American Samoa Medicaid State Agency
Office of the Governor
American Samoa Government

OUT-OF-COUNTRY MEDICAID PROVIDER ENROLLMENT APPLICATION

I/We, hereby apply to participate as a Provider and request for assignment of a Vendor and Provider Number under the American Samoa Medicaid Program.

Please Type or Print in Ink

Legal Business Name		
Doing Business As		
Type of Applicant (check one): ☐ Hospital ☐ FQHC/CHC ☐ Supplier ☐ Private Provider		
U.S. Bank Name	*U.S. Bank Routing Number*	*U.S. Bank Account No.*
Business Mailing Address		
Business Email	*Telephone*	*Fax*

PLEASE PROVIDE COPIES OF CURRENT BUSINESS LICENSE/CERTIFICATE OF TAX ID AND NATIONALLY RECOGNIZED MEDICAL CERTIFICATION AND CREDENTIALING DOCUMENTS.

PLEASE ATTACH LIST OF ALL PARTICIPATING HOSPITALS, PHYSICIANS OR ANY HEALTH PROFESSIONALS AFFILIATED WITHIN GROUP OR FACILITY PRACTICE WHO WILL BE PROVIDING SERVICES AND PROVIDE CURRENT PROFESSIONAL LICENSES/CERTIFICATES INFORMATION BELOW, AND ATTACH COPIES OF CURRENT PROFESSIONAL LICENSES/CERTIFICATES INCLUDING CURRICULUM VITAE, DIPLOMA, ETC. (ADD ADDITONAL SHEETS IF NEEDED).

PROVIDER NAME	SPECIALTY	CERTIFICATION	CONTACT INFO

American Samoa Medicaid Program Provider Agreement And Conditions Of Participation

The Provider agrees to the following terms and conditions:

1. To abide by the applicable provisions of the American Samoa Medicaid Program. Upon certification by the American Samoa Medicaid Program, I/We agree to abide by the policies and procedures contained in the American Samoa Medicaid State Plan.

2. To comply with the Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L. 94-135), and all requirements issued pursuant to the respective Title, Section and/or Act as promulgated by the regulations of the U.S. Department of Health and Human Services and hereby give assurance that I/We will immediately take any measure necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excused from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program.

3. To keep all records necessary to disclose fully, upon request, the extent of care and/or services provided to eligible American Samoa Medicaid beneficiaries, and to furnish these records to the American Samoa Medicaid State Agency, the Secretary of the U.S. Department of Health and Human Services, and any other regulatory agency as requested.

4. To comply with the provisions of HIPAA. In this Agreement "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub L. No. 104-191

5. That (1) information provided by the American Samoa Medicaid State Agency to a provider and by a provider will be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient. (2) Any information about Medicaid Providers and recipients shall be confidential, and shall not be disclosed. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the information.

6. To accept the established American Samoa Medicaid Programs reimbursement and payments as full payment and no to bill, accept or retain payments from patients or relatives for any additional amount.

7. To submit all charges within ninety (90) days after service date except for Medicaid with Third Party Liability (TPL) which should be submitted within sixty--(60) additional days from the receipt date of the TPL payments/statements.

8. To submit all claims/bills to the following address:

    American Samoa Medicaid State Agency
    Finance Division
    P.O. Box 998383
    Pago Pago, American Samoa 96799
    Telephone Number: (684) 699-4777/4778/4779
    Fax Number: (684) 699-4780

9. The violation of any of the conditions stated above would mean either of the following depending upon the discretion of the Director of the Medicaid State Agency:

    A. Withholding of claims and payments until a thorough investigation is made, or
    B. Denial of payment and /or suspension or termination from participation.

10. To provide the Medicaid State Agency any operation updates as soon as changes are in effect to include the list of physicians or any health professionals affiliated within institutional practice and renewal, termination or suspension of licenses and certificates.

11. That claims reconciliation is limited to three (3) years from the date of service.

12. We may be suspended or terminated from participation in the American Samoa Medicaid Program for non-adherence to any of the program requirements iterated in the Medicaid State Plan and Medicaid Policies and Procedures, and for violation of any provisions including, and not limited to, the following:

    a. Full and accurate disclosure of any person or persons convicted of a criminal offense relating to Medicaid or Medicare

    b. Fraud against the Medicaid Program, including but not limited to, the claiming and receipt of payment or payment for services not rendered, submission of a duplicate claim to the Medicaid program with intent to defraud and acceptance of payments for services already paid, or deliberate preparation of a claim in a manner which causes higher payment the amount entitled to.

    c. Requiring and receiving payment from a beneficiary that is a covered benefit under the American Samoa Medicaid State plan.

13. That this agreement may be terminated by a 60-day written notification by either the Provider or the Director of the Medicaid State Agency.

We have read all of the Provider Agreement and Condition of Participation in the American Samoa Medicaid Program and fully understand agree to its terms.

PROVIDER'S AUTHORIZED REPRESENTATIVE NAME | DATE

PRINT PROVIDER'S AUTHORIZED OFFICIAL NAME

PROVIDERS'S AUTHORIZED OFFICIAL TITLE

The Medicaid State Agency agrees:

1. To reimburse Provider for covered services in accordance with the program covered benefits.

2. That the American Samoa Medicaid State Agency will provide the Provider with written notice(s) of changes to the American Samoa Medicaid State Plan policies and procedures within thirty--(30) days of the effective date of said changes.

3. To process all "clean" claims within forty-five (45) days after receipt of invoices from Provider, clean claims are claims that can be processed without obtaining additional information and /or documentation from the Provider for the service.
   I have read the agreement/conditions of the American Samoa Medicaid Provider Agreement and fully understand and agree to the terms and conditions provided therein.

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MEDICAID'S AUTHORIZED OFFICIAL SIGNATURE | DATE

PRINT MEDICAID AUTHORIZED OFFICIAL NAME

MEDICAID'S AUTHORIZED OFFICIAL TITLE

FOR AMERICAN SAMOA MEDICAID STATE AGENCY USE ONLY

APRROVED: _____ _____

Sandra King Young, Medicaid Director DATE

EFFECTIVE DATE OF CONTRACT: _____

DATE OF CONTRACT TERMINATED: _____

PROVIDER NO./CODE: _____

VENDOR NO: _____