New Mexico Medicaid Project
1720-A Randolph Road SE
Albuquerque, NM 87106
505-246-9988 505-246-8485 (fax)

Dear Medicaid Provider Applicant:

Thank you for your interest in becoming a New Mexico Medicaid provider. A provider participation agreement packet is enclosed. Please read the following instructions carefully before completing the agreement(s).

The application process takes 6-8 weeks from the date a properly completed provider participation agreement is received. When your agreement is approved, a unique provider identification number will be assigned to you. Do not provide services to New Mexico Medicaid clients until your Medicaid provider number has been assigned and you have received a copy of the New Mexico Medicaid Program Policy Manual and Billing Instructions.

In order for us to process your provider participation agreement in a timely manner, please follow these guidelines:

- The **MAD Form 312, *PROVIDER PARTICIPATION AGREEMENT – INDIVIDUAL APPLICANT WITHIN A GROUP*** should be completed by individual applicants who perform services within a group or organization. Payments will be made only to the group or organization. No payments will be made directly to the individual.

- The **MAD Form 335, *PROVIDER PARTICIPATION AGREEMENT*** should be completed by groups, organizations, or individual applicants to whom payment will be made.

- When applying for a group Medicaid provider number, include an agreement for the group (MAD 335) as well as individual agreements (MAD 312) for each practitioner who will be a member of the group if they do not already have a Medicaid number. For a group that already has an active Medicaid provider number that wishes to enroll an individual within their group, complete an agreement (MAD form 312) for the individual only. For practitioners who already have an assigned Medicaid number and who wish to be affiliated with a newly enrolling group, a signed letter must be submitted by the enrolled provider stating they wish to be affiliated with the group.

- **Please do not use "highlighter" or "whiteout" on the agreement(s) or on any of the attachments**. Agreements that are submitted with "highlighter" or "whiteout" will be returned without any further processing. To correct information on the agreement, make one line across the incorrect information and write in the corrected information. The person making the corrections should initial the changes.

- Review the enclosed *Type and Specialty List and Documentation Requirements* and select the **provider type** and **provider specialty (if applicable)** that best describes your practice, license and/or certification. If you are unsure which **provider type or specialty** to use, please contact the Provider Enrollment Unit at 1-800-299-7304 or 505-246-0710, option #3, then #5.

- If services have already been provided on an emergency basis, you may enter a requested effective date on the last page (signature page) of the Provider Participation Agreement. The date requested should be no more than 120 days prior to the date the completed agreement is being sent to ACS. **There is no guarantee that the requested effective date will be granted, as the Medical Assistance Division will make the final determination.**

- The enclosed W-9 form must be completed for applicants submitting a MAD 335, Provider Participation Agreement. The purpose of the W-9 is to assure that payments to providers are reported to the IRS with names and numbers that match IRS records. If you are a business, corporation, or sole proprietorship, enter the ID number assigned by the IRS. **Please attach a copy of the letter or other proof from the IRS assigning this tax identification number.**

- If you are enrolling as an individual, you must enter your Social Security number and date of birth on the agreement. Even if you are an individual who will be billing under a group number, you must enter your Social Security number and date of birth. You will bill your claims using the group provider number, which will be reported to the IRS with the group name and tax identification number.

- Tax exempt providers must submit a copy of their 501(c)3 tax-exempt letter.

- Every provider who completes a MAD 335 agreement and who renders services within New Mexico must provide their New Mexico Tax and Revenue identification number (box 19 of the agreement).

- The applicant's Medicare number and/or DEA number must be included on the agreement, if applicable. Also include a copy of the Medicare letter and/or DEA registration certification with the agreement. If the DEA number and/or Medicare number is/are pending at the time of application, please send ACS a copy of the certification when you receive this information.

- Applicants completing the MAD 335 form should also complete the enclosed Addendum form that requests information regarding Medicare carrier(s).

- New Mexico Medicaid project staff may need to obtain additional information from you in order to process your agreement. Please indicate a contact name and telephone number in the space provided on the last page of the Provider Participation Agreement.

- The applying provider must sign and date the agreement. **Please sign in blue ink only! Only an original signature with a date is acceptable. We cannot accept signature stamps or copies of signatures.** Applications with signatures that cannot easily be determined as original will be returned for correction. This standard is ***strictly*** enforced.

- Please be sure to include all required documentation as listed on the attached *Provider Participation Agreement, MAD 312 and 335 forms* and *Type and Specialty List and Documentation Requirements*. Required documentation may include:

    - Professional licensure
    - Agency licensure or certification
    - Business license
    - DEA registration certificate
    - New Mexico Non-Residential Pharmacy License (for certain out-of-state providers)
    - Proof of malpractice or liability insurance
    - Federal tax identification letter
    - CLIA certificate
    - Physician board specialty certification
    - Medicare certification letter
    - JCAHO accreditation letter
    - FQHC certification and interim rates
    - Medicare letter setting reimbursement rates for Rural Health Clinics (RHCs)
    - Renal dialysis Medicare composite rate letter

- If you plan to submit claims electronically, please review the *HIPAA Claims Submission Instructions* information that is attached to this packet.

If you have ANY questions at all, please do not hesitate to contact ACS's Provider Enrollment Unit at 1-800-299-7304 or 505-246-0710, option #3, then #5.

Sincerely,

Provider Enrollment
ACS

For Medicaid Use *Only* - Provider Number

STATE OF NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION
PROVIDER PARTICIPATION AGREEMENT

THIS AGREEMENT IS FOR GROUPS, ORGANIZATIONS, OR INDIVIDUAL APPLICANTS TO WHOM PAYMENTS WILL BE MADE. IF THE APPLICANT IS AN INDIVIDUAL APPLYING FOR A PROVIDER NUMBER ONLY FOR IDENTIFYING SERVICES BILLED THROUGH A GROUP PRACTICE OR OTHER ORGANIZATION AND PAYMENTS WILL BE MADE TO THAT GROUP OR ORGANIZATION, THIS FORM SHOULD NOT BE USED. USE FORM MAD 312 INSTEAD.

RETURN completed application to:
New Mexico Medicaid Project
c/o ACS
1720 - A Randolph Rd.
Albuquerque, NM 87106

TO BE COMPLETED BY ALL APPLICANTS:

Name of Applicant (1)	Professional Title *(M.D., D.D.S., etc.)* (2)

Physical Location - No. & Street (P.O. Box not accepted. *Address at which services are rendered is required)* - City State Zip Code County
(3)

Billing Address (please list an address even if it is the same as the physical location address listed above in #3) Street or P.O. Box City State Zip Code (4)	Work Telephone No. - **REQUIRED** ( ) (6(a)
Mailing Address - **Official correspondence will be sent to this address** (please list an address even if it is the same as the physical location address listed above in #3 or the billing address listed above in #4) Street or P.O. Box City State Zip Code (5)	Billing Telephone No. (6b)

State License Number *(Attach copy of license)* (7)	License Issued By (8)	License Expiration Date (9)	Provider Type *(See attached list)* (10)	Provider Specialty *(See attached list)* (11)	(12) Social Security Number	(13) Birth Date For Individuals

IF PAYMENTS ARE MADE DIRECTLY TO THE APPLICANT, THE FOLLOWING MUST BE COMPLETED.

(14) ☐ an individual ☐ non-corporate business entity ☐ partnership or professional association
☐ sole proprietorship ☐ corporation ☐ governmental entity or public school

Federal Tax Number *(Attach Federal Tax letter received from the IRS)* (15)	Federal Tax Name *(Attach W-9 form)* (16)	☐ Check here if SSN is used in lieu of Tax Number (17)
Doing Business As (Name) (18)	NM Tax & Revenue ID Number *(if services are provided in NM)* (19)	☐ Check here if not-for-profit, (20) and attach copy of 501(c)3

COMPLETE IF APPLICABLE:

(21) E-Mail Address:

New Mexico Medicaid Number *(If previously assigned)* (22)	HMO Affiliation? ☐ Yes ☐ No (23) Name of plans in which you participate:

CLIA Number (for providing laboratory services) *(Attach copy of certificate)* (24)	National Provider I.D. (NPI) or UPIN Number (if assigned) (25)	DEA Number (for drug prescribers) *(Attach copy of certificate)* (26)	NABP # *(For Pharmacies)* (27)

To be completed by physicians only. Are you board certified? ☐ Yes ☐ No If yes, attach a copy of certificate.
(28) If not board certified, attach specialty certification from residency program or letter from the chairperson of your residency program stating that you received training in your specialty area.

(29) CERTIFIED UNDER TITLE XVIII MEDICARE? . . ☐ Yes ☐ No If yes, attach copy of letter.
JCAHO CERTIFIED? . . . . . ☐ Yes ☐ No If yes, attach copy of certification letter.

(30) **Fiscal Year End Date** _____/_____/_____

(31) Medicare Provider Number(s) *(Attach Medicare letter(s))* _____ Medicare Carrier or Intermediary _____

(32) **Identify individuals who will be providing services for which payments will be made directly to your group or organization.**

Individual's Name	Title	License Number	Provider Type	Provider Specialty	New Mexico Medicaid Number (If previously assigned)	For Medicaid Project Office Use Only

Please attach a separate page if additional space is needed.

IF THE APPLICANT IS AN INDIVIDUAL, IDENTIFY ANY OTHER ORGANIZATION(S) THAT YOU WILL BILL UNDER:

Organization or Group Name:	Organization or Group **Medicaid** Number:	Organization or Group **Medicare** Number:

(33) Please attach a separate page if additional space is needed.

(34) (a) Have you ever had a license revoked, suspended or denied in New Mexico or any other state? . . . . . ☐ Yes ☐ No
(b) Have you or any of the owners or principals ever been convicted of any criminal offense? . . . . . ☐ Yes ☐ No
(c) Have you or any of the owners or principals ever been excluded or suspended from participation in the Title XVIII (Medicare), Title XIX (Medicaid) or any other health care program? . . . . . ☐ Yes ☐ No
If yes to any of the above three questions, attach a brief statement of situation; date; state, city, county and professional association or court which handled the matter; any precinct case identification; and the adjudication or other result.

OWNERSHIP INFORMATION - The following information must be provided and updated, as applicable, if payments are to be remitted to a provider group, partnership, or association:

1. Name and address of each person with an ownership or controlling interest in the entity or any subcontractors in which the entity has or had direct or indirect ownership totaling five percent (5%) or more and whether any of these person(s) named is related to another as spouse, child, or sibling.

Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship

2. Name and address of any other entity in which a person with an ownership or controlling interest in the entity also has an ownership or controlling interest.

Name of Entity	Address	Telephone Number	Name of Person with Interest

3. Name of any person, agent, managing employee, or any other person who has ownership or controlling interest equal to five percent (5%) or greater in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program, or other state Medicaid program.

Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation

This Agreement, between the New Mexico Human Services Department (HSD) and the applicant as provider, specifies the terms and conditions for the provision of medical services to Medicaid clients. The Agreement shall be effective when completed in full with all required documentation attached and when signed by the provider and HSD, and shall remain in effect until terminated pursuant to the terms set out below.

ARTICLE I - OBLIGATIONS OF THE PROVIDER

The Medicaid provider shall:

1.1. Abide by all federal, state, and local laws, rules, and regulations, including but not limited to, those laws, regulations, and policies applicable to providers of medical services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by HSD.

1.2. Furnish services, bill for services, and receive payment for services only upon approval of this Agreement by the MAD Director or his/her designee.

1.3. Comply with all billing instructions, reimbursement, audit, recoupment, and withholding provisions distributed by HSD. All rates, policies, procedures, or rules of any kind relating to billing instructions, reimbursement, audit, recoupment, and withholding provisions furnished to providers must be specifically approved in writing by the MAD Director or his/her designee to be effective.

1.4. Maintain and keep updated program policies, instructions on billing and utilization review, and other pertinent material distributed by HSD.

1.5. Furnish and update complete information on provider address, licensing, certification, board specialities, corporate names, and parties with direct or indirect ownership or controlling interest and information on the conviction of delineated criminal or civil offenses by providers or parties with direct or indirect ownership or controlling interest at least sixty (60) days prior to the contemplated change or within ten (10) days after the conviction. Any payment by HSD on the basis of erroneous or outdated information is the responsibility of the provider and is subject to recoupment, criminal investigative costs, and/or civil penalties.

1.6. Comply with all federal, state, and local laws and regulations regarding the provider's authority to operate a business in New Mexico including, but not limited to, licensure, registration to pay gross receipts tax, permit requirements, and employee tax filing requirements.

1.7. Assume sole responsibility for all applicable taxes, insurance, licensing, and other costs of doing business.

1.8. Verify that an individual is eligible for a specified medical program administered by HSD.

1.9. Maintain the confidentiality of client information and records in accordance with state and federal laws, including 42 C.F.R. § 431.305, 8.100.100.13 and .14 NMAC, and regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1.10. Render covered services to eligible clients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political belief, disability, or source of payment as per 45 C.F.R. § 80.3(a) and (b), 45 C.F.R. § 84.52, and 42 C.F.R. § 447.20.

1.11. Assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Submission of false claims or fraudulent representation may subject the provider to termination, criminal investigations and charges, and other sanctions specified in the MAD Provider Program Manual.

1.12. Retain any and all original medical or business records as are necessary to verify the treatment or care of any client for which the provider received payment from HSD to provide that benefit or service, services or goods provided to any client for which the provider received payment from HSD, amounts paid by HSD on behalf of any client, and other records required by HSD for at least six (6) years from the date of creation or until ongoing audits are settled, whichever is longer. Services that have been billed to HSD which are not substantiated in the provider's record are subject to recoupment.

1.13. Upon closure of office or facility, inform HSD where records pertaining to Medicaid recipients will be located.

1.14. Furnish immediately to the Medicaid Agency, the Secretary of Health and Human Services, or the Medicaid Fraud Control Unit, at no cost, access to records in any format requested as described above and any information regarding payments claimed by the provider for furnishing services to clients. Permit the inspection of facilities used in the provision of services to clients by the U.S. Secretary of Health and Human Services, HSD, the Medicaid Fraud Control Unit, or HSD designees. Failure to comply with this provision constitutes a violation of federal and state Medicaid law and may result in immediate withholding of any pending or future payments. If records are requested by mail, the provider shall furnish the records within five (5) working days of the receipt of the request or as provided for in the request.

1.15. Accept as payment in full the amount paid by HSD for services furnished to clients in accord with the reimbursement structure in effect for the period during which services were provided as per the HSD reimbursement policy. No exceptions to, or waiver, of standard reimbursements will be permitted without the express written consent of the MAD Director or his/her designee.

1.16. Not collect payments from the client or any financially-responsible relative or representative of that client for services furnished to the client, except as allowed and specifically delineated by HSD.

1.17. Seek payment from any other payor or insurer before seeking payment from HSD, in the event the client is covered by an insurance policy or health plan, including Medicare. Refund to HSD the lesser of the payment received from a liable third party or the amount payable under medical programs administered by HSD and not bill HSD the difference between the payment received from the third party based on a "preferred patient care agreement" or "discount" arrangement and the provider's billed charge.

1.18. Not refuse to furnish services to an eligible client because of a third party's potential liability for payment for the services, except in instances in which a client who is covered by an HMO plan is seeking services from a provider who does not participate in the HMO plan network and would not be paid for services by the HMO plan.

1.19. Inform HSD immediately when an attorney or other party requests information related to the services rendered to a client that were paid by HSD and upon receipt of any knowledge of pending or active legal proceedings involving clients.

1.20. When furnishing services to clients who sustained injury in an accident or another action that may be subject to a legal proceeding, agree to the following:

(A) Hospital providers must either file a claim with HSD within 120 days of the date of hospital discharge or impose a hospital lien on the potential recovery from the liable third party. If the hospital provider elects to impose a lien, the provider is prohibited from filing a claim with HSD for payment of any unpaid balance resulting from the third party recovery or from seeking payment from the client.

(B) Non-hospital providers must accept the payment made by HSD as payment in full. A non-hospital provider may not seek additional payment for those services from the client even if the client

subsequently received a monetary award or settlement from the liable party.

1.21. When entering into contracts with the Medicaid managed care organizations (MCOs) contracting with HSD for the provision of managed care services to the Medicaid population, agree to be paid by the MCOs at any amount mutually-agreed between the provider or provider group and the MCOs, or failing that, the then current and "applicable reimbursement rate" based on the provider type. The "applicable reimbursement rate" is defined as the rate paid by HSD to providers participating in Medicaid or other medical programs administered by HSD and excludes disproportionate share hospital and medical education payments.

ARTICLE II - OBLIGATION OF THE HUMAN SERVICES DEPARTMENT

HSD shall:

2.1. Distribute information necessary to participate in medical programs administered by HSD, including program policies, billing instructions, utilization review instructions, and other pertinent materials. The provider must contact HSD to request any additional program policy manuals, billing and utilization review instructions, and other pertinent materials.

2.2. Process payments in a manner delineated by federal guidelines either internally or through a delineated fiscal agent contractor.

2.3. Reimburse providers for furnishing covered services or procedures to eligible clients. Reimbursement is based on the HSD fee schedule, reimbursement rate, or reimbursement methodology in place at the time services are furnished by the provider. No exception to, or waiver of, standard reimbursement will be permitted without the express written consent of the MAD Director or his/her designee.

2.4. Conduct administrative investigations and administrative proceedings to ensure that providers comply with the terms of this Agreement and federal and state law pertaining to the administration of the health care programs administered by HSD, including the Medicaid Provider Act.

ARTICLE III - PATIENT SELF-DETERMINATION ACT

Nursing facility, intermediate care facility, hospital, home health agency, and hospice providers shall:

3.1. Furnish written information to all adult clients receiving medical care concerning their right to make decisions about medical care; accept or refuse medical or surgical treatment; and formulate arrangements for a living will or durable power of attorney.

3.2. Document in the client's medical record whether he/she has executed an advance directive which complies with New Mexico law on advance directives. The provision of care shall not be based on whether the client has executed an advance directive.

3.3. Inform each adult client, orally and in writing, at the time of facility admission or initiation of treatment, of the client's legal rights during his/her facility stay or course of treatment

ARTICLE IV - SUBMISSION OF COST REPORTS

4.1. Providers delineated by HSD who are reimbursed on a cost basis shall furnish HSD or its designee with such financial reports, audited or certified cost statements, and other substantiating data as necessary to establish a basis for reimbursement.

4.2. Cost statements or other data are to be furnished no later than 150 days following the closure of the provider's fiscal accounting period. Failure to comply with this provision will result in suspension of payment until the required statements and other data are provided.

ARTICLE V - STATUS OF PROVIDER

The provider, its agents, and employees are independent contractors who perform professional services for clients served through health care programs administered by HSD and are not employees of HSD. The provider shall not purport to bind HSD nor the State of New Mexico to any obligation not expressly authorized herein unless HSD has given the provider express written permission to do so.

ARTICLE VI - CHANGE IN OWNERSHIP

6.1. As soon as possible, but at least sixty (60) days prior to a change in ownership or status, any provider must notify HSD of the proposed change in ownership. Upon completion of the transfer of ownership, the initial provider participation agreement is terminated. The new owner must complete and receive approval of a new Medical Assistance Provider Participation Agreement before submitting any claims to HSD. Any payment by HSD on the basis of erroneous information due to the lack of notice is the responsibility of the previous provider and is subject to recoupment.

6.2. The previous owner shall be responsible for any overpayments and is entitled to receive payments from HSD up to the date of ownership transfer, unless otherwise specified in the contract for transfer of ownership.

6.3. The new owner shall furnish to HSD, upon receipt of a written request, the contract or other applicable documents specifying the terms of the change in ownership and responsibilities delineated in this Agreement.

6.4. HSD reserves the right to withhold all pending and other claims until the right to payments and/or recoupment is determined, unless the new owner agrees in writing to be liable for any recoupment or overpayment amounts.

6.5. For providers who are reimbursed on a cost basis and subject to cost settlements, HSD shall impose a lien and/or a penalty of up to ten percent (10%) of the purchase price against the previous owner until such time as the final cost settlement is completed and amounts owed, if applicable, are remitted to HSD.

ARTICLE VII - TERMINATION OF PROVIDER AGREEMENT

7.1. Provider status may be terminated without cause if the provider or HSD gives the other written notice of termination at least sixty (60) days prior to the effective date of the termination.

7.2. HSD will terminate this Agreement for cause, with thirty (30) days notice, if a provider, his/her agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(A) Misrepresents, by commission or omission, any information on the provider agreement enrollment form.

(B) Has previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in a health care program administered by HSD, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

(C) Is convicted under federal or state law of a criminal offense relating to the delivery of the goods, services, or supplies, under a health care program administered by HSD, any other state's Medicaid Program, Medicare, or any other public or private health or health insurance program.

(D) Is convicted under federal or state law of a criminal offense relating to the neglect or abuse of a patient in connection with the delivery of any goods, services, or supplies.

(E) Is convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

(F) Is convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(G) Is convicted under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude or acts against the elderly, children, or infirm.

(H) Is sanctioned pursuant to a violation of federal or state laws or rules relative to a health care program administered by HSD, any other state's Medicaid Program, Medicare, or any other public health care or health insurance program.

(I) Is convicted under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (C) through (H) of this subsection.

(J) Violates licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided.

(K) Fails to pay recovery properly assessed or pursuant to an approved repayment schedule under a health care program administered by HSD.

7.3. Provider status may be terminated immediately, without notice, in instances in which the health and safety of clients in institutions are deemed to be in immediate jeopardy; are subject to an immediate or serious threat; or when it has been demonstrated, on the basis of reliable evidence, that a provider has committed fraud, abuse, or other illegal or sanctionable action. For purposes of this provision, institutional providers include nursing facilities, intermediate care facilities for the mentally retarded, all residential psychiatric treatment facilities, group homes, and other facility-based residential treatment programs.

7.4. HSD reserves the right to terminate this Agreement for cause as summarized in this Agreement and as delineated in Section MAD-960, SANCTIONS AND REMEDIES of the Medical Assistance Division Provider Policy Manual.

ARTICLE VIII - IMPOSITION OF SANCTIONS FOR FRAUD OR MISCONDUCT

8.1. If the provider obtains an excess payment or benefit willfully, by means of false statement, representation, concealment of any material fact, or other fraudulent scheme or devise with intent to defraud, criminal sentences and fines and/or civil monetary penalties shall be imposed pursuant to, but not limited to, the Medicaid Fraud Act, NMSA 1978, §§ 30-44-1 et seq., 42 U.S.C. § 1320a-7b, and 42 C.F.R. § 455.23.

8.2. In addition to the above criminal civil penalties, HSD may impose monetary or non-monetary sanctions, including civil monetary penalties for provider misconduct or breach of any of the terms of this Agreement.

8.3. HSD may take any or a combination of the following actions against a provider for violation of the Medicaid Provider Act, NMSA 1978 §§ 27-11-1 et seq.:

(A) Imposition of an administrative penalty of not more than $5,000 for engaging in any practice that violates the Act; each separate occurrence of such practice constitutes a separate offense;

(B) Issue an administrative order requiring the provider to (1) cease or modify any specified conduct or practices engaged in by it or its employees, subcontractors, or agents; (2) fulfill its contractual obligations in the manner specified in the order; (3) provide any service that has been denied; (4) take steps to provide or arrange for any services that it has agreed or is otherwise obligated to make available; or (5) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by any opposing parties; or

(C) Suspend or revoke this Agreement.

8.4. HSD may elect to pursue one or a combination of all the delineated sanctions, as applicable.

ARTICLE IX - REFUSAL TO EXECUTE AN AGREEMENT

HSD will not execute an Agreement with a provider if the provider, his/her agent, managing employee, or any person having an ownership interest equal to five percent (5%) or greater in the health care provider commits or has committed any of the violations listed in Article 7.2. of this Agreement or other provisions delineated in Section MAD-960, REMEDIES AND SANCTIONS of the MAD Provider Policy Manual.

ARTICLE X - RECIPIENT FUND ACCOUNT

Nursing facilities, swing bed hospitals, and intermediate care facilities for the mentally retarded shall establish and maintain an acceptable system of accounting for recipients' personal funds, in the manner prescribed by HSD, in those cases in which clients entrust their personal funds to the facility.

ARTICLE XI - PRECONDITION FOR PARTICIPATION

The provider understands that signing this Agreement is a precondition for participating in health care programs administered by HSD. A provider understands that the provision of services, billing of services, and receipt of payments for services cannot occur until this Agreement is completed by the provider and approved for execution by HSD.

ARTICLE XII - NO WAIVERS

No terms or provisions of this Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and executed by the party claiming to have waived or consented.

ARTICLE XIII - APPLICABLE LAW

This Agreement shall be governed by the laws of the State of New Mexico. All legal proceedings arising from unresolved disputes under this Agreement are subject to administrative and judicial review as provided for in MAD-980, PROVIDER HEARING, of the MAD Provider Policy Manual.

ARTICLE XIV - ASSIGNMENT

The provider shall not assign or transfer any obligation, duty, or other interest in this Agreement, nor assign any claim for monies due under this Agreement without authorization of HSD. Any assignment or transfer which is not authorized by HSD shall be void.

ARTICLE XV - INDEMNIFICATION

The provider shall indemnify, defend, and hold harmless the State, HSD, its agents, and employees from any and all actions, proceedings, claims, demands, costs, damages, and attorney's fees, from all liabilities or expenses of any kind from any sources accruing to or resulting from the provider or its employees in connection with the performance of this Agreement and from all claims of any person or entity that may be directly or indirectly injured or damaged by the provider or its employees in the performance of this Agreement.

ARTICLE XVI - ENTIRE AGREEMENT

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter contained in this Agreement, and all such covenants, agreements, and understandings have been merged into this Agreement. No prior agreements, covenants, or understandings, either verbal or otherwise, of the parties or their agents shall be valid or enforceable unless contained in this Agreement.

This Agreement shall not be altered, changed, revised, or amended except by written instrument executed by the parties in the same manner as in this Agreement. Amendments shall contain an

effective date. Any amendments to this Agreement shall not be binding upon either party until approved in writing by HSD.

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and telephone number.

Contact Person: . . . . . .

Telephone Number: . . . . . .

BY SIGNATURE, THE PROVIDER AGREES TO ABIDE BY AND BE HELD TO ALL FEDERAL, STATE, AND LOCAL LAWS, RULES, AND REGULATIONS, INCLUDING, BUT NOT LIMITED TO THOSE PERTAINING TO MEDICAID AND THOSE STATED HEREIN. BY SIGNATURE, THE PROVIDER SOLEMNLY SWEARS UNDER PENALTY OF PERJURY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE.

Provider Name	Title - *(If applicable)*
Signature *(Original - Blue ink)*	Date

HUMAN SERVICES DEPARTMENT APPROVAL

☐ APPROVED ☐ NOT APPROVED

Reasons Not Approved:

. . . . . .

. . . . . .

. . . . . .

. . . . . .

Dates of Agreement: From_____ To:_____

Authorized Signature

Title	Date

ENTER QUANTITIES:	SNF / NF Beds	NF Beds	ICF Beds

Subject to Automatic Cancellation - Based upon revisit and correction of deficiencies	Date

FOR HUMAN SERVICES DEPARTMENT USE ONLY