Instructions

MAD 220 Form for EHR Program

NM Medicaid EHR Incentive Program

Instructions:	**The Eligible Professional (identified in Section I, Box 1) fills out the information, initials the form at the bottom of page 1, and signs the form at the top of page 2.**

Page 1, Section I: The information in Section I applies to the Eligible Professional.

1. Complete all boxes in Section I. If a question does not apply, state "N/A" for not applicable. Do not white-out or alter information on the form.
2. Box 4 – Location address must be the physical address of the Eligible Professional's medical or dental practice – not a separate administrative or billing office. Box 5 allows for a separate mailing address.
3. Box 12 – Answer Yes or No to all three questions and initial for each question.
4. Contact Person – Fill out the information for the Eligible Professional's contact person at the end of Section I.

Page 1, Section II: The information in Section II applies to the Incentive Payment Recipient (Payee) – the individual, group or business entity to whom the Eligible Professional is assigning payment.

5. Complete all boxes in Section II. If a question does not apply, state "N/A" for not applicable. Do not white-out or alter information on the form.
6. If the Eligible Professional in Section I is assigning payment to himself or herself, all boxes in Section II still must be completed, even if some of the information is duplicative.
7. Box 17 – Location address must be the physical address of the Incentive Payment Recipient's medical or dental practice – not a separate administrative or billing office. Box 16 allows for a separate mailing address.
8. Box 24 – Select For Profit or Non-Profit. If Non-Profit is selected, a 501c(3) letter from the IRS must be attached with the MAD 220 Form. Government entities, including IHS, are exempted from this requirement.
9. Box 27 – A fully executed W-9 for the Incentive Payment Recipient must be attached to the MAD 220 Form. The W-9 form is available at www.irs.gov .

Page 2: The signature of the Eligible Professional and the signature of the legal representative for the Incentive Payment Recipient are both required on page 2. Signatures need to be in BLUE INK.

10. The Eligible Professional named in Section 1, Box 1, must sign the form (in blue ink) at the top of page 2. The signature must match completely the name stated there. For example, William B. Smith in Section I, Box 1 should not be signed Bill Smith.
11. Box 28 -- The authorized legal representative for the Incentive Payment Recipient named in Section II, Box 14 must certify by signature (in blue ink) that the information provided in Box 28 is true & correct. Signature is required even if *No* is checked.
12. Mail completed and signed MAD 220 Form to the address provided at the top of page 1:
    EHR Incentive Program c/o Conduent
    P.O. Box 27460
    Albuquerque, NM 87125-7460
13. For questions or assistance in completing the MAD 220 Form, call 1-800-299-7304; choose option 5, then choose option 2.

Note: The MAD 220 Form should be mailed to the address above **before** the Eligible Professional begins the EHR Incentive Program registration and attestation process at the state level registry. Failure to do so may delay the registration process and will impede payment.

Once the MAD 220 Form has been approved, the Eligible Professional will appear in the State Level Registry. The Eligible Professional and, if different, the assigned payee, will be notified of their Medicaid provider number for the EHR Incentive Program. The assigned payee will use any **new** Medicaid number to register for an Electronic Funds Transfer (EFT) by clicking on New Mexico Medicaid web portal

Mail Completed Application to:
EHR IP Program c/o CONDUENT P.O. Box 27460 Albuquerque, NM 87125-7460

This form must be completed to initiate the EHR Incentive Payment process before registration in the State Level Registry if any one of the three boxes below applies: (check appropriate box) The provider who is eligible for incentive payments –

Is *not* enrolled in the Medicaid Fee-for-Service program, but is enrolled as a provider in one or more Medicaid managed care organizations (MCO). Please list the MCO(s) on the line below in which the eligible provider is currently enrolled:

____

____

Is enrolled only as a *rendering* provider in the Medicaid Fee-for-Service program (services are billed by a group, clinic, or other entity) but the eligible provider wants to receive the incentive payment rather than assigning payment to the group, clinic, or other entity.

Is enrolled in the Medicaid Fee-for-Service program and the eligible provider wants to assign the incentive payments to that group, clinic or other entity *and* that group, clinic, or other entity is *not* the same type of provider as the eligible provider.
(Such as when a CNP or CNM assigns payment to a physician group; a pediatrician assigns payment to a non-pediatrician group; a physician assigns payment to anyone other than a physician group; a dentist assigns payment to anyone other than a dental group; or when any provider assigns payment to a hospital, FQHC, or RHC.)

SECTION I: IDENTIFY THE ELIGIBLE PROFESSIONAL PROVIDER

(1) Name	(2) National Provider Identifier (NPI)	(3) License Information Number State Expiration Date

(4) Location Address	City	County	State	Zip Code
(5) Mailing address for correspondence	City	County	State	Zip Code

(6) Check the appropriate box. The eligible provider is a:

Physician, Non-Pediatrician **Certified Nurse Practitioner** **Certified Nurse Midwife**
Physician Assistant in an FQHC or RHC **Pediatrician** **Dentist**

(7) If currently enrolled as a Medicaid provider, please indicate the current Medicaid ID number(s).

(8) Email Address	(9) Phone Number	(10) Social Security Number	(11) Date of Birth

(12)

A) Have you ever had a license revoked, suspended or denied in any state? **YES** **NO** **Initial_________**
B) Have you ever been convicted of any criminal offense? **YES** **NO** **Initial_________**
C) Have you ever been excluded or suspended from participation in Title XVIII (Medicare), Title XIX (Medicaid), Title XX (Block Grants to States for Social Services), Title XXI (SCHIPS) or any other health care program? **YES** **NO** **Initial_________**

If YES to any of the above three questions, attach a brief statement of situation; date; city, county and professional association or court which handled the matter; any precinct case identification, and the adjudication or other result. If deemed appropriate, Medical Assistance Division (MAD) may undertake its own investigation. Depending on the issue, and/or MAD investigation, if deemed appropriate, MAD may exclude the applicant from participation in Electronic Health Records Incentive Program.

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list a contact person, active e-mail address (as this is the likeliest means by which you will be contacted), and telephone number.

Contact Person: ____

Active e-mail Address: ____ ***Telephone Number:*** ______________________________

SECTION II: IDENTIFY THE INCENTIVE PAYMENT RECIPIENT

Complete the information below for the individual, group, clinic or other entity who will receive the incentive payment.

(13) Check applicable box:

The eligible provider identified in Section I will receive the incentive payment.

The eligible provider identified in Section I will assign the payment to an affiliated group, clinic or other entity.

(14) Name of Incentive Payment Recipient

(15) Phone Number for Incentive Payment Recipient

(16) Mailing address for correspondence	City	County	State	Zip Code
(17) Location Address	City	County	State	Zip Code

(18) Check the appropriate box. The incentive payment recipient is a:

Physician, Non-Pediatrician **Certified Nurse Practitioner** **Certified Nurse Midwife**
Physician Assistant in an FQHC or RHC **Pediatrician** **Dentist**

(19) Indicate the Medicaid ID Number of the incentive payment recipient, if currently enrolled as a Medicaid Fee-for-Service provider:

(20) National Provider Identifier (NPI) of the incentive payment recipient:

(21) Federal Tax Number or Social Security Number of incentive payment recipient:
(Payments will be reported on 1099 form using this number.)

(22) Business Name (DBA) of the incentive payment recipient:

(23) Federal Tax (legal) name of the incentive payment recipient: (must match IRS letter)

(24) Select one:
for profit **non-profit [attach 501(c)3]**

(25) Are federal tax payments current? If not, attach an explanation.
YES **NO**

(26) Email Address

(27) A fully executed W-9 is required to be attached. Please check here to affirm that you have attached a fully executed W-9 (available at: www.irs.gov).
YES **NO**

APPLICANT INITIAL HERE __________________ CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

The eligible provider and, if different, the incentive payment recipient will be notified of the provider number of the incentive payment recipient, at which time the incentive payment recipient must register for electronic funds transfer (EFT) in order to receive payments electronically. Registration for EFT can be done through the New Mexico Medicaid web portal at https://nmmedicaid.conduent.portal.com/

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Original signature required. Please use ***blue ink*** *only.*

By signature, I agree to abide by and be held to all federal, state, and local laws, rules, and regulations, including, but not limited to, NMAC 8.300.22 and related instructions.

I am attesting that I understand that payment will be from federal and/or state funds and that any falsification or concealment of a material fact may be prosecuted under federal and/or state law.

INDIVIDUAL PROVIDER:

Printed Name of Individual Provider (*listed in box #1 on page 1*): ______________________________

Signature of Individual Provider: ______________________________ **Date:** ______________

The Incentive Payment Recipient must complete the following:

(28)Has the eligible provider, group, clinic or other entity to whom the incentive payment is being assigned, or any person who has ownership or control interest in the provider, group, clinic, or entity to whom the incentive payment is being assigned, or any person who is an agent, service provider or managing employee of the provider, group, clinic, or other entity to whom the incentive payment is being assigned, been convicted of a criminal offense related to that person's involvement in any program under Title XVIII (Medicare), Title XIX (Medicaid), or the Title XX (Block Grants to States for Social Services), or Title XXI (SCHIPS) services program since the inception of those programs? If yes, give the name(s) of person(s) and description(s) of offense(s). Please use additional pages if necessary:

YES ☐ **NO** ☐

FOR STATE PURPOSES ONLY

NAME	SOCIAL SECURITY NUMBER	DESCRIPTION	FOR STATE PURPOSES ONLY
			Sanction Verified?: ☐ Yes ☐ No Match Found?: ☐ Yes ☐ No
			Sanction Verified?: ☐ Yes ☐ No Match Found?: ☐ Yes ☐ No
			Sanction Verified?: ☐ Yes ☐ No Match Found?: ☐ Yes ☐ No

By signature, I certify that the above information is true and correct.

Printed name of authorized legal representative for the incentive payment recipient (listed in box #13) : ______________________________ ***Title:*** ______________

Signature of authorized legal representative for the incentive payment recipient (listed in box #13): ______________________________ ***Date:*** ______________

FOR STATE PURPOSES ONLY:

HUMAN SERVICES DEPARTMENT APPROVAL

☐ APPROVED ☐ NOT APPROVED

Reasons Not Approved:

Dates of Agreement: From: ______________

Authorized Signature **Date**

Eligible Professional Provider MEDICAID ID created in MMIS? **Medicaid ID Number :**

☐ **Yes** ☐ **No** ☐ **Bill Code "F"** ☐ **Status Code 60** ☐ **Already Exists** **MEDICAID ID/SPECIALTY CODE:** ________ _________ ______________

Incentive Payment Recipient MEDICAID ID created in MMIS? **Medicaid ID Number :**

☐ **Yes** ☐ **No** ☐ **Bill Code "F"** ☐ **Status Code 60** ☐ **Already Exists** **MEDICAID ID/SPECIALTY CODE:** ______________ ______________

The eligible provider and, if different, the incentive payment recipient will be notified of the provider number of the incentive payment recipient, at which time the incentive payment recipient must register for electronic funds transfer (EFT) in order to receive payments electronically. Registration for EFT can be done through the New Mexico Medicaid web portal at https://nmmedicaid.portal.conduent.com/