



MARYLAND  
Department of Health

**Addendum Cover Page for Maryland  
Medical Assistance Program Application  
FACILITY/ORGANIZATION  
PT 51 EPSDT THERAPEUTIC BEHAVIORAL SERVICES**

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**  
**Monday – Friday from 7am – 7pm.**

All providers are required to use the electronic Provider Revalidation and Enrollment Portal, or ePREP ([eprep.health.maryland.gov](http://eprep.health.maryland.gov)) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the “Additional Information” section under “Practice Information” within the ePREP ([eprep.health.maryland.gov](http://eprep.health.maryland.gov)) “Applications” tab, along with any additional documents requested within the addendum.

**Provider Information**

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

**After you receive your Medical Assistance enrollment approval,  
please register with Beacon Health Options for authorization.**

To register:

1. Visit <http://maryland.beaconhealthoptions.com/index.html>
2. Click on “Behavioral Health Providers”
3. Click on “Register”
4. Complete the Provider Online Services Registration form that appears

Should you have any questions regarding Beacon Health Options registration, please contact:  
Beacon Provider Relations: Phone: (800) 888-1965 – Email: [marylandproviderrelations@beaconhealthoptions.com](mailto:marylandproviderrelations@beaconhealthoptions.com)

Please visit [health.maryland.gov/ePREP](http://health.maryland.gov/ePREP) for more information about ePREP



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**\*In order to enroll as an EPSDT TBS provider you must already be enrolled as a DDA, PRP, OMHC, or Mobile Treatment provider.**

**Section I:**

Please check the box for services your facility is enrolled to render, and provide the appropriate Maryland Medical Assistance Provider Number (MA#):

- |   |           |
|---|-----------|
| <input type="checkbox"/> DDA              | MA# _____ |
| <input type="checkbox"/> PRP              | MA# _____ |
| <input type="checkbox"/> OMHC             | MA# _____ |
| <input type="checkbox"/> Mobile Treatment | MA# _____ |

**Section II:**

Please upload a copy of the corresponding license(s) for the service(s) checked in the above list and upload the document(s) to [ePREP](#):