MAP-814 ***Please print or type.***

**COMMONWEALTH OF KENTUCKY**
**DEPARTMENT FOR MEDICAID SERVICES**
**And/Or**
**KENTUCKY HEALTH CARE PARTNERSHIP**

# EPSDT SPECIAL SERVICES SHORT FORM

**(Currently Enrolled Under Kentucky Medicaid Services – see exclusions below*)**

# PROVIDER APPLICATION

1. _____
**Current Medicaid Provider Number**
**(Must be currently enrolled non-excluded provider* to use this form.)**

2. _____
**Provider Name - OR Entity Name Enrolling**
☐ **Applying as Individual** ☐ **Applying as Entity/Group**

3. _____
**Doing Business As (DBA)** *(Other names also known as)*

4. _____
**Type of Service**

5. _____
**Date Provider Requests Effective Enrollment**

6. _____
**Name of Individual with Signature Authority**

7. _____
**Title of Individual with Signature Authority**

8. **FEIN (if applicable):** [__][__][__][__][__][__][__][__][__]
**or SSN** [__][__][__][__][__][__][__][__][__]

**I understand that all elements of my current agreement with Kentucky Medicaid will be met under EPSDT Special Services enrollment activities as further authorized below.**

**Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I continue to hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with this additional application for participation in the Kentucky Medicaid Program. I further certify that, if I keep medical records on an electronic database, those records are confidential and patient privacy is protected (KRS 205.510).**

**Provider Signature:**

_____

Name (please print): _____

Title: _____

Date: _____

**Health Care Partnership Signature:** _____

Name (please print): _____

Title: _____

Date: _____

**Department for Medicaid Services Signature:** _____

Name (please print): _____

Title: _____

Date: _____

***EXCLUDES PRIMARY CARE, RURAL HEALTH, IMPACT PLUS, NON-EMERGENCY TRANSPORTATION, QMB ONLY, AND WAIVER SERVICE ONLY PROVIDERS.**