SANDHILLS CENTER
Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Provider Payment Agreement

Please complete all fields.

Provider Legal Business Name: _____ Date of Request: _____

DBA Name (if applicable):_____

Provider Type: ☐Agency ☐Hospital ☐Licensed Independent Practitioner ☐Group Practice

☐CABHA ☐Facility Only

Classification: ☐Not for Profit ☐C-Corp ☐ S-Corp ☐Sole Proprietorship ☐Limited Liability Partnership ☐Cooperative ☐Government ☐ General Partnership ☐Limited Liability Corp (LLC)

Physical Address (Street, City, State, Zip+4): _____

Mailing Address (if different): _____

Phone Number: _____ Email Address: _____

Federal Tax ID#: _____ Medicaid Number: _____

NPI Number: _____ Taxonomy Number: _____

*** Additional required for Licensed Independent Practitioner (LIP):**

Social Security #: _____ Date of Birth: _____

Name as appears on Degree: _____

Highest Degree/ Date earned/Academic Institution: _____

Consumer Name(s): _____

Consumer Date of Birth:

Consumer Medicaid Number:

Date(s) of Service: (start date and end date; see #7 below) _____

Service Code(s) with Service Description: _____

Notice to Provider:

Please note: **For hospitals, the PPA is used for inpatient care only. Services provided in the Emergency Department of a hospital do not require a PPA but should be billed directly; please see (insert link for ED billing here).**
***P*lease send the completed Provider Payment Agreement with the additional required documentation to:** Alexis Wright at alexisw@sandhillscenter.org, or fax: 336-389-6127 or mail to Sandhills Center, Attn: Contracts Unit, 201 N. Eugene Street, Greensboro, NC 27401.

The following documents must be included in the packet in order to process your payment request:

1. Signed Provider Payment Agreement
2. Proof of professional liability insurance coverage.
   NOTE: Required coverage is $1,000,000/$3,000.000.
3. Copies of provider's North Carolina licensure, current registration, and DEA certificate (if applicable.
4. Completed W-9 form.
5. Signed Trading Partner Agreement (TPA).
6. Completed Sandhills Center Service Authorization Request (SAR) form for all services.
   - Under the *Request for Service* on the SAR, please include the service code and service description.
   - The first date of service is the effective date.
   - The last day of service is the end date. (*For inpatient services, the last date of service is the day prior to discharge. SHC does not reimburse for the day of discharge.)*
   - The dates on the SAR should match the dates on the Provider Payment Agreement.
7. Copies of clinical notes for each day of service for which you are requesting reimbursement,
8. For inpatient services, copy of discharge summary as well as clinical notes for each day of service.

Timely Filing: Sandhills Center is strictly enforcing the timely filing of claims as posted on our website:

On the website, click on the "For Providers" tab, then click on the "Finance, Claims and Reimbursements" link on the left side of the page. The "Timely Filing Letter" is the 6th bullet on the page.

http://www.sandhillscenter.org/wp-content/uploads/gravity_forms/5-5ec8d7b302c060c872ed3c10d9f3d357/2016/08/Timely-filing-letter-and-guidelines-2016.pdf

Timely filing means that a submitted claim is complete and has been reviewed for medical necessity and approved for payment on or before the initial claims timely filing deadline.

Provider understands and agrees that reimbursement rates are established by Sandhills Center Provider agrees to accept payment from Sandhills Center as payment in full. In the event an overpayment has been made to Provider, Sandhills Center will provide an invoice to the Provider including the Enrollee(s) name and date(s) of service in question and the amount of overpayment. Provider shall have thirty (30) days from date of such notification to either appeal the determination or to remit the invoiced amount.

IN WITNESS WHEREOF:

The parties hereto have caused this Agreement to be signed by their respective Chief Officers and duly attested, the day, the month, and year first above written.

Sandhills Center

By: _____
Victoria Whitt Date
CEO

Provider Name

By: _____
Signature and Title Date

_____
Print Name

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act. General Statute 159.

By: _____
Hannah Brown Date
Finance Director