July 27, 2026

RE: Public Comment Period — Guam Medicaid and Medically Indigent Program (MIP) Provider Manual, Chapter 200: Provider Enrollment

Dear Guam Medicaid and MIP Provider Community,

The Guam Department of Public Health and Social Services (DPHSS), Bureau of Health Care Financing and Administration (BHCFA), is releasing Chapter 200: Provider Enrollment of the new Guam Medicaid and MIP Provider Manual for a formal public comment period. We invite all enrolled and prospective providers, billing agents, professional associations, and other stakeholders to review the draft and submit written comments.

Why We Are Issuing a New Provider Manual

Guam Medicaid and MIP are committed to aligning with federal Medicaid requirements and improving program integrity, transparency, and consistency for all participating providers. The new Provider Enrollment Manual represents a significant update from prior guidance materials. We recognize that this chapter represents a meaningful change in how enrollment requirements are communicated and documented.

This level of detail is intentional to support compliance with federal requirements. The chapter is designed to give providers clear, complete information about enrollment requirements, screening processes, recordkeeping obligations, and ongoing compliance responsibilities—so that there is less ambiguity and fewer surprises during the enrollment process. Our goal is not to create burden, but to reduce it over time by making expectations explicit from the start.

What Is Included in Chapter 200

Chapter 200 covers provider participation requirements, including initial enrollment, reenrollment, revalidation, and reactivation; eligibility requirements by provider type; the application process and required documentation; federal screening and risk-level requirements; site visit procedures; provider agreements; audit obligations; how to report and process changes to enrollment information; and grounds for suspension, termination, and reinstatement.

This is the first of several chapters that will be released. Additional chapters will address topics such as covered services, billing and claims, prior authorization, and appeals. We will announce each chapter's public comment period in advance.

What This Means for Current Providers

We understand that transitions of this nature require time and adjustment. If you are already enrolled in Guam Medicaid or MIP, your current enrollment remains in effect. The new manual will apply to enrollment actions, revalidations, and change requests on or after the final release of the manual. Providers will be given adequate notice before any new requirements take effect, and DPHSS will provide implementation guidance and training opportunities ahead of the effective date.

We strongly encourage you to read Chapter 200, even if you have been an enrolled provider for many years. Some requirements, including federally required screenings and background checks, timelines for reporting changes, and revalidation procedures—are described in greater specificity

in this update than in previous guidance. Familiarizing yourself with these provisions now will help you avoid disruptions to your enrollment status.

Resources to Help You Navigate the New Requirements

DPHSS has prepared a Provider Enrollment FAQ document and a training presentation, which are available alongside this manual during the comment period. These materials are intended to supplement the manual and answer common questions in plain language. The Provider Enrollment Unit will be providing more information and guidance prior to implementation of changes to requirements.

Online Portal: https://www.bhcfguam.com/login.jsp

How to Submit Comments

Written comments on Chapter 200 may be submitted by email to PublicComment@dphss.guam.gov.

The public comment period will remain open through August 17, 2026. Please indicate "Chapter 200 Public Comment" in the subject line or on the envelope. All comments will be reviewed and considered before the manual is finalized.

We are grateful for the care and dedication that Guam's provider community brings to serving Medicaid and MIP beneficiaries. Your feedback during this process is essential to developing a manual that works well for both providers and the patients you serve. We look forward to your input.

FOR PUBLIC COMMENT

Guam Medicaid and Medically Indigent Program

Chapter 200

Provider Enrollment

V1.0

Table of Contents

1.0 Background

Chapter 200, Provider Enrollment, provides an overview of the enrollment requirements for a provider in the Guam Medicaid program. Other participation requirements are included in other chapters of the manual. Unless otherwise specified, all references to the Guam Medicaid program will include the Medically Indigent Program (MIP).

Providers rendering services to Guam Medicaid program beneficiaries must be enrolled and approved as providers by the Department of Public Health and Social Services (DPHSS) Bureau of Health Care Financing Administration (BHCFA) to bill the Guam Medicaid program for rendered services. Guam Medicaid program healthcare providers include individual practitioners, institutional providers, and providers of medical equipment, goods, and services related to care. Unless otherwise specified, requirements in this chapter apply to all provider types.

Additional requirements that apply to most or all providers, such as those for prior authorization, timely claims filing, maintenance of records, recovery of overpayments, audits, and appeals, can be found in other applicable chapters.

Requirements specific to a provider type can be found in the applicable manual section.

A provider will not be enrolled, reenrolled, reactivated, or revalidated until all screening activities applicable to that provider are completed.

1.1 Provider Enrollment Types

1.1.1 Initial Enrollment

Initial enrollment occurs when a provider not previously enrolled in the Guam Medicaid program completes the enrollment process. Requirements are:

- Submission of a complete enrollment application and provider agreement
- Verification of credentials (licenses, certifications, national provider identifiers [NPIs])
- Ownership and management of employee disclosures
- Screening appropriate to risk level (site visit, fingerprinting, exclusion checks)
- Execution of a provider agreement

All steps of the enrollment process must be completed in their entirety before claims may be paid.

1.1.2 Reenrollment

Reenrollment occurs when a provider has been terminated or otherwise removed from Medicaid and seeks to reestablish/reactivate its enrollment. A reenrollment is processed as a new enrollment, with the same requirements and validation steps. Reenrollment requirements are:

- Full screening equal to initial enrollment, including all applicable verification and exclusion checks

- Review of prior enrollment history, including any previous terminations, sanctions, or adverse actions
- Execution of a new provider agreement
- Resolution of any outstanding suspension, overpayments, or other program integrity issues prior to approval

1.1.3 Reactivation

Consistent with reenrollment requirements, reactivation requires the state Medicaid agency (SMA) to follow the same screening and approval steps applicable to new provider enrollment. Reactivation requirements are:

- Full screening equivalent to initial enrollment, including all applicable verification and exclusion checks
- Review of the provider's prior enrollment history, including any previous termination, sanctions, or adverse actions
- Execution of a new provider agreement
- Resolution of any outstanding suspension, overpayments, or other program integrity issues prior to approval

1.1.4 Revalidation

Revalidation is the process by which a provider is required to update and validate enrollment information to maintain continued participation in the Guam Medicaid program. In accordance with 42 CFR § 455.414, all providers must be revalidated at least every five (5) years.[1] Failure to complete revalidation requirements will result in deactivation or termination of the provider's enrollment. Revalidation requirements are:

- Submission of an updated enrollment application, including all required disclosure and current credentialing information
- Completion of risk-based screening, consistent with federal and program requirements, which might include site visits, fingerprint-based criminal background checks (FCBCs), and other screening measures applicable to the provider's risk level

Continued enrollment is contingent upon successful completion of all revalidation requirements within the time frame specified by the Guam Medicaid program.

The Guam Medicaid program/MIP might conduct provider revalidation activities prior to the routine revalidation due date when necessary to support program integrity, ensure continued compliance with federal and state enrollment requirements, or align with operational needs.

[1] United States Federal Government. April 6, 2026. "42 CFR § 455.414." United States Federal Government. Accessed April 12, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.414

Routine revalidation shall occur no less frequently than every five years in accordance with 42 CFR § 455.414.

Additional information regarding revalidations can be found in Section 10.0 – Revalidations (click here).

1.2 Provider Enrollment Determinations

Medicaid enrollment determinations are made through a structured review process in which the Medicaid agency evaluates whether an applicant meets all federal and state participation requirements. Providers must first submit a complete and accurate enrollment application, including required documentation such as licensure, certifications, ownership disclosures, and an active NPI. Guam Medicaid program staff then conduct screening activities based on the provider's categorical risk level, such as verifying licensure, performing database checks, completing site visits for moderate- and high-risk providers, and conducting FCBCs when required. Once all screening requirements under 42 Code of Federal Regulations (CFR) Part 455 Subpart E are satisfied, the agency performs a final review to confirm eligibility and compliance before approving or denying the application.[2]

1.2.1 Approval

When Guam Medicaid program staff approve an enrollment application, the following occurs:

- Official enrollment notification is issued to the provider. Notification could include a welcome letter, assignment of a unique provider identification number and/or vendor identification number, and instructions for accessing the provider portal. The provider portal is used to submit claims, update enrollment information, and manage ongoing participation in the program. Providers may access the portal here.
- The provider's enrollment status is activated in the Medicaid Management Information System (MMIS) or other applicable systems. Activation enables the provider to submit claims for covered services furnished to eligible Medicaid beneficiaries.
- Access to billing and claims submission is granted, including guidance, training materials, or technical instructions to support compliance submission and reimbursement processes.
- The provider is notified of the effective date and end date of enrollment, which governs when services may be billed and reimbursed under the program.

These steps help ensure the provider is fully set up to participate in the Guam Medicaid program and can begin serving Medicaid beneficiaries in accordance with program rules.

[2] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

1.2.2 Enrollment Denials or Termination

Providers who do not meet the federal enrollment requirements in 42 CFR § 455.416, will be denied or have their enrollments terminated.[3] The Medicaid agency will comply with Section 1902(a)(3) of the Social Security Act (SSA) and the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.[4]

Under 42 CFR § 455.416, the Medicaid agency must deny the provider's enrollment application in the following circumstances:

- The provider, or any person with 5% or more direct or indirect ownership interest in the provider, has been convicted of a criminal offense related to that person's involvement with Medicare and Medicaid in the last 10 years, unless the Medicaid agency determines that denial is not in the Medicaid program's best interests and documents that determination in writing. (42 CFR § 455.416(b))
- The provider is terminated under Medicare or under the Medicaid plan of any other state or territory. (42 CFR § 455.416(c)) This provision is limited to *terminations* as defined in 42 CFR § 455.101.[5] In contrast to the other circumstances in which denial is required, in this circumstance, the Medicaid agency does not have the authority to determine that denial is not in the Medicaid program's best interests.
- The provider, a person with an ownership or control interest of the provider, or an agent or managing employee of the provider fails to submit timely or accurate information, unless the Medicaid agency determines that denial is not in the Medicaid program's best interests and documents that determination in writing (42 CFR § 455.416(d)).[6]
- The provider, or any person with 5% or greater direct or indirect ownership interest in the provider, fails to submit a set of fingerprints as prescribed by the Medicaid agency within 30 days of a CMS or Medicaid agency request, unless the Medicaid agency determines that denial is not in the Medicaid program's best interests and documents that determination in writing (42 CFR § 455.416(e)).

[3] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

[4] Social Security Administration. n.d. "State Plans for Medical Assistance." Social Security Administration. Accessed January 23, 2026 https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

[5] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.101." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B/section-455.101

[6] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

- The provider fails to permit access to provider locations for any site visits under 42 CFR § 455.432[7], unless the Medicaid agency determines that denial is not in the Medicaid program's best interests and documents that determination in writing (42 CFR § 455.416(f)).

Other reasons that a Medicaid agency might deny a provider's application are:

- Incomplete application, including missing documentation
- Unresolved screening issues under 42 CFR § 455.434 or 42 CFR § 455.416
- Exclusions or sanctions
- Failure to submit timely or accurate information

1.2.3 Reactivation of Provider Enrollment

Under 42 CFR 455.420,[8] reactivation requires the Guam Medicaid program to complete the same screening and approval steps applicable to a new provider enrollment. Any reactivation of a provider must include rescreening and payment of application fees as required by 42 CFR § 455.460.[9]

1.2.4 Retroactive Enrollment Start Dates

Retroactive provider enrollment is limited to three (3) months prior to the date the completed application is approved.

Upon approval of enrollment, BHCFA will notify the provider via email. The approval email will include the provider portal credential username, provider's vendor number, provider identification number, and the effective date. The provider passwords will be sent as a separate email for security purposes.

1.3 Ordering, Referring, and Prescribing Providers

42 CFR 455.410[10] states Medicaid agencies must require all ordering, prescribing, or referring physicians or other professionals providing services under the Guam Medicaid program/MIP to

[7] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.432." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.432

[8] Centers for Medicare & Medicaid Services, Department of Health and Human Services. February 2, 2011. "42 CFR 455.420." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.420

[9] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.460." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.460

[10] Centers for Medicare & Medicaid Services, Department of Health and Human Services. February 2, 2011. "42 CFR 455.410." Centers for Medicare & Medicaid Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/part-455/section-455.410

be enrolled as participating providers. Most physicians and eligible professionals enroll in the Guam Medicaid program to be reimbursed for the covered services they provide to Medicaid beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act (ACA),[11] CMS requires certain physicians and eligible professionals (providers) to enroll in the Medicaid program solely to order, refer, or prescribe services for Medicaid beneficiaries. These providers do not and will not send claims to the Guam Medicaid program for the services they furnish. Examples of providers who might enroll in Medicaid solely for ordering, referring, and prescribing include those who are:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Medicine
- Doctors of Dental Surgery
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Physician Assistants
- Certified Clinical Nurse Specialists
- Nurse Practitioners
- Clinical Psychologists
- Certified Nurse Midwives
- Clinical Social Workers

Any services ordered/referred/prescribed by a practitioner not enrolled in the Guam Medicaid program will not be reimbursed.

[11] 111th United States Congress. March 23, 2010. "Patient Protection and Affordable Care Act, Public Law 111-148." United States Congress. Accessed January 23, 2026

2.0 Eligibility Requirements

To participate in Medicaid, providers must meet eligibility requirements before enrolling. Those requirements are to be properly licensed with the territory Medicaid agency, to meet federal and territory screening and disclosure requirements, to execute a signed Medicaid provider agreement, and to comply with all applicable federal and territory laws, regulations, and guidance.

2.1 General Provider Requirements

2.1.1 Active Licensure/Certification

Federal regulation 42 CFR § 424.516 requires compliance with federal and territory licensure, certification, and regulatory requirements based on the type of services or supplies the provider or supplier type will furnish and bill Medicare/Medicaid.[12]

The territory's Medicaid agency must verify the state or territory licenses providers and that such provider licenses have not expired or are not currently limited.

If a provider continues to receive payment for services rendered after the expiration or termination of a professional license, the payment will be subject to recoupment and, if applicable, referred to the Office of the Attorney General of Guam. The provider applicant must provide current Guam medical/professional licensure, health professional licenses, and supporting documents, including a curriculum vitae. Medicaid will terminate providers who fail to maintain their current professional license.

Prescribing health professionals must provide their Drug Enforcement Administration (DEA) number for controlled drug prescribing.

2.1.2 Active National Provider Identifier or Register for National Provider Identifier With the National Plan and Provider Enumeration System

Federal rule governing NPIs comes from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically its Administrative Simplification Standards.[13]

The National Plan and Provider Enumeration System (NPPES) assigns and maintains NPI numbers for healthcare providers and organizations in the United States (U.S.). The provider applicant must provide NPI(s) for business/facility/clinic and health professionals, along with supporting documentation. The NPI is a unique identification number for covered health care

[12] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 424.516." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/part-424/section-424.516

[13] 104th Congress. January 29, 1992. "Health Insurance Portability and Accountability Act of 1996." 104th Congress. Accessed January 23, 2026 https://www.bing.com/ck/a?!&&p=b631e3f02ed690f4776ef259a88c34d5d6bfb4df1dd972beb862e7586615c133JmltdHM9MTc2NjEwMjQwMA&ptn=3&ver=2&hsh=4&fclid=07f9a297-7df8-6eb0-1f36-b6677c166f17&psq=hipaa+1996+act&u=a1aHR0cHM6Ly93d3cuY29uZ3Jlc3MuZ292LzEwNC9wbGF3cy9wdWJsMTkxL1BMQVctMTA0cHVibDE5MS5wZGY

providers. Providers who need an NPI should contact the National Provider Plan and Enumeration System (NPPES) to apply.

Covered health care providers, all health plans, and health care clearinghouses must use the NPIs in administrative and financial transactions adopted under HIPAA. The NPI is a 10-digit number that does not carry other information about health care providers, such as the state or territory in which they live or their medical specialty.

2.1.3 Pass Federal Exclusion Checks

42 CFR Part 1001 defines the basis for mandatory and permissive exclusions from participation in Medicare, Medicaid, and all other federal health care programs.[14] Guam Medicaid program staff shall complete all required federal exclusion checks prior to approving provider enrollment. Exclusion checks can change over time, and providers must successfully pass all exclusion checks in effect at the time of the review. In addition to federally mandated exclusion systems and files, Guam Medicaid program staff can review any other databases, state exclusion lists, or supplemental screening resources deemed appropriate to validate provider eligibility and promote program integrity.

Providers have an affirmative duty to check whether individuals/entities are excluded before hiring, contracting, or billing Medicaid.

2.1.4 Meet Federal Screening Level Requirements

42 CFR § 455.450 requires screening of Medicaid provider applications based on categorical risk.[15] The Guam Medicaid program must screen all applications, including applications for a new practice location, and any applications received in response to a reenrollment or revalidation of enrollment request based on a categorical risk level of *limited*, *moderate*, or *high*. If a provider could fit within more than one (1) risk level described in this section, the highest screening level applies. Additional information on risk-level screening can be found in Appendix B (click here).

Enhanced risk screenings conducted by Medicaid agencies/territories are a critical program integrity safeguard designed to help prevent fraud, waste, and abuse and help ensure compliance with federal enrollment requirements. These screenings are applied to providers designated as moderate or high risk under federal regulations and might include actions such as FCBCs, site visits, license and ownership verification, exclusion checks, and ongoing monitoring of enrollment data.

2.1.5 Provide Specialty Information with Proof of Training

The provider applicant shall attest to their own specialty and/or the specialties of their personnel and shall submit supporting credentialing documentation. Required documentation includes, at

[14] Office of Inspector General-Health Care, Department of Health and Human Services. January 29, 1992. "42 CFR Part 1001." Office of Inspector General-Health Care, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001

[15] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR Part 455." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455

the minimum, verification of postgraduate training in the applicable specialty field (and any Guam-specific requirements, i.e., board certifications).

2.1.6 Active Emergency Medical Transportation Certification/License

Emergency medical transportation/ambulance providers must be actively certified or licensed by the Office of Emergency Medical Services.

2.1.7 Active Medicare Certification (If applicable, by provider type)

Please refer to Appendix B for health care facilities requiring Medicare certification (click here).

2.1.8 Clinical Laboratory Improvement Act Certification

Providers with laboratories must be certified under the Clinical Laboratory Improvement Act (CLIA) for the tests they perform to enroll as providers. It is the responsibility of the laboratory provider to notify the BHCFA within 60 days of any changes to the facility's CLIA certification status, including updates to approved test specialties. CLIA certification is valid for up to two (2) years.

2.1.9 Billing Agent and Clearinghouse

The provider applicant may retain a billing agent/clearinghouse to prepare, edit, and/or submit claims on its behalf.

The provider must provide a copy of the Business Associate Agreement (BAA) between itself and the agent/clearinghouse to satisfy the HIPAA regulatory requirements and establish legal responsibility between the parties.

A provider may retain a billing agent to process its claims, but payment is assigned to the provider/entity. The payment may be made in the provider's name through the billing agent when a written notification from the authorized representative listed in the current provider file is submitted to BHCFA.

2.2 Employer Identification Number/Federal Tax Identification Number

The provider applicant must provide their employer identification number (EIN)/federal tax identification number (TIN) and attach supporting documents, including a signed W-9 Form, business license, and proof of federal TIN. A Guam EIN/TIN is also required for off-island businesses and subcontractors conducting business on Guam, in accordance with GCA Title 11, Chapter 70.

An individual provider's TIN is either their Social Security Number (SSN) or their federal TIN if incorporated.

A group provider or facility's TIN is the federal TIN the Guam Department of Revenue and Taxation assigned to the group, entity, or corporation.

2.3 Disclosure of Ownership and Control

In accordance with 42 CFR 455.104-455.106, the provider applicant must fully disclose any ownership or controlling interest held by the provider in any other entity also enrolled as an approved provider for the Guam Medicaid program or MIP.

The provider applicant shall also disclose any ownership, financial, or managerial interest help by the provider, or by any immediate member (including a blood relative or in-law), in any entity that furnishes medical services or supplies, or that is enrolled in an approved provider for the Guam Medicaid program or MIP.

Disclosures shall include, as applicable:

- The name and address of each person or entity with an ownership or controlling interest
- The nature and extent of the ownership or controlling interest
- Identification of any managing employees, agents, or business with which a provider or related parties have a financial relationship

All required disclosures are subject to verification and review as part of the provider enrollment, screening, revalidation, reenrollment, or reactivation process. Failure to fully and accurately disclose required ownership or control information could result in denial, termination, or other adverse enrollment action, consistent with federal and program requirements.

3.0 Enrollment Application Process

3.1 Enrollment Steps

The enrollment steps below are outlined to assist providers in understanding application requirements and responsibilities and reducing incomplete submissions and processing delays.

Table 1. Enrollment Steps

Steps	
1	Provider begins application
2	Provider enters demographic detail and enrollment type information
3	Provider uploads all required documentation
4	Medicaid staff receives provider application
5	Medicaid staff conduct screenings
6	Medicaid staff conduct site visit, and fingerprinting is completed (moderate and high-risk providers only as applicable)
7	Medicaid staff complete final review and approve or deny the application
8	Provider receives confirmation of approved enrollment
9	Provider file activated in MMIS or applicable system

3.1.1 Provider Portal

Guam Department of Public Health and Social Services Provider Portal

The Guam Medicaid Provider Enrollment Portal serves as the primary online platform for healthcare providers and organizations seeking to enroll, revalidate, update, or maintain participation in the Guam Medicaid program. Through the portal, providers can submit enrollment applications, upload required supporting documentation, monitor application status, and manage provider information electronically.

Prior to accessing the portal, providers should ensure they have all necessary documentation readily available, including National Provider Identifier (NPI) information, business licenses, tax identification documents, W-9 forms, professional licenses, and any applicable certifications or disclosure forms. Providers should carefully review all instructions and application requirements before submission to avoid processing delays or incomplete applications. It is recommended that users maintain copies of all submitted documentation and monitor portal notifications or email correspondence for requests related to additional information, corrections, or enrollment determinations.

3.2 Enrollment Process

3.2.1 Providers Eligible to Enroll

Providers currently licensed, certified, accredited, or enrolled under Guam law, or under another state or territory's law, can apply for enrollment in the Guam Medicaid program/MIP. Providers enroll by submitting a paper or electronic application to the Guam Medicaid program/MIP.

Submission of an enrollment application does not guarantee enrollment, and not all provider types are eligible for enrollment in the Medicaid program.

4.0 Application Requirements

The applicant must complete all required application fields, sign the application, and submit all applicable forms as prescribed by the Guam Medicaid program. The applicant shall also submit copies of all current licensure, certification, and/or accreditation required for enrollment.

The provider applicant shall disclose whether any professional license, certification, or accreditation has ever been revoked, suspended, restricted, or otherwise subject to any adverse action in any state, territory, or jurisdiction.

By signing the application form, the provider agrees to comply with all applicable laws, regulations, and policies of the Guam Medicaid program. This includes Title XIX of the SSA, the CFR, and all applicable territory and federal laws, standards, guidelines, and program instructions. A provider agreement and ownership/control disclosures are required for every person or institution providing services.

The provider further authorizes and gives consent to the Guam Medicaid program to conduct all required and permissible screening, verification, background checks, and reviews—including database checks, site visits, FCBCs, and information sharing with other government entities—as necessary to determine and maintain eligibility for program participation.

Provision of false information or failure to disclose information mandated by the federal requirements during the application process could result in denial of enrollment, and the case could be referred to the appropriate legal authority.

4.1 Required Documentation

4.1.1 Enrollment Documentation

The table below outlines the documents providers need to submit to enroll in the Guam Medicaid program/MIP.

Table 2. Required Documentation

	Required Documentation
✓	Valid state or territory license/certification
✓	Active NPI confirmation
✓	Government-issued ID (individual providers)
✓	Business license or articles of incorporation (business or corporation)
✓	W-9 form
✓	Ownership/Control Disclosure
✓	Managing Employee Disclosure (business or corporation)
✓	Signed Provider Agreement
✓	License, Accreditation, or Board Certification (if applicable)
✓	Proof of liability/malpractice insurance (if applicable)

Required Documentation	
✓	Electronic Funds Transfer (EFT) form, and a deposit slip

4.2 Required Screenings

Newly enrolling and revalidating providers, including ordering, referring, and prescribing professionals, will be screened in accordance with 42 CFR 455.410.

4.2.1 Federal Exclusion Checks

Per 42 CFR Part 1001[16] and 42 CFR Part 102,[17] federal exclusion checks are screenings to ensure that individuals or entities are not barred from participation in federal health care programs (e.g., Medicare, Medicaid, the Children's Health Insurance Program [CHIP]) due to fraud, abuse, or other disqualifying conduct.

If a provider, owner, employee, or contractor is excluded, no federal health care program funds can be paid for items or services they furnish, order, prescribe, or manage.

4.2.2 State or Territory Exclusion Checks

State or territory exclusion checks are reviews conducted against state or territory-level exclusion or sanction lists to ensure providers, owners, managing employees, and certain staff are not barred from participation in state or territory Medicaid programs or other state or territory health programs.

They complement but do not replace federal exclusion checks.

4.2.3 Taxpayer Identification Number Matching

Per 42 CFR Part 455, TIN matching is a verification process used to confirm that a TIN—such as an SSN or EIN—correctly matches the legal name on file with the Internal Revenue Service (IRS). States and territories must use data matches when verifying eligibility (including SSN/citizenship matches with the Social Security Administration).[18]

[16] Office of Inspector General-Health Care, Department of Health and Human Services. January 29, 1992. "42 CFR Part 1001." Office of Inspector General-Health Care, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001

[17] Office of Inspector General-Health Care, Department of Health and Human Services. January 29, 1992. "42 CFR Part 1002." Office of Inspector General-Health Care, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1002

[18] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR Part 455." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 12, 2026 https://www.ecfr.gov/current/title-42/part-424/section-424.516

4.2.4 Relying on Screenings by Medicare or Another State or Territory's Medicaid Program

42 CFR § 455.410(c)[19] explicitly allows a state or territory's Medicaid agency to rely on the results of provider screening performed by:

- Medicare contractors (i.e., screening done for Medicare enrollment)
- Medicaid agencies or CHIP of other states or territories

This means a state or territory could use another program's screening results to satisfy its own provider screening requirements instead of performing a full, separate screening.

4.2.5 Enrollment Screening by Risk Level

In accordance with 42 CFR Part 455, 42 CFR § 489.18,[20] and the Center for Medicare & Medicaid Services (CMS) enrollment screening requirements, Medicaid agencies are required to conduct risk-based screening for the following enrollment transactions, as applicable:

- Initial enrollment applications
- Revalidation applications
- Change of ownership application
- Application to add a new practice location
- Applications reporting a new owner, regardless of ownership percentage, submitted as a change of information or other enrollment transactions under Title XIX

Screening is conducted based on CMS risk assessment and the assignment of a provider type to one of the following risk levels:

- Limited risk
- Moderate risk
- High risk

4.2.6 Provider Types by Screening Risk Level

Provider types by screening category include, but are not limited to, the following:

- **Limited Risk**: physicians, audiologists, and ambulatory surgical centers (ASCs)

[19] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.410." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.410

[20] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.410." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 12, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-A/section-489.18

- **Moderate Risk**: ambulance providers, physical therapists (PTs), independent laboratories
- **High Risk**: newly enrolling skilled nursing facilities (SNF), home health agencies, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers

The Guam Medicaid program shall apply screening requirements consistent with the provider's assigned risk for each applicable enrollment transaction.

The SMA reserves the right to assign or escalate a provider's screening risk level on a provider-specific or service-specific basis where risk is elevated, based on program integrity concerns, compliance history, the nature of services furnished, credible allegations, or other factors identified by the Guam Medicaid program. When risk is escalated, all screening requirements applicable to the higher risk level shall apply, consistent with federal requirements.

See Appendix B for additional information (click here).

5.0 Screening and Risk Levels

42 CFR 455 Subpart E[21] assures the Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77), and 1902(kk) of the SSA.

Table 3. Screening and Risk Levels

Medicaid Activities	Limited Risk	Moderate Risk	High Risk
Disclosures and Database Checks • Obtain disclosures regarding ownership and possible criminal activities • Check exclusion databases	✓	✓	✓
On-Site Visit • Conduct on-site visits to confirm the accuracy of information submitted by the provider in the enrollment application	Not Applicable	✓	✓
Fingerprints • Conduct FCBCs of the provider or, in the case of an institutional provider, each person with a 5% or more ownership interest	Not Applicable	Not Applicable	✓

[21] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR Part 455 Subpart E." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E

6.0 Site Visits

Conducting on-site visits is one element of compliance with the risk-based screening requirement under 42 CFR § 455.450.[22] Under 42 CFR § 455.450(b)(2) and (c)(1), the Medicaid agency must conduct on-site visits in accordance with 42 CFR § 455.432 when screening providers that the agency has designated as "moderate" or "high" categorical risk.[23]

For a list of provider types and their categorical risk level, see Appendix B (click here).

The Guam Medicaid program:

- Must conduct pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Guam Medicaid program. The purpose of the site visit will be to verify the information submitted to the Guam Medicaid program is accurate and to determine compliance with federal and state or territory enrollment requirements.
- Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the Guam Medicaid program to conduct unannounced on-site inspections of all provider locations.

See Appendix B for additional information (click here).

6.1 Failure to Permit Access

Under 42 CFR § 455.416(f),[24] the Guam Medicaid program must terminate or deny enrollment if the provider fails to permit access to a location for a site visit under 42 CFR § 455.432, unless the Guam Medicaid program determines that termination or denial is not in the Medicaid program's best interests and documents that determination in writing.

[22] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.450." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.450

[23] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.432." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 12, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.432

[24] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

7.0 Provider Agreement

All providers enrolled in the Guam Medicaid program or MIP shall enter into a written agreement with the Medicaid agency. The provider agreement is a legally binding agreement between the provider and the DPHSS-BHCFA.

The provider agreement shall include, but is not limited to, requirements that the provider agrees to the following requirements:

- **Maintain Records**: Maintain records necessary to fully disclose the extent of services furnished and retain such records for the required retention period, which is seven (7) years for the Guam Medicaid program, unless a longer retention period is otherwise required
- **Furnish Information Upon Request**: Make records and information available, upon request, to the state or territorial Medicaid agency, CMS, the Medicaid Fraud Control Unit (MFCU), or any other law enforcement or investigative entity, in accordance with applicable federal and territorial requirements
- **Comply with Ownership and Control Disclosure Requirements**: Comply with all ownership and controlling interest disclosure requirements as specified in 42 CFR Part 455[25]
- **Advance Directives Compliance**: Hospitals, nursing facilities, home health agencies, and hospices must comply with advanced directive requirements
- **Use NPI**: Furnish and include NPI on all Medicaid claims (42 CFR Part 431.107)

Each provider shall complete and sign a provider agreement affirming compliance with all applicable laws, regulations, rules, policies, and program instructions governing the furnishing and reimbursement of services or goods to Medicaid or MIP beneficiaries.

The provider is responsible for ensuring its employees and contractors comply with the terms of the agreement.

Approval of a provider agreement does not guarantee reimbursement for "not covered" services.

7.1 Provider Identification Number

When a provider is enrolled, the provider is assigned a unique one to three-digit alpha or numeric provider ID. The provider ID number is used in the DPHSS-BHCFA system's internal provider files to process claims transactions and communications. The provider ID number identifies the provider/entity that performed/provided the service on the claims and explanation of benefits (EOBs)/payment reports.

A provider can enroll in more than one (1) provider specialty and is assigned a provider ID number for each. The provider must notify DPHSS-BHCFA to add another provider specialty

[25] United States Federal Government. April 6, 2026. "42 CFR Part 455." United States Federal Government. Accessed April 12, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455

under their agreement. The notification must include the effective date, pertinent documents, and referencing certification/documentation for the service.

The provider ID number is assigned to the person/entity that signed the agreement and cannot be transferred to or used by any other person/entity.

7.2 Vendor Identification Number

When a provider is enrolled, they are assigned a unique 8-digit alphanumeric vendor ID. The vendor ID number is for the fiscal system, the Department of Administration (DOA), internal vendor files, and processing fiscal transactions and communications. The vendor ID number identifies the provider/entity that will receive claims payments and EOBs/payment reports.

The vendor ID number is also associated with the mailing address of the provider/entity for the payment. An EFT can be requested from the fiscal agent, DOA, for the distribution of payments. An EFT form with an original signature(s) must be completed and submitted to the fiscal agent by an authorized representative listed on the current provider file for a legitimate bank account.

The vendor ID number is assigned to the person or entity that signed the agreement and cannot be transferred to or used by any other person or entity.

7.3 BHCFA Portal User ID and Password

When a provider is enrolled, the provider is assigned a unique ID, separate from its provider or vendor ID, and a password. Providers are allowed three (3) unique portal IDs and passwords (management, billing, and clinic/facility) for each provider ID.

8.0 Changes and Maintenance Requirements

42 CFR § 455.104(c) requires that providers disclose changes to their enrollment information to the Medicaid agency.[26] This includes updates to ownership or control interests, managing employees, practice locations, and other critical data elements. ***Providers must disclose changes within 35 calendar days of the change occurring*** using the Guam Medicaid/MIP Provider Change of Information Form.

Failure to provide timely and accurate updates can result in denial or termination of enrollment, as well as denial of claims for services rendered during periods of noncompliance. The Medicaid agency is responsible for ensuring all disclosures are up to date and taking appropriate action if providers do not comply with these requirements. This process helps maintain program integrity and helps ensure that only eligible and properly vetted providers participate in Medicaid.

8.1 Physical, Mailing and Email Address Changes

The provider must provide a written notification of any change in physical, mailing, or email address. The notification must include the new address, previous address, and the effective date.

Medicaid and MIP payment and payment reports are sent to the physical, mailing, and email address listed on the BHCFA and fiscal agent computer system, so any address change must be promptly reported by the provider.

8.2 Name Change

The provider must provide a written notification of a change in name. The notification must include the new name, previous name, provider identification number, and the effective date of the change. If the name change is due to a change in ownership, the procedures for a change in ownership must be followed.

8.3 Telephone and Fax Number Changes

The provider must provide a written notification of changes in telephone and fax numbers. The notification must include the new telephone and fax numbers, previous telephone and fax numbers, and the effective date of the change.

8.4 Medicare Status Change

A provider that requires Medicare certification must provide a written notification of any change in its Medicare number or status.

[26] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 4/3/2026 "42 CFR Part 455.104" Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 7, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B/section-455.104

8.5 Group Membership Change

The provider must provide written notification when an individual member joins or leaves the group. The notification must include the individual member's name, effective date, and—if joining—the professional license, curriculum vitae, and, if applicable, specialty documentation and certifications.

8.6 Specialty Change

The provider must provide written notification of a change in or addition of a specialty. The notification must include the effective date and, if a new or added specialty, the supporting certification and documentation.

8.7 Ownership Change

A change of ownership occurs whenever the stock or assets and liabilities of a business are purchased or transferred by the existing owners to new owners.

Instances in which parent corporations acquire or merge with their wholly owned subsidiaries and in which the name of a company changes, but neither the company owners nor the federal TIN change, are generally not considered changes of ownership.

The provider must provide notification of any proposed change of ownership 60 days prior to the date on which that ownership change will occur. The notification must include the name of the new owner and the date of the change of ownership.

The new owner must submit a new provider agreement. If the provider agreement is not received prior to the date of the change of ownership, there will be a lapse between the termination date of the old provider ID number and the start date of the new provider ID number. There will be no retroactive payments to the new provider, and payments received by the previous provider during the enrollment lapse will be subject to recoupment.

8.8 Federal TIN Change

The provider must provide notification of a change in federal TIN. The notification must include the effective date, the new federal TIN, and if applicable, the new name. The provider and vendor ID numbers must be terminated, and new provider and vendor ID numbers must be established for the new federal TIN.

8.9 Billing Agent Change

The provider must provide notification of a change in the billing agent. The notification must include the Medicaid provider number, name of the old and new billing agents, effective date of the change in the billing agent, and a copy of the new Billing Agent Agreement.

9.0 Revalidation

Revalidation is federally required under 42 CFR § 455.414 and requires the Medicaid agency to periodically confirm that enrolled providers continue to meet all program enrollment and screening requirements. In accordance with federal regulations, revalidation must occur at least once every five (5) years for all provider types.[27]

As part of the revalidation process, the Medicaid agency shall conduct full screening appropriate to the provider's assigned risk level, which might include, as applicable:

- Verification of licensure and credentials
- Review of federal and state databases and exclusion lists
- Site visits
- FCBCs for providers subject to high-risk screening

Providers that fail to complete revalidation by the established due date shall not receive Medicaid payments until revalidation and all required screening activities are successfully completed. Any payments made during a lapse in revalidation could be considered improper payments and subject to recovery.

The Medicaid agency can rely on screening conducted by Medicare or another state or territorial Medicaid program, provided all federal criteria are met. However, the Guam Medicaid program remains responsible for obtaining required disclosures, maintaining documentation, and ensuring overall compliance with federal and program requirements.

The purpose of revalidation is to support ongoing program integrity, help ensure continued provider eligibility, and help prevent fraud, waste, abuse, and improper payments within the Guam Medicaid program and MIP.

[27] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.414." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.414

10.0 Suspensions, Terminations, and Reinstatements

An enrollment *suspension* occurs when a provider's Medicaid billing privileges are temporarily suspended. Billing privileges might be restored upon the provider's submission of required updated information and successful resolution of the issue that resulted in the suspension, provided all enrollment requirements are met.

Termination occurs when the Guam Medicaid program takes action to revoke a provider's billing privileges and either the provider has exhausted all applicable appeal rights or the time frame to file an appeal has expired.

A termination reflects a determination the provider is no longer eligible to participate in the Guam Medicaid program. There is no expectation on the part of the provider, supplier, eligible professional, or the Medicaid program that the termination is temporary.

Termination might also be required when a provider, supplier, or eligible professional has been terminated or had billing privileges revoked for cause by Medicare or another state or territorial program, including, but not limited to, reasons related to fraud, program integrity, or quality of care, consistent with applicable federal requirements.

Reinstatement can occur when the Guam Medicaid program's termination period has ended and a provider is eligible to reapply for Medicaid enrollment. Reinstatement of billing privileges is not guaranteed. To be reinstated, a provider must:

- Submit a new enrollment application, as required
- Successfully meet all applicable enrollment, screening, and program enrollment requirements in effect at the time of the review

10.1 Termination by Federal Authorities

A provider can be suspended or terminated from the program(s) for any of the following reasons.

10.1.1 Terminated Under Medicare or Other State or Territory Medicaid Program

Per the Social Security Act (SSA) Section 1902,[28] the provider is terminated under Medicare or under the Medicaid plan of any other state or territory (42 CFR § 455.416(c)).[29] This provision is limited to *terminations* as defined in 42 CFR § 455.101.[30] In contrast to the other circumstances

[28] Social Security Administration. n.d. "State Plans for Medical Assistance." Social Security Administration. Accessed January 23, 2026 https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
[29] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416
[30] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.101." Centers for Medicare & Medicaid Services, Department of Health and Human Services.

in which denial is required, the Guam Medicaid program does not have the authority to determine that denial is not in the Medicaid program's best interests.

When the Guam Medicaid program terminates a provider based on another state's termination, the appeal of the termination will only address whether the provider was in fact terminated by the initiating program, not the reasons for the original decision. For determining if a provider has been terminated by another state or Medicare, the provider is only considered terminated when they have exhausted appeal rights or the timeline for appeal has expired.

Pending final determination of termination status, providers could be suspended and prohibited from billing. Licensing agencies determine whether a provider can continue to provide services.

10.1.2 Criminal Conviction

The provider, or any person with 5% or more direct or indirect ownership interest in the provider, was, within the preceding 10 years, convicted (as defined in 42 CFR § 1001.2)[31] of a federal or territory criminal offense related to that person's involvement with Medicare, Medicaid, or CHIP. This requirement applies unless the Guam Medicaid program determines that termination is not in the Medicaid program's best interests and documents that determination in writing (42 CFR § 455.416(b))[32]

10.1.3 Failure to Comply With Screening Requirements

The provider, or any person with 5% or more direct or indirect ownership interest in the provider, did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E.[33]

10.1.4 Failure to Submit Fingerprints

The provider, or any person with 5% or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Guam Medicaid program within 30 days of a CMS or Medicaid agency request, unless the Guam Medicaid program determines the termination or denial of enrollment is not in the best interests of the Medicaid program and the Guam Medicaid program documents that determination in writing 42 CFR § 455.416(e).[34]

Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B/section-455.101

[31] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 1001.2." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001/subpart-A/section-1001.2

[32] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

[33] Centers for Medicare & Medicaid Services, Department of Health and Human Services. February 2, 2011. "42 CFR Part 455 Subpart E." Centers for Medicare & Medicaid Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E

[34] [41] [42] Centers for Medicare & Medicaid Services, Department of Health and Human Services. n.d. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services.

10.1.5 Failure to Submit Timely and Accurate Information

The provider or a person with an ownership control interest, an agent, or managing employee of the provider failed to submit timely and accurate information, unless the Medicaid agency determines that termination is not in the Medicaid program's best interests and documents that determination in writing 42 CFR § 455.416(d).[35]

10.1.6 Failure to Permit On-Site Review Access

The provider fails to permit access to provider locations for any site visit, unless the Medicaid agency determines the termination is not in the best interests of the Medicaid program (42 CFR § 455.416(f)).

10.1.7 Mandatory Terminations

Terminations include both mandatory and discretionary terminations. *For Cause* mandatory and discretionary terminations are identified as follows:

- **Criminal Conviction**. Where the provider, or any person with a 5% or more direct or indirect ownership interest in the provider, was, within the preceding 10 years, convicted (as defined in 42 CFR § 1001.2)[36] of a federal or state criminal offense related to that person's involvement with Medicare, Medicaid, or CHIP. This requirement applies unless the SMA determines termination is not in the Medicaid program's best interests and documents that determination in writing (42 CFR § 455.416(b)).
- **Failure to Comply With Screening Requirements**. Where the provider, or any person with a 5% or more direct or indirect ownership interest in the provider, did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E (42 CFR § 455.416(a)).
- **Failure to Submit Fingerprints**. Where the provider, or any person with a 5% or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the SMA within 30 days of a CMS or SMA request, unless the SMA determines the termination or denial of enrollment is not in the best interests of the Medicaid program and the SMA documents that determination in writing (42 CFR § 455.416(e)).
- **Failure to Submit Timely and Accurate Information**. Where the provider or a person with an ownership control interest, an agent, or managing employee of the provider failed to submit timely and accurate information, unless the SMA determines that

Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

[37]Centers for Medicare & Medicaid Services, Department of Health and Human Services. 4/3/2026 "42 CFR Section 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 7, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

[36] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 4/3/2026 "42 CFR Section 1001.2." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 7, 2026 https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001/subpart-A/section-1001.2

termination is not in the Medicaid Program's best interests and documents that determination in writing (42 CFR § 455.416(d)).[37]

- **On-Site Review**. Where the provider fails to permit access to provider locations for any site visit, unless the SMA determines the termination is not in the best interests of the Medicaid program (42 CFR § 455.416(f)).
- **Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment**. Where the provider's enrollment has been terminated or revoked *for cause* by Medicare or another state's Medicaid program and such termination has been published in the Data Exchange System (DEX), the SMA shall terminate the provider's enrollment in its program (42 CFR § 455.416(c), 42 CFR § 455.101).[38]
    - Please note: States that receive a letter from the Center for Clinical Standards and Quality (CCSQ) regarding an involuntary termination of a provider are to follow the termination action reflected in the letter and terminate the provider's Medicaid agreement promptly. However, states must refrain from reporting the termination to DEX until the Medicare revocation is reflected in DEX. SMAs should impose the same termination effective date as the Medicare revocation.

10.1.8 Discretionary Terminations

Discretionary terminations can be "for cause" terminations.

Reasons for discretionary termination include, but are not limited to:

- Billing with a suspended license
- False or misleading information provided
- Improper prescribing practices
- Inability to verify identity of provider
- Misuse of billing number
- Noncompliance with licensure or other standards
- Failed on-site review
- DEA certification suspended or revoked
- Provider conduct

[37] Centers for Medicare & Medicaid Services, Department of Health and Human Services. April 3, 2026. "42 CFR 455.416." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 7, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.416

[38] Centers for Medicare & Medicaid Services, Department of Health and Human Services. April 3, 2026. "42 CFR 455.101." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed April 7, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B/section-455.101

- Failure to repay an overpayment to the provider
- Falsification of medical records

10.1.9 Termination by Guam Medicaid Program Authorities

A provider can be suspended or terminated from the Guam Medicaid program or MIP for any of the following reasons:

- Failure or refusal to make available to BHCFA and federal agencies and their authorized representatives' immediate access to patients' records.
- Failure or refusal without reasonable justification to keep adequate written records necessary to fully disclose the type and extent of services or supplies provided to beneficiaries.
- Revocation or suspension of a professional license.
- Criminal complaint, indictment by a grand jury or information about a conviction of a provider by a state or territory or federal court for an offense involving the provider's enrollment in the program(s). These could remain the basis for suspension or termination even though the complaint, information, or indictment results in acquittal.
- Fraud against the program(s) or abuse of health care services.
- Determination by a peer review organization that a provider failed to provide adequate quality services to beneficiaries of the program(s) as judged against the accepted medical community standards in Guam.
- Intentional failure to repay overpayments made by the program(s).
- Any effort by the provider to interfere with, hinder, or stop any investigation by any local or federal agency into fraud or abuse in the program(s).
- Provider failure to reveal the existence of any relationship that might be subject to conflict of interest rules or program disclosure requirements.

11.0 Application Fee

Per 42 CFR § 455.460, beginning on or after March 25, 2011, Guam Medicaid program and MIP must collect the applicable application fee before executing a provider agreement with a prospective or reenrolling provider.[39] **Exceptions** are as follows:

- Individual physicians or nonphysician practitioners
- Providers who are enrolled in either of the following:
    - Title XVIII of the SSA (Medicare)
    - Another state or territory's Title XIX or XXI plan (Medicaid or CHIP)
- Providers that have paid the applicable application fee to:
    - A Medicare contractor
    - Another state or territory

If the fees collected by a state or territory agency in accordance with paragraph (a) of this section exceed the cost of the screening program, the state or territory agency must return that portion of the fees to the federal government.

11.1 Fee

Institutional providers and suppliers, such as DMEPOS suppliers and opioid treatment programs, pay an application fee when enrolling, reenrolling, revalidating, or adding a new practice location. Physicians, nonphysician practitioners, physician organizations, nonphysician organizations, and Medicare Diabetes Prevention program suppliers are exempt from the application fee.

There are times when the Medicaid agency will not collect an enrollment fee from institutional providers and suppliers. If the provider is Medicare-enrolled, or if Guam Medicaid relies on enrollment in another state or territory's Medicaid plan, the fee will not be collected.

Federal regulations define "institutional provider[s] of medical or other items or services or supplier" to include, but not be limited to:

- The range of ambulance service suppliers
- Ambulatory surgery centers (ASCs)
- Community mental health centers (CMHCs)
- DMEPOS

[39] Centers for Medicare & Medicaid Services, Department of Health and Human Services. February 2, 2011. "42 CFR 455.460." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.460

- End-stage renal disease (ESRD) facilities
- Histocompatibility laboratories
- Home health agencies (HHAs)
- Hospices
- Hospitals, including, but not limited to, acute inpatient facilities, inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), and physician-owned specialty hospitals
- Independent clinical laboratories
- Outpatient physical therapy/occupational therapy/speech pathology services
- Pharmacies
- SNFs
- Rural health clinics (RHCs)

11.2 Hardship Exception

The Guam Medicaid program can, on a case-by-case basis, exempt a provider of medical or other items or services, or a supplier, from the imposition of an application fee under this subparagraph if it determines that the imposition of the application fee would result in hardship. The Guam Medicaid program can waive the application fee under this subparagraph for providers enrolled in a state or territory Medicaid program for which the state or territory demonstrates that imposing the fee would impede beneficiary access to care. Hardship exceptions are granted on a case-by-case basis. A written request for a hardship exception, including any supporting documentation describing the hardship and justifying an exception to the application fee, should be submitted with the provider application for enrollment.

12.0 Appeals

There is currently no formal appeals process for providers to challenge an enrollment decision. The provider will need to resubmit the application packet, making any necessary corrections before resubmitting it to the Guam Medicaid program.

DPHSS reserves the right to establish a formal appeals process.

13.0 Moratoria

Under federal regulations, CMS and Medicaid agencies can impose moratoria on the enrollment of specific provider types. Access to care must be considered before imposing a Medicaid moratorium.

13.1 CMS-Imposed Moratoria

Under 42 CFR § 455.470(a),[40] the Medicaid agency will impose temporary moratoria on enrollment of new providers or provider types identified by the secretary as posing an increased risk to the Medicaid program (42 CFR § 455.470(a)(2)).

13.2 State and Territory Imposed Moratoria

Under 42 CFR § 455.450(b),[41] the Medicaid agency can impose temporary moratoria on enrolling new providers or provider types the Medicaid agency identifies as having a significant potential for fraud, waste, or abuse and that the secretary identifies as being at high risk for fraud, waste, or abuse (42 CFR § 455.470(b)(1)).

Under 42 CFR § 455.470(c), the Medicaid agency must impose the moratorium for an initial period of six (6) months. (42 CFR § 455.470(c)(1)) If the Medicaid agency determines it necessary, it can extend the moratorium in six-month increments. (42 CFR § 455.470(c)(2)) Each time, the Medicaid agency must document in writing the necessity for extending the moratorium. (42 CFR § 455.470(c)(3)) This documentation must be made available to CMS for concurrence prior to the extension.

The Medicaid agency has considerable discretion regarding other aspects and parameters of administering such moratoria.

[40] Centers for Medicare & Medicaid Services, Department of Health and Human Services. February 2, 2011. "42 CFR 455.470." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.470

[41] Centers for Medicare & Medicaid Services, Department of Health and Human Services. February 2, 2011. "42 CFR 455.450." Centers for Medicare & Medicaid Services, Department of Health and Human Services. Accessed January 23, 2026 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.450

14.0 Change Log

Page	Update Description	Effective Date

DISCLAIMER: This document does not address all the complexities of Medicaid policies and procedures and must be supplemented with all state and federal Laws and Regulations. Contact the Guam Medicaid program for coverage, prior authorization requirements, service limitations, and other practitioner information.

Appendices

Appendix A – Acronyms

Acronym	Description
ASC	Ambulatory Surgery Center
ACA	Affordable Care Act
BAA	Business Associate Agreement
BHCFA	Bureau of Health Care Financing Administration
CCSQ	Center for Clinical Standards and Quality
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Act
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CRNA	Certified Registered Nurse Anesthetist
DEA	Drug Enforcement Agency
DEX	Data Exchange System
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOA	Department of Administration
DPHSS	Department of Public Health and Social Services
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EOB	Explanation of Benefits
ESRD	End-Stage Renal Disease
FCBC	Fingerprint-Based Criminal Background Check
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act
IDTF	Independent Diagnostic Testing Facility
IPF	Inpatient Psychiatric Facility
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
LCSW	Licensed Clinical Social Worker
MFCU	Medicaid Fraud Control Unit

Acronym	Description
MIP	Medically Indigent Program
MMIS	Medicaid Management Information System
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
PT	Physical Therapist
RHC	Rural Health Clinic
SMA	State Medicaid Agency
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSN	Social Security Number
TIN	Taxpayer Identification Number
U.S.	United States

Appendix B – Provider Type Requirements Chart

Provider Type	Provider Type Code	Programs Covered	License Required	Medicare Certification Required	CLIA Certification Required	DEA Certification Required	Other Required	Risk Level (Limited, Moderate, High)	Enrollment Fee Required
Advance Diagnostic Imaging	39		Yes	Yes	No	No	-	Limited	Yes
Ambulance Service Provider	23	Medicaid, MIP, ABP	Yes	Yes	No	Yes	-	**Moderate**	Yes
Ambulatory Surgical Center (ASC)	13	Medicaid, MIP, ABP	Yes	Yes	Yes	Yes	-	Limited	Yes
Anesthesiology Assistant	05	Medicaid, MIP, ABP	Yes	No	No	Yes	-	Limited	No
AU Other	57		No	No	No	No	-	Limited	Yes
Audiologist	28	Medicaid, MIP, ABP	Yes	No	No	No	-	Limited	No
Cardiac Rehabilitation and Intensive Cardiac Rehabilitation	04		No	Yes	No	No	-	Limited	Yes
Certified Clinical Nurse Specialist	38		Yes	No	No	Yes	-	Limited	No
Certified Nurse Midwife	08		Yes	No	No	Yes	-	Limited	No
Certified Registered Nurse Anesthetist (CRNA)	09		Yes	No	No	*	*DEA certification required if prescribing	Limited	No
Chiropractor	06	MIP, ABP	Yes	No	No	No	-	Limited	No
Clinic or Group Practice	32	Medicaid, MIP, ABP	Yes	Yes	No	Yes	-	Limited	Yes
Clinical Laboratory	31	Medicaid, MIP, ABP	Yes	Yes	Yes	No	-	**Moderate**	Yes
Department Store	49		No	No	No	No	-	Limited	Yes
Grocery Store	50		No	No	No	No	-	Limited	Yes

Provider Type	Provider Type Code	Programs Covered	License Required	Medicare Certification Required	CLIA Certification Required	DEA Certification Required	Other Required	Risk Level (Limited, Moderate, High)	Enrollment Fee Required
Home Health Agency	46	Medicaid, MIP, ABP	Yes	Yes	No	Yes	-	**High - Initial Enrollment Moderate - Revalidations**	Yes
Hospital - General	42	Medicaid, MIP, ABP	Yes	Yes	No	Yes	-	Limited	Yes
Independent Diagnostic Testing Facility (IDTF)	11	Medicaid, MIP, ABP	Yes	Yes	No	No	-	**Moderate**	Yes
Indian Health Service Facility	51		No	Yes	No	No	-	Limited	Yes
Individual Certified Orthotist	19		Yes	No	No	No	-	Limited	No
Individual Certified Prosthetist	20		Yes	No	No	No	-	Limited	No
Individual Certified Prosthetist-Orthotist	21		Yes	No	No	No	-	Limited	No
Intermediate Care Nursing Facility	44		Yes	Yes	No	No	-	Limited	Yes
Licensed Clinical Social Worker (LCSW)	37	Medicaid, MIP, ABP	Yes	No	No	No	-	Limited	No
Mammography Center	10		Yes	Yes	No	No	-	Limited	Yes
Mass Immunizer Roster Biller	34		No	Yes	No	No	-	Limited	Yes
Medical Supply Company with Orthotist	15	Medicaid, MIP, ABP	Orthotist Yes	Yes	No	No	-	**High - Initial Enrollment Moderate - Revalidations**	Yes

Provider Type	Provider Type Code	Programs Covered	License Required	Medicare Certification Required	CLIA Certification Required	DEA Certification Required	Other Required	Risk Level (Limited, Moderate, High)	Enrollment Fee Required
Medical Supply Company with Orthotist-Prosthetist	17	Medicaid, MIP, ABP	Orthotist-Prosthetist Yes	Yes	No	No	-	**High - Initial Enrollment Moderate - Revalidations**	Yes
Medical Supply Company with Pedorthic Personnel	54	Medicaid, MIP, ABP	Pedorthists Yes	Yes	No	No	-	**High - Initial Enrollment Moderate - Revalidations**	Yes
Medical Supply Company with Pharmacist	22	Medicaid, MIP, ABP	Pharmacist Yes	Yes	No	No	-	**High - Initial Enrollment Moderate - Revalidations**	Yes
Medical Supply Company with Respiratory Therapist	48	Medicaid, MIP, ABP	Respiratory Therapist Yes	Yes	No	No	-	**High - Initial Enrollment Moderate - Revalidations**	Yes
Medical Supply Company with Prosthetist	16	Medicaid, MIP, ABP	Prosthetist Yes	Yes	No	No	-	Limited	Yes
Nurse Practitioner	14		Yes	No	No	Yes	-	Limited	No
Occupational Therapist in Private Practice	30	Medicaid, MIP, ABP	Yes	*	No	No	*Outpatient services require Medicare Certification	Limited	No
Ocularist	56	Medicaid, MIP, ABP	No	No	No	No	-	Limited	No
Optician	40	Medicaid, MIP, ABP	No	No	No	No	-	Limited	No
Optometry	07	Medicaid, MIP, ABP	Yes	No	No	*	DEA certification required if prescribing	Limited	No

Provider Type	Provider Type Code	Programs Covered	License Required	Medicare Certification Required	CLIA Certification Required	DEA Certification Required	Other Required	Risk Level (Limited, Moderate, High)	Enrollment Fee Required
Oral Surgery (Dentist)	03	Medicaid, MIP, ABP	Yes	No	No	Yes	-	Limited	No
Other Medical Supply Company	18	Medicaid, MIP, ABP	Yes	Yes	No	No	-	**High - Initial Enrollment** **Moderate - Revalidations**	Yes
Other Nursing Facility	45		Yes	Yes	No	No	-	Limited	Yes
Oxygen Supplier	52	Medicaid, ABP	No	Yes	No	No	-	**High - Initial Enrollment** **Moderate - Revalidations**	Yes
Pedorthic Personnel	53		No	No	No	No	-	Limited	No
Pharmacy	47	Medicaid, MIP, ABP	Yes	Yes	Yes	Yes	-	Limited	Yes
Physical Therapist in Private Practice	29	Medicaid, MIP, ABP	Yes	*	No	No	*Outpatient services require Medicare Certification	**Moderate**	No
Physician	01	Medicaid, MIP, ABP	Yes	No	No	*	DEA certification required if prescribing	Limited	No
Physician Assistant	41	Medicaid, MIP, ABP	Yes	No	No	*	DEA certification required if prescribing	Limited	No
Podiatry	12	Medicaid, MIP	Yes	No	No	*	DEA certification required if prescribing	Limited	No
Portable X-Ray Supplier	27		Yes	Yes	No	No	-	**Moderate**	Yes
Psychologist, Clinical	26	Medicaid, MIP, ABP	Yes	No	No	No	-	Limited	No

Provider Type	Provider Type Code	Programs Covered	License Required	Medicare Certification Required	CLIA Certification Required	DEA Certification Required	Other Required	Risk Level (Limited, Moderate, High)	Enrollment Fee Required
Public Health or Welfare Agency	24		No	Yes	No	No	-	Limited	Yes
Radiation Therapy Center	35	Medicaid, MIP, ABP	Yes	Yes	No	No	-	Limited	Yes
Registered Dietitian or Nutrition Professional	33		Yes	No	No	No	-	Limited	No
Rehabilitation Agency	55		Yes	Yes	No	No	-	**Moderate**	Yes
Skilled Nursing Facility	43	Medicaid, MIP, ABP	Yes	Yes	No	No	Certified by the Health Standard Quality Bureau of Health Care Financing Administration	**High - Initial Enrollment** **Moderate - Revalidations**	Yes
Slide Preparation Facility	36		Yes	Yes	Yes	No	-	**Moderate**	Yes
Speech Language Pathologist	02		Yes	*	No	No	*Outpatient services require Medicare Certification	Limited	No
Voluntary Health or Charitable Agency	25		If providing licensed healthcare services, appropriate facility and practitioner licenses are required.	Yes	No	No	-	Limited	Yes