MAP-380
(Rev 09/10)

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

This addendum to the Provider Agreement is made and entered into as of the _____day of
(Day)
_____, _____, by and between the Commonwealth of Kentucky, Cabinet for Health and
(Month) (Year)
Family Services, Department for Medicaid Services, hereinafter referred to as the Cabinet, and

_____, _____
(Provider Name) (Provider Address)

_____, _____, _____
(City) (State) (Zip Code)

hereinafter referred to as the provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Health and Family Services, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as

_____, _____, _____
(Type of provider) (Provider Number) NPI (National Provider Identifier)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP

B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent

C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media"

"This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may by prosecuted under applicable Federal and State Law."

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

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2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

Either party shall have the right to terminate this Addendum upon written notice without cause.

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

(Provider)

_____

(Provider Signature)

_____, _____
(Contact Person) (First and Last Name) (Title)

_____, _____
(Date) (Telephone Number)

_____, _____
(Software Vendor and/or Billing Agency) (Media)

Please return form to:
Electronic Claims Submission
P.O. Box 2016
Frankfort, KY 40602-2016
Phone: 800-205-4696
Fax: 502-209-3200