Maryland Outpatient Mental Health Provider
Quality Incentive Program (QuIP)
Value Intensive Program (VIP)

Enrollment Form

Provider Name _____

VO Provider # _____

Primary Contact Name _____

Primary Phone & Fax _____

Confirm by Checking I or II

I. ☐ **Requesting enrollment ONLY in QuIP**

II. ☐ **Requesting enrollment in QuIP and as VIP provider (must select A or B)**

A. ☐ **Case Management offered through provider's own staff**

B. ☐ **Case Management offered through agreement with CM agency**

Name of CM Agency:_____

Submit this enrollment form to ValueOptions® Maryland via fax at 410-691-4001.
Send to the attention of Provider Relations.

Maryland OMS Providers
Quality Incentive Program (QuIP)
Value Intensive Program (VIP)

OMS Service Locations and CSAs

Duplicate this sheet as many times as needed to ensure all service locations are identified.

OMS Service Location Name _____

Medicaid ID # _____

Address Line 1 _____

Address Line 2 _____

City, State Zip _____

CSA _____

OMS Service Location Name _____

Medicaid ID # _____

Address Line 1 _____

Address Line 2 _____

City, State Zip _____

CSA _____

OMS Service Location Name _____

Medicaid ID # _____

Address Line 1 _____

Address Line 2 _____

City, State Zip _____

CSA _____

Submit this two page enrollment form and Quality Plan to ValueOptions® Maryland via fax at 410-691-4001. Send to the attention of Provider Relations.