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._____
Provider Name—or Name of Entity Enrolling
☐ **Applying as Individual** ☐ **Applying as Entity/Group**

2. _____
Doing Business as (DBA) ***(Other names also know as)***

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

4. _____
NPI (National Provider Identifier) Number

5._____
Type of Service

6. _____
Date Provider Requests Effective Enrollment

7._____
Name of Individual with Signature Authority

8._____
Title of Individual with Signature Authority

9. FEIN (if applicable): [__][__][__][__][__][__][__][__][__][__]
or Social Security Number [__][__][__][__][__][__][__][__][__][__]

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 from 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 provider service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health and Family Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each education 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 2005.510).
***EXCLUDES PRIMARY CARE, RURAL HEALTH, IMPACT PLUS, NON-EMERGENCY TRANSPORTATION, QMB ONLY, AND WAIVER SERVICE ONLY PROVIDERS.**

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: _____

Please return form to:
Kentucky Medicaid Provider Enrollment
P.O. Box 2110
Frankfort, KY 40602-2110

CLEAR FORM