Early Steps Provider Billing Guide

Early Steps Contracted Provider Billing Guidelines

Background

As a contracted provider you are responsible for your business. You may be operating as one of the following:

Sole Proprietorship
Partnership
S Corporation
Corporation
Limited Liability Company (LLC)

For more information on types of business go to https://www.irs.gov/businesses/small-businesses-self-employed/business-structures

Factors to consider:

- If you are using a name other than your own, you will need to register it at Sunbiz https://efile.sunbiz.org/ficregintro.html
- Most counties require you register your business and obtain a business license. Check with your county tax collector on how to obtain a Business License and if the payment of addition business taxes is required.
- If you are not a sole proprietor you will need to obtain Workers Compensation coverage or an exemption for your business.
- If you are not a sole proprietor you will need to verify employment eligibility for all your employees, in accordance with e-verify.
- For more information on starting your own business go to http://dos.myflorida.com/library-archives/research/florida-information/business/starting-a-business-in-florida/

Early Steps is the payer of last resort

ES is the payer of last resort (per Policy Handbook and Operations Guide (PHOG) and Code of Federal regulations 34CFR 303.510). This means that you will need to bill private insurance and Medicaid for the services you provide prior to billing early steps funds. If the insurance company or Medicaid does not pay you, or pays you less than the early steps/medicaid rate, then you will submit a denial to ES so we can use Part C (early steps) funds for payment. You will hear private insurance referred to as TPIN (third party insurance) and Medicaid as MED as these are the codes we use in the early steps data system.

A. The order in which funding for services are to be sought is as follows (PHOG 1.4.5):

1. Commercial insurance
2. Medicaid
3. Community funding
4. Other state program funds
5. Other federal program funds
6. IDEA, Part C funds

B. When a child has both Medicaid and Private Health insurance, Medicaid requires all the private insurance company is billed prior to submitting the claim to Medicaid (Medicaid Rules). **However, ITDS providers are not required to bill Private insurance and can submit claims directly to Medicaid.**

When a child has private insurance or Medicaid, a copy of the explanation of benefits (EOB) sometimes known as the remittance advice (RA) or explanation of payment (EOP) must be submitted with each claim showing a valid and non-correctable denial reason.

Enrolling with Early Steps, Medicaid and Other Insurance providers

Credentialing and Re-Credentialing

When you apply to become a provider for early steps you will go through a credentialing process. This means we will ask for documentation to show you have the necessary qualifications to become an early steps provider. We ask all providers to also register with CAQH so their information can be easily accessed by the Medicaid plans. You can find the application for CAQH here https://proview.caqh.org/pr/registration. You must send us copies of your documents when they are renewed, for example we will need your new auto insurance declaration page every 6-months when your policy renews. Early Steps require all our ITDS providers to be re-credentialed every three years, and our licensed providers will be updated every two years at the time they receive their new license. A copy of our credentialing policies can be found on our website at www.hpcswf.com.

Enrolling with Medicaid

When you become an early steps enrolled provider you are required to enroll in Medicaid as an Early Intervention Provider (Provider Type 81). In addition, Occupational therapists, Physical therapists, Speech Language pathologists, Nurses, Licensed Mental health counselors and other licensed providers are also required to enroll in the Medicaid Therapy program as the specific provider type. Licensed providers will therefore receive two Medicaid numbers, one for EI and one for therapy. Medicaid has many different programs, the Early Intervention Services program pays for Early Steps evaluations and Early Intervention Service visits. The Medicaid Early Intervention Service Handbook can be found at http://ahca.myflorida.com/medicaid/review/specific_policy.shtml. When a child has Medicaid the services are billed to the Medical Managed Assistance (MMA) plan that the child is enrolled in. Occasionally a child may have full Medicaid an is not enrolled in an MMA plan. In this case the Medicaid service will be billed directly to AHCA through the Medicaid portal.

The Medicaid enrollment application can be accessed at https://portal.flmmis.com/FLPublic/Provider_Enrollment/tabId/50/Default.aspx

The Medicaid Early Intervention enrollment application requires the following

1. Provider NPI number (this can be found at https://nppes.cms.hhs.gov/NPPES/Welcome.do)
2. Taxonomy code (The code for EI Provider type is 222Q00000X)

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Please ensure all your documents have **EXACTLY** the same name and address. Your NPI number must show the same name and must list ALL the taxonomy codes you used on your Medicaid applications.

Medicaid Therapy Program

Medicaid has a Therapy programs for services delivered by Occupational therapists, Physical therapists and Speech Language pathologists. Each discipline now has a handbook listed under rules on the AHCA website at http://ahca.myflorida.com/medicaid/review/specific_policy.shtml. As a therapist you must enroll as both a Medicaid EI provider and a Medicaid Therapy provider. One you receive your two different Medicaid numbers you will n to enroll with each different MMA plan. Our Local Early Steps (LES) has contracts with most of the plans in our area (see "Medicaid Managed Care" below for your options on how to enroll with each plan).

Medicaid Enrollment Details

Once you're enrolled check your details are 100% correct in the Medicaid Provider Master list http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml
and on the early steps provider master list https://floridaearlysteps.com/provider-resources/

Medicaid Managed Care Plans

Agreements between the LES and the Medicaid MMA plans were addressed in the legislation that went into effect on July 1, 2016. (391.308 F.S.). You will need to try to enroll in the Medicaid MMA Plans in your region. To find out more about the plans in your region follow this link: https://flmedicaidmanagedcare.com/. For some of the MMA plans you have the option to join the plan by signing a joinder to the contract the Health Planning Council holds with the MMA plan. For the plans that offer this you read the contract and if you agree you sign the joinder and supply any additional documentation the plan requires. Please note if you don't sign the joinder and don't have a contract with the plan you are still required to bill the plan as an out-of-network provider. All plans have agreed to pay providers who bill as out-of-network while they are enrolling with the plan.

Medicaid MMA Plan	Coverage under HPC contract	MMA Plan Contact Information
Aetna	Joinder available To sign a direct contract with Aetna please contact Kimberly Bygrave.	**Kimberley Bygrave (Kim), BSHA, CPC** *Network Relations Consultant* Aetna Better Health of Florida **T:** (954) 858-3312 **M:** (561) 517-7591 **F:** (844) 235-1340 **E:** bygravek@aetna.com
Sunshine	Providers have automatic coverage under HPC, however Sunshine prefers to contract with you individually	**Frederick D. McCoy** **5130 Sunforest Drive** **Suite 300** **Tampa, Florida33634** **Direct (954) 552-8295** **Toll-Free: 1-866-796-0530 ext. 41367** **Frederick.D.McCoy@SunshineHealth.com** **practitioneradds@CENTENE.COM** **www.SunshineHealth.com**

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		https://www.sunshinehealth.com/providers/resources/early-Intervention-services.html
Simply	Providers are Automatically covered under Letter of Agreement	**Keishly Torres** **keishly.torres@anthem.com**
Community Care Plan CCP	Providers don't need an agreement they can submit billing and a W9 form. However you can pursue a contract with them by reaching out to Johana Lopez.	Community Care Plan: Johana Lopez jlopez@ccpcares.org - (954) 622-3323
United	Providers are being paid "out-of-network" we have yet to negotiate a contract	**Amy S. Rice** Director Behavioral Network Services, SE Region (FL, NC, SC, PR, VI) **amy.rice@optum.com** Phone: 813-877-6829 Cell: 813-495-8704 Fax: 877-329-9286
Humana	Humana will negotiate individual contracts with providers	**Elba Martinez** Provider Contracting Professional II | FL Medicaid Network Administration LTC 3501 SW 160th Avenue, Miramar, FL 33027 C 754 230 7899 | O 305 626 5505 | F 305 370 6065 Emartinez1@humana.com

Each MMA Plan has provided a document explaining how to bill for your service as an early steps provider. These can be found on the Web as listed above. Do not delay submitting your billing to Medicaid while awaiting confirmation of your enrollment with the MMA plan, because some plans wait to receive billing from you before they enroll you in their MMA plan. We strongly recommend you submit your W9 form to the plan above so they will have your details and know how to pay you when you do submit claims.

Note: You do not have to accept a contract with a Medicaid MMA plan if they offer you a rate lower than the Medicaid rate. **Warning:** If you do accept a rate lower than the Medicaid rate Early Steps cannot pay the difference in the amount you receive, because Medicaid payments must be accepted by their providers as payments in Full (Medicaid General Rule). If you are offered a rate lower than the Medicaid rate try to negotiate, please send a copy of the offer to us so we can share it at the state level. If you are unable to negotiate the current Medicaid rate with the MMA plan you must submit a complaint to AHCA through the complaint portal and send a copy to us for our records.

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MMA Plan Billing Contacts

Plan Name	Billing Contact	Email Address	Phone Number
Aetna	Kimberley Bygrave Kristen Bobe	BygraveK@aetna.com BobeK1@aetna.com	561-517-7591 860-900-4673
CCP	Amira Richards Marya Rodriguez	arichards@ccpcares.org mayrrodriguez@ccpcares.org CCP.PROVIDER@ccpcares.org	954-622-3338 954-622-3343
CMS	Frederick D. McCoy	Frederick.D.McCoy@sunshinehealth.com SunshineProviderRelations@Sunshinehealth.com	(954) 552-8295
Humana	Elba Martinez	LMedicaidResolution@humana.com emartinez1@Humana.com	754-230-7899
Molina	Joel Izurieta Dongdow "DeeDee "Gordon	Joel.Izurieta@MolinaHealthCare.com Dongdow.Gordon@MolinaHealthcare.com	407-461-2764 305-849 -4076
Simply	Keishly Torres Danae Villar	EISbillinginquirires@simplyhealthcareplans.com danae.villar@simplyhealthcareplans.com	813-830-6900 Ext. 106121-0205
Sunshine	Frederick D. McCoy	Frederick.D.McCoy@sunshinehealth.com SunshineProviderRelations@Sunshinehealth.com	(954) 552-8295
United	Heather Simpson	heather.simpson@optum.com	

Service Authorizations

1. Authorizations to provide the services to Early Steps families can be found on the IFSP.
2. If you do not have a current IFSP showing valid authorization dates please contact the child's service coordinator. If services are provided to clients without authorization on the IFSP part C funds cannot be used to reimburse claims.
3. Pay attention to the frequency and duration of services , because services provided outside of these parameters will not be covered by Early Steps. Also review the authorization dates. Early Steps authorizations are not written for more than 6 months, and any services provided when the authorization has expired will not be reimbursed.
4. Payer codes we use are:
    a. MED = Medicaid
    b. TPIN = Third Party Insurance
    c. CONTM = Child has a Medicaid number but Part C will be billed.
    d. CONTI – Child has Insurance but part C will be billed.
    e. CONT = Part C – Early Steps funds.

5. Services may require prior authorization from a child's private insurance plan. It is the provider's responsibility to obtain the prior authorization.
6. Medicaid Early Intervention Services covered under the Medicaid program do not require prior authorization.
7. The Service coordinators will send a copy of the child's IFSP to each MMA plan.
8. Therapy Services on the IFSP will be covered by the Medicaid MMA plans. Most plans accept the IFSP as the authorizing document for therapy. Therapy must be billed to the MMA plans with the TL modifier after the therapy code to avoid the requirement for Prior authorization. For example 97110 TL, 92507 TL, 97530 TL
9. Use the information on the Insurance card to contact the family's commercial insurance. If you have a contract with a commercial insurance company or your own contract with a Medicaid MMA plan special instructions for obtaining prior authorization may be found in your contract. Availity can also be used to submit requests for prior authorizations in some cases (e.g. Florida Blue)
10. When calling the insurance company or plan representative, be sure to document, the date, time, who you are speaking with and any reference numbers for your call.
11. If authorization is not granted ask for a refusal in writing.
12. Document the call, the date, the person's name and any confirmation numbers.
13. You must check the child's Medicaid and Insurance status at each session to ensure nothing has changed.

EIIF services and Medicaid

No authorization is needed for any EI service **EIIF (T1027SC)** when a child is enrolled in a Medicaid MMA plan. The IFSP is considered the authorizing document, for all therapy and intervention services.

Therapy services and Modifier use

Therapy services must be submitted with the modifier TL to show they are for children with early steps.

Therapy Services and straight Medicaid

At this time you must apply for prior authorization for therapy services for children with Straight Medicaid. Use the EQ Health web portal to apply for prior authorization. Be sure to include documentation that the child is in early steps. If you are denied prior authorization please submit a complaint in the AHCA complaint portal. If you find a child has straight Medicaid after services have been delivered you must submit a request for retroactive authorization. https://fl.eqhs.com/

Insurance Billing For Services

In-network / Out of network.

Insurance plans offer in-network benefits when a provider is enrolled as a participating provider with the network. Some insurance plans may also offer out-of–network benefits. There are different procedures for billing insurance companies if you are in the network or out of network. If you have a participating provider number or a contract with the insurance company you can bill as an in-network provider. To obtain a participating provider number you must apply to the insurance company to be

credentialed. Each company has different enrollment procedures. To bill as an in-network provider you should follow the instructions in the participating provider manual. You must call the insurance company and try to obtain prior authorization for all evaluations and services, document your attempt.

You need to bill Medicaid and Third party Insurance for your service whether you are in-network or out-of-network. If you are out of network it is likely you will need to file a paper claim. The address for out of network filing of paper claims can be found on the back of the insurance card. Remember to use a **CMS-1500 form.** Most insurance companies won't accept the claim if it is not on the CMS-1500 form. They also often require a typed form free from errors to consider it a "clean claim". Free templates for printing onto the forms can be found at https://www.pdffiller.com/en/project/113177471.htm?f_hash=434eac&reload=true forms can be found at http://www.ahcipa.com/NEWsite/wp-content/uploads/2015/11/CMS1500.pdf If you file a an out-of-network provider, please alert the family to the possibility the family may receive a check from the insurance company that should be given to you.

Prior Authorization

All providers except ITDS provide types, must call the private insurance company prior to the **evaluation** or **service** to request prior authorization. Denials submitted to early steps due to no prior authorization cannot be paid unless there is a log of attempts to obtain the authorization.

Time Limits

Most insurance companies have a 60 day time limit for filing a claim. If you file the claim after 60 days and are denied by the insurance company for late filing early steps funds can't be used to pay you. Straight Medicaid has a 12 month limit for filing a claim.
Most of the MMA plans have a 180 day time limit for filing initial claims, Humana may have 90 or 120 days in some contracts, check your contract if you have one. All the plans have a 90 day limit for correcting or appealing incorrectly submitted or denied claims. For children with both third party insurance and Medicaid you must submit the initial claim to the insurance within 60 days and you have 60 days after receipt of the denial from the third party insurance to submit the claim to Medicaid. For children with TPIN you must submit the initial claim to the insurance within 60 days and you have 60 days after receipt of the denial to submit the claim to Early Steps.

Medicaid Portals

When you obtain a Medicaid number you will have access to the free Medicaid portal found at https://home.flmmis.com. The Portal is used to check Medicaid eligibility, and can be used to submit claims when a child has Straight Medicaid. You can also request access to the portals of the MMA plans when you sign a contract with them and you can submit claims directly through their portal.

Coding for Commercial Insurance

There are two different types of Medical coding used for billing claims. The Current Procedural Terminology (**CPT**) is a medical **code** set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. Medicaid currently uses codes from the Healthcare Common Procedure Coding System **HCPCS**, (often pronounced by its acronym as "hick picks"). HCPCS is a set of health care

procedure **codes** based on the American Medical Association's Current Procedural Terminology (**CPT**). When billing a commercial insurance company for an EI session you should still **use the HCPCS code T1027SC**. Evaluations should be billed using the most appropriate code for the provider discipline.

Fee Schedule / Taxonomy Codes

All the codes used to bill Medicaid and the MMA plans for early intervention services and therapy can be found on the Medicaid fee schedules at http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml.

Parental Permission to bill Commercial Insurance and Medicaid

Parents must give permission in writing for early steps providers to bill private insurance and to release information to Medicaid. Permission to bill is found on the child's IFSP and on the permission form. Parents can chose to allow only some services to be billed to their insurance, or all of their services. It is important to let parents know they will not occur any deductible or copay charges when early steps providers bill their insurance for services. This can result in the fees for the services they receive from early steps being applied to the families insurance deductible and as early steps covers the deductible this can reduce the cost of the deductible to the parents. With many parents having high deductible plans this can be very valuable to parents. In addition, the early steps program only has a limited amount of funds to sustain the program. Without the funds from commercial insurance and Medicaid paying for services, the system will not be able to continue to function at the current funding level. Please note if a family has both Commercial insurance and Medicaid, the provider required by law to bill the commercial insurance before submitting a claim to Medicaid (Medicaid Third Party liability Policy, https://portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_TPL/tabid/45/desktopdefault/+/Default.aspx).

When a parent gives consent to bill after the date of service.

When a parent gives consent to bill Medicaid even after the date of service the provider must bill all prior services to the Medicaid program. However, if the child has private insurance the consent to bill private insurance only applies to dates of service on or after the consent date.

Health Savings Accounts and Health Reimbursement Accounts

A health savings account (HSA) can be funded by a parent, an employer or both. Some insurances are linked directly to the HSA account so if a service is applied to the deductible the funds are taken directly from the HSA account. Work with the service coordinator to find out if the HSA is funded by the employer or the parent. Explain carefully to the parent that if we bill their insurance it could take the deductible funds directly from their HSA account and they may want to consider denying access to billing their insurance. Health reimbursement accounts (HRA's) are typically funded by the employer and we can bill insurance that draws from these type of accounts as it is not directly paid by the parent.

Availity

Availity is free billing software you can use to submit your claims to private insurance electronically. Information about Availity can be found at https://www.availity.com/products/practices-and-medical-groups

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Availity

Availity is a free billing platform that can be used to bill most private insurance companies and most of the Medicaid plans. To sign up for Availity go to https://www.availity.com/

Discrimination

The Health Planning Council considers the refusal to provide a service to clients based on ethnicity, race, socio-economic status, color, religion, disability, gender, sexual orientation, marital status, or type of third party insurance coverage as discrimination, which is prohibited in your provider contract. In the event a third party denies a claim , early steps will pay for the services authorized on the child's IFSP therefore eliminating any financial risk to the provider for accepting a family with a third party insurance coverage. Discrimination against early steps families will lead to disciplinary action and could lead to termination of the provider contract.

Local Early Steps Invoice

Your invoices to early steps are due on the first of each month. We request the services from the 16th of one month to the 15th of the following month are submitted electronically to us on the 1st of the next month. This gives the provider two weeks to prepare their monthly invoice. HPC has 30 days to pay the invoices received on the first of the month.

The submitted documentation must include:

1. The Natural Environment Service Log
2. The invoice with the total amount being claimed from early steps part C funds.
3. Any denials for services that have not been paid by third party payers.
4. State Travel reimbursement form.

Invoices submitted with missing or incorrect information will not be processed and will be returned to you for correction within 5 days.

Denials and Partial Payments

When a child has Medicaid or other Commercial Insurance a valid denial is required before part C funds can be used to pay for the services.

Examples of valid Explanation of Benefits (EOB) or Remittance advice (RA) are listed below.

Blanket Denials

Blanket denials will display a reason such as "Not a covered service", or "Child not eligible on Date of Service". Blanket denials are only valid for a specific child. Billing must be submitted independently for children with similar plans to obtain a denial specific to the child. When you receive a "blanket" denial submit the denial with your billing. The same denial can be resubmitted for future billing dates as it indicates the service will never be paid.

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Limited Denials

An example of a limited denial is "Exceeds maximum number of allowed visits". These denials will reset at the end of the year which for most insurance companies is January 1st at the start of a new calendar year. These claims will need to be billed to the insurance company again when the period resets.

Per Event Denials

Denials such as "Deductible" and "partial payments" (where the insurance company pays less than the early steps reimbursement amount) **must be** submitted for each date of service (DOS) for which you are requesting payment. We are unable to predict when a child's deductible will be met, so each visit has to be billed and a denial obtained. Remember when services are billed to a families insurance and applied to the deductible, early steps covers the deductible payment to the provider, hence lowering the cost to the family of meeting the deductible. With the increase in high deductible plans this is very beneficial for families.

Unacceptable Denials

1. Denials that do not show the reason for the denial.
2. Payment denied because **no prior authorization** was obtained, except when the services needed to begin within the 30 days and the provider made unsuccessful attempts to obtain the prior authorization prior to the commencement of services. Or when prior authorization was refused by the company. **Please submit documentation of all attempts to obtain the authorization.**
3. Denials showing **inadequate documentation** was received. In this situation the provider should resubmit the documentation.
4. Denials showing a **duplicate claim.** This shows the provider may possibly have received payment for this service in the past.
5. Denials for claims filed **outside the time frame for submission**, unless records are submitted documenting the providers attempts to submit the claim on-time. Remember most insurance companies and MMA plans have 6-month time limit for filing a claim, not one year like straight Medicaid.

When you are unable to obtain a denial

If you are unable to obtain a denial. Please submit documentation of at least three attempts to obtain the denial. Document the dates and times you called, the names of people you spoke to, what they said, and any confirmation numbers. Insurance companies have 60 days to get a denial to you, so you must wait 60 days before submitting your attempts to get a denial. If you don't get a denial you must submit documentation to early steps showing your **log of attempts** to get a written denial and that you made a complaint with the Office of Insurance at https://apps.fldfs.com/ESERVICE/Default.aspx. or a complaint to Medicaid at https://ahca.myflorida.com/medicaid/florida-medicaid-complaints

Why presenting the correct Denial is important.

Presenting a correct denial is important because it protects you from being accused of Healthcare Insurance Fraud. Being paid by two different payers for the same service is considered fraud. Be sure to cover yourself and obtain acceptable denials or clearly document your attempts to do so.

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Making a complaint to Medicaid

When Medicaid denies payment or pays you incorrectly contact the plan directly using the list of contacts for early steps billing (see above). If you do not get a satisfactory solution within 7 days you should report the problem to AHCA using the complaint portal found at https://www.flmedicaidmanagedcare.com/complaint#%2F

If you don't get a satisfactory resolution within 14 days, you should contact Early Steps with the details of the problem including the claim number, information about the date you attempted to work with the plan and the date you submitted the complaint to AHCA. Please include copies of all EOB and denials received. We can escalate the complaint through ESSO if necessary.

Steps to take when denied incorrectly by Medicaid or Private Insurance

1. Contact the MMA plan directly using the contacts listed above
2. If you do not receive a response and resolution with the MMA plan within 1 week submit a complaint to AHCA or the Office of insurance
3. Submit a summary of the problem, with a copy of the official complaint number and any documentation received to Trina Puddefoot trainpuddefoot@hpcswf.com
4. The documentation will be reviewed and sent to ESSO. Interim part-C payments can be made to the provider while the provider continues to work on resolution with the MMA plan.

Who to contact for help.

PDCC – Professional Development Credentialing Coordinator.

Once you have completed your credentialing with early steps and are enrolled as an early steps provider your main point of contact will be the PDCC for your region.

SW – Jennifer Soler jennifersoler@hpcswf.com (239) 774-9671

GC – Karina Herrera karinaherrera@hpcswf.com (941) 806-8544

The PDCC can help you answer questions about your enrollment, billing, contacting your zone team or mentor and can put you in contact with the people to help answer your questions.

Billing Assistance

If you have a billing question, we have a billing support meeting the last Monday of each month at 4pm. Celeste Reyes will be on the call for the first 10 minutes to see if anyone arrives and can help answer your billing questions.

Join Zoom Meeting
https://us06web.zoom.us/j/86193717862?pwd=TWt5WlJqTWd4YnBFK0JLdWNjSzh6dz09
Meeting ID: 861 9371 7862
Passcode: 8961

You can also reach out to your designated billing specialist, if you are not sure who that is you can reach the team leader Brooke Goldstein at brookegoldstein@hpcswf.com

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References and resources.

Early Steps Policy Handbook and Operations Guide,
https://floridaearlysteps.com/program-policies-and-guidance/

Florida Medicaid Laws and Rules: http://www.ahca.myflorida.com/medicaid/review/index.shtml

IDEA Part C Federal Register: https://www.federalregister.gov/documents/2011/09/28/2011-22783/early-intervention-program-for-infants-and-toddlers-with-disabilities

Florida State Statutes:
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0391/Sections/0391.308.html

Medicaid Provider Master List
http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml

The latest provider contract and all forms can be found on our website at
https://hpcswf.com/programs/early-steps/early-steps-providers77