New Mexico Medicaid Project
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Albuquerque, NM 87106
505-246-9988 505-246-8485 (fax)

TYPE AND SPECIALTY LIST AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

Please use the following listing to determine the type (and specialty, if applicable) that you should apply under as well as the documentation that should be submitted with your Provider Participation Agreement(s). Detailed specific provider eligibility requirements and limitations on services in the Medicaid Program are specified in the MEDICAL ASSISTANCE PROGRAM POLICY MANUAL. If you have any questions, please contact ACS at the above number.

Please note that on the attached listing: "MAD" refers to the New Mexico Medical Assistance Division; "DOH" refers to the New Mexico Department of Health; and "CYFD" refers to the New Mexico Children, Youth, and Families Department.

GROUP PROVIDERS AND REQUIRED DOCUMENTS

The following individual provider types can enroll as groups within New Mexico Medicaid. Payments will be made to the group rather than to the individual providers. Servicing providers must also be enrolled in New Mexico Medicaid.

See specific requirements for individuals on the following pages.

Provider Name	Provider Type
Audiologists	331
Chiropractors	341
Dental Hygienists	423
Dentists	421
LISWs	444
LMFTs	436
LPCCs	435
Midwifes, Certified Nurse	322
Midwifes, Lay	323
Nurses, Certified Nurse Anesthetists	318
Nurses, Certified Nurse Practitioners	316
Nurses, Clinical Nurse Specialists	306
Nurses, Psychiatric Clinical Nurse Specialists	443
Occupational Therapists (Not Certified)	452
Occupational Therapists (Certified)	451
Opticians	334
Optometrists	335
Orthotists	336
Physical Therapists (Not Certified)	454
Physical Therapists (Certified)	453
Physicians	301/302
Podiatrists	325
Prosthetists	337
Prosthetists and Orthotists	338
Psychologists	431
Speech Therapists for Children	457

- Groups should complete the Provider Participation Agreement MAD 335 form and list the individuals providing services in box #32 of the provider participation agreement.

- Each of the individuals within the group should also be enrolled and complete the Provider Participation Agreement MAD 312 form (if they are not already actively enrolled in New Mexico Medicaid). For individuals already actively enrolled in New Mexico Medicaid, a signed letter should be submitted by the provider stating that they wish to be associated with the group.

- A business license must be submitted for all group applications, if business licenses are issued in your city/county/state.

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

GENERAL REQUIREMENTS

All provider types must supply the following information:

1. Complete W-9 (for providers completing Provider Participation Agreement, MAD 335 form only)
2. Proof of malpractice or liability insurance
3. Business license (for providers completing Provider Participation Agreement, MAD 335 form only)
4. Medicare letter designating provider # if participating with Medicare

Other: Certain providers are required to supply the following information:

1. Federal tax identification letter from the IRS (if federal tax # is listed in box 15 of MAD 335 form)
2. 501(c)3 tax exempt letter from the IRS (if box 20 on MAD 335 form is checked)
3. CLIA certificate (if CLIA # is listed in box 24 of MAD 335 form)
4. DEA certificate (if DEA # is listed in box 18 of MAD 312 form or box 26 of MAD 335 form)

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Adult Psychosocial Rehabilitation	441	080	* COPY OF DOH CERTIFICATE
Ambulance (Air)	401	None	* COPY OF DOH LICENSE *NOTE: OUT-OF-STATE AIR AMBULANCES ARE ENROLLED ONLY IF EMERGENCY SERVICES HAVE BEEN PROVIDED.*
Ambulance (Ground)	402	None	* COPY OF TARIFF FROM THE PUBLIC REGULATION COMMISSION (formerly State Corporation Comm.) * CERTIFICATE OF CONVENIENCE AND NECESSITY FROM THE PUBLIC REGULATION COMMISSION (formerly State Corporation Commission)
Ambulatory Surgical Center	364	None	* COPY OF DOH LICENSE * LETTER FROM HCFA/CMS CERTIFYING CENTER TO PARTICIPATE IN MEDICARE AS A FREE-STANDING AMBULATORY SURGICAL CENTER
Ambulatory Surgical Center (Indian Health Services or Tribal 638 Contracts)	364	None	* COPY OF LETTER FROM HCFA/CMS APPROVING FACILITY AS AN AMBULATORY SURGICAL CENTER
Anesthetist Assistant (EFFECTIVE JUNE 1, 2003)	319	None	* COPY OF ANESTHESIA ASSISTANT LICENSE * COPY OF CERTIFICATION FROM THE NATIONAL COMMISSION ON THE CERTIFICATION OF ANESTHESIOLOGISTS ASSISTANTS (NCCAA) *NOTE: ANESTHESIA ASSISTANTS MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. ANESTHESIA ASSISTANTS ARE NOT REIMBURSED DIRECTLY & MUST PRACTICE UNDER THE SUPERVISION OF LICENSED ANESTHESIOLOGISTS.*
Audiologist	331	None	* COPY OF AUDIOLOGIST LICENSE * COPY OF CERTIFICATION FROM THE AMERICAN SPEECH & HEARING ASSOCIATION
Behavior Management Services for Children	441	081	* COPY OF CYFD CERTIFICATION * LIST OF BOARD MEMBERS TO INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS
Blood Service Facility	321	None	* COPY OF LICENSE

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Case Management (In-State Only)			
Chronically Mentally Ill	462	060	* MUST BE CERTIFIED BY DOH
Medically At Risk (EPSDT) Children	462	061	* THE CASE MANAGEMENT AGENCY MUST SUBMIT A LETTER (ON AGENCY'S LETTERHEAD) STATING THAT THEY ARE A GOVERNMENT OR COMMUNITY AGENCY, AN INDIAN TRIBAL GOVERNMENT, INDIAN HEALTH SERVICE, OR A FEDERALLY QUALIFIED HEALTH CENTER
Developmentally Disabled Children	462	062	* MUST BE CERTIFIED BY DOH AND/OR CYFD
Developmentally Disabled Adults	462	063	* MUST BE CERTIFIED BY DOH
Maternal and Child Care (Families First)	462	064	* MUST BE CERTIFIED BY DOH, CERTIFICATION LETTER NEEDED FROM FAMILIES FIRST PROGRAM DIRECTOR
Traumatic Brain Injury	462	065	* THE CASE MANAGEMENT AGENCY MUST SUBMIT A LETTER (ON AGENCY'S LETTERHEAD) STATING THAT THEY ARE A GOVERNMENT OR COMMUNITY AGENCY, AN INDIAN TRIBAL GOVERNMENT, INDIAN HEALTH SERVICE, OR A FEDERALLY QUALIFIED HEALTH CENTER
Abused & Neglected Adults	462	066	* MUST BE A GOVERNMENT AGENCY (OR THEIR DELEGATE) WHICH BY LAW RECEIVES REPORTS OR ALLEGATIONS OF ABUSE, EXPLOITATION, OR NEGLECT AND WHO BY NEW MEXICO STATE LAW IS REQUIRED TO PROVIDE ADULT PROTECTIVE SERVICES FOR THE TARGET POPULATION
SED Children	462	067	* MUST BE CERTIFIED BY DOH AND/OR CYFD
Chiropractor	341	None	* COPY OF CHIROPRACTOR LICENSE * MEDICARE NUMBER MUST BE LISTED ON PROVIDER PARTICIPATION AGREEMENT AND HCFA/CMS LETTER SHOWING MEDICARE # MUST BE INCLUDED WITH THE AGREEMENT *NOTE: COVERAGE IS LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE ONLY.*
Clinic, Licensed Diagnostic Treatment Ctr Non-Profit	311	None	* COPY OF DOH LICENSE *NOTE: INDIVIDUAL PRACTITIONERS MUST ALSO BE ENROLLED IN NM MEDICAID & MUST BE LISTED IN BOX #32 OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM. THIS TYPE SHOULD NOT BE USED FOR PHYSICIAN GROUPS. SEE TYPES 301 & 302 FOR PHYSICIAN GROUPS.*
Clinic, Family Planning	312	None	* COPY OF DOH LICENSE
Clinic, Federally Qualified Health Center (FQHC)	313	None	* COPY OF LETTER FROM HCFA/CMS CERTIFYING CENTER AS AN FQHC * COPY OF LETTER FROM HCFA/CMS STATING FACILITY'S INTERIM RATE * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM *NOTE: SATELLITE SITES FOR FQHCs SHOULD APPLY FOR SEPARATE PROVIDER NUMBERS. INDIVIDUAL PROVIDERS EMPLOYED BY OR UNDER CONTRACT WITH FQHCs MUST ALSO BE ENROLLED WITH NEW MEXICO MEDICAID AND ISSUED PROVIDER NUMBERS.*

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Clinic, Rural Health			
Free Standing Facility	314	None	* COPY OF HCFA/CMS LETTER CERTIFYING CLINIC AS A RURAL HEALTH CLINIC * COPY OF MEDICARE LETTER SETTING REIMBURSEMENT RATE * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM
Hospital Services	315	None	* COPY OF HCFA/CMS LETTER CERTIFYING CLINIC AS A RURAL HEALTH CLINIC * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM
Dental Services	422	None	* COPY OF CURRENT LICENSE FROM THE BOARD OF DENTAL HEALTH CARE *NOTE: DENTISTS WHO WILL BE PROVIDING SERVICES SHOULD BE LISTED IN BOX #32 OF THE MAD 335 FORM. SERVICING PROVIDERS MUST ALSO BE ENROLLED IN NM MEDICAID.*
Pharmacy Services	417	None	* COPY OF CURRENT LICENSE FROM THE BOARD OF PHARMACY * LIST NABP # IN BOX #27 OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM
Counselor, Master's Level, Licensed	445	None	* COPY OF PROFESSIONAL ART THERAPIST (LPAT) LICENSE **OR** * COPY OF PROFESSIONAL MENTAL HEALTH COUNSELOR (LPC) LICENSE **OR** * COPY OF MENTAL HEALTH COUNSELOR (LMHC) LICENSE *NOTE: MASTER'S LEVEL LICENSED COUNSELORS MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. MASTER'S LEVEL LICENSED COUNSELORS ARE NOT REIMBURSED DIRECTLY. REIMBURSEMENT IS MADE TO COMMUNITY MENTAL HEALTH CENTERS, FEDERALLY QUALIFIED HEALTH CENTERS, INDIAN HEALTH SERVICES, EPSDT SCHOOL-BASED PROVIDERS OR ADULT PSYCHOSOCIAL REHABILITATION AGENCIES.*
Day Treatment	441	082	* COPY OF CURRENT CYFD CERTIFICATION * LIST OF BOARD MEMBERS TO INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS
Dental Hygienist **(EFFECTIVE OCTOBER 1, 2002)**	423	None	* COPY OF DENTAL HYGIENIST LICENSE * COPY OF COLLABORATIVE PRACTICE DENTAL HYGIENIST CERTIFICATION * COPY OF COLLABORATIVE PRACTICE AGREEMENT(S) BETWEEN THE DENTAL HYGIENIST & EACH CONSULTING DENTIST (AGREEMENTS MUST BE SIGNED & DATED BY BOTH THE DENTAL HYGIENIST AND DENTIST) * CURRENT LISTING OF CONSULTING DENTIST / DENTISTS, TO INCLUDE DENTISTS' NAMES, ADDRESSES, TELEPHONE NUMBERS, AND NEW MEXICO MEDICAID PROVIDER NUMBERS *NOTE: IN ORDER TO MAINTAIN ACTIVE MEDICAID ENROLLMENT, DENTAL HYGIENISTS MUST SUBMIT THE FOLLOWING INFORMATION ANNUALLY: (1) COPY OF SIGNED AND DATED COLLABORATIVE PRACTICE AGREEMENT(S) BETWEEN THE DENTAL HYGIENIST AND EACH CONSULTING DENTIST AND (2) CURRENT LISTING OF CONSULTING DENTIST(S) (INCLUDING DENTISTS' NAMES, ADDRESSES, TELEPHONE NUMBERS, AND NEW MEXICO MEDICAID FROM THE PREVIOUS YEAR. A COPY OF THE DENTAL HYGIENIST PROFESSIONAL PROVIDER NUMBERS) -- EVEN IF THE INFORMATION HAS NOT CHANGED LICENSURE ALSO MUST BE SUBMITTED UPON EXPIRATION.*

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Dentist-Individual			* COPY OF CURRENT DENTAL LICENSE
General Dentistry	421	055	* DEA CERTIFICATE, IF APPLICABLE
Oral Surgery	421	056	
Dentist-Group			* COMPLETE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, AND LIST DENTISTS WHO WILL
General Dentistry	421	055	BE PROVIDING SERVICES IN BOX #32. PAYMENTS WILL BE MADE TO THE GROUP RATHER THAN
Oral Surgery	421	056	TO THE INDIVIDUAL DENTISTS. SERVICING PROVIDERS MUST ALSO BE ENROLLED IN NM MEDICAID.
			* COPY OF BUSINESS LICENSE
Department Store	411	None	* COPY OF BUSINESS LICENSE
Dietician, Licensed	333	None	* COPY OF DIETICIAN LICENSE *NOTE: DIETICIANS MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. DIETICIANS ARE NOT REIMBURSED DIRECTLY. REIMBURSEMENT IS MADE TO THE GROUP/ORGANIZATION.*
Durable Medical Equipment	414	None	* SEE MEDICAL SUPPLY COMPANY
Early Intervention Services	441	083	* COPY OF PROVIDER CERTIFICATION LETTER FROM THE EARLY CHILDHOOD COORDINATOR, FAMILY INFANT TODDLER PROGRAM, DOH
Group Home			* SEE RESIDENTIAL TREATMENT CENTER, NON-JCAHO ACCREDITED
Handivan	403	None	*NOTE: PROVIDER PARTICIPATION AGREEMENT, MAD 335 IS SUBMITTED WITH "GENERAL REQUIREMENTS" INDICATED AT THE TOP OF THIS TYPE & SPECIALTY LIST. UPON REVIEW, MAD WILL ISSUE A "LETTER OF INTENT" TO ENABLE THE PUBLIC REGULATIONS COMMISSION TO ISSUE A PERMIT TO THE APPLICANT. MAD WILL APPROVE THE MEDICAID APPLICATION ONLY AFTER RECEIPT OF A COPY OF THE PRC PERMIT FROM THE APPLICANT.* * COPY OF WARRANTY (REQUIRED FOR NON-PROFIT BUSINESS ONLY)
Handivan -- Tribal Government (not I.H.S. & Tribal 638 Contract Programs)	403	None	* COPY OF LETTER OF EXEMPTION FROM TARIFF AND CERTIFICATE OF CONVENIENCE AND NECESSITY FROM THE PUBLIC REGULATION COMMISSION (formerly State Corporation Comm.) * PROOF OF INSURANCE
Hearing Aid Supplier	412	None	* COPY OF PROFESSIONAL LICENSE FROM REGULATION & LICENSING DEPARTMENT
Home & Community Based Waivers			* INDIVIDUAL APPLICATION FOR EACH WAIVER
Developmentally Disabled Waiver	344	070	* FEDERAL TAX IDENTIFICATION NUMBER
Disabled and Elderly Waiver	344	071	* GROSS RECEIPTS TAX NUMBER
HIV/AIDS Waiver	344	072	* COPY OF 501(c)3 LETTER IF APPLICABLE
Medically Fragile Waiver	344	073	
DD Waiver Case Management	344	074	
Disabled & Elderly Waiver -- Case Management	344	075	*NOTE: SERVICE ADDRESS MUST BE WITHIN THE STATE OF NEW MEXICO.*
HIV/AIDS Waiver -- Case Management	344	076	
Medically Fragile Waiver -- Case Management	344	077	
Home Health Agency	361	None	* COPY OF HOME HEALTH AGENCY LICENSE * COPY OF HCFA/CMS LETTER VERIFYING MEDICARE CERTIFICATION * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM * PAGE TWO OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, MUST BE COMPLETED TO INCLUDE OWNERSHIP DISCLOSURE (NAMES, ADDRESSES, AND PHONE NUMBERS)

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Hospice	362	None	* COPY OF HOSPICE LICENSE * COPY OF HCFA/CMS LETTER VERIFYING MEDICARE CERTIFICATION * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM * PAGE TWO OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, MUST BE COMPLETED TO INCLUDE OWNERSHIP DISCLOSURE (NAMES, ADDRESSES, AND PHONE NUMBERS)
Hospital - Inpatient/Outpatient **General, acute care hospital**	201	None	* COPY OF LICENSE FROM THE DOH * COPY OF HCFA/CMS LETTER VERIFYING MEDICARE HOSPITAL CERTIFICATION OR JCAHO ACCREDITATION LETTER * COPY OF CLIA CERTIFICATE * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM
Hospital, Rehabilitation Unit in a General Acute Hospital -- PPS Exempt	202	None	* COPY OF LICENSE FROM THE DOH * COPY OF HCFA/CMS LETTER VERIFYING MEDICARE HOSPITAL CERTIFICATION OR JCAHO ACCREDITATION LETTER * COPY OF CLIA CERTIFICATE * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM * PPS EXEMPT UNITS IN DRG HOSPITALS NEED TO SUBMIT A HCFA/CMS LETTER STATING THEY MEET PPS EXEMPTION REQUIREMENTS
Hospital, Psychiatric Unit in a General Acute Hospital -- PPS Exempt	204	None	* COPY OF LICENSE FROM THE DOH * COPY OF HCFA/CMS LETTER VERIFYING MEDICARE HOSPITAL CERTIFICATION OR JCAHO ACCREDITATION LETTER * COPY OF CLIA CERTIFICATE * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM * PPS EXEMPT UNITS IN DRG HOSPITALS NEED TO SUBMIT A HCFA/CMS LETTER STATING THEY MEET PPS EXEMPTION REQUIREMENTS
Hospital, Psychiatric	205	None	* COPY OF SPECIAL HOSPITAL (PSYCHIATRIC) LICENSE FROM DOH * COPY OF HCFA/CMS LETTER VERIFYING MEDICARE HOSPITAL CERTIFICATION OR JCAHO ACCREDITATION LETTER * COPY OF CLIA CERTIFICATE * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM
Rehabilitation Hospital	203	None	* COPY OF SPECIAL HOSPITAL (REHABILITATION) LICENSE FROM DOH * COPY OF HCFA/CMS LETTER VERIFYING MEDICARE HOSPITAL CERTIFICATION OR JCAHO ACCREDITATION LETTER * COPY OF CLIA CERTIFICATE * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM
Hospital-Swing Bed	213	None	* CONTACT MAD, PLANNING AND PROGRAM OPERATIONS BUREAU, 505-827-3156 FOR INFORMATION

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Hospital - Indian Health Service or Tribal 638 Contract Facility			
Hospital	221	100	* COPY OF HCFA/CMS CERTIFICATION AS AN IHS FACILITY OR COPY OF TRIBAL 638 CONTRACT W/IHS * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM *NOTE: PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, MUST LIST SERVICING PROVIDERS IN BOX #32. SERVICING PROVIDERS MUST ALSO BE ENROLLED IN NM MEDICAID AS APPROPRIATE.*
Dental	221	102	* COPY OF HCFA/CMS CERTIFICATION AS AN IHS FACILITY OR COPY OF TRIBAL 638 CONTRACT W/IHS * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF MAD 335 FORM *NOTE: PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, MUST LIST SERVICING DENTISTS IN BOX #32. SERVICING DENTISTS MUST ALSO BE ENROLLED IN NM MEDICAID AS APPROPRIATE.*
Intermediate Care Facility for MR, Privately Owned	214	None	* GROSS RECEIPTS TAX NUMBER * FEDERAL IDENTIFICATION NUMBER * COPY OF 501(c)3 LETTER, IF APPLICABLE
Intermediate Care Facility for MR, State Owned	215	None	* GROSS RECEIPTS TAX NUMBER * FEDERAL IDENTIFICATION NUMBER * COPY OF 501(c)3 LETTER, IF APPLICABLE
IV Infusion Services	415	None	* COPY OF BUSINESS LICENSE
Laboratory, Clinic	351	None	* COPY OF CLIA CERTIFICATE OF WAIVER OR A CERTIFICATE OF REGISTRATION APPLICABLE TO THE CATEGORY OF PROCEDURES PERFORMED BY THE LABORATORY * COPY OF BUSINESS LICENSE
Laboratory, Clinic with X-Ray	353	None	* COPY OF CLIA CERTIFICATE OF WAIVER OR A CERTIFICATE OF REGISTRATION APPLICABLE TO THE CATEGORY OF PROCEDURES PERFORMED BY THE LABORATORY * COPY OF BUSINESS LICENSE
LADAC (Licensed Alcohol and Drug Abuse Counselor)	440	None	* COPY OF LADAC LICENSE *NOTE: LADACs MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. LADACs ARE NOT REIMBURSED DIRECTLY. REIMBURSEMENT IS MADE TO COMMUNITY MENTAL HEALTH CENTERS, OUTPATIENT HOSPITAL FACILITIES, INDIAN HEALTH SERVICES, FEDERALLY QUALIFIED HEALTH CENTERS, TRIBAL HEALTH CLINICS, OR SCHOOL-BASED PROVIDERS.*
LMFT (Licensed Marriage & Family Therapist)	436	None	* COPY OF LMFT LICENSE
LPCC (Licensed Professional Clinical Mental Health Counselor)	435	None	* COPY OF LICENSE WITH EITHER "LPCC" OR THE TITLE "PROFESSIONAL CLINICAL MENTAL HEALTH COUNSELOR" DESIGNATED ON IT
Lodging/Meals Provider	346	None	* COPY OF BUSINESS LICENSE
Medical Supply Company (DME Provider)	414	None	* COPY OF BUSINESS LICENSE

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Mental Health Clinic, not certified by DOH	432	None	* COPY OF BUSINESS LICENSE *NOTE: SERVICING PROVIDERS (PSYCHIATRISTS, PSYCHOLOGISTS, CLINICAL NURSE SPECIALISTS, LISWs, LPCCs, OR LMFTs) MUST ALSO BE ENROLLED IN NEW MEXICO MEDICAID AND MUST BE LISTED IN BOX #32 OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM.*
Mental Health Community Center, certified by DOH	433	None	* COPY OF CERTIFICATION FROM THE DOH * COPY OF BUSINESS LICENSE *NOTE: SERVICING PROVIDERS (PSYCHIATRISTS, PSYCHOLOGISTS, CLINICAL NURSE SPECIALISTS, LADACs, LISWs, LPCCs, OR LMFTs) MUST ALSO BE ENROLLED IN NEW MEXICO MEDICAID AND MUST BE LISTED IN BOX #32 OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM.*
Midwife, Certified Nurse	322	None	* COPY OF LICENSE THAT STATES "CERTIFIED NURSE MIDWIFE"
Midwife, Lay	323	None	* COPY OF LICENSE THAT STATES "LICENSED MIDWIFE"
Nurse - Certified Nurse Anesthetist	318	None	* COPY OF LICENSE * DEA CERTIFICATE, IF APPLICABLE
Nurse - Certified Nurse Practitioner			* COPY OF LICENSE
General	316	090	* COPY OF NATIONAL BOARD CERTIFICATION
Family	316	091	* COPY OF DEA CERTIFICATE, IF APPLICABLE
Pediatrics	316	092	
Obstetrics	316	093	
Nurse - Clinical Nurse Specialist	306	None	* COPY OF NM BOARD OF NURSING LICENSE WITH THE TITLE "CLINICAL NURSE SPECIALIST" DESIGNATED ON IT * COPY OF DEA CERTIFICATE, IF APPLICABLE
Nurse - Psychiatric Clinical Nurse Specialist	443	None	* COPY OF NM BOARD OF NURSING LICENSE WITH THE TITLE "CLINICAL NURSE SPECIALIST" DESIGNATED ON IT * COPY OF CERTIFICATION BY THE AMERICAN NURSES ASSOCIATION (ANA) OR ANOTHER RECOGNIZED NATIONAL NURSING ORGANIZATION THAT INDICATES A CLINICAL SPECIALTY IN ADULT, ADOLESCENT, CHILD PSYCHIATRIC OR MENTAL HEALTH NURSING * COPY OF DEA CERTIFICATE, IF APPLICABLE
Nursing Facility-Privately Owned	211	None	* CONTACT MAD, PLANNING AND PROGRAM OPERATIONS BUREAU, 505-827-3156 FOR INFORMATION
Nursing Facility-State Owned	212	None	* CONTACT MAD, PLANNING AND PROGRAM OPERATIONS BUREAU, 505-827-3156 FOR INFORMATION
Nursing, Private Duty Nursing Agency	324	None	* COPY OF NM HOME HEALTH AGENCY LICENSE OR * COPY OF LETTER FROM HCFA/CMS SHOWING CERTIFICATION AS AN FQHC
Nutritionist and Dietician Services			* SEE DIETICIAN SERVICES

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Occupational Therapist-Licensed (not certified)	452	None	* COPY OF OCCUPATIONAL THERAPIST LICENSE
Occupational Therapist-Licensed & Certified	451	None	* COPY OF OCCUPATIONAL THERAPIST LICENSE * COPY OF MEDICARE CERTIFICATION *NOTE: LICENSED & CERTIFIED OCCUPATIONAL THERAPISTS MUST HAVE A MEDICARE PROVIDER NUMBER & BE CERTIFIED BY MEDICARE FOR PRIVATE PRACTICE*
Optician	334	None	* COPY OF BUSINESS LICENSE
Optometrist	335	None	* COPY OF OPTOMETRIST LICENSE
Orthotist	336	None	* COPY OF BUSINESS LICENSE
Oxygen Supplier	414	None	* COPY OF BUSINESS LICENSE
Personal Care Agency	363	None	* CONTACT MAD, PLANNING AND PROGRAM OPERATIONS BUREAU, 505-827-3187 FOR INFORMATION
Pharmacist Clinician	320	None	* COPY OF LICENSE * LETTER FROM BOARD OF PHARMACY STATING THAT THE APPLICANT MAY PRACTICE AS A PHARMACIST CLINICIAN *NOTE: PHARMACIST CLINICIANS MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. PHARMACIST CLINICIANS ARE NOT REIMBURSED DIRECTLY AND MUST PRACTICE UNDER THE DIRECTION AND SUPERVISION OF LICENSED PHYSICIANS.*
Pharmacy - In-State	416	None	* COPY OF CURRENT PHARMACY LICENSE * COPY OF DEA CERTIFICATE * NABP # SHOULD BE LISTED IN BOX #27 OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM.
Pharmacy - Indian Health Services or Tribal 638 Contract	416	None	* COPY OF 638 CONTRACT W/IHS * COPY OF DEA CERTIFICATE * LIST NABP # IN BOX #27 OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM.
Pharmacy - Out-of-State	416	None	* COPY OF CURRENT PHARMACY LICENSE * COPY OF DEA CERTIFICATE * LIST NABP # IN BOX #27 OF THE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM. * COPY OF A NEW MEXICO NON-RESIDENTIAL PHARMACY LICENSE MUST BE SUBMITTED BY PHARMACIES LOCATED OUTSIDE OF NEW MEXICO THAT SHIP, MAIL, OR DELIVER IN ANY MANNER PRESCRIPTION DRUGS TO NEW MEXICO PATIENTS OR CONSUMERS
Physical Therapist-Licensed (not certified)	454	None	* COPY OF PHYSICAL THERAPIST LICENSE
Physical Therapist-Licensed & Certified	453	None	* COPY OF PHYSICAL THERAPIST LICENSE * COPY OF MEDICARE CERTIFICATION *NOTE: LICENSED & CERTIFIED PHYSICAL THERAPISTS MUST HAVE A MEDICARE PROVIDER NUMBER & BE CERTIFIED BY MEDICARE FOR PRIVATE PRACTICE*

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Physician - Individual - MD	301	See Pg 14	* COPY OF MD LICENSE * COPY OF SPECIALTY CERTIFICATION (NATIONAL BOARD CERTIFICATION, RESIDENCY PROGRAM CERTIFICATION, OR LETTER FROM CHAIRPERSON OF RESIDENCY PROGRAM STATING THAT TRAINING WAS RECEIVED IN THE SPECIALTY AREA) * COPY OF DEA CERTIFICATE * PROOF OF MALPRACTICE OR LIABILITY INSURANCE
Physician - Group - MD	301	See Pg 14	* COMPLETE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, AND LIST PHYSICIANS WHO WILL BE PROVIDING SERVICES IN BOX #32. PAYMENTS WILL BE MADE TO THE GROUP RATHER THAN TO THE INDIVIDUAL PHYSICIANS. INDIVIDUALS MUST ALSO BE ENROLLED IN NM MEDICAID. * COPY OF BUSINESS LICENSE
Physician - Individual - DO	302	See Pg 14	* COPY OF DO LICENSE * COPY OF SPECIALTY CERTIFICATION (NATIONAL BOARD CERTIFICATION, RESIDENCY PROGRAM CERTIFICATION, OR LETTER FROM CHAIRPERSON OF RESIDENCY PROGRAM STATING THAT TRAINING WAS RECEIVED IN THE SPECIALTY AREA) * COPY OF DEA CERTIFICATE * PROOF OF MALPRACTICE OR LIABILITY INSURANCE
Physician-Group-DO	302	See Pg 14	* COMPLETE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, AND LIST PHYSICIANS WHO WILL BE PROVIDING SERVICES IN BOX #32. PAYMENTS WILL BE MADE TO THE GROUP RATHER THAN TO THE INDIVIDUAL PHYSICIANS. INDIVIDUALS MUST ALSO BE ENROLLED IN NM MEDICAID. * COPY OF BUSINESS LICENSE
Physician-Professional Component for a Hospital	303	See Pg 14	* COMPLETE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, AND LIST PHYSICIANS WHO WILL BE PROVIDING SERVICES IN BOX #32. PAYMENTS WILL BE MADE TO THE GROUP RATHER THAN TO THE INDIVIDUAL PHYSICIANS. INDIVIDUALS MUST ALSO BE ENROLLED IN NM MEDICAID. * COPY OF BUSINESS LICENSE
Physician-Professional Component for a Residential Provider	304	See Pg 14	* COMPLETE PROVIDER PARTICIPATION AGREEMENT, MAD 335 FORM, AND LIST PHYSICIANS WHO WILL BE PROVIDING SERVICES IN BOX #32. PAYMENTS WILL BE MADE TO THE GROUP RATHER THAN TO THE INDIVIDUAL PHYSICIANS. INDIVIDUALS MUST ALSO BE ENROLLED IN NM MEDICAID. * COPY OF BUSINESS LICENSE
Physician Assistant	305	None	* COPY OF PHYSICIAN ASSISTANT LICENSE * COPY OF CERTIFICATE FROM THE NATIONAL COMMISSION OF PHYSICIAN ASSISTANTS * FOR I.H.S. OR TRIBAL 638 CONTRACT PROVIDERS, A COPY OF THE CERTIFICATE FROM THE NATIONAL COMMISSION OF PHYSICIAN ASSISTANTS IS REQUIRED--A LICENSE IS NOT REQUIRED *NOTE: PHYSICIAN ASSISTANTS MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. PHYSICIAN ASSISTANTS ARE NOT REIMBURSED DIRECTLY AND MUST PRACTICE UNDER LICENSED PHYSICIANS.*
Podiatrist	325	None	* COPY OF PODIATRY LICENSE
Prosthetist	337	None	* COPY OF BUSINESS LICENSE
Prosthetist & Orthotist	338	None	* COPY OF BUSINESS LICENSE

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Psychologist (Ph.D., Ed.D., or Psy.D.)	431	None	* COPY OF LICENSE -- CLINICAL PSYCHOLOGIST NOT "PSYCHOLOGIST ASSOCIATE"
Psychologist, Associate Licensed	439	None	* COPY OF PSYCHOLOGIST ASSOCIATE LICENSE *NOTE: LICENSED PSYCHOLOGIST ASSOCIATES MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. LICENSED PSYCHOLOGIST ASSOCIATES ARE NOT REIMBURSED DIRECTLY. REIMBURSEMENT IS MADE TO COMMUNITY MENTAL HEALTH CENTERS, FEDERALLY QUALIFIED HEALTH CENTERS, INDIAN HEALTH SERVICES, EPSDT SCHOOL-BASED PROVIDERS OR ADULT PSYCHOSOCIAL REHABILITATION AGENCIES.*
Psychologist, School Certified	438	None	* COPY OF SCHOOL PSYCHOLOGIST LICENSE ISSUED BY THE STATE DEPARTMENT OF EDUCATION *NOTE: SCHOOL CERTIFIED PSYCHOLOGISTS MUST BE SUPERVISED BY A PSYCHIATRIST OR A Ph.D. OR Psy.D., OR Ed.D. LICENSED AS A PSYCHOLOGIST BY THE NEW MEXICO PSYCHOLOGIST EXAMINERS BOARD. LICENSED SCHOOL PSYCHOLOGISTS MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. SCHOOL CERTIFIED PSYCHOLOGISTS ARE NOT REIMBURSED DIRECTLY. REIMBURSEMENT IS MADE TO LOCAL EDUCATION AGENCIES (LEAs).*
Radiology Facility	352	None	* COPY OF BUSINESS LICENSE
Radiology Facility with Clinic Laboratory	353	None	* CLIA CERTIFICATE OF WAIVER OR A CERTIFICATE OF REGISTRATION APPLICABLE TO THE CATEGORY OF PROCEDURES PERFORMED BY THE LABORATORY. * COPY OF BUSINESS LICENSE
Rehabilitation Center, Certified	455	None	* COPY OF DOH LICENSE -- LICENSE CAN BE FOR EITHER A LIMITED DIAGNOSTIC AND TREATMENT CENTER OR A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) * MEDICARE CERTIFICATION LETTER AS A REHABILITATION CENTER
Renal Dialysis Facility	447	None	* COPY OF DOH LICENSE * COPY OF MEDICARE LETTER FROM HCFA/CMS CERTIFYING FACILITY AS A RENAL DIALYSIS FACILITY * COPY OF MEDICARE COMPOSITE RATE LETTER * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF THE PROVIDER PARTICIPATION AGREEMENT FORM, MAD 335
Residential Treatment Center, JCAHO Accredited	216	None	* COPY OF CYFD CERTIFICATION * COPY OF JCAHO ACCREDITATION AS A CHILDREN'S RTC * LIST OF BOARD MEMBERS TO INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF THE PROVIDER PARTICIPATION AGREEMENT FORM, MAD 335
Residential Treatment Center, Non-JCAHO Accredited	217	None	* COPY OF CYFD CERTIFICATION * LIST OF BOARD MEMBERS TO INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS * FISCAL YEAR-END DATE SHOULD BE LISTED IN BOX #30 OF THE PROVIDER PARTICIPATION AGREEMENT FORM, MAD 335

TYPE AND SPECIALTY SELECTION AND DOCUMENTATION REQUIREMENTS FOR PROVIDER PARTICIPATION AGREEMENTS

PROVIDER NAME	Provider Type	Provider Specialty	REQUIREMENTS
Schools	345	None	* LETTER OF INTENT * SIGNED JOINT POWERS AGREEMENT BETWEEN THE HUMAN SERVICES DEPARTMENT AND THE SCHOOL * COLLABORATIVE PLAN NEEDS TO BE SENT BY THE SCHOOL TO SDE
Audiologist in the Schools	331	None	* COPY OF AUDIOLOGIST LICENSE
Case Management in the Schools	462	061	* SUBMITTAL OF THE *SCHOOL-BASED CASE MANAGEMENT SERVICES INDIVIDUAL QUALIFICATION CERTIFICATION FORM* (form is attached to the Provider Participation Agreement packet) SIGNED BY LEA REPRESENTATIVE VERIFYING THAT THE APPLICANT MEETS THE CASE MANAGEMENT QUALIFICATIONS IN MAD POLICY
LISW in the Schools	444	None	* COPY OF LISW LICENSE
Occupational Therapist in the Schools	452	None	* COPY OF OCCUPATIONAL THERAPIST LICENSE FROM THE REGULATION AND LICENSING DEPT. * COPY OF LICENSE FROM THE STATE DEPARTMENT OF EDUCATION
Physical Therapist in the Schools	454	None	* COPY OF PHYSICAL THERAPIST LICENSE FROM THE REGULATION AND LICENSING DEPT. * COPY OF LICENSE FROM THE STATE DEPARTMENT OF EDUCATION
Speech Therapist in the Schools	458	None	* COPY OF LICENSE FROM THE REGULATION AND LICENSING DEPT. * COPY OF LICENSE FROM THE STATE DEPARTMENT OF EDUCATION
Social Worker, LISW (Licensed Independent Social Worker)	444	None	* COPY OF LISW LICENSE
Social Worker, LMSW (Licensed Master's Level Social Worker)	437	None	* COPY OF MASTER'S SOCIAL WORKERS (LMSW) LICENSE *NOTE: LMSWs MUST COMPLETE THE PROVIDER PARTICIPATION AGREEMENT, MAD 312 FORM. LMSWs ARE NOT REIMBURSED DIRECTLY. REIMBURSEMENT IS MADE TO COMMUNITY MENTAL HEALTH CENTERS, FEDERALLY QUALIFIED HEALTH CENTERS, INDIAN HEALTH SERVICES, EPSDT SCHOOL-BASED PROVIDERS OR ADULT PSYCHOSOCIAL REHABILITATION AGENCIES.*
Speech Therapist for Children	457	None	* COPY OF LICENSE FROM THE REGULATION AND LICENSING DEPT.
Swing Bed portion of a Hospital	213	None	* CONTACT MAD, PLANNING AND PROGRAM OPERATIONS BUREAU, 505-827-3156 FOR INFORMATION
Taxi	404	None	*NOTE: PROVIDER PARTICIPATION AGREEMENT, MAD 335 IS SUBMITTED WITH "GENERAL REQUIREMENTS" INDICATED AT THE TOP OF THIS TYPE & SPECIALTY LIST. UPON REVIEW, MAD WILL ISSUE A "LETTER OF INTENT" TO ENABLE THE PUBLIC REGULATIONS COMMISSION TO ISSUE A PERMIT TO THE APPLICANT. MAD WILL APPROVE THE MEDICAID APPLICATION ONLY AFTER RECEIPT OF A COPY OF THE PRC PERMIT FROM THE APPLICANT.* * COPY OF WARRANTY (REQUIRED FOR NON-PROFIT BUSINESS ONLY)
Taxi -- Tribal Government (not I.H.S. & Tribal 638 Contract Programs)	404	None	* COPY OF LETTER OF EXEMPTION FROM TARIFF AND CERTIFICATE OF CONVENIENCE AND NECESSITY FROM THE PUBLIC REGULATION COMMISSION (formerly State Corporation Comm.) * PROOF OF INSURANCE
Treatment Foster Care Services	218	None	* COPY OF CYFD CERTIFICATION AND LICENSE * COPY OF PROTECTIVE SERVICES DIVISION CHILD PLACEMENT AGENCY LICENSE * LIST OF BOARD MEMBERS TO INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS

SPECIALTIES FOR PHYSICIANS

Specialty	Code		Specialty	Code
ALLERGY	003		OPHTHALMOLOGY	018
ALLERGY, PEDIATRIC	043		ORTHOPEDIC SURGERY	020
ANESTHESIOLOGY	005		PAIN MANAGEMENT	027
CARDIOLOGY	006		PATHOLOGY	022
CARDIOLOGY, PEDIATRIC	042		PEDIATRICS	037
DERMATOLOGY	007		PERIPHERAL VASCULAR DISEASE	023
EAR, NOSE & THROAT	004		PHYSICAL MEDICINE & REHABILITATION	025
EMERGENCY MEDICINE	021		PLASTIC SURGERY	024
ENDOCRINOLOGY	048		PREVENTIVE MEDICINE	046
EYE, EAR, NOSE & THROAT	017		PROCTOLOGY	028
FAMILY PRACTICE	008		PSYCHIATRY	026
GASTROENTEROLOGY	010		PSYCHIATRY, CHILD/ADOLESCENT	047
GENERAL PRACTICE	001		PUBLIC HEALTH	044
GENERAL SURGERY	002		PULMONARY DISEASE	029
GERIATRICS	038		RADIATION THERAPY	032
HAND SURGERY	040		RADIOLOGY	030
HEMATOLOGY/ONCOLOGY	011		THORACIC SURGERY	033
INTERNAL MEDICINE	041		UROLOGY	034
MANIPULATIVE THERAPY	012		MULTIPLE SPECIALTIES (FOR GROUPS ONLY)	049
NEONATOLOGY	019			
NEPHROLOGY	039			
NEUROLOGICAL SURGERY	014			
NEUROLOGY	013			
NUCLEAR MEDICINE	036			
OB-GYN	016			
OBSTETRICS	015			