material provision of this Agreement and any provision of the Privacy and Security Rules.

7.2.1 Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

a) Provide notice of breach and an opportunity for Business Associate to reasonably and promptly cure the breach or end the violation, and terminate this BAA if Business Associate does not cure the breach or end the violation within the reasonable time specified by Covered Entity; or

b) Immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible; or

c) If termination, cure, or end of violation is not feasible, Covered Entity shall report the violation to the Secretary.

7.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 7.3.2 and 7.3.5 below, Business Associate shall at its own expense either return and/or destroy all PHI and other confidential information received, from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Business Associate.

7.3.1 The Business Associate shall consult with the Covered Entity as necessary to assure an appropriate means of return and/or destruction and shall notify the Covered Entity in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the Covered Entity.

7.3.2 This provision (Section 7.3 and its subsections) shall not prohibit the retention of a single separate, archived file of the PHI and other confidential TennCare information by the Business Associate if the method of such archiving reasonably protects the continued privacy and security of such information and the Business Associate obtains written approval at such time from the Covered Entity. Otherwise, neither the Business Associate nor its subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein in subsection 7.3.5.

7.3.3 The Parties agree to anticipate the return and/or the destruction of PHI and other TennCare confidential information, and understand that removal of the confidential information from Business Associate's information system(s) and premises will be expected in almost all circumstances. The Business Associate shall notify the Covered Entity whether it intends to return and/or destroy the confidential with such additional detail as requested. In the event Business Associate determines that returning or destroying the PHI and other confidential information received by or created for the Covered Entity at the end or other termination of the Service Agreement is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible.

7.3.4 Except for Business Associate Agreements in effect prior to April 21, 2005 when the Security Rule became effective, for the renewal or amendment of those same

Agreements, or for other unavoidable circumstances, the Parties contemplate that PHI and other confidential information of the Covered Entity shall not be merged or aggregated with data from sources unrelated to that Agreement, or Business Associate's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of the Covered Entity at the conclusion of the Service Agreement, or otherwise make an express alternate agreement consistent with the provisions of Section 7.3 and its subsections.

7.3.5 Upon written mutual agreement of the Parties that return or destruction of PHI is unfeasible and upon express agreement as to the means of continued protection of the data, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and/or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3 of this Agreement shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Headings. Paragraph Headings are used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

8.6 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, fax numbers

and to promptly supplement this Agreement as necessary with corrected information. **Notifications relative to Sections 2.5, 3.4 and 3.5 of this Agreement must be reported to the Privacy Officer pursuant to Section 3.6.**

COVERED ENTITY:	BUSINESS ASSOCIATE:
Darin Gordon	_____
Director	_____
Department of Finance and Adm.	_____
Bureau of TennCare	_____
310 Great Circle Road	_____
Nashville, TN 37243	_____
Phone: (877) 224-0219	_____
Fax: (615) 532-9140	Fax: _____

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.7 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

8.8 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement and the Service Agreement (s).

8.10 Compensation. There shall be no remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative

requirements of Tennessee State government and Services Agreement(s) referenced herein.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

STATE OF TENNESSEE, TITLE XIX AGENCY	**BUSINESS ASSOCIATE**
By: _____	By: _____
Date:_____	Date:_____
Assistant Commissioner	_____
State of Tennessee, Dept of Finance & Adm.	_____
310 Great Circle Road	_____
Nashville, Tennessee 37243	_____
Phone: (877) 224-0219	Phone: _____
Fax: (615) 532-9140	Fax: _____

Bureau of TennCare/Medicaid

Provider Enrollment

310 Great Circle Road

Nashville, TN 37243 – 1700

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 3 GROUP APPLICATION
www.state.tn.us/tenncare/Providers/enroll.html

(Check All That Apply)	_____ Change of Ownership
_____ New Enrollment	_____ Reactivation
_____ MCC Medicaid No.	_____ Adding Practice/Satellite Location
_____ Medicare/Medicaid No.	_____ Name Change and Tax ID # Change

Indicate Provider Type (Check One)		
_____ Clinic	_____ Group	_____ X-Ray Clinic
_____ Hospice	_____ Independent Lab	Nursing Homes:
Hospital:	_____ Ambulatory Surgical Ctr.	_____ ICF
_____ Acute	_____ DME Supplier	_____ SNF
_____ Critical Access	_____ Home Health Agency	_____ ICF/MR
_____ Rehabilitation	_____ Rural Health Clinic	_____ Other _____

Legal Business Name: _____

D/B/A: _____

Practice Location: _____
(No P.O. Box #)

City: _____ **State:** _____ **Zip Code + 4:** _____

Telephone: _____ **Fax:** _____ **County:** _____

If the name and address to which checks and remittance advices are to be sent is different from the name and address above, please provide that information below. This pay-to information should match the W-9 form.

Legal Business Name as reported to the IRS: _____

Street Address or P.O. Box: _____
(Pay-To Address)
City: _____ **State:** _____ **Zip Code + 4:** _____

Telephone No.: _____ **Fax No.:** _____

Federal Tax No. (IRS No.): _____ **DEA No.:** _____

Applying For: Part A _____ **Part B** _____

Medical Specialty: _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

_____

_____

Medical supplies and durable medical equipment only — briefly describe the types of items and equipment you propose to supply to Medicaid recipients:

_____

_____

Federal Medicare No.: _____ **State Medicaid No.:** _____

NPI Number: _____

Taxonomy: _____, _____, _____, _____

Submit copies of professional and/or business licenses, accreditations, certifications, and registrations specifically required to operate as a health care provider.

Date of Issuance: _____ **Expiration Date:** _____

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes ____ No ____. If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.

Please list the full name of every owner, with Social Security number and percent of ownership (required). If owned by corporation, please list corporate officers with same information. Use additional paper if necessary.

	Name	Title	SSN	% Ownership
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP: _____

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): _____

Previous Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code + 4:** _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Signature: _____ **Date:** _____

(Original Signature of Administrator, Agent, or Owner)

Printed Name: _____ **Title:** _____

SUBSTITUTE W-9 FORM

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

2. Circle the most appropriate category below: (please circle only one)

1) Individual (not an actual business)
2) Joint account (two or more individuals)
3) Custodian account of a minor
4) a. Revocable savings trust (grantor is also trustee)
   b. So-called trust account that is not a legal or valid trust under state law
5) Sole proprietorship (using a social security number for the taxpayer ID)
6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
7) A valid trust, estate, or pension trust
8) Corporation
9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
10) Partnership
11) A broker or registered nominee
12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)

3. Fill in your taxpayer identification number below: (please complete only one)

1) If you circled number 1-5 above, fill in your Social Security Number

   __ __ __ - __ __ - __ __ __ __

2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

   __ __ - __ __ __ __ __ __ __

Sign and date the form:

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

MEDICAL ASSISTANCE PARTICIPATION AGREEMENT
(MEDICAID/TENNCARE TITLE XIX PROGRAM)
Between
THE STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
Bureau of TennCare
And

_____
PROVIDER NAME

FOR
LEVEL I NURSING SERVICES

This Provider Agreement, hereinafter referred to as the "Contract" and/or "Agreement", by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the "Department" or "TennCare", and _____, hereinafter referred to as the "Contractor" or the "Facility", is for the provision of Long Term Care Services in a Nursing Facility (NF) as further defined below:

THE TERMS, OBLIGATIONS AND CONDITIONS

I. The Facility Agrees:

A. Patient Care:

1. To provide Level I care to eligible individuals in accordance with all applicable State and Federal laws, rules, and regulations.

2. To maintain all necessary records on each recipient at the Facility in accordance with State and Federal regulations. These records and pertinent staff are to be made available to the Department and its authorized representatives on request.

3. To participate with the Department's Independent Professional Review Team in the evaluation of the necessity, adequacy, quality and appropriateness of care and of each recipient's physical and mental condition in order to determine the kinds and amounts of care needed.

4. To acknowledge and take the appropriate corrective action indicated by the Independent Professional Review Team's report within the time limits specified by the Department.

5. To comply with the State and Federal Regulations which govern the admission, transfer or discharge policies for recipients.

6. To provide the Department or its authorized representative with a completed pre-admission evaluation for each recipient as required by State and Federal Regulations. If application is made while the patient is in the Facility the pre-admission evaluation must be completed prior to requesting payment for services.

7. To provide the Department with certification and recertification that the level of care is necessary and appropriate. (This requirement is satisfied by the dated signature of the attending physician on the appropriate form.)

8. To ensure that a physician sees each recipient at an interval of no less than once every sixty (60) days unless an alternative visitation schedule is approved by the Department.

9. To ensure that all medications are reviewed monthly by a registered nurse and at least quarterly by a physician.

10. To prearrange for physician services in the event of an emergency or the non-availability of the attending physician.

11. To have on file and make available to the Department's authorized personnel, on request, copies of the transfer forms used when transferring a resident from one Facility to another (i.e., nursing homes, skilled facilities, hospitals, etc.) and to provide referral information to other facilities.

12. To safeguard all required records and information from loss or unauthorized use, and to maintain them for a minimum of ten (10) years following recipient's discharge or death.

13. To provide or arrange for social services, as needed by the recipient, which are designed to promote the preservation of the resident's physical and mental health.

14. To have on file and make available to the Department's authorized representative, on request, a social service plan of care in each resident's record. This plan will be evaluated periodically by the facility and altered appropriately.

15. In the event the facility does not employ a licensed pharmacist, to have a formal agreement with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration, disposal and record keeping of drugs and biologicals.

16. To provide an activities program designed to encourage restoration to self-care and maintenance of normal activity.

17. To have on file and make available to the Department's authorized representative, on request, a plan for individual and group activity developed for each resident in accordance with his or her needs, interests and capabilities. This plan must be reviewed with the resident's participation to the extent practicable, as often as needed but no less than quarterly.

18. To provide or make arrangements for each resident, the needed specialized and supportive rehabilitative services and restorative nursing care.

19. To accept periodic compliance reviews and to comply with the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The Facility further gives assurance that, as a condition of receiving payment from TennCare for care and services for which Federal funds are used, no distinction on grounds of race, color, national origin or handicap is made in accepting individuals for care or in the treatment or services provided. It is further agreed that subject to appropriate legal and professional limitations, records of admission (or intake), discharge, and other operations controlling the conditions of care or service provided will be made available to the Commissioner of the Department or his designated representative for review at any time that the Department or the Tennessee Department of Health receives an official complaint of discrimination made by or on behalf of any applicant, recipient, or other beneficiary of the nursing home program.

20. To have on file and make available on request of the authorized representatives of the Department and the Comptroller of the Treasury, a system designed and utilized to ensure the integrity of the recipient's personal financial resources. This system will be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable Code of Federal Regulations.

21. To ensure compliance of the Facility with all Federal and State statutes, regulations, and guidelines regarding reimbursement and patient care by making timely corrections of any deficiencies made known to the Facility.

22. To have in force an approved utilization review plan in accordance with State and Federal Regulations. The plan must be written and must provide for a review of the necessity for continued stay at least every six months or more frequently if indicated at the time of assessment.

23. To promptly notify the Department of Human Services office in the county in which the facility is located when a recipient is admitted, or

when there is a known change in circumstances and give notification prior to the recipient's discharge.

24. To mail NF records to the Department upon request of the Department.

B. Reimbursement:

1. To accept the amount of vendor payment from the Department and patient liability as payment in full for all covered services.

2. To make no charge for covered services provided to a recipient of Medicaid/TennCare which is in excess of charges made to other patients being provided the same type of services in the Facility.

3. To accept the reimbursable cost rate established by the Comptroller of the Treasury as the maximum rate to be allowed for the Facility's covered services. (The Comptroller of the Treasury will establish per diem reimbursement rates for the institutions or distinct parts thereof rendering intermediate care. The Comptroller of the Treasury will advise both the provider and the Department of any new rate or rate change).

4. To submit to the Comptroller of the Treasury a cost report on forms designated by the Comptroller at the Facility's fiscal year end. This report will be due three months from the end of the designated fiscal period. Such cost report must be completed in accordance with the principles of cost reimbursement as set out by the Department or the Comptroller of the Treasury. In the event that the Facility does not file the required information by the due date, unless an extension in writing has been granted, the institution shall be entitled to a maximum reimbursable per diem rate of not more than four dollars ($ 4.00) in accordance with state law.

5. To allow the Department, the Comptroller of the Treasury or their agents to audit the cost report and records of a Facility in order to verify the cost data or other information submitted by the provider and to investigate possible infractions of Intermediate Care regulations, and to maintain such records in accordance with any regulations promulgated by the Comptroller of the Treasury.

6. To have on file and make available to the Department's authorized personnel and to the Comptroller of the Treasury or its agent, all contracts for covered services provided by a provider other than the Facility itself.

7. To complete, in duplicate, itemized statements of extra charges for supplies or services extraneous to regular routine Level I care. The original itemized statement will be given to the recipient or other appropriate third party. The first copy will be kept on file by the Facility and be subject to State audit for a period of three years or until audited. The recipient-patient will not be charged for items included in the

determination of Reimbursable Per Diem Cost Per Patient, nor will the Facility charge for health services available to recipients under the Medicare or other Medicaid/TennCare Programs.

8. To execute a written financial contract with each recipient-patient or with his or her agreed-upon representative upon admission of the patient. The contract will set out the rate of regular patient charge, if less than the reimbursable cost. Also, it shall designate the patient's financial resources which will be forthcoming from all sources and applied toward meeting the cost of care. One copy of the financial contract will be maintained in the Facility's files.

C. Disclosure of Ownership And Related Information:

1. To keep any records necessary to disclose the extent of services the provider furnishes to recipients.

2. To furnish the Medicaid/TennCare agency, the Centers for Medicaid and Medicare Services (CMS), or the State Medicaid/TennCare fraud control unit on request any information contained in the records including information regarding payments claimed by the provider for furnishing services under the plan.

3. To disclose to the Department the identity of any person who has an ownership or control interest in the Facility, or is an agent or managing employee of the Facility.

4. To disclose to the Department the name and address of each person with an ownership or control interest in the Facility, or is an agent or managing employee of the Facility.

5. To inform the Department of the name and address of each person with an ownership or control interest in the disclosing entity or in a subcontractor in which the disclosing entity has a direct or indirect ownership interest of five (5) percent or more.

6. To name any other disclosing entity in which a person(s) with an ownership or control interest in the disclosing entity also has an ownership or control interest. This applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person.

7. To keep copies of all requests and the responses to them in accordance with I. C. 6. above and to make them available to CMS or the Medicaid agency upon request and advise the Medicaid agency when there is no response to a request.

8. To submit within thirty-five (35) days of the date of request by the CMS or the Medicaid agency full and complete information about:

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000.00 during the twelve (12) month period ending on the date of the request.

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the facility and any subcontractor, during the five (5) year period ending on the date of the request.

9. To disclose to the Department the identity of any person in accordance with I. C. 3. above that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid/TennCare or the Title XX services Program since the inception of those programs.

II <u>The Department Agrees:</u>

A. To reimburse the Facility on a timely basis in the amount of vendor payment not to exceed the maximum Reimbursable Per Diem Rate established by the Comptroller of the Treasury.

B. To provide such expertise and assistance to the Facility in reference to governmental regulations of the Intermediate Care Facility program as may be required by the Facility.

III <u>The Department and Facility Mutually Agree:</u>

A. That the term "Administrator" appearing in the signature portion of the Contract is interpreted to mean the present Administrator of the Facility or his successor.

B. That, in the event the U. S. Department of Health and Human Services terminates the Facility from the program, the Department will not be liable for the payments suspended by such action.

C. This Agreement will automatically terminate no later than the 60th day following the end of the time period specified for the correction of non-waived deficiencies cited during the federal certification process, if such deficiencies have not been corrected, or substantial progress made in correcting these deficiencies. This process is subject to applicable State and Federal Regulations pertaining to appeals.

D. That the Department may cancel this Agreement in accordance with State and Federal regulations when in its judgment the Facility has failed to abide by the terms and conditions of said Agreement. The Department may also immediately suspend payments for any future services under this Agreement. Within 30 days of such suspension, the Facility will have the right to request a fair hearing so that it may show cause why such payments should be reinstated.

E. That as the Federal standards for participation are amended, modified, or changed, the Department shall immediately furnish the Facility a copy of any such changes, and the Facility shall accept such amendment, modification, or change by acknowledging such change within 30 days from receipt thereof; such signed acknowledgement by the Facility shall become a part of this Agreement, the same as if written into the Agreement, and the failure of the Facility to execute the acknowledgement and return it to the Department shall constitute an automatic revocation of this Agreement.

F. That the effective date for vendor payments shall be the date that the Facility attains participating status as determined by the Department under Federal standards for participation and that such determination shall be made a part of this Agreement.

G. That should the Office of the Comptroller, through audit of the Facility, discover that amounts have been overcharged and collected from the individual recipients; the Facility will place the overcharged amounts in escrow accounts, approved by the Department, for the recipients, should the Facility choose to contest these findings. Otherwise, the Facility will promptly reimburse the recipients.

H. That should the Office of the Comptroller, through audit of the Facility, discover irregularities which in its opinion constitute overpayments to the Facility by the Department, the Department may withhold the amount of such overpayments from future payments to the Facility until an amount equal to that overpaid by the Department has been collected from payments otherwise due the Facility. The reimbursement of these overpayments, upon request by the Facility, may be made on an installment payment plan.

I. The Facility, or the State, may cancel this Agreement by providing the other party with thirty (30) days written notice of such intent.

Confidentiality of Records.

Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the

State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

HIPAA Compliance.

Contractor warrants to the State that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the State in the course of performance of the Contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep the State and Contractor in compliance with HIPAA, including but not limited to business associate agreements.

Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (MFCU) Access to Contractor and Provider Records Office of TennCare Inspector General Access to Contractor, Provider, and Enrollee Records

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, MFCU and TennCare OIG shall be health oversight agencies as defined at 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. When acting in their respective capacities as health oversight agencies, MFCU and TennCare OIG do not need authorization to obtain enrollee protected health information (PHI). Because MFCU and TennCare OIG will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to disclosures to MFCU or TennCare OIG that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d).

The Contractor shall immediately report to MFCU all factually based known or suspected fraud, abuse, waste and/or neglect of a provider or Contractor, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return money allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing MFCU, and must cooperate fully in any investigation by MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers who have access to any administrative, financial, and/or medical records that relate to the delivery of items or services for which TennCare monies are expended, shall, upon request, make them available to MFCU or TennCare OIG. In addition, the MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, during normal business hours, except under special

circumstances when after hour admission shall be allowed. MFCU shall determine any and all special circumstances.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to TennCare OIG. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. Shall the need arise, TennCare OIG must be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours.

The Contractor shall inform its participating and non-participating providers that as a condition of receiving any amount of TennCare payment, the provider must comply with this Section of this Contract regarding fraud, abuse, waste and neglect.

Debarment and Suspension.

To the best of its knowledge and belief, the Contractor certifies by its signature to this Contract that the Contractor and its principals:

A. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;

B. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

C. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and

D. have not within a three (3) year period preceding this Contract had one or more public transactions (Federal, State, or Local) terminated for cause or default.

Contract Beginning Date : _____

Contract Ending Date: _____

Automatic Cancellation Clause Date: _____
Subject to Provision III – C (See Page 6)

Name of NURSING FACILITY : _____

Address : _____

_____

Provider Number : _____

NH License # _____

By : _____ _____
Date

Name and Title

Tennessee Department of Finance and Administration, Title XIX Agency

By : _____ _____
Commissioner Date

National Provider Identifier (NPI) Collection Form
(Individual/ Solo Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information
(Please make additional copies if required)

Provider Last Name	First Name	Middle	Title

Existing Medicaid ID's	SSN	EIN Number

Section 2 – NPI Information

NPI Number _____

Taxonomy Codes

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

City	State	ZIP

Phone Number	Fax Number	Provider e-mail Address

Section 4 – Contact Information

Name of Individual Completing Form _____

Phone Number	Fax Number	Contact e-mail Address

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 248-4386 or (866) 456-8059
Field	**Instruction**
Section 1 – Provider General Information	
Provider Last Name	(Required) Enter the provider's last name.
First Name	(Required) Enter the provider's first name.
Middle	(Optional) Enter the provider's middle name.
Title	(Required) Enter the provider's title.
Existing Medicaid ID's	(Required) Enter all currently assigned Medicaid provider numbers.
SSN	(Required) for an individual provider. Enter the Social Security Number.
EIN Number	(Required) Enter the Employer Identification Number (could be SSN).
Section 2 – NPI Information	
National Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location ZIP of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider e-mail Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact e-mail Address	(Optional) Enter the e-mail address of the individual completing this form.
Signature and Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.

National Provider Identifier (NPI) Collection Form
(Group Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information

Business Name _____

Doing Business As (Name) _____

Medicaid ID	EIN	NPI

Taxonomy Codes _____ _____ _____

_____ _____ _____

Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	SSN	Taxonomy	Taxonomy

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

City	State	ZIP

Phone Number	Fax Number	Provider Email Address

Section 4 – Contact Information

Name of Individual Completing Form _____

Phone Number	Fax Number	Contact Email Address

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Group Practices

Send the completed NPI Collection Form via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 741-0028
Field	**Instruction**
Section 1 – Provider General Information and NPI Information	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Section 2 – Group Member - NPI Information	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Social Security Number	(Required) Enter the Individual Provider SSN.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.