SCHOOL DISTRICT ADDENDUM

TO THE SOUTH DAKOTA MEDICAID PROVIDER AGREEMENT

This document serves as a formal addendum to your South Dakota Medicaid Provider Agreement and enables you to become an enrolled School District provided for in ARSD 67:16:37.

As a participating Provider, the Provider hereby agrees to the provisions of the Provider Agreement and the following:

A. **Recognition.**

1. The school district is recognized by the South Dakota Board of Education.

B. **Professional Staff.** Medical care is provided by professional staff who:

1. Meet the requirements of ARSD 67:16:37 and in the case of psychologists, physical therapists, occupational therapists, speech-language pathologists, and audiologists, the professional staff are enrolled as SD Medicaid providers who are associated to the Provider's online enrollment record.
2. Are either employed by or under contract with the Provider.
3. Are not billing the SD Medicaid program separately for their services.

C. **Recipient Selection and Care.**

1. The Provider will accept Medicaid eligible recipients for care and treatment.

2. The Provider will apply any restrictions on the type of services made available, and/or type of health conditions or any other criteria relating to the acceptance of persons for care and treatment to all persons seeking services from the provider, regardless of Medicaid status.

3. Participate in cost determination or expenditure validation activities as requested.

To Be Completed By Provider

I declare and affirm under the penalties of perjury that this Addendum has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further declare and affirm under the penalties of perjury that any claim to be submitted pursuant to this Addendum will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct.

Provider NPI: _____ Date: _____

Provider Name: _____
(Legal Name of Organization)

By: _____ Name/Title: _____
Authorized Signature Printed Name of Signatory

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TO BE COMPLETED BY MEDICAL SERVICES

APPROVED BY: _____ REFERENCE NUMBER: _____

DATE: _____ NEW _____ REVALIDATION _____