

CSM SUPPORT GUIDE – IMPORTANT INFORMATION

The DAAS website has links to all forms now used by the Provider Certification Unit available at:

http://www.daas.ar.gov/provider_services.html

USEFUL TIPS

- Direct Deposit is the only type of payment method available for providers (no checks are mailed to providers).
- If a provider does not have a checking account, then the provider can use a debit card account to set-up his/her pay for direct deposit. If the provider does not have a debit card account, then the provider can contact Palco to receive help in acquiring a debit card.
- The selected provider(s) will **ONLY** be paid for their **assigned hours** on the current plan of care.
- If HP contacts a provider and tells him/her that there are no provider agreements, then please direct the provider to call the DAAS Provider Certification Unit. The provider must call **501-682-2441** and ask for the Provider Certification Unit.
- When HP sends the PIN Notification Letter to the provider, the letter does **NOT authorize the provider to start submitting claim forms to HP**. The DAAS RN will contact the provider to determine the effective date to submit claims. The notification letter DAAS sends to the provider, once DAAS receives the PIN notification from HP, states that the employer's DAAS nurse and Case Support Manager have been notified of the provider's approval.
- The DAAS RN will contact the provider and the provider's employer in the near future to discuss when the provider may begin work, how to bill for work time, the services available through HP Provider Assistance Program, and other important information.
- Providers can request a monthly (Direct Deposit) pay stub by sending Palco a letter requesting to receive future paystubs. The provider can fax or mail their signed and dated request to Palco. Palco's fax number: **501-821-0045**
- Please use the **daas.providers@arkansas.gov** email address to submit forms and/or questions.
- When a provider's name changes, use the **Change of Name Form**, and only use the **Change of Address Form** for an address change. When both a name and address need to be changed, both forms must be completed and submitted.

To access the Medicaid website, agency and environmental modification providers should visit:

<https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/inchoice.aspx>

Content Guide

- **Provider Certification Staff List**
- **“How the Provider Enrollment Application Process Works”**
- **“How the Environmental Modifications Process Works”**
- **Sample – Environmental Modifications Claim Form**
- **HP Welcome Letter (Sent to provider when HP assigns PIN.)**
- **Sample Letter – DAAS /Provider Certification (Sent when we are notified by HP that the PIN has been assigned.)**
- **Sample Expiration Notification Letter (Sent when the provider’s certificate has expired, and they have to reapply to be reinstated as a provider.)**
- **Sample – Attendant Care Claim Form**

PROGRAM CERTIFICATION STAFF**daas.providers@arkansas.gov****Office of LTC- slot S408-688-8430 or 501-682-8487****PALCO: Sherri Birley 501-753-4933 Provider Certification Unit FAX # 682-6245**

Staff	Position Title	Phone
Kevin Sullivan	Program Administrator	320-6582
Tami Rogers	Program Certification Manager	320-6583
Brenda Haney	Program Certification Manager	320-6587
Wanda Deloney	Administrative Specialist III	320-6465
Rick Paskel	Administrative Specialist II	320-6563
Julie Hatch	Program Certification Supervisor	320-6013
Richard Morgan	Administrative Specialist III/ EXTRA HELP	320-6590
Randy Triplett	Extra Help	N/A
Michelle Goodrich	Assisted Living	501-320-6198
Ramona Sangalli	Adult Family Home	501-320-6579
HP	1-800-457-4454 501-376-2211	Voice mail Option 2 - Claims processing Voice mail Option 3 - Provider enrollment

How the Provider Enrollment Process Works

Once your application is received by the Provider Certification Unit, we review it for accuracy. If there are corrections needed or if there is incomplete information, the Provider Certification Unit will contact you to let you know what follow up is required.

NOTE: Please allow a minimum of 2 weeks for HP to assign you a Medicaid Provider Information Number (PIN).

Once you receive your Medicaid PIN, follow these steps:

1. Once HP assigns you a Medicaid PIN number, HP will send you a letter stating that you are “eligible” to bill. **However, you are not authorized by Medicaid to work at this time.**
2. The Provider Certification Unit will send you a New Provider Information Packet, which contains your Attendant Care PIN number, your DAAS AAPD Provider Certificate, and a payroll calendar.
3. A DAAS RN will contact you to establish your work start date. After the start date is established, the RN will also provide the start date to the Provider Certification Unit.
4. After you are contacted by the DAAS RN, please allow **1-2 weeks** for the Provider Certification Unit to process your start date.

If you have not heard from the DAAS RN or from this office within the timeframes shown above, please call 501-682-2441 and ask for the Provider Certification Unit.

The quicker documents are returned, the quicker this process will go. When making copies of your driver’s license or social security card, please be sure it is clear and readable.

TIPS

How the Environmental Modification Claims Process Works

NOTE: Please be sure the following has been completed on your claim form to assist in getting your claim processed timely.

We must receive the original claim form. No copies will be accepted.

Once we receive your claim form, the Provider Certification Unit will review your claim for accuracy and for completeness. If corrections are needed, the Provider Certification Unit will contact you or the client's CSM to let you know what follow-up is required.

If we receive a correctly completed Environmental Modification claim form, we will forward the claim form to HP for processing.

Environmental Modification Claim Form Checklist

- Client Signature** is on the claim form.
- Diagnosis codes** are on the claim form.
- Dates of service** - Due to HP's processing procedures please use the date the work was completed—example 04/10/2015-04/10/2015.
- Provider Federal Tax ID number.**
- Provider PIN number.**
- The **CSM** must **initial and date** the claim form on the bottom right side of the claim form.
- Total dollar amount** being requested is accurate.
- Claim form has **the name of the provider, the provider's address, and the provider's phone number.**
- Client satisfaction statement** is properly signed and dated.
- Mail the **claim form** to:

**DHS/DAAS
ATTN: Certification Unit
PO BOX 1437-Slot S-530
Little Rock, AR 72203-1437**

If you have questions, please call 501-682-2441 and ask for the Provider Certification Unit.

1. MEDICARE MEDICAID CHAMPUS CAMPVA GROUP HEALTHPLAN (SSN or ID) FECA OTHER (ID)

la. INSURED I.D. NUMBER (for program in item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE
MM DD YY Gender Male

4. INSURED NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)
CITY AR
ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURER'S ADDRESS (No. Street)
CITY
ZIP CODE TELEPHONE (Include Area Code)

8. PATIENT STATUS
Single Married Other
Employed Full-Time Student Part-Time Student

9. OTHER INSURANCE'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS)
b. AUTO ACCIDENT? PLACE (State)
c. OTHER ACCIDENT? YES NO
10d. RESERVED FOR LOCAL USE

11. INSURER'S POLICY GROUP OR FECA NUMBER
INSURED'S DATE OF BIRTH MM DD YY GENDER M F
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE:

13. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. Give First Date MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN / OTHER SOURCE 17a. ID. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? Yes No \$ charges

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24 e BY LINE)
1. 34400

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

A		B					C		D		E	F	G	H	I	J	K
DATES OF SERVICE							Place	PROCEDURES, SERVICES, OR SUPPLIES		DIAGNOSIS	\$		EPSDT				RESERVED FOR
FROM	TO	MM	DD	YY	MM	DD	YY	Service	CPT/HCPCS	MODIFIER	CODE	CHARGES	HOURS	Plan	EMG	COB	
								12	S5165		34400						
								12	S5165								
								12	S5165								
								12	S5165								
								12	S5165								
								12	S5165								

24. FEDERAL TAX ID. NUMBER SSN FIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) Yes No

25. FEDERAL TAX ID. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) Yes No

28. TOTAL CHARGES \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (ICERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Name: _____

33. PROVIDER INFORMATION
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE #: _____

SIGNED Provider Signs & Dates DATE

**ARKANSAS
DEPARTMENT OF**



**DIVISION of
Aging and Adult
Services
PROVIDER CERTIFICATION UNIT**



P.O. Box 1437, Slot S-530 · Little Rock, AR 72203-1437 501-682-2441 · Fax: 501-682-8155 · TDD: 501-682-2443

[REDACTED] SAMPLE LETTER- SENT TO A NEW CERTIFIED PROVIDER
ALONG WITH THEIR CERTIFICATE AND 2015 PALCO PAYROLL SCHEDULE

SUBJECT: Alternatives for Adults with Physical Disabilities (AAPD)
Provider Identification Number (PIN): 111111111

CONGRATULATIONS! You are a valued provider to an AAPD recipient. Please observe the do's and don'ts to becoming the Best Provider you can be!

- ✓ **DO** renew your certificate two months prior to your expiration date. You can find the renewal application at: http://www.daas.ar.gov/provider_services.html. Click on *Annual Renewal for client-employed individuals*. Print form and mail to: DAAS/AAPD- Slot S530- PO Box 1437-Little Rock AR 72203

Your recent application for an AAPD provider certification is approved. Please mark your calendar now to remind you that this certificate expires 12/31/2015 [REDACTED]

Your employer's nurse and Case Support Manager have been advised of your approval. **They will be in contact with you and your employer in the near future to discuss when you may begin work**, how to bill for your work time, the services available to you through HP Provider Assistance Program and other important information.

Keep in mind that your employment is at the will of the client. The certificate is revoked immediately upon termination of employment. The status of your PIN is also dependent on your fully abiding by the regulations of the AAPD Program.

Among your responsibilities is to maintain complete and accurate time records and a log of the tasks that you perform. These documents serve as justification for your pay. Your employer's CSM can provide guidance in fulfilling this duty. Failure to maintain justification for payments can result in you having to repay undocumented costs.

Two months prior to the expiration of your certificate, please locate a renewal application on line at: www.daas.ar.gov/provider_services.html. Click on *Annual Renewal for client-employed individuals*. Print this form and mail to: DAAS/AAPD PO Box 1437- Slot S-530 Little Rock AR 72203.

We thank you for our dedicated work and look forward to our continued partnership that keeps your employer healthy and at home.

- **DON'T** work more than 40 hours per week. A work week starts on Sunday and ends at 12:01am Saturday.
- **DON'T** work for more than one client per day.

**Provider Certification Unit
Arkansas Department of Human Services**

www.arkansas.gov/dhhs
Serving more than one million Arkansans each year



Division of Aging
and Adult Services



P.O. Box 1437, Slot S-530 · Little Rock, AR 72203-1437
501-682-2441 · Fax: 501-682-8155 · TDD: 501-682-2443

December 3, 2014

SUBJECT: Alternatives for Adults with Physical Disability:

EMPLOYER:

Your recent application to renew your AAPD provider certification is approved. Please mark your calendar now to remind you that this certificate expires on **12/31/2015** it is your responsibility to ensure that it is renewed on an annual basis. This certificate enables you to continue working for client's name and receive compensation from Medicaid for work performed in accordance with the client's Plan of Care.

Keep in mind that your employment is at the will of the client. The certificate will be revoked immediately upon termination of employment. The status of your PIN is also dependent on your fully abiding by the regulations of the AAPD Program. You are strongly advised to periodically review **Service Agreement** that you and your employer entered into, as well as the **Attendant Care Manual** to refresh your memory on your responsibilities as a Medicaid provider. Both documents can be found on the DAAS website at http://www.daas.ar.gov/provider_services.html. (Please contact our office at 501-682-2441 if you need a copy of the documents mailed to you.)

Among your responsibilities is to maintain complete and accurate time records and a daily log of the tasks that you perform each day. These documents serve as justification for your payment claim. Failure to maintain justification for payments can result in you having to repay undocumented costs.

We thank you for your dedicated work.

Sincerely,

Provider Certification Unit

