



# Virginia Provider Enrollment (PE)

## User Guide

### *Medicaid Enterprise System (MES)*

**Release: 30.15**

**Release Date: 10/2025**

*Note: This user guide will continue to be updated to reflect new functionality or changes.*



## Privacy and Security Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule<sup>1</sup> and the American Recovery and Reinvestment Act (ARRA) of 2009 requires that covered entities protect the privacy and security of individually identifiable health information.



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# I Introduction and Overview

The Virginia Department of Medical Assistance Services (DMAS) Provider Services Solution, known as PRSS, is an electronic enrollment application that guides the provider through the enrollment and revalidation processes. It walks users through all the enrollment information needed based on Enrollment, Provider, Specialty, and Risk Type.

When a provider becomes eligible with Virginia Medicaid, they will also be able to access the PRSS Provider Portal which is a secure site where a provider can maintain their enrollment information and access direct links to member eligibility, service authorization, claims history, and other valuable resources.

## Overview

This document, the *Provider Enrollment User Guide*, is designed to help providers understand how the Provider Screening process works and how to successfully complete an enrollment application. Examples in the guide illustrate functionality and are based on applications created using publicly available information. Tax numbers, birth dates, and other data presented are created for training purposes and is not personally identifiable information (PII).

The guide is organized into the following functional areas:

- Provider Screening Service
- Enrollment Types
- New Enrollment
- Credentials
- Provider Type
- Disclosures

Use the Provider Enrollment process to do the following:

- Request enrollment/contract with a plan
- Submit copies of licenses, insurance, and other documents required for both VA FFS and Managed Care Plans
- Sign a provider agreement
- Complete any other steps unique to a plan

## PRSS Features

The Provider Enrollment Portal is designed to streamline the enrollment and revalidation process with the following features:

### Registration

An Application Tracking Number (ATN) is assigned at the beginning of the enrollment process, enabling users to save data and resume the process later. The registration number is sent to the user-provided email address. After the enrollment is created, changes are saved at each step of the enrollment application. You can resume at any time and continue with the last saved step or return to previous steps. See [Registration](#) for details.

### Enrollment Status

Throughout the enrollment process, the Application Tracking Number (ATN) can be used to check the status of the enrollment (Partial, Waiting for Attachments, Pending review, Returned to Provider, Approved, Denied.) See [Enrollment Status](#) for details.

### Address Verification

Addresses entered throughout the application are validated against the US Postal Service, reducing the risk of submissions containing inaccurate address information. See [Addresses](#) for additional details.

### Potential Duplicate Provider Warning

Data fields to alert the user if key enrollment details match an existing active provider or in-progress enrollment. See [Potential Duplicate Service Location](#) for additional details.

### Identifier Format Validations

Format validation is performed for common provider identifiers such as NPI, CLIA and DEA to prevent accidental, incorrect entries.

### Electronic Attachments

Users can upload attachments electronically during the enrollment process. See [Attachments](#) for details by enrollment, provider, and specialty type.

### Customized Questions

While some questions are common to all Providers, others are specific to the Enrollment, Provider, Specialty, and Risk of the Provider.



## Progress Bar

This bar displays the user's progress in completing the application.



## Pre-Populated Data

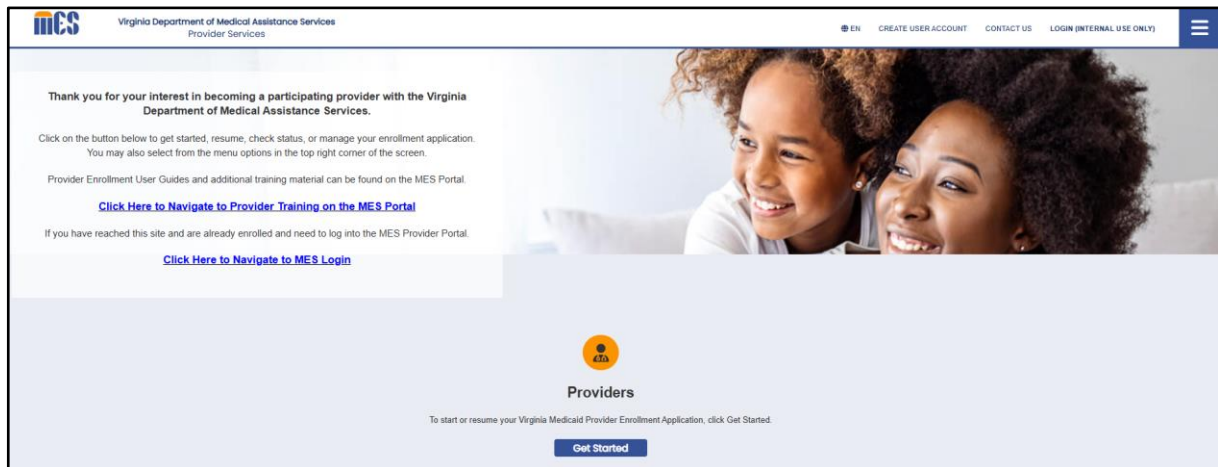
Pre-populated data minimizes data entry during the revalidation and re-enrollment of a terminated provider. Users can review existing data, update data where applicable, and attach any required documents. Users are required to provide information that could not be pre-populated.

## Navigating the System

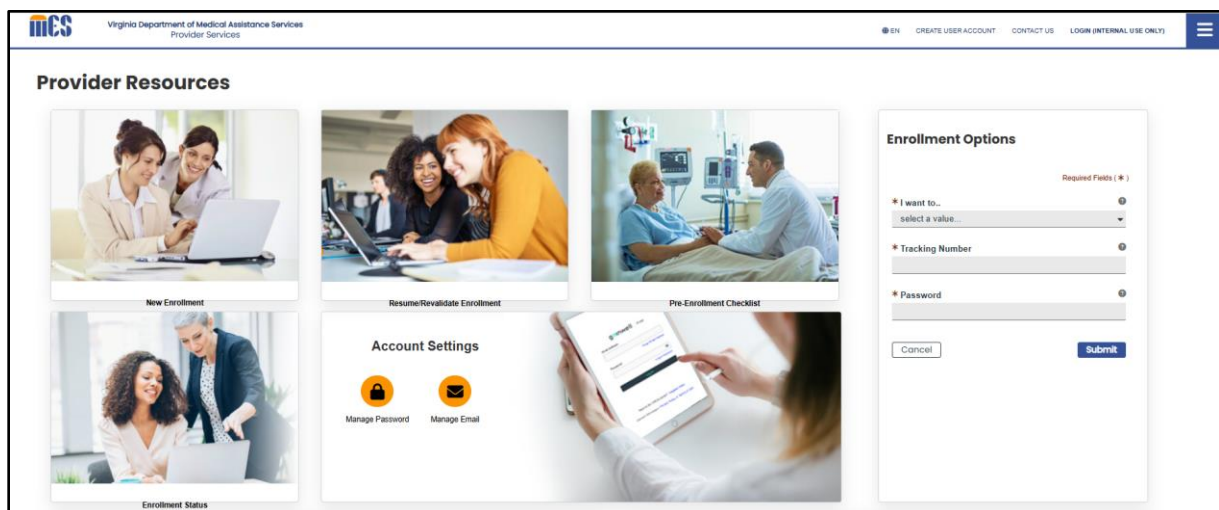
Providers will be guided through each page of enrollment, from the general information on the first page to the final print on the last page. An Application Tracking Number (ATN) lets users check the status of enrollment requests.

Complete the following steps to open Provider Enrollment Portal:



1. Click **Get Started** under Providers on the Welcome page.



2. This takes you to the Provider Resources Page where you have the option to review Pre-Enrollment Checklist, start a New Enrollment, Check Enrollment Status and under Enrollment Options you can select to **Resume**, **Revalidate**, or **Check Status** and by entering your ATN and Password, then clicking **Submit**. These options will be reviewed in more detail in Section IV Enrolling as a Virginia Medicaid Provider.



## Guidelines

- Required fields are marked with a blue asterisk.
- Field level help is available wherever the  icon displays.
- Page level help () is available in the right-hand corner of the application, which provides an overview of the enrollment page.
- Click **Print** in the top-right corner of the application to print a PDF copy of the completed enrollment steps.
- Click **Application Fee on** the Print panel to print a coversheet for the created enrollment when mailing or faxing information to the enrollment team is required. NOTE: Only provider types listed on the coversheet require an application fee.
- Click the - (minus sign) in the upper-right corner of the page to collapse panels. Click the + (plus-sign) to expand panels.
- Click **Yes** or **No** in popup windows that display error messages. The **X** in the top-left corner of the warning is not actionable and will not return you to a previous screen.
- Edit entries within a panel by clicking the pencil icon.
- Click **Clear** on any Search panel to deselect the search criteria.
- Click **Cancel** to ignore any new entries made on the screen.
- Click **Delete** to remove an entry from the panel.
- Click **Previous** to return to the previous page. No data entered on the current page is saved.

## II Provider Screening

### Provider Screening and Risk Level Definitions

The 21st Century Cures Act (Cures Act) 114 P.P.255 requires all states to screen Medicaid providers, both in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) upon enrollment. An abbreviated screening is also performed monthly for any provider who participates in the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years. The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited," "moderate," or "high."

### Provider Screening Requirements

Provider screening requirements include those listed in the following table.

Risk Category	Screening Requirements
Limited Risk Providers	The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations and State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.
Moderate Risk Providers	In addition to the screening requirements applicable to the limited risk provider category listed above, unannounced pre- and/or post-enrollment site visits apply to moderate risk providers. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.
High Risk Providers	In addition to the screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high-risk category may be required to undergo criminal background check(s) and submit fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening.



## Application Fee Requirements

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment, revalidation, or reactivation, and when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice. CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid or Medicare program or has been granted hardship approval by Medicare. Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS denies the hardship request, then providers must pay the application fee within 30 calendar days from the date of the CMS notification; otherwise, the application for enrollment will be rejected. An appeal of hardship exception determination must be made to CMS pursuant to 42 CFR 424.514.

## Screening Requirements by Provider Type

Provider Type	Risk Category	Application Fee	Site Visit	Fingerprint and Background Check
001 - Hospital	Limited	Yes	No	No
003 - Private Inpatient Psychiatric Hospital	Limited	Yes	No	No
007 - State Mental Health Hospital	Limited	Yes	No	No
010 - Nursing Facility	Limited	Yes	No	No
014 - Rehabilitation Hospital	Limited	Yes	No	No
015 - Intermediate Care Facility	Limited	Yes	No	No
017 - Intermediate Care Facility-Developmental Disability	Limited	Yes	No	No
020 - Physician	Limited	No	No	No
022 - Treatment Foster Care Case Management	Limited	No	No	No
023 - Nurse Practitioner	Limited	No	No	No
026 - Chiropractor	Limited	No	No	No
030 - Podiatrist	Limited	No	No	No
031 - Optometrist	Limited	No	No	No
036 - Baby Care	Limited	No	No	No
038 - Hearing Aid Specialist	Limited	No	No	No
039 - Therapists - OPR Only	Limited	No	No	No
042 - Dental Medical (CPT)	Limited	No	No	No
043 - Nursing Service Providers	Limited	No	No	No
044 - Audiologist	Limited	No	No	No
045 - Specialist/Technician	Limited	No	No	No
046 - Hospice	Moderate	Yes	Yes	No
048 - Dental Clinic Medical	Limited	No	No	No
049 - Ambulatory Surgery Center	Limited	Yes	No	No
051 - Clinics	Limited	Yes	No	No
054 - Indian Health Services	Limited	Yes	No	No
056 - Waiver Services	Limited	No	No	No



057 - Outpatient Rehabilitation Facility	Limited	Yes	No	No
059 - Home Health Agency	<b>New/Re- Enrollment - High Revalidation - Moderate</b>	Yes	Yes	Yes
060 - Pharmacy	Limited	Yes	No	No
061 - Pharmacy-Long Term Care	Limited	Yes	No	No
062 - Durable Medical Equipment	<b>New/Re- Enrollment - High Revalidation - Moderate</b>	Yes	Yes	Yes
063 - Private Duty Nursing Services	Limited	No	No	No
064 - Prosthetic and Orthotics	<b>New/Re- Enrollment - High Revalidation - Moderate</b>	Yes	Yes	Yes
070 - Laboratory	Moderate	Yes	Yes	No
071 - Imaging Centers	Moderate	Yes	Yes	No
072 - Local Education Agency	Limited	No	No	No
077 - Residential Treatment Facility	Limited	Yes	No	No
080 - Emergency Transportation	Moderate	Yes	Yes	No
082 - Emergency Medical Technician	Limited	No	No	No
099 - Qualified Medicare Crossover	Limited	No	No	No
100 - Temporary Detention Order (TDO)	Limited	No	No	No
104 - Full PACE (Program for All Inclusive Care for Elderly)	Limited	No	No	No
105 - Certified Professional Midwife	Limited	No	No	No
108 - Early Intervention Services	Limited	No	No	No
117 - Doula	<b>New/Re- Enrollment - High Revalidation - Moderate</b>	No	No	Yes
120 - Physician Assistant	Limited	No	No	No
130 - Podiatry Assistant	Limited	No	No	No
141 - Military Healthcare Provider	Limited	No	No	No
156 - Behavioral Health Services	Limited	No	No	No
256 - Behavioral Health Practitioner	Limited	No	No	No
268 - Pharmacist	Limited	No	No	No
331 - Optical Clinic	Limited	No	No	No
339 - Therapists - MCO Only	Limited	No	No	No
356 - Behavioral Health Clinic	Moderate	Yes	Yes	No
456 - Behavioral Health Clinic and Services	Moderate	Yes	Yes	No
700 - Meals	Limited	No	No	No
701 - Lodging	Limited	No	No	No
703 - Blood bank	Limited	No	No	No
704 - Eye Bank	Limited	No	No	No
990 - Group Practice	Limited	No	No	No



## III Enrollment Types

### Overview of Enrollment Types

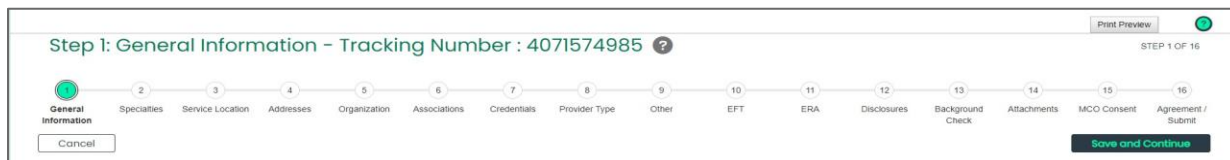
The enrollment system offers the following types:

- Facility
- Group
- Individual
- Individual within a Group
- Atypical
- OPR (Ordering, Prescribing, or Referring)

Not all Enrollment Types are available for all Provider Types and Specialties. For example, a pharmacy can only enroll as a facility, while a physician can enroll as either an Individual, an Individual within a Group, or OPR Provider.

### Facility

Facility Enrollment type applies to “brick and mortar” entities such as hospitals, clinics, pharmacies, home health agencies or emergency transportation providers that want to provide medical services and submit reimbursement claims for those services. Facilities must enroll using NPI - Type 2 Organization. Depending on Provider, Specialty, and Risk Type, the following progress bar and



Step 1: General Information - Tracking Number : 4071574985 ?

STEP 1 OF 16

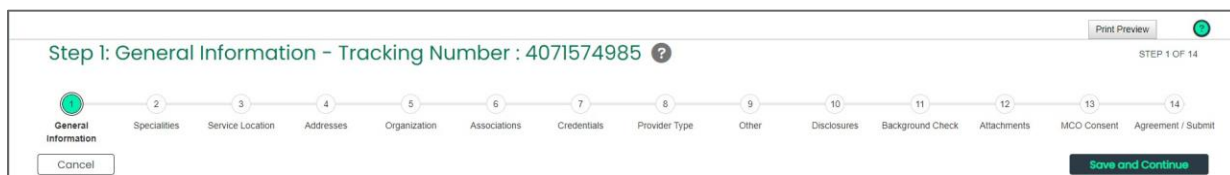
1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization 6 Associations 7 Credentials 8 Provider Type 9 Other 10 EFT 11 ERA 12 Disclosures 13 Background Check 14 Attachments 15 MCO Consent 16 Agreement / Submit

Cancel Save and Continue

pages might appear for a Facility enrollment.

### Group

A Group Enrollment type is a Group Practice who has two or more rendering providers doing business together under a Group Practice NPI. All payments made are reported to the IRS against the group EIN. The following progress bar with pages might appear for a Group enrollment.



Step 1: General Information - Tracking Number : 4071574985 ?

STEP 1 OF 14


1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization 6 Associations 7 Credentials 8 Provider Type 9 Other 10 Disclosures 11 Background Check 12 Attachments 13 MCO Consent 14 Agreement / Submit

Cancel Save and Continue

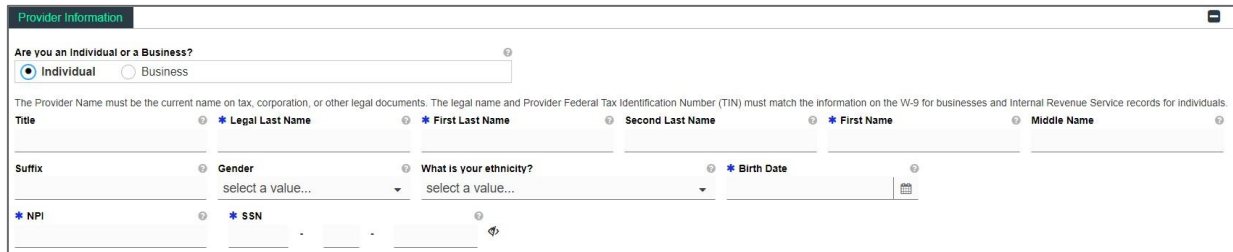
## Individual

The Individual Enrollment type is appropriate for individual practitioners who are both the rendering and billing Provider. All payments made are reported to the IRS against the individual's Social Security Number if enrolling as an Individual, or against the EIN if enrolling as a business.

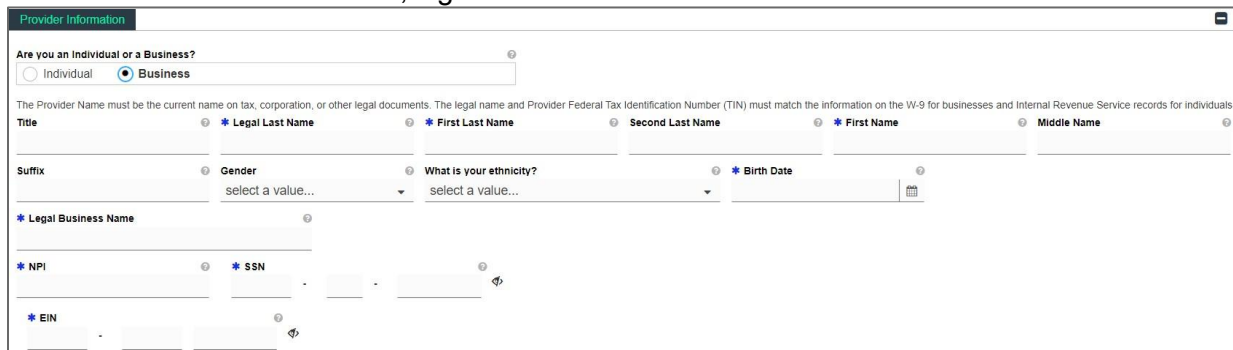
Individual Enrollment Types can also enroll as an Individual within a Group during one enrollment transaction and select a Group Association. The following progress bar with pages might appear for an Individual Enrollment type.



Individual providers can be either a business or an individual. Users are prompted to select one so the correct data can be collected. For an individual, PRSS collects first and last name, Social Security number, and date of birth.



For an Individual as a business, legal name and EIN details are collected.



## Individual within a Group

The individual within a Group Enrollment type is appropriate for practitioners who are rendering providers. All billing for the provider's services is provided by one or more groups. All payments made are reported to the IRS against the group EIN.

The following progress bar with pages might appear for an Individual within a Group enrollment.



**NOTE:** For Individual within a Group enrollment, a warning message displays if details entered on the General page match an existing provider. The enrollment can be continued, or details corrected as needed to enroll a new provider.

## Atypical

Atypical Enrollment type Providers may submit HIPAA transactions. Atypical providers do not meet the HIPAA definition of a health care Provider and do not need to receive an NPI number.

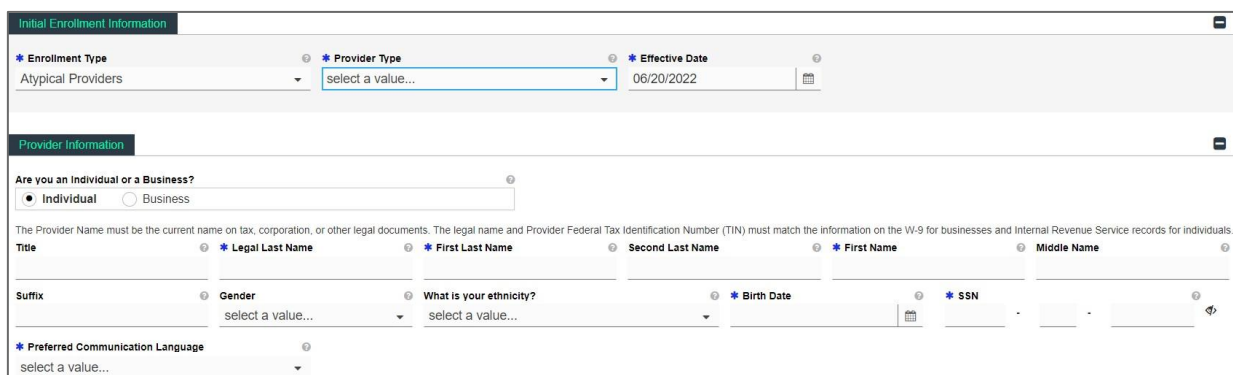
The following progress bar with pages might appear for an Atypical enrollment



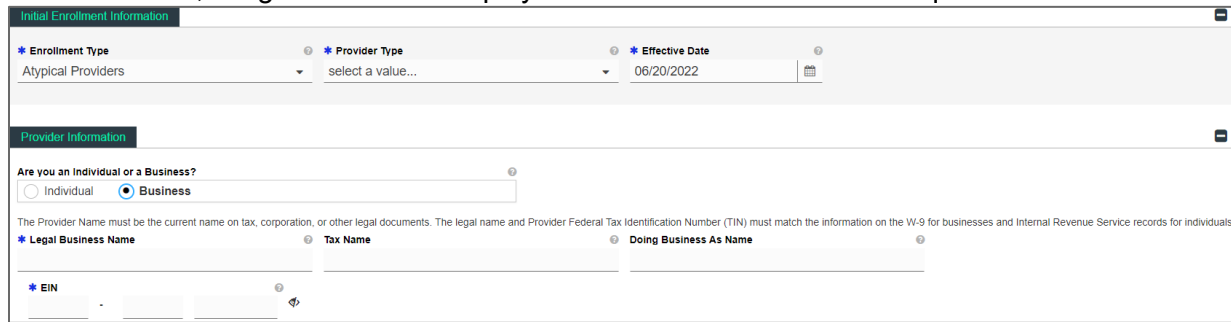
An Atypical Provider type can be either a business or an individual. Users are prompted to select one so that the correct data can be collected. For an individual, first and last name, Social Security number, and date of birth are collected.

### NOTES:

- A provider who also participates with an MCO cannot enroll as an Atypical Provider. MCO providers must obtain an NPI.
- Users assigned an NPI number do not qualify for an Atypical Enrollment Type.



For a business, a legal name and Employer Identification Number are required.



## Ordering, Prescribing, Referring (OPR)

42 CFR 455.410(b) states that state Medicaid agencies must require all ordering, referring, and prescribing physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ORP providers to enroll to meet new program integrity requirements designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid members originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. There is one exception: the provider enrollment requirements do not apply to physicians who order or refer services for a Medicaid member in a risk-based managed care plan. A provider that does not participate with Virginia Medicaid currently but may order, refer, or prescribe to Medicaid members, must be enrolled to ensure claims will be paid to the servicing provider who is billing for the service. As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

OPR Enrollment Types can optionally provide an Association to facilities.

The following progress bar with pages might appear for an OPR enrollment.



The following Provider Types can enroll as an OPR.

OPR Eligible Providers	
Audiologist	Physicians including Psychiatrists
Clinical Psychologists	Professional Counselors
Clinical Social Workers	Psychiatric Clinic Nurse Specialists
Marriage and Family Therapists	School Psychologists
Nurse Practitioners	School Social Workers
Occupational Therapists	Speech and Language Pathologists
Physical Therapists	

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## IV Enrolling as a Virginia Medicaid Provider

### Things to do Prior to Enrollment

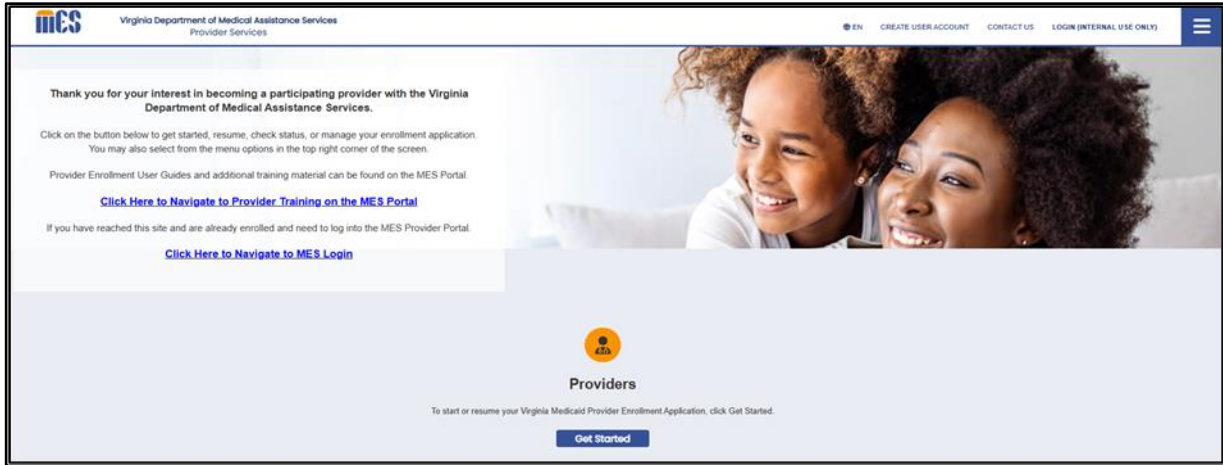
All Virginia Medicaid Fee for Service (FFS) and Managed Care Organization (MCO) Providers must be screened according to the ACA Provider Screening Regulations and enrolled through MES of Virginia Medicaid Provider Enrollment Services (PRSS).

**Note** – A provider enrolling as an MCO Only provider, must enroll and be screened through PRSS prior to establishing a contract with one or more MCO Programs.

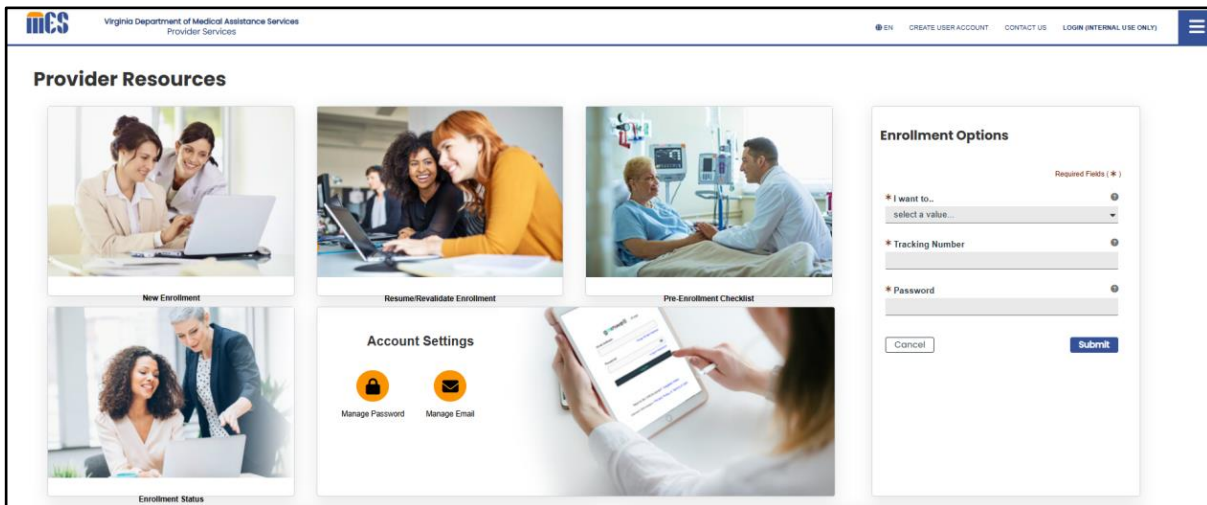
1. Providers must ensure that they are enrolled as the correct provider type/specialty.
2. During the enrollment process, please review that you are enrolling with the correct enrollment, provider and specialty type(s) that align with your license/certification and other specific state's coverage rules.
3. Providers may also review the weekly provider extract located here to avoid duplication of enrollment by provider type/specialty.
  - a. The weekly extract does not include all provider specialties for which the provider is eligible. Providers should review and maintain their provider information for accuracy via the secure provider portal.
  - b. Weekly extract can be found here:  
<https://vamedicaid.dmas.virginia.gov/provider/mco>
  - c. For Mental Health (MH), Psychiatric Residential Treatment Facility (RPTF), and Waiver providers, the weekly extract does not include all specialties in which they are currently enrolled.
4. Providers are responsible for ensuring they continue to meet the license and certification requirements for their provider type/specialty as a MH, RPTF, and Waiver provider.
5. For some Providers, enrollment may require special license/certifications and submission of a yearly Memorandum of Understanding (MOU) from the Department of Behavioral Health and Developmental Services (DBHDS) or for Residential Treatment Facilities, the Restraint and Seclusion letter. If a provider does not meet this requirement, they may become ineligible.
6. Enrolling with incorrect provider type/specialty may impact claims, timely enrollment, and ability to render services to Virginia Medicaid Members.
7. It is the provider's responsibility to review enrollment requirements and provider specific information to maintain eligibility in one or more of the Virginia Department of Medical Services programs.

## Get Started

1. Click **Get Started** under Providers on the Welcome page.

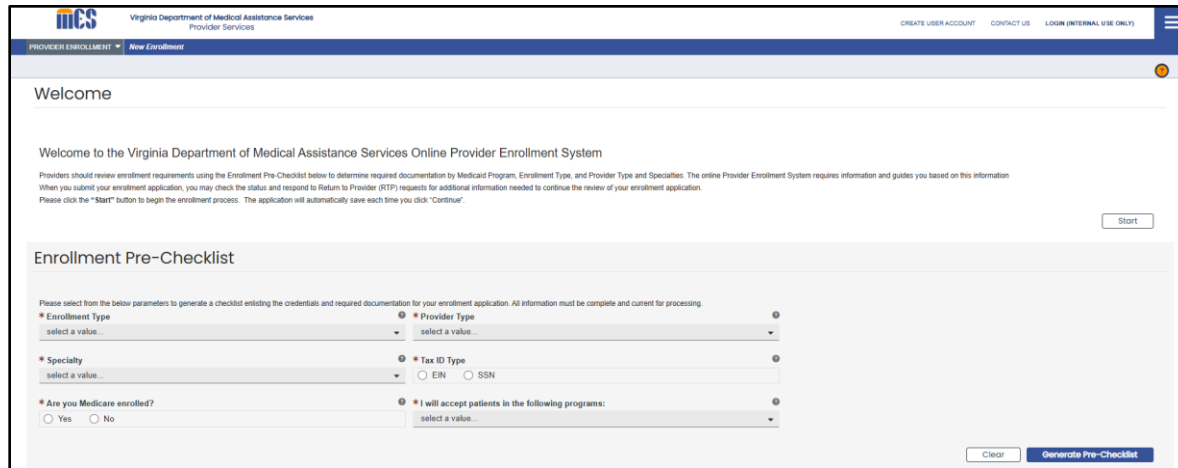


2. Click the Provider Resource icon, then select New Enrollment, Pre-Enrollment Checklist, or other Enrollment Options.



## Welcome Page

The Welcome page provides guidance for the information required to complete the application.



**Virginia Department of Medical Assistance Services**  
Provider Services

CREATE USER ACCOUNT   CONTACT US   LOGIN (INTERNAL USE ONLY)

PROVIDER ENROLLMENT   **New Enrollment**

### Welcome

Welcome to the Virginia Department of Medical Assistance Services Online Provider Enrollment System

Providers should review enrollment requirements using the Enrollment Pre-Checklist below to determine required documentation by Medicaid Program, Enrollment Type, and Provider Type and Specialties. The online Provider Enrollment System requires information and guides you based on this information. When you submit your enrollment application, you may check the status and respond to Return to Provider (RTP) requests for additional information needed to continue the review of your enrollment application. Please click the "Start" button to begin the enrollment process. The application will automatically save each time you click "Continue".

[Start](#)

### Enrollment Pre-Checklist

Please select from the below parameters to generate a checklist entailing the credentials and required documentation for your enrollment application. All information must be complete and current for processing.

<p><b>* Enrollment Type</b> select a value...</p>	<p><b>* Provider Type</b> select a value...</p>
<p><b>* Specialty</b> select a value...</p>	<p><b>* Tax ID Type</b> <input type="radio"/> EIN   <input type="radio"/> SSN</p>
<p><b>* Are you Medicare enrolled?</b> <input type="radio"/> Yes   <input type="radio"/> No</p>	<p><b>* I will accept patients in the following programs:</b> select a value...</p>

[Clear](#)   [Generate Pre-Checklist](#)

1. Click **Start** to begin the Provider Enrollment application, or
2. Click **Generate Pre-Checklist** to generate a checklist with details about credentials and documents required to complete an enrollment application. This is optional, and users can begin applications without generating the enrollment checklist.



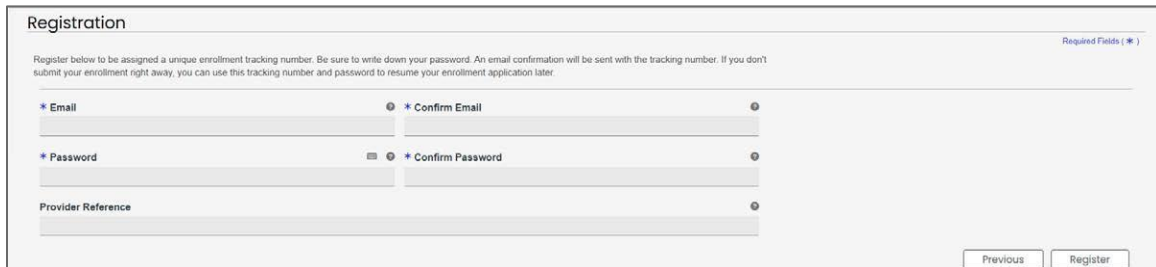
## Registration

Registration is required for each application. An Application Tracking Number (ATN) is assigned to each registered application. Select a password between 8 and 20 characters, including at least one number, one upper-case, and one lower-case alphanumeric character.

The ATN and password enable users to resume the application, if necessary, or to check the status after submission. Reference the ATN on any documentation submitted during the application or revalidation process. The ATN also makes it easier to locate applications for users who call for assistance.

1. Enter the following information to register:

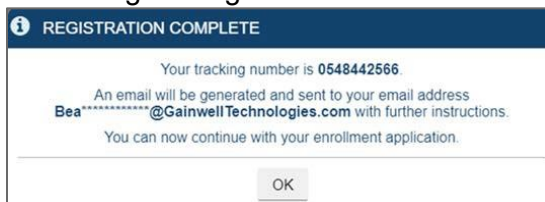
- Email
- Confirm Email
- Password
- Confirm Password
- Provider Reference (if applicable)



The screenshot shows a 'Registration' form with the following fields: Email, Confirm Email, Password, Confirm Password, and Provider Reference. Each field has a required field indicator (a blue asterisk). Below the fields are 'Previous' and 'Register' buttons. A note at the top states: 'Register below to be assigned a unique enrollment tracking number. Be sure to write down your password. An email confirmation will be sent with the tracking number. If you don't submit your enrollment right away, you can use this tracking number and password to resume your enrollment application later.'

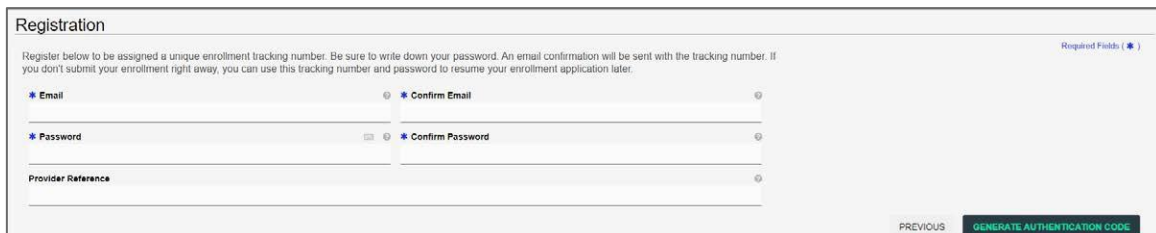
**Tip!** Provider Reference is optional and appears at the top of each enrollment step. Details commonly include provider name and NPI.

2. Click **Register** to continue. The system generates a tracking number and a message confirming the registration was successfully completed.



The screenshot shows a 'REGISTRATION COMPLETE' message box. It contains the following text: 'Your tracking number is 0548442566', 'An email will be generated and sent to your email address. Bea\*\*\*\*\*@GainwellTechnologies.com with further instructions.', and 'You can now continue with your enrollment application.' There is an 'OK' button at the bottom.

3. Enter email and confirm email information, then click **GENERATE AUTHENTICATION CODE**.

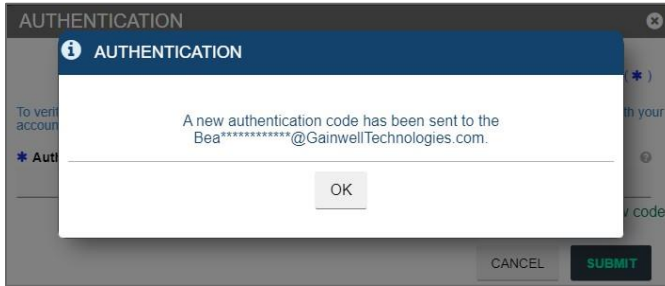


This screenshot is identical to the one above, but the 'Register' button has been replaced with a 'GENERATE AUTHENTICATION CODE' button. The 'Previous' button remains.

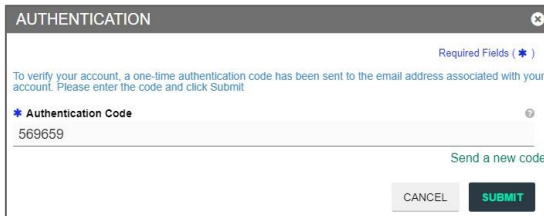


A message displaying an Authentication code was sent to the provider's email address.

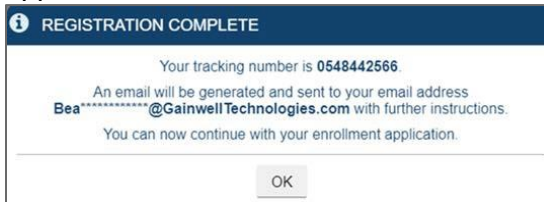
4. Click **OK** and check the email inbox to retrieve the code.



5. Enter Authentication Code and click **SUBMIT**.




The system generates a tracking number, then displays it in a message confirming the registration was successfully completed and the provider may continue with the enrollment application.




A registration confirmation email is sent containing the following (a sample is referenced below):

- Tracking Number
- Confirmation Email
- Password
- Confirmation Password
- Provider Reference (if applicable)

### New Enrollment Registration Notification


appshcproducttd01team@gainwelltechnologies.com

To 

If there are problems with how this message is displayed, click here to view it in a web browser.  
 Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

Congratulations! You have successfully registered for your provider enrollment application with the State Medical Assistance Program. Below is your tracking number that has been associated with your enrollment application. If you have not submitted your application, it will remain valid for 30 days from the last time you updated it.

Tracking Number: 0548442566  
 Password: P\*\*\*\*\*4



To resume your partially completed enrollment, simply access the site at the address below and enter your enrollment tracking number and the password you entered during the registration process.

<https://tenant1foraks.test.mapshc.com/ProviderEnrollment/EnrollmentResume/>

If you have any questions or concerns, please contact Provider Enrollment at your earliest convenience.

Sincerely,

State Medical Assistance Program  
 Provider Enrollment  
[appshcproducttd01team@gainwelltechnologies.com](mailto:appshcproducttd01team@gainwelltechnologies.com)  
 Contact us: 1-888-555-1212

<http://www.GainwellTechnologies.com>


1775 Tysons Blvd Tysons, VA

When the contact's email address is updated on a Revalidation Enrollment or added for a new enrollment; the question "Do you wish to update your registered email address with entered contact email address?" displays. If the answer selected is **YES**, the registration email address is updated with the entered email address. If **NO**, the registration email address is not updated.

#### Contact Information

Title

Last Name

Smith

Address Line 1

3000 HANOVER ST

City

PALO ALTO

State

California

Phone Type

Mobile

Telephone Number

123-456-7899

Telephone Number Extension

Fax Number

Email Address

Test@mail.com

Confirm Email

Test@mail.com

Preferred Communication

Email

First Name

Middle Name

Suffix

ALERT CONFIRMATION

Do you wish to update your registered email address with entered contact email address

**NOTE:** When a contact's email address and registered email address are the same, the question will not display.

## General Page

The General page to begin the application.

1. Select the Enrollment Type, which determines the information required to complete the application.
2. Enrollment Types and Provider Type Specialty Requirements are documented in tables within this Chapter.

General

Initial Enrollment Information

Enrollment Type

Individual

Provider Type

Physician

Effective Date

08/21/2023

Provider Information

Are you an Individual or a Business?

☒ Individual
 ☐ Business

The Provider Name must be the current name on tax, corporation, or other legal documents. The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9 for businesses and Internal Revenue Service records for individuals.

Title

Legal Last Name

First Last Name

Second Last Name

First Name

Middle Name

Bennett

Mathew

Thomas

Suffix

Gender

What is your ethnicity?

Birth Date

select a value...

select a value...

08/09/1988

NPI

SSN

6126587594

...

2153

Preferred Communication Language

English

Are you currently enrolled as a Provider?

☐ Yes
 ☒ No

Were you previously enrolled as a Provider?

☐ Yes
 ☒ No

Are you Medicare enrolled?

☐ Yes
 ☒ No

If you choose "FFS and MCO" or "MCO (s) only", your information will be shared with the selected MCO programs. This application does not guarantee participation with the Managed Care Organizations. Each organization is independent. Please select the appropriate option.

I will accept patients in the following programs:

MCO(s) only

Please select the programs to which you are applying. You must choose at least one.

ABC Healthcare

Are you registered with CAQH?

☐ Yes
 ☒ No

General Credential Information

Please list the other names under which you have been known.

Create New

Name

Effective Date

End Date

Edit

There are no records found.

Please select your place of birth.

City

State

Country

select a value...

select a value...

select a value...

ECFMG Number

ECFMG Certificate Issue Date

UPIN

Contact Information

Title

\* Last Name

\* First Name

Middle Name

Suffix

\* Address Line 1

Address Line 2

\* City

\* State

\* Country

\* ZIP Code/ Postal Code

\* Phone Type

\* Phone Number

Phone Extension

Fax Number

Email Address

Confirm Email

\* Preferred Communication

3. Complete all required fields.

**NOTE:** Address may be required based on provider type and configuration.

4. Click **Save and Continue**.

## Understanding Your Options

- After the information on this page is saved, you cannot change the Enrollment Type or Provider Type. If the wrong application is selected, you must cancel the enrollment and begin a new one. For guidance in selecting the correct enrollment type, see [Enrollment and Provider Types](#) beginning on Page 25.
- The Effective Date is the first date on which eligible services can be rendered and reimbursed. You may request a retroactive date the allowed configured time prior to allowed application submission date, but it is subject to approval.
  - All **new or returning providers** will now be enrolled in the DMAS provider system, known as PRSS, based on the month they apply or request reinstatement after any lapse in PRSS enrollment participation.
  - Reinstatements are allowed only for specific criterion and approval by DMAS.
- Depending on the selected Provider Type, the system generates a message that discloses the provider's risk level: limited, moderate, or high-risk. For more information, see **Provider Screening and Risk Level Definitions** in **Chapter II Provider Screening Requirements**.
- If the response to Are you currently enrolled as a Provider? is **Yes**, the system generates a message prompting you to revalidate. Click **Yes** and the system displays the Revalidation page. From there, enter the Application Tracking Number (ATN) included in the revalidation notification, which ensures that current information is pre-populated. If the response is **No**, you must change the answer to currently enrolled to **No** to proceed with the application.
- If the response to Were you previously enrolled as a Provider? is **Yes**, a Service Location ID must be entered to match a previous Provider record. The provider

completes information on the General page to raise the re-enrollment request. After the request is placed successfully, the provider receives a notification to resume the application. This ensures all current information is pre-populated and the application is submitted as a re-enrollment. If the response is **No**, you can proceed with the application.

**NOTE:** Only previously active providers for which contracts are no longer active and inactive providers who have not been terminated for cause may use the re-enrollment option.

- The information requested in the Contact Information panel is only for enrollment-related questions and notifications. You can identify contacts for payment and mailing information later in the application.
- Preferred Communication Language is captured on the General Information page as a drop-down selection. This is captured so that notifications can be sent to providers in their preferred language if more than one is available Enrollment Options

The table in this section below provides all enrollment eligible providers by their enrollment type (Atypical (AT), Individual within a Group (IG), Group, Individual (I), Facility/Organization (F), or Ordering, Prescribing, or Referring (OPR) provider eligible enrollment options by provider and specialty types and programs (VA FFS, MCO, or Both).



PT Code	PT Description	PS Code	PS Description	VA FFS Only, MCO Only, Both	Atypical (VA FFS Only)	Facility	Group	Ind	Ind w/l Group	OPR
001	Hospital	001	Acute Care Hospital	Both	No	Yes	No	No	No	No
001	Hospital	002	State Mental Health Hospital for the Aged	Both	No	Yes	No	No	No	No
001	Hospital	004	Long Stay Hospital	Both	No	Yes	No	No	No	No
001	Hospital	008	Medical Surgery - Mental Health Hospital	Both	No	Yes	No	No	No	No
001	Hospital	009	Medical Surgery - Developmental Disability Hospital	Both	No	Yes	No	No	No	No
001	Hospital	012	Mental Health Long Stay Hospital	Both	No	Yes	No	No	No	No
001	Hospital	100	Mammography Certification	Both	No	Yes	No	No	No	No
001	Hospital	116	Early Intervention Services	Both	No	Yes	No	No	No	No
001	Hospital	119	Early Intervention Case Management	Both	No	Yes	No	No	No	No
001	Hospital	186	Ventilator	Both	No	Yes	No	No	No	No
001	Hospital	189	Complex	Both	No	Yes	No	No	No	No
001	Hospital	191	NF Private Room	Both	No	Yes	No	No	No	No
001	Hospital	192	Rehabilitation	Both	No	Yes	No	No	No	No
001	Hospital	301	Critical Care Hospital	MCO Only	No	Yes	No	No	No	No
001	Hospital	913	Mental Health Partial Hospitalization (MH-PHP)	Both	No	Yes	No	No	No	No
001	Hospital	918	ARTS - ASAM 2.5 Partial Hospitalization Services	Both	No	Yes	No	No	No	No
003	Private Inpatient Psychiatric Hospital	003	Private Inpatient Psychiatric Hospital	Both	No	Yes	No	No	No	No
003	Private Inpatient Psychiatric Hospital	913	Mental Health Partial Hospitalization (MH-PHP)	Both	No	Yes	No	No	No	No



003	Private Inpatient Psychiatric Hospital	918	ARTS - ASAM 2.5 Partial Hospitalization Services	Both	No	Yes	No	No	No	No
007	State Mental Health Hospital	007	State Mental Health Hospital	Both	No	Yes	No	No	No	No
010	Nursing Facility	006	Skilled Nursing Facility - Mental Health	Both	No	Yes	No	No	No	No
010	Nursing Facility	010	Skilled Nursing Facility	Both	No	Yes	No	No	No	No
010	Nursing Facility	013	Alzheimer Center (Dementia Center)	MCO Only	No	Yes	No	No	No	No
010	Nursing Facility	016	Intermediate Care Facility - Mental Health	Both	No	Yes	No	No	No	No
010	Nursing Facility	186	Ventilator	Both	No	Yes	No	No	No	No
010	Nursing Facility	189	Complex	Both	No	Yes	No	No	No	No
010	Nursing Facility	191	NF Private Room	Both	No	Yes	No	No	No	No
010	Nursing Facility	192	Rehabilitation	Both	No	Yes	No	No	No	No
010	Nursing Facility	413	Christian Science Facility	MCO Only	No	Yes	No	No	No	No
010	Nursing Facility	513	Custodial Care Facility	MCO Only	No	Yes	No	No	No	No
014	Rehabilitation Hospital	014	Rehabilitation Hospital	Both	No	Yes	No	No	No	No
014	Rehabilitation Hospital	116	Early Intervention Services	Both	No	Yes	No	No	No	No
014	Rehabilitation Hospital	119	Early Intervention Case Management	Both	No	Yes	No	No	No	No
015	Intermediate Care Facility	015	Intermediate Care Facility	Both	No	Yes	No	No	No	No
015	Intermediate Care Facility	186	Ventilator	Both	No	Yes	No	No	No	No
015	Intermediate Care Facility	189	Complex	Both	No	Yes	No	No	No	No
015	Intermediate Care Facility	191	NF Private Room	Both	No	Yes	No	No	No	No
015	Intermediate Care Facility	192	Rehabilitation	Both	No	Yes	No	No	No	No
017	Intermediate Care Facility-Developmental Disability	017	Intermediate Care Facility - Developmental Disability	FFS Only	No	Yes	No	No	No	No



019	Comprehensive Outpatient Rehabilitation Facility	139	Comprehensive Outpatient Rehabilitation Facility	FFS Only	No	Yes	No	No	No	No
020	Physician	047	Substance Abuse - Anesthesiology	Both	No	No	No	Yes	Yes	Yes
020	Physician	053	Family Practitioner	Both	No	No	No	Yes	Yes	Yes
020	Physician	056	General Practice	Both	No	No	No	Yes	Yes	Yes
020	Physician	057	Anesthesiologist	Both	No	No	No	Yes	Yes	Yes
020	Physician	058	Colon & Rectal Surgery	Both	No	No	No	Yes	Yes	Yes
020	Physician	059	Dermatologist	Both	No	No	No	Yes	Yes	Yes
020	Physician	060	Internal Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	061	Neurological Surgery	Both	No	No	No	Yes	Yes	Yes
020	Physician	062	Obstetrics and Gynecology	Both	No	No	No	Yes	Yes	Yes
020	Physician	063	Ophthalmology	Both	No	No	No	Yes	Yes	Yes
020	Physician	064	Orthopedic Surgeon	Both	No	No	No	Yes	Yes	Yes
020	Physician	065	Otolaryngology	Both	No	No	No	Yes	Yes	Yes
020	Physician	066	Pathology	Both	No	No	No	Yes	Yes	Yes
020	Physician	067	Pediatrician	Both	No	No	No	Yes	Yes	Yes
020	Physician	068	Physical Medicine and Rehabilitation	Both	No	No	No	Yes	Yes	Yes
020	Physician	069	Plastic Surgery	Both	No	No	No	Yes	Yes	Yes
020	Physician	070	Preventive Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	071	Neurology	Both	No	No	No	Yes	Yes	Yes
020	Physician	072	Radiology	Both	No	No	No	Yes	Yes	Yes
020	Physician	074	Cardiothoracic Surgery	Both	No	No	No	Yes	Yes	Yes
020	Physician	075	Urology	Both	No	No	No	Yes	Yes	Yes
020	Physician	080	Oral Surgeon	Both	No	No	No	Yes	Yes	Yes
020	Physician	100	Mammography Certification	Both	No	No	No	Yes	Yes	No
020	Physician	124	Intern	Both	No	No	No	No	No	Yes
020	Physician	127	Telemedicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	138	Office Based Opioid Treatment	Both	No	No	No	Yes	Yes	Yes
020	Physician	147	Substance Abuse - Family Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	160	Nuclear Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	171	Psychiatry	Both	No	No	No	Yes	Yes	Yes
020	Physician	173	General Surgeon	Both	No	No	No	Yes	Yes	Yes





020	Physician	174	Medical Genetics	Both	No	No	No	Yes	Yes	Yes
020	Physician	247	Substance Abuse - Internal Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	260	Emergency Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	273	Transplant Surgery	Both	No	No	No	Yes	Yes	Yes
020	Physician	347	Substance Abuse - Psychiatry and Neurology	Both	No	No	No	Yes	Yes	Yes
020	Physician	360	Neuromusculoskeletal Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	447	Substance Abuse - Preventive Medicine	Both	No	No	No	Yes	Yes	Yes
020	Physician	460	Hospitalist	MCO Only	No	No	No	Yes	Yes	Yes
020	Physician	560	Clinical Pharmacology	Both	No	No	No	Yes	Yes	Yes
022	Treatment Foster Care Case Management	222	Treatment Foster Care Case Management	Both	Yes	Yes	No	No	No	No
023	Nurse Practitioner	022	Women's Health	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	023	Family	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	024	Pediatric	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	107	Adult	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	108	Geriatric	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	109	Neonatal	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	110	Acute Care	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	111	Psychiatric	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	112	Certified Nurse Midwife	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	138	Office Based Opioid Treatment	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	243	Certified Registered Nurse Anesthetist	Both	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	307	Community Health	MCO Only	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	308	Perinatal	MCO Only	No	No	No	Yes	Yes	Yes



023	Nurse Practitioner	309	Primary Care	MCO Only	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	310	School	MCO Only	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	311	Obstetrics/Gynecology	MCO Only	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	312	Occupational Health	MCO Only	No	No	No	Yes	Yes	Yes
023	Nurse Practitioner	547	Substance Abuse - Nurse Practitioner	Both	No	No	No	Yes	Yes	Yes
026	Chiropractor	126	Chiropractor	Both	No	No	No	Yes	Yes	Yes
030	Podiatrist	030	Podiatrist	Both	No	No	No	Yes	Yes	Yes
031	Optometrist	031	Optometrist	Both	No	No	No	Yes	Yes	Yes
036	Baby Care	036	Care Coordination	Both	Yes	Yes	No	No	No	Yes
036	Baby Care	037	Nutritional Services	Both	Yes	Yes	No	No	No	Yes
036	Baby Care	038	Patient Education	Both	Yes	Yes	No	No	No	Yes
036	Baby Care	039	Homemaker Services	Both	Yes	Yes	No	No	No	Yes
036	Baby Care	237	Registered Dietician	Both	No	Yes	No	No	No	Yes
038	Hearing Aid Specialist	238	Hearing Aid Specialist	Both	No	No	No	Yes	Yes	No
039	Therapists - OPR Only	043	Speech-Language Pathologist	Both	No	No	No	No	No	Yes
039	Therapists - OPR Only	045	Occupational Therapist	Both	No	No	No	No	No	Yes
039	Therapists - OPR Only	154	Physical Therapist	Both	No	No	No	No	No	Yes
042	Dental Medical (CPT)	082	Pedodontist	Both	No	No	No	Yes	Yes	Yes
042	Dental Medical (CPT)	083	Endodontist	Both	No	No	No	Yes	Yes	Yes
042	Dental Medical (CPT)	085	Oral Pathologist	Both	No	No	No	Yes	Yes	Yes
042	Dental Medical (CPT)	086	Dental Anesthesiology	Both	No	No	No	Yes	Yes	Yes
042	Dental Medical (CPT)	178	General Practice	Both	No	No	No	No	No	Yes
042	Dental Medical (CPT)	180	Oral Surgeon	Both	No	No	No	Yes	Yes	Yes



043	Nursing Service Providers	143	Nursing Service Providers	MCO Only	No	No	No	Yes	Yes	Yes
044	Audiologist	044	Audiology	Both	No	No	No	Yes	Yes	Yes
045	Specialist/Technician	245	Specialist/Technician	MCO Only	No	No	No	Yes	Yes	No
046	Hospice	046	Hospice	Both	No	Yes	No	No	No	No
048	Dental Clinic Medical	041	Dental Clinic	Both	No	Yes	No	No	No	No
049	Ambulatory Surgery Center	249	Ambulatory Surgical Center	Both	No	Yes	No	No	No	No
051	Clinics	050	Renal Dialysis Clinic	Both	No	Yes	No	No	No	No
051	Clinics	052	Federally Qualified Health Center	Both	No	Yes	No	No	No	No
051	Clinics	100	Mammography Certification	Both	No	Yes	No	No	No	No
051	Clinics	138	Office Based Opioid Treatment	Both	No	Yes	No	No	No	No
051	Clinics	151	Health Department Clinic	Both	No	Yes	No	No	No	No
051	Clinics	153	Rural Health Clinic	Both	No	Yes	No	No	No	No
051	Clinics	202	Developmental Disabilities	MCO Only	No	Yes	No	No	No	No
051	Clinics	203	Emergency Care	MCO Only	No	Yes	No	No	No	No
051	Clinics	205	Family Planning, Non-Surgical	MCO Only	No	Yes	No	No	No	No
051	Clinics	206	Genetics	MCO Only	No	Yes	No	No	No	No
051	Clinics	207	Infusion Therapy	MCO Only	No	Yes	No	No	No	No
051	Clinics	208	Military Outpatient	MCO Only	No	Yes	No	No	No	No
051	Clinics	209	Magnetic Resonance Imaging (MRI)	MCO Only	No	Yes	No	No	No	No
051	Clinics	210	Methadone	MCO Only	No	Yes	No	No	No	No
051	Clinics	211	Medically Fragile Infants and Children Day Care	MCO Only	No	Yes	No	No	No	No
051	Clinics	212	Podiatric	MCO Only	No	Yes	No	No	No	No
051	Clinics	213	Primary Care	MCO Only	No	Yes	No	No	No	No
051	Clinics	214	Pain	MCO Only	No	Yes	No	No	No	No
051	Clinics	215	Radiology	MCO Only	No	Yes	No	No	No	No
051	Clinics	216	Student Health	MCO Only	No	Yes	No	No	No	No
051	Clinics	217	Sleep Disorder	MCO Only	No	Yes	No	No	No	No



051	Clinics	219	Urgent Care	MCO Only	No	Yes	No	No	No	No
051	Clinics	220	Veterans Affair	MCO Only	No	Yes	No	No	No	No
051	Clinics	221	Oncology	MCO Only	No	Yes	No	No	No	No
051	Clinics	223	Birthing	MCO Only	No	Yes	No	No	No	No
051	Clinics	271	Substance Abuse Clinic	MCO Only	No	Yes	No	No	No	No
051	Clinics	321	Clinic/Center	MCO Only	No	Yes	No	No	No	No
051	Clinics	323	Ambulatory Fertility Facility	MCO Only	No	Yes	No	No	No	No
051	Clinics	324	Augmentative Communication	MCO Only	No	Yes	No	No	No	No
051	Clinics	325	Corporate Health	MCO Only	No	Yes	No	No	No	No
051	Clinics	326	Migrant Health	MCO Only	No	Yes	No	No	No	No
054	Indian Health Services	454	Indian Health Services	FFS Only	No	Yes	No	No	No	No
056	Waiver Services	116	Early Intervention Services	Both	Yes	Yes	No	Yes	No	No
056	Waiver Services	119	Early Intervention Case Management	Both	Yes	Yes	No	Yes	No	No
056	Waiver Services	163	Private Duty Nursing Services	Both	No	Yes	No	No	No	No
056	Waiver Services	462	Assistive Technology	Both	No	Yes	No	No	No	No
056	Waiver Services	562	Environmental Modifications	Both	No	Yes	No	No	No	No
056	Waiver Services	662	Electronic Home-Based Supports	Both	No	Yes	No	No	No	No
056	Waiver Services	801	Adult Day Health Care	Both	Yes	Yes	No	No	No	No
056	Waiver Services	803	Benefits Planning	Both	Yes	Yes	No	No	No	No
056	Waiver Services	804	Case Management (State Plan Option)	Both	Yes	Yes	No	No	No	No
056	Waiver Services	805	Center Based Crisis Support (non-professionals and professionals)	Both	Yes	Yes	No	No	No	No
056	Waiver Services	806	Community Based Crisis Support (non-professionals and professionals)	Both	Yes	Yes	No	No	No	No
056	Waiver Services	807	Community Coaching	Both	Yes	Yes	No	No	No	No



056	Waiver Services	808	Community Engagement Tier 1 - 4	Both	Yes	Yes	No	No	No	No
056	Waiver Services	809	Community Guide	Both	Yes	Yes	No	No	No	No
056	Waiver Services	810	Companion Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	811	Consumer Directed Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	812	Crisis Support Services (non-professional and professionals)	Both	Yes	Yes	No	No	No	No
056	Waiver Services	813	Family and Caregiver Training Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	814	Group Day Support Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	815	Group Home Residential and Customized Group Home Residential	Both	Yes	Yes	No	No	No	No
056	Waiver Services	816	Group Supported Employment	Both	Yes	Yes	No	No	No	No
056	Waiver Services	817	Independent Living Support Services - Tier 1 - 4	Both	Yes	Yes	No	No	No	No
056	Waiver Services	818	Individual Supported Employment	Both	Yes	Yes	No	No	No	No
056	Waiver Services	819	In-Home Support Services and Customized In-Home Support Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	820	Peer Mentor Supports	Both	Yes	Yes	No	No	No	No
056	Waiver Services	821	Personal Care Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	822	Respite Care Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	823	Shared Living	Both	Yes	Yes	No	No	No	No
056	Waiver Services	824	Sponsored Residential and Customized Sponsored Residential	Both	Yes	Yes	No	No	No	No



056	Waiver Services	825	Supported Living Residential Tier 1 - 4 and/or Customized Supported Living Residential	Both	Yes	Yes	No	No	No	No
056	Waiver Services	826	Therapeutic Consultation (professional)	Both	No	Yes	No	Yes	No	No
056	Waiver Services	827	Therapeutic Consultation (non-professional)	Both	No	Yes	No	Yes	No	No
056	Waiver Services	828	Transition Services	Both	Yes	Yes	No	No	No	No
056	Waiver Services	829	Workplace Assistive Services	Both	Yes	No	No	No	No	No
056	Waiver Services	831	Non-emergency Transportation	Both	No	Yes	No	Yes	No	No
056	Waiver Services	834	Skilled Nursing	Both	No	Yes	No	No	No	No
056	Waiver Services	835	Congregate Nursing	Both	No	Yes	No	No	No	No
056	Waiver Services	836	Alzheimer Waiver	Both	Yes	Yes	No	No	No	No
056	Waiver Services	841	Brain Injury Case Management	Both	No	Yes	No	No	No	No
057	Outpatient Rehabilitation Facility	116	Early Intervention Services	Both	No	Yes	No	No	No	No
057	Outpatient Rehabilitation Facility	119	Early Intervention Case Management	Both	No	Yes	No	No	No	No
057	Outpatient Rehabilitation Facility	157	Outpatient Rehabilitation Facility	Both	No	Yes	No	No	No	No
059	Home Health Agency	054	Hospital Based	Both	No	Yes	No	No	No	No
059	Home Health Agency	055	Non-Hospital Based	Both	No	Yes	No	No	No	No
059	Home Health Agency	116	Early Intervention Services	Both	No	Yes	No	No	No	No
059	Home Health Agency	119	Early Intervention Case Management	Both	No	Yes	No	No	No	No
060	Pharmacy	168	Pharmacy Services	Both	No	Yes	No	No	No	No
060	Pharmacy	269	Home Infusion	Both	No	Yes	No	No	No	No



061	Pharmacy-Long Term Care	169	Unit Dose Pharmacy	Both	No	Yes	No	No	No	No
061	Pharmacy-Long Term Care	322	Long Term Care Pharmacy Non-UD	Both	No	Yes	No	No	No	No
062	Durable Medical Equipment	262	Durable Medical Equipment	Both	No	Yes	No	No	No	No
062	Durable Medical Equipment	362	Personal Emergency Response Services	Both	No	Yes	No	No	No	No
062	Durable Medical Equipment	462	Assistive Technology	Both	No	Yes	No	No	No	No
062	Durable Medical Equipment	562	Environmental Modifications	Both	No	Yes	No	No	No	No
062	Durable Medical Equipment	662	Electronic Home-Based Supports	Both	No	Yes	No	No	No	No
063	Private Duty Nursing Services	116	Early Intervention Services	Both	No	Yes	No	No	No	No
063	Private Duty Nursing Services	119	Early Intervention Case Management	Both	No	Yes	No	No	No	No
063	Private Duty Nursing Services	163	Private Duty Nursing Services	Both	No	Yes	No	No	No	No
064	Prosthetic and Orthotics	264	Prosthetic/Ortho Services	Both	No	Yes	No	No	No	No
070	Laboratory	098	Independent Laboratory	Both	No	Yes	No	No	No	No
070	Laboratory	298	Physiological Laboratory	Both	No	Yes	No	No	No	No
070	Laboratory	398	Military Clinical Medical Laboratory	Both	No	Yes	No	No	No	No
070	Laboratory	498	Dental Laboratory	Both	No	Yes	No	No	No	No
071	Imaging Centers	198	Diagnostic and Imaging Centers	Both	No	Yes	No	No	No	No
072	Local Education Agency	018	Special Ed - Audiologist	FFS Only	No	Yes	No	No	No	No
072	Local Education Agency	019	Special Ed - Personal Care Services	FFS Only	No	Yes	No	No	No	No



072	Local Education Agency	020	Special Ed - Transportation	FFS Only	No	Yes	No	No	No	No
072	Local Education Agency	025	Special Ed - Nursing Services	FFS Only	No	Yes	No	No	No	No
072	Local Education Agency	026	Special Ed - Psych Services	FFS Only	No	Yes	No	No	No	No
072	Local Education Agency	027	Special Ed - Physical Therapy	FFS Only	No	Yes	No	No	No	No
072	Local Education Agency	028	Special Ed - Occupational Therapy	FFS Only	No	Yes	No	No	No	No
072	Local Education Agency	029	Special Ed - Speech/Language Therapy	FFS Only	No	Yes	No	No	No	No
072	Local Education Agency	051	School Based Clinic/Practitioner	FFS Only	No	Yes	No	No	No	No
077	Residential Treatment Facility	077	Residential Treatment Facility	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	115	Therapeutic Group Home - Level B	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	118	EPSDT Therapeutic Group Home	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	132	ARTS - Residential Treatment - ASAM 3.7 - Child	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	133	ARTS - Residential Treatment - ASAM 3.1 - Adults	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	135	ARTS - Residential Treatment - ASAM 3.5 - Adults	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	132	ARTS - Residential Treatment - ASAM 3.7 - Adults	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	177	Residential Crisis Stabilization	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	229	ARTS - Residential Treatment - ASAM 3.1 - Child	Both	No	Yes	No	No	No	No
077	Residential Treatment Facility	232	ARTS - Residential Treatment - ASAM 3.5 - Child	Both	No	Yes	No	No	No	No





077	Residential Treatment Facility	233	ARTS - Residential Treatment - ASAM 3.3 - Adults	Both	No	Yes	No	No	No	No
080	Emergency Transportation	121	Air Transport	Both	No	Yes	No	No	No	No
080	Emergency Transportation	149	Neonatal Ambulance	Both	No	Yes	No	No	No	No
080	Emergency Transportation	201	Ambulance	Both	No	Yes	No	No	No	No
080	Emergency Transportation	251	Water Transportation	Both	No	Yes	No	No	No	No
082	Emergency Medical Technician	182	Emergency Medical Technician (Paramedic)	MCO Only	No	No	No	Yes	Yes	No
082	Emergency Medical Technician	183	Emergency Medical Technician (Intermediate)	MCO Only	No	No	No	Yes	Yes	No
082	Emergency Medical Technician	184	Emergency Medical Technician (Basic)	MCO Only	No	No	No	Yes	Yes	No
082	Emergency Medical Technician	185	Personal Emergency Response Attendant	MCO Only	No	No	No	Yes	Yes	No
099	Qualified Medicare Crossover	199	Qualified Medicare Crossover Only	Both	No	Yes	No	Yes	Yes	No
100	Temporary Detention Order (TDO) Provider	200	Temporary Detention Order (TDO) Provider	TDO Only	No	Yes	No	Yes	Yes	No
104	Full PACE (Program for All Inclusive Care for Elderly)	113	Full PACE (Program for All Inclusive Care for Elderly)	FFS Only	No	Yes	No	No	No	No
105	Certified Professional Midwife	105	Certified Professional Midwife	FFS Only	No	No	No	Yes	Yes	Yes
108	Early Intervention Services	116	Early Intervention Services	Both	Yes	Yes	No	Yes	No	No
108	Early Intervention Services	119	Early Intervention Case Management	Both	Yes	Yes	No	Yes	No	No



117	Doula	717	Doula	Both	No	No	No	Yes	Yes	No
120	Physician Assistant	120	Physician Assistant	MCO Only	No	No	No	Yes	Yes	Yes
130	Podiatry Assistant	330	Podiatry Assistant	MCO Only	No	No	No	Yes	Yes	No
141	Military Healthcare Provider	241	Military Healthcare Provider	MCO Only	No	No	No	Yes	Yes	No
156	Behavioral Health Services	137	Opioid Treatment Program	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	138	Office Based Opioid Treatment	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	900	Case Management - Mental Health	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	901	Functional Family Therapy	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	902	Community Stabilization	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	903	Applied Behavioral Analysis (ABA)	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	904	Assertive Community Treatment (ACT)	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	905	Intensive In Home	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	906	Mental Health Skill Building	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	907	One on One Supports in Residential	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	908	Peer Support Services	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	909	Psychosocial Rehabilitation Services	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	910	Independent Assessment, Certification and Coordination Team (IACCT)	Both	No	Yes	No	No	No	No



156	Behavioral Health Services	911	Independent Assessment, Certification and Coordination Team (IACCT) - Follow up - Assessment	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	912	Therapeutic Day Treatment for Children	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	913	Mental Health Partial Hospitalization (MH-PHP)	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	914	ARTS - Substance Abuse - Case Management	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	915	ARTS - Alcohol/SA Services Intensive OP Services	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	916	ARTS - Alcohol/SA Services Individual Peer Support	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	917	ARTS - Alcohol/SA Services Group Peer Support	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	918	ARTS - ASAM 2.5 Partial Hospitalization Services	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	919	Mental Health Intensive Outpatient Services	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	920	Mobile Crisis Response	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	921	23-Hour Crisis Stabilization	Both	No	Yes	No	No	No	No
156	Behavioral Health Services	922	Multisystemic Therapy (MST)	Both	No	Yes	No	No	No	No
231	Optician	231	Optician	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	021	Licensed Professional Counselor	Both	No	No	No	Yes	Yes	Yes



256	Behavioral Health Practitioner	076	Licensed Clinical Social Worker	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	101	School Psychologist	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	102	Marriage and Family Therapist	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	103	Substance Abuse Practitioner	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	104	Behavioral Analyst	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	125	Clinical Psychologist	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	134	Clinical Nurse Specialist	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	175	School Social Worker	Both	No	No	No	No	No	Yes
256	Behavioral Health Practitioner	176	Social Worker	Both	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	179	School Counselor	Both	No	No	No	No	No	Yes
256	Behavioral Health Practitioner	204	Psychoanalyst	MCO Only	No	No	No	Yes	Yes	Yes
256	Behavioral Health Practitioner	225	Psychologist	MCO Only	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	234	Clinical Nurse Services	MCO Only	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	235	Poetry Therapist	MCO Only	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	470	Substance Abuse - Licensed Professional Counselor	Both	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	471	Substance Abuse - Psychologist	Both	No	No	No	Yes	Yes	No



256	Behavioral Health Practitioner	472	Substance Abuse - Licensed Clinical Social Worker	Both	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	473	Substance Abuse - Marriage and Family Therapist	Both	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	474	Substance Abuse - Clinical Nurse Specialist	Both	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	910	Independent Assessment, Certification and Coordination Team (IACCT)	Both	No	No	No	Yes	Yes	No
256	Behavioral Health Practitioner	911	Independent Assessment, Certification and Coordination Team (IACCT) - Follow up - Assessment	Both	No	No	No	Yes	Yes	No
268	Pharmacist	268	Pharmacist	Both	No	No	No	Yes	Yes	No
331	Optical Clinic	331	Optical Clinic	Both	No	Yes	No	No	No	No
339	Therapists - MCO Only	043	Speech-Language Pathologist	MCO Only	No	No	No	Yes	Yes	No
339	Therapists - MCO Only	045	Occupational Therapist	MCO Only	No	No	No	Yes	Yes	No
339	Therapists - MCO Only	145	Occupational Therapy	MCO Only	No	No	No	Yes	Yes	No
339	Therapists - MCO Only	154	Physical Therapist	MCO Only	No	No	No	Yes	Yes	No
339	Therapists - MCO Only	239	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	MCO Only	No	No	No	Yes	Yes	No
339	Therapists - MCO Only	254	Physical Therapy	MCO Only	No	No	No	Yes	Yes	No
339	Therapists - MCO Only	339	Rehabilitation	MCO Only	No	No	No	Yes	Yes	No
339	Therapists - MCO Only	343	Speech and Language Therapy	MCO Only	No	No	No	Yes	Yes	No
356	Behavioral Health Clinic	141	Behavioral Health Clinic	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	137	Opioid Treatment Program	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	138	Office Based Opioid Treatment	Both	No	Yes	No	No	No	No



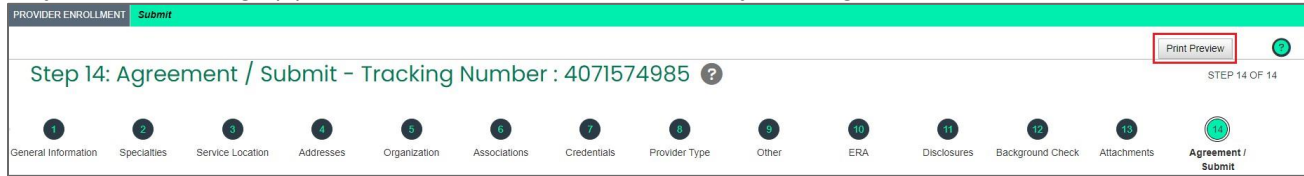
456	Behavioral Health Clinic and Services	141	Behavioral Health Clinic	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	900	Case Management - Mental Health	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	901	Functional Family Therapy	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	902	Community Stabilization	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	903	Applied Behavioral Analysis (ABA)	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	904	Assertive Community Treatment (ACT)	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	905	Intensive In Home	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	906	Mental Health Skill Building	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	907	One on One Supports in Residential	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	908	Peer Support Services	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	909	Psychosocial Rehabilitation Services	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	910	Independent Assessment, Certification and Coordination Team (IACCT)	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	911	Independent Assessment, Certification and Coordination Team (IACCT) - Follow up - Assessment	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	912	Therapeutic Day Treatment for Children	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	913	Mental Health Partial Hospitalization (MH-PHP)	Both	No	Yes	No	No	No	No



456	Behavioral Health Clinic and Services	914	ARTS - Substance Abuse - Case Management	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	915	ARTS - Alcohol/SA Services Intensive OP Services	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	916	ARTS - Alcohol/SA Services Individual Peer Support	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	917	ARTS - Alcohol/SA Services Group Peer Support	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	918	ARTS - ASAM 2.5 Partial Hospitalization Services	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	919	Mental Health Intensive Outpatient Services	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	920	Mobile Crisis Response	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	921	23-Hour Crisis Stabilization	Both	No	Yes	No	No	No	No
456	Behavioral Health Clinic and Services	922	Multisystemic Therapy (MST)	Both	No	Yes	No	No	No	No
700	Meals	700	Meals	MCO Only	No	Yes	No	No	No	No
700	Meals	701	Home Delivered	MCO Only	No	Yes	No	No	No	No
701	Lodging	702	Lodging	MCO Only	No	Yes	No	No	No	No
703	Blood Bank	703	Blood Bank	MCO Only	No	Yes	No	No	No	No
704	Eye Bank	704	Eye Bank	MCO Only	No	Yes	No	No	No	No
990	Group Practice	990	Single and Multi-Specialty Group	Both	No	No	Yes	No	No	No

## Printing the Enrollment Application

Any completed page(s) of the application can be printed by clicking the **Print Preview**.



PROVIDER ENROLLMENT **Submit**

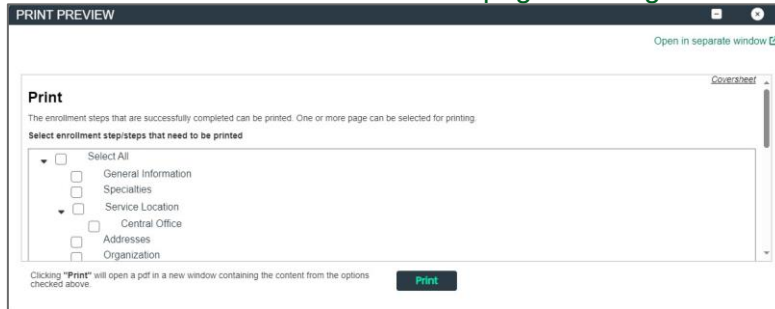
Step 14: Agreement / Submit – Tracking Number : 4071574985 ?

STEP 14 OF 14

1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization 6 Associations 7 Credentials 8 Provider Type 9 Other 10 ERA 11 Disclosures 12 Background Check 13 Attachments 14 Agreement / Submit

**Print Preview**

1. Scroll and check sections and pages to be generated for the print preview.



PRINT PREVIEW

Open in separate window

**Print**

The enrollment steps that are successfully completed can be printed. One or more page can be selected for printing.

Select enrollment steps that need to be printed

☐ Select All

☐ General Information

☐ Specialties

☒ Service Location

☐ Central Office

☐ Addresses

☐ Organization

Clicking "Print" will open a pdf in a new window containing the content from the options checked above.

**Print**

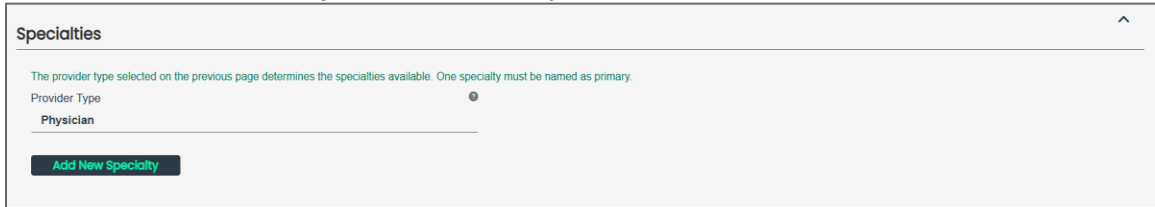
**NOTE:** Enrollment PDF/pages are generated in the language selected during enrollment when more than one is offered. Additionally, because of Group Associations grid size considerations, Zip Code, Effective Date, and End Date columns are not included.



## Specialties

The enrollment application presents a list of specialties and taxonomies Provider Type selected on the General page. The list may also be constrained based on the programs selected, as some specialties may not be eligible to participate in Fee For Service or an MCO Program.

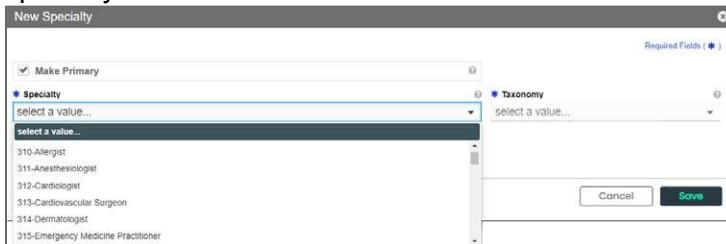
1. Click **Add New Specialty** to add a specialty.



The screenshot shows the 'Specialties' page with a header bar. Below the header, there is a message: 'The provider type selected on the previous page determines the specialties available. One specialty must be named as primary.' Below this message, there is a 'Provider Type' dropdown menu set to 'Physician'. At the bottom of the page, there is a green button labeled 'Add New Specialty'.

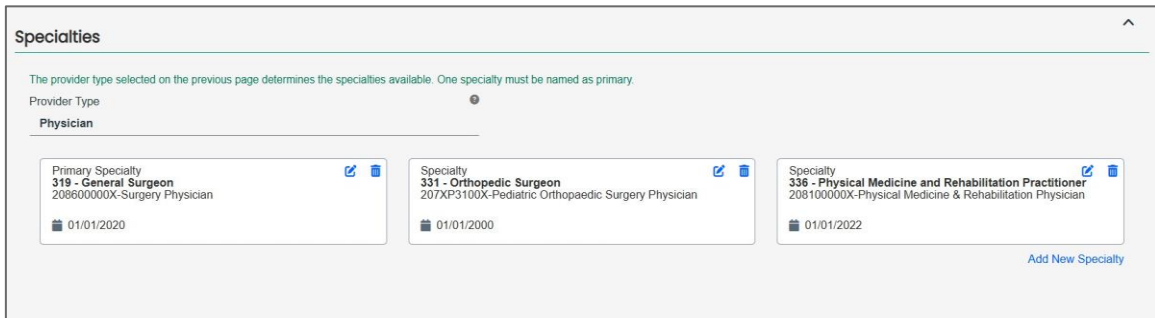
**NOTE:** You can enter multiple specialties but must select one as the primary.

2. Select a Specialty from the drop-down list, then select a Taxonomy from those allowed for that specialty.



The screenshot shows the 'New Specialty' dialog box. It has a 'Make Primary' checkbox which is checked. There are two dropdown menus: 'Specialty' and 'Taxonomy'. The 'Specialty' dropdown is open, showing a list of specialties including '310-Allergist', '311-Anesthesiologist', '312-Cardiologist', '313-Cardiovascular Surgeon', '314-Dermatologist', and '315-Emergency Medicine Practitioner'. The 'Taxonomy' dropdown is also open, showing a list of taxonomies. At the bottom of the dialog, there are 'Cancel' and 'Save' buttons.

3. Click **Save**.



The screenshot shows the 'Specialties' page after saving three specialties. The 'Provider Type' dropdown is still set to 'Physician'. There are three specialty cards displayed: 'Primary Specialty 319 - General Surgeon 208600000X-Surgery Physician' with a date of '01/01/2020', 'Specialty 331 - Orthopedic Surgeon 207XP3100X-Pediatric Orthopaedic Surgery Physician' with a date of '01/01/2000', and 'Specialty 336 - Physical Medicine and Rehabilitation Practitioner 208100000X-Physical Medicine & Rehabilitation Physician' with a date of '01/01/2022'. Each card has an edit icon and a delete icon. At the bottom right, there is a blue link labeled 'Add New Specialty'.

**Tip!** Use the Edit icon to change information, Delete icon to remove a specialty, or click the **Add New Specialty** links to create other specialties.

**NOTE:** Review of the Provider and Specialty Type requirements are recommended to avoid enrollment application being returned for correction or denial.

- All taxonomies under which services are rendered and billed must be included in the application. Use the Additional Taxonomy panel (when available) to add taxonomies as needed.
- Users will not be allowed to save and continue until a primary specialty is selected.

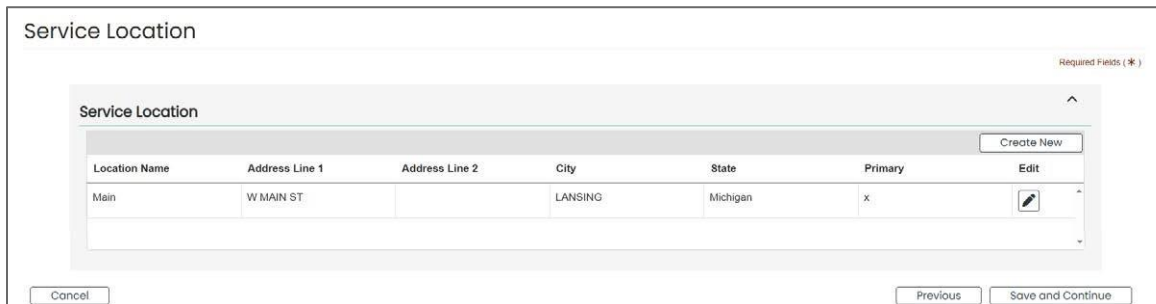
## Service Location Information

Enter the service location address and all other associated information related to the service location. The service location address is collected for Individual, Facility, Atypical, Group, and Ordering Prescribing & Rendering enrollment types.

- Providers enrolling as Individuals within a Group are not prompted for service location address because the system defaults to information provided by the group. However, other applicable details service address information is collected.
- Individuals within a Group providers can enter multiple 14-digit service location details for a Group.
- Some providers may enter more than one service location per application according to the specific provider and specialty type.
- Service Address Information is available to the public.

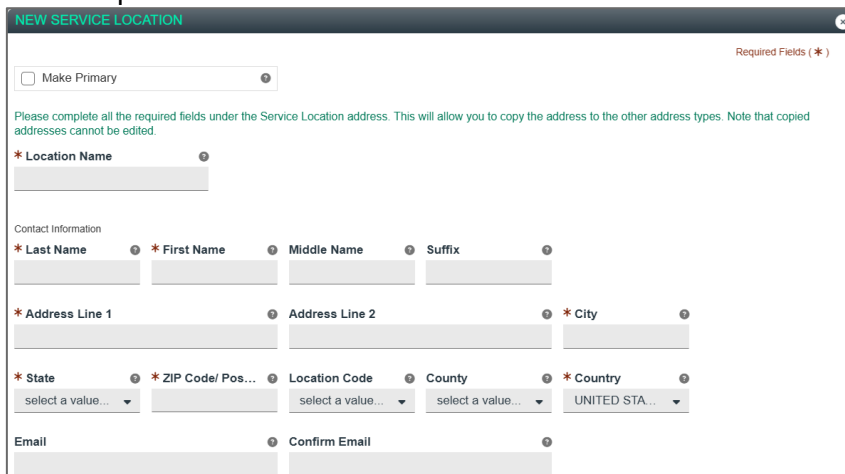
Complete the following steps on the Service Location page to capture the service location address and all related information.

1. Click **Create New** to enter a new service location address and details.



The screenshot shows the 'Service Location' page. At the top, there is a 'Service Location' header and a 'Create New' button. Below this is a table with the following columns: Location Name, Address Line 1, Address Line 2, City, State, Primary, and Edit. The table contains one row of data: 'Main', 'W MAIN ST', (empty), 'LANSING', 'Michigan', 'x', and an edit icon. At the bottom of the page, there are 'Cancel', 'Previous', and 'Save and Continue' buttons.

2. Enter required address information.



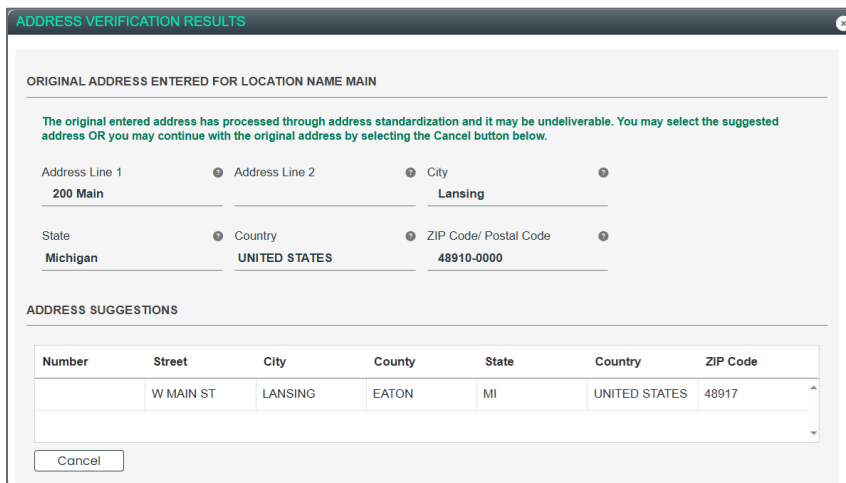
The screenshot shows the 'NEW SERVICE LOCATION' form. It includes a 'Make Primary' checkbox and a 'Required Fields (\*)' indicator. A message states: 'Please complete all the required fields under the Service Location address. This will allow you to copy the address to the other address types. Note that copied addresses cannot be edited.' The form contains the following fields:
 

- \* Location Name (text input)
- Contact Information:
  - \* Last Name (text input)
  - \* First Name (text input)
  - Middle Name (text input)
  - Suffix (text input)
- \* Address Line 1 (text input)
- Address Line 2 (text input)
- \* City (text input)
- \* State (dropdown menu, currently showing 'select a value...')
- \* ZIP Code/ Pos... (text input)
- Location Code (dropdown menu, currently showing 'select a value...')
- County (dropdown menu, currently showing 'select a value...')
- \* Country (dropdown menu, currently showing 'UNITED STA...')
- Email (text input)
- Confirm Email (text input)

3. Complete one of the following actions to select an address on the Address Verification Results window:

- Double-click on an address listed in Address Suggestions.
- Click **Cancel** to accept the originally entered address.

**NOTE:** Some providers and specialty types may require additional service location details.



ADDRESS VERIFICATION RESULTS

ORIGINAL ADDRESS ENTERED FOR LOCATION NAME MAIN

The original entered address has processed through address standardization and it may be undeliverable. You may select the suggested address OR you may continue with the original address by selecting the Cancel button below.

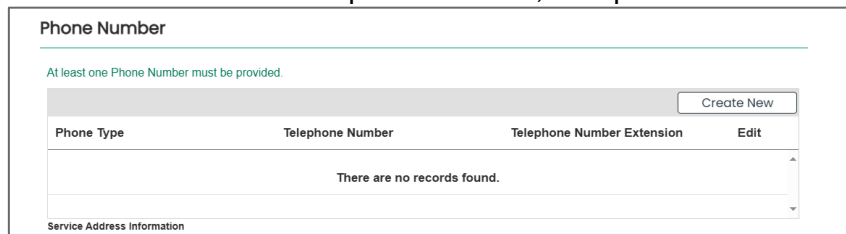
Address Line 1: 200 Main, Address Line 2: , City: Lansing, State: Michigan, Country: UNITED STATES, ZIP Code/ Postal Code: 48910-0000

ADDRESS SUGGESTIONS

Number	Street	City	County	State	Country	ZIP Code
	W MAIN ST	LANSING	EATON	MI	UNITED STATES	48917

Cancel

4. Click **Create New** to add a phone number, then provide Hours of Operation information.



Phone Number

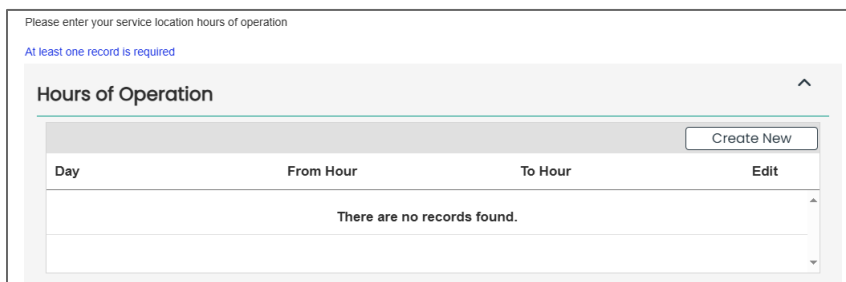
At least one Phone Number must be provided.

Create New

Phone Type	Telephone Number	Telephone Number Extension	Edit
There are no records found.			

Service Address Information

**NOTE:** Hours of Operation may be required for some provider types. Click **Create New** to add details when needed. Fields may be pre-populated when revalidating enrollments.



Please enter your service location hours of operation

At least one record is required

Hours of Operation

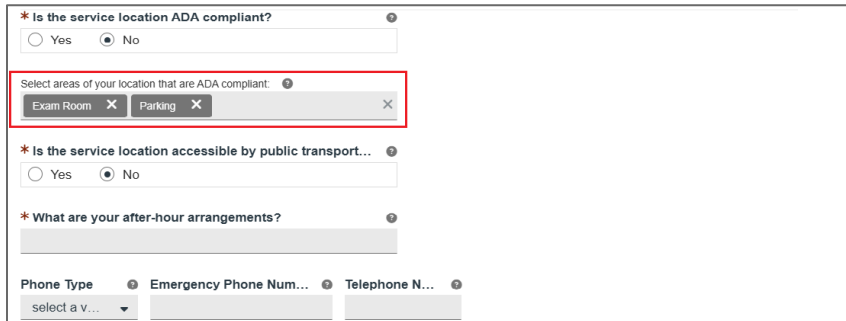
Create New

Day	From Hour	To Hour	Edit
There are no records found.			

## 5. Americans with Disabilities Act (ADA) Compliance.

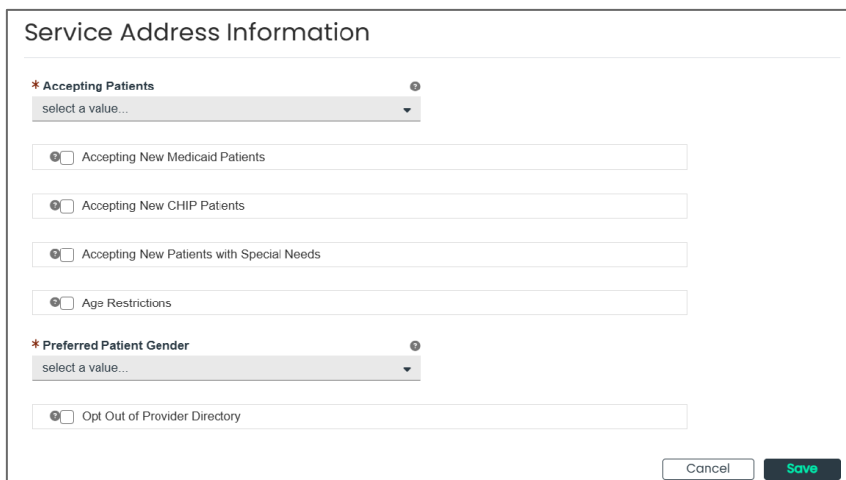
- If applicable, provide the following additional information for the practice location.

**NOTE:** This information includes details about service assistance providers and based on configuration, may include indication of ADA compliance. In the following example, **Exam Room** and **Parking** are listed as ADA compliant.



## 6. Accepting Patient Information.

- Complete the Service Address Information and select appropriate boxes specifying types of new patients your location accepts.
  - New Medicaid Patients
  - New Children's Health Insurance Program (CHIP) Patients
  - Accepting New Patients with Special Needs
  - Any age or gender restrictions



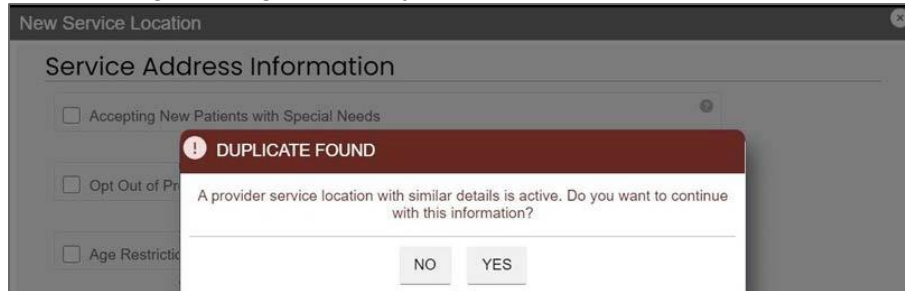
## 7. Click **Save**.

## Potential Duplicate Service Location

Based on provider enrollment information, the Duplicate Found message may be displayed. Key details such as Provider, Specialty, Services Address, NPI, EIN/SSN are used to match an enrollment application already submitted but not yet finalized, or if the provider is already enrolled and active provider.

To continue to the next page with entered details, the provider must click **YES** in the popup or **NO** to stay on the same page and make changes. If **YES** is selected, then after the enrollment is approved, a new service location is added for the matched provider.

The warning message is displayed on the Service Location and Submit pages.



Additional duplicate-related messages in the following table may also be displayed.

The Message...	Appears on the...	When...
A duplicate application with the same details has been submitted with ATN (0). Do you want to continue with this information?	General page for an IG (Individual within a Group) enrollment and for Individual, Facility, OPR, Group, and Atypical enrollment types if ZIP Code is <b>not</b> used in criteria to match possible duplicate enrollment applications for any of these enrollment types	a match is made to an in-process enrollment application.
	Service Location page for Individual, Facility, OPR, Group, and Atypical enrollment types when ZIP Code is used to match possible duplicate enrollment applications	a match is made to an in-process enrollment application.
A provider 14-digit service location with similar details is active. Do you want to continue with this information?	Service Location page for Individual, Facility, OPR, Group, and Atypical enrollment types when ZIP Code is used in criteria to match possible duplicate provider locations, otherwise the message appears on the General page	a match is made to an existing active provider location.
A provider with similar details is already associated with a group. Do you want to continue with this information?	General page	an active IG provider with matching details already exists.

## Other Addresses

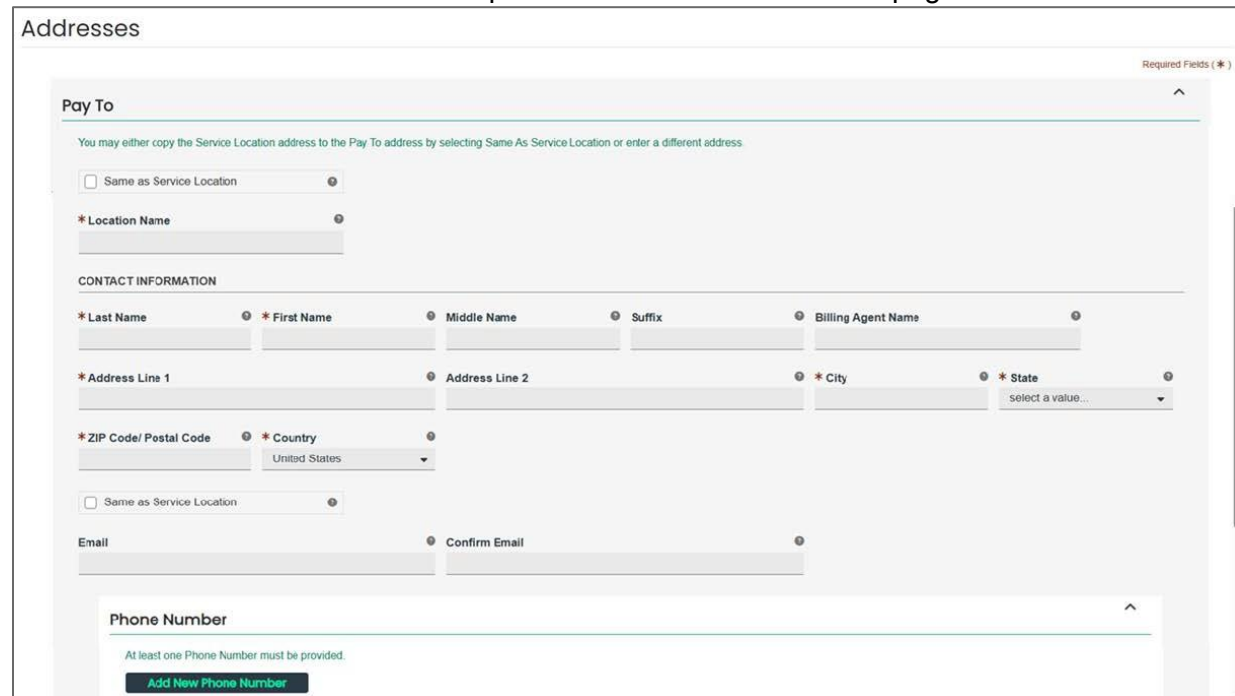
The application supports multiple address types apart from the service location address. Mail To and Pay To address information is required for the following enrollment types:

- Individual
- Atypical
- Group
- Facility

Providers enrolling as Individuals within a Group are not prompted for address information because the system defaults to information provided by the group.

Ordering, Prescribing, and Referring (OPR) enrollments require Mail To addresses only apart from the service location address, as no payments are made to OPR providers.

The service location address entered on the Service Location page can be copied to the Pay To and Mail To panels, as applicable. Fields are grayed out and prepopulated upon checking the Same as Service Location box as fields are copied from the Service Location page.




Addresses are checked against US Postal Service records. When the system finds a more complete address, an address option from the following table displays. Double-click the option presented to continue. If the address is not presented or does not match, it can be overridden.

Option	This is used...
IRS	Address on W-9, SS-4, or other IRS documentation.

Option	This is used...
Remit To	to have Explanation of Benefit (EOB) information sent to an address different than the Pay To address if configured to do so.
Doing Business As	if the enrollment team has questions specific to Doing Business As information provided earlier in the application. Presentation of this address type depends on configuration.

## Phone Numbers

Phone number information must be provided on the Addresses page. Click **Add New Phone Number** to add required Phone Type and Phone Number.



The form is titled "NEW PHONE NUMBER" and contains three required fields: "Phone Type" (a dropdown menu with "Mobile" selected), "Phone Number" (a text field containing "555-555-5555"), and "Phone Extension" (an empty text field). There are "Cancel" and "Save" buttons at the bottom right.

After saving, provided details display in a "card" on the Phone Number panel.



The panel is titled "Phone Number" and displays a card with the following information: "Phone Type: Mobile" and "Telephone Number Extension: 555-555-5555". There are edit and delete icons next to the card. Below the card is a link that says "Add New Phone Number".

**Tip!** Use the Edit icon to change displayed information, Delete icon to remove phone information, or click the **Add New Phone Number** link to add another phone number.

## Organization

Use the Organization page to provide the information about your organization.

Organization
Required Fields ( \* )

**Organizational Details**

If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.  
 If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.

**\* Organization Type** ⓘ
 

For Profit Corporation

**\* Tax Classification** ⓘ
 

Sole Proprietor

Entities doing business in the State, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. For more information on the registration process, please go to the Secretary of State website at <https://www.gainwelltechnologies.com/healthcare/>

☒ Registered with Secretary Of State ⓘ
 

**Business Start Date** ⓘ
 

01/01/2020 ⓘ

☒ Incorporated ⓘ
 

**Incorporation Date** ⓘ
 

01/01/2020 ⓘ

☒ Chain Affiliated ⓘ

☒ Operated by Management Company ⓘ

☒ Domestic Owned Corporation ⓘ

☒ Foreign Owned Corporation ⓘ

CANCEL

PREVIOUS

SAVE AND CONTINUE



## Associations

The Associations page displays an Association panel for Facility, Group enrollment types, Individual within a Group and OPR Providers. Associations are only permitted with enrolled, active providers.

The following associations are allowed:

- Facilities and OPR providers can be associated.
- Groups and Individual within a Group providers can be associated.
- The following associations are not allowed:

**NOTE: Enrollment**, Provider Type and Specialty to determine if association information is required.

## Group Associations

Group and Individuals within a Group can be associated and will present the Association step with the on the Associations panel. Individuals within a Group must associate to a 14-digit SL ID at time of enrollment. The Individual Association list displays details about the individuals so the enrolling provider can view the providers being associated in the enrollment. These details include:

- Provider Location ID
- Provider Name (First, Middle, and Last)
- Effective Date for this association (depending on state's configuration)
- End Date for this association (may not be presented in new enrollments depending on the state's configuration; always presented for Revalidation and prepopulated Re-enrollments)

## Facility/Organization Associations

Facility/Organizations and Ordering, Prescribing, and Referring enrolled provider can be associated and will present the Association step with the on the Associations panel. Individuals within a Group must associate to a 14-digit SL ID at time of enrollment. The Individual Association list displays details about the individuals so the enrolling provider can view the providers being associated in the enrollment. These details include:

- Provider Location ID
- Provider Name (First, Middle, and Last)
- Effective Date for this association (depending on state's configuration)
- End Date for this association (may not be presented in new enrollments depending on the state's configuration; always presented for Revalidation and prepopulated Re-enrollments)

1. Click **CREATE NEW** to create an association.

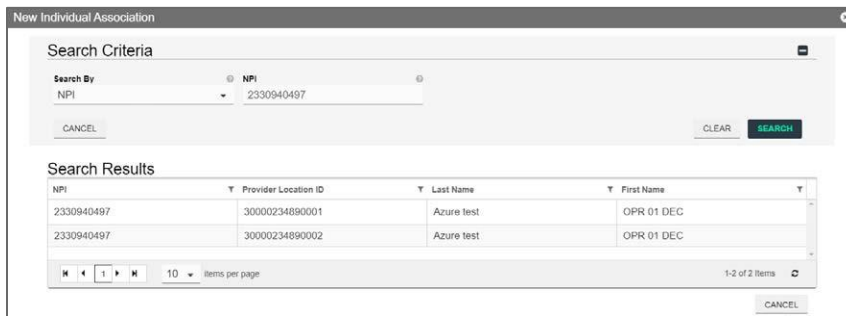


2. Select Provider Location ID or NPI and click **SEARCH**. If an exact match exists, the fields will be populated.



3. Search by Provider Location ID or NPI and click a Search Result row.

**Tip!** You can use a “starts with” search if the exact location ID is unknown.



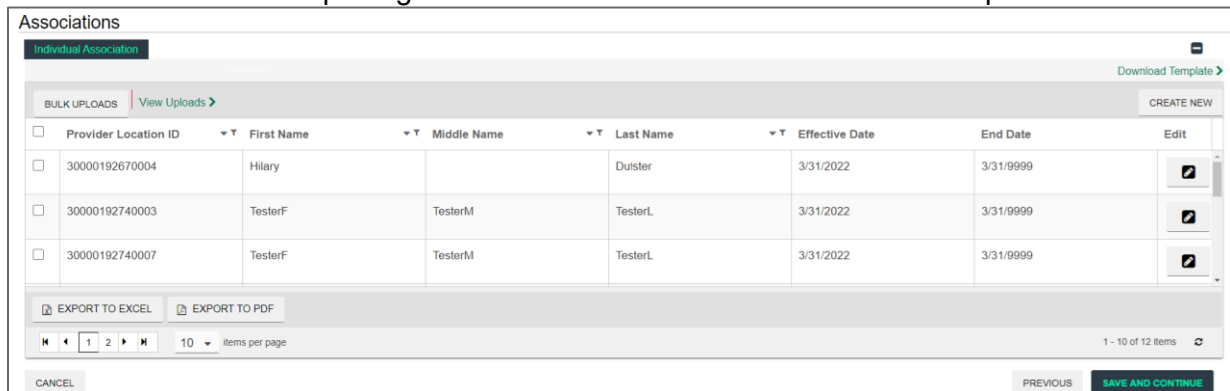
4. Select the desired record from the search results, search again, or click **CANCEL**. The selected provider's location populates the panel.



5. If your state requires Effective and End Dates, enter the Effective (or start) Date of the association; first date of the relationship between providers. If there is no known end date, select a distant future date (e.g., 12/31/9999).

6. Click **SAVE**. The new association is added to the Associations list.

Association grids allow paging, sorting, and filtering of associated providers by Provider Location ID and Names columns. Exporting all records in the list to Excel or PDF is also possible.



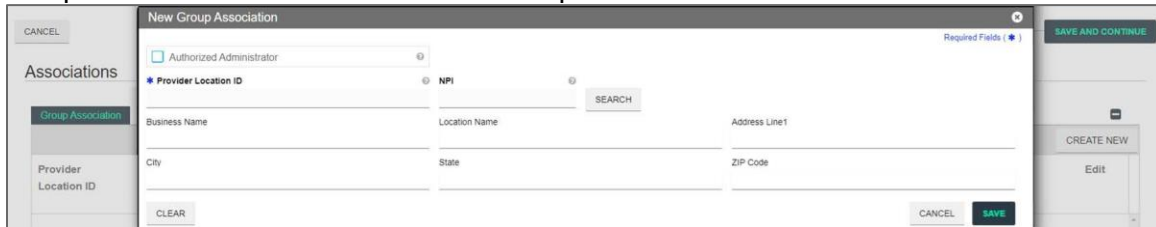
**NOTE:** The number of records displayed per page can be selected from the drop-down.

## Group/Facility Association – Authorized Administrator

If available, an Individual in a Group or OPR provider can grant access to one of the associated Group/Facility providers to allow access and management of IG/OPR provider data in the External Portal as an Authorized Administrator. A column displays on the page identifying the role.

Complete the following steps to designate a group or facility as an Authorized Administrator when adding an association:

1. Click **CREATE NEW** on the Associations page, then check the Authorized Administrator box and provide other details for the New Group Association.



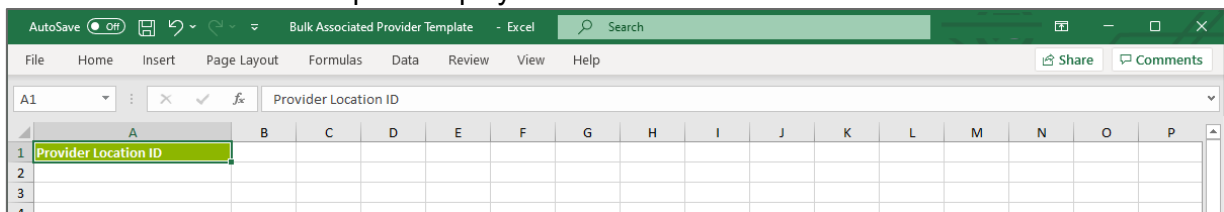
## Associations Bulk Updates

Providers may upload many Associations for Group and Facility enrollment types by using the Microsoft Excel template available for download.

1. Click **Download Template** on the Associations page.

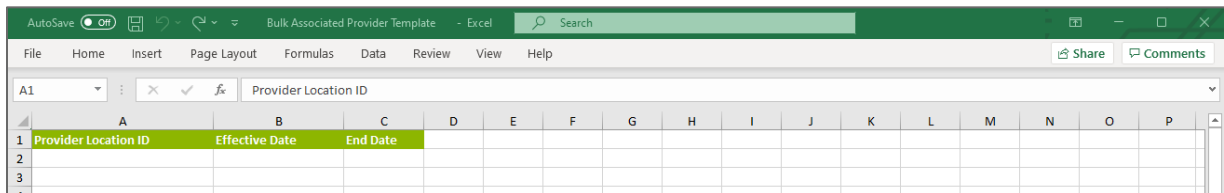


The downloaded Excel template displays a Provider Location ID column.



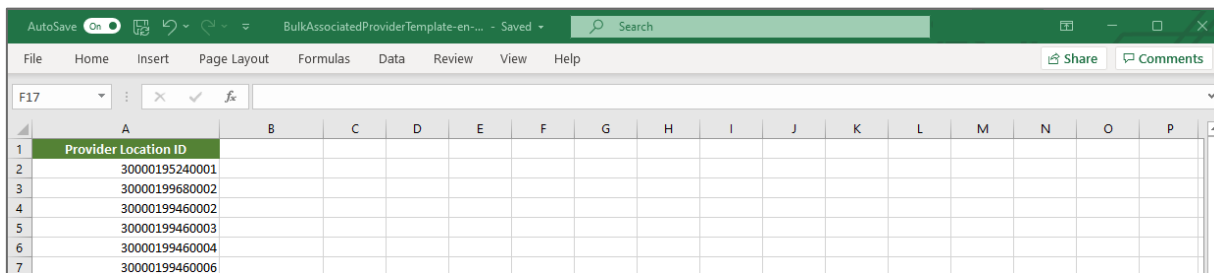
Provider Location ID																	

Based on configuration, Effective Date and End Date columns may also be present in the Excel file. Dates should be entered in MM/DD/YYYY format.



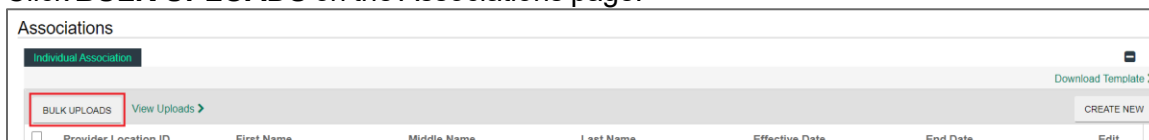
Provider Location ID	Effective Date	End Date															

2. Enter Provider Location IDs, and Effective and End Date if applicable, then save the Excel template.



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	Provider Location ID															
2	30000195240001															
3	30000199680002															
4	30000199460002															
5	30000199460003															
6	30000199460004															
7	30000199460006															

- Click **BULK UPLOADS** on the Associations page.



Associations

Individual Association

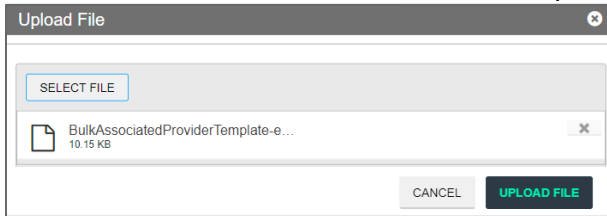
**BULK UPLOADS** View Uploads >

Download Template >

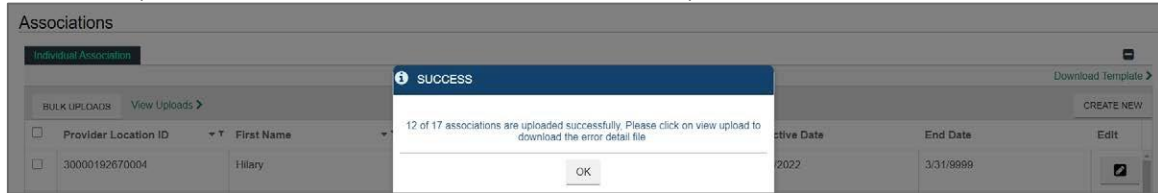
CREATE NEW

<input type="checkbox"/>	Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
--------------------------	----------------------	------------	-------------	-----------	----------------	----------	------

- Click **SELECT FILE** to select the Excel template to upload, then click **UPLOAD FILE**.



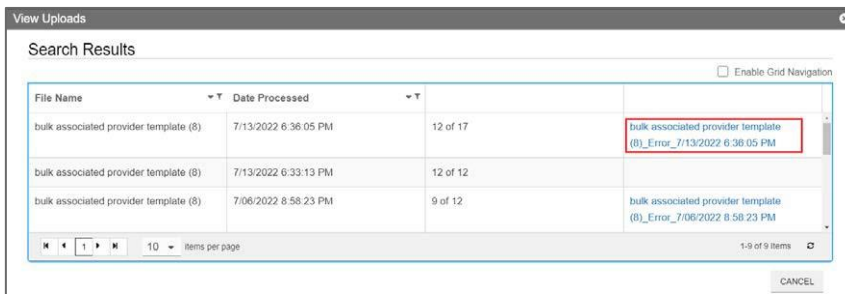
- Click **OK** when the success message displays indicating that '**N** out of **NNN** records were uploaded (where **N** indicates number of associations).



- Click **View Uploads** to download a file of Provider Location IDs that errored out.

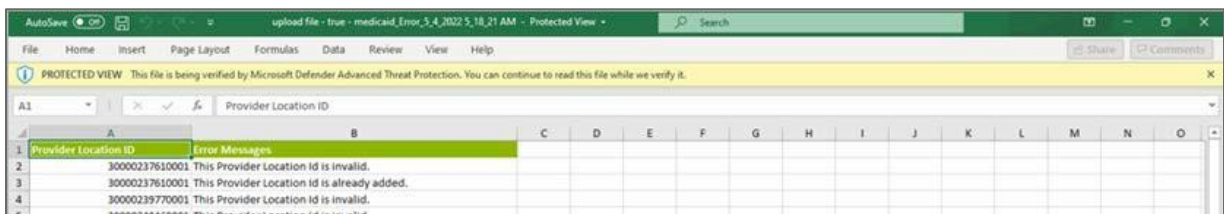


- Click a link in the Error File Name column to download and review records that errored out.



- Review the list of error messages.

**NOTE:** File Name is displayed in FileName\_Error\_DateTimeStamp format.



The following example shows errors displayed on the Excel template with Effective and End Date columns.

Provider Location ID	Effective Date	End Date	Error Messages
30000171560001	31-03-2022	31-01-9999	This Provider Location Id is invalid.
30000171570001	30-03-2022	02/31/9999	Effective Date is not valid or not in MM/DD/YYYY format.
30000172320001	31-01-2022	31-03-9999	End Date is not valid or not in MM/DD/YYYY format.
30000171850001	28-02-2022	04/31/9999	This Provider Location Id is invalid.
			End Date is not valid or not in MM/DD/YYYY format.

- Correct records on the Excel template, then save and re-upload the file.

## Deleting Association Records

You can delete an individual record, or all records as needed.

- Take one of the following actions on the Individual Association panel:
  - Check the Select All box besides Provider Location ID to select all associated provider records. (All records across the pages are selected for deletion.)

Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
30000192740003	TesterF	TesterM	TesterL	3/31/2022	3/31/9999	[Edit]
30000192740007	TesterF	TesterM	TesterL	3/31/2022	3/31/9999	[Edit]
30000192750001	OPR_Revalidation_Address		JJ	2/10/2022	3/31/9999	[Edit]

- Check the box beside individual records to select.

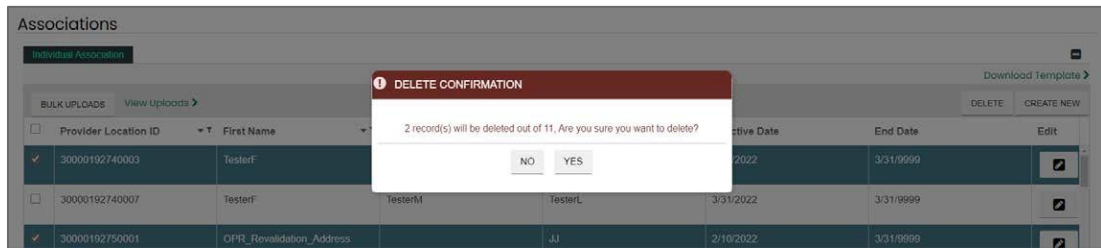
Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
30000192750002	OPR_Revalidation_Ad...		JJ	3/31/2022	3/31/9999	[Edit]
30000193320001	Adishree		Pandita	3/31/2022	3/31/9999	[Edit]
30000194420001	Prov		OrdPreRef	3/31/2022	3/31/9999	[Edit]

- Click **DELETE**, then **YES** on the Delete Confirmation message, which displays a message like either of the below examples:

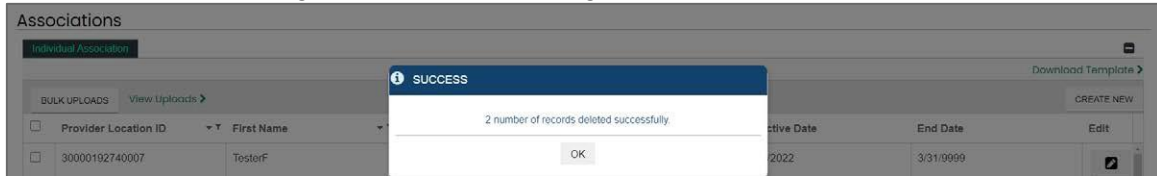
- All records

Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
30000192740003	TesterF	TesterM	TesterL	3/31/2022	3/31/9999	[Edit]
30000192740007	TesterF	TesterM	TesterL	3/31/2022	3/31/9999	[Edit]

- Selected individual records



3. Click **OK** to acknowledge the Success message.



## Create Associations

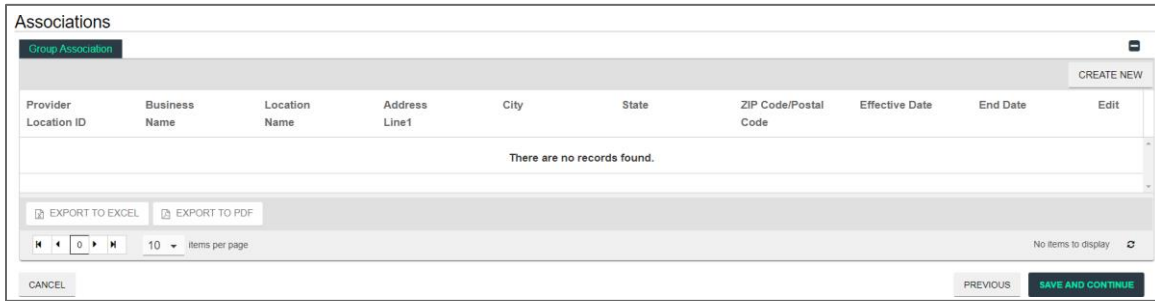
The Association grid requires an Individual Within a Group provider to identify one or more groups with which the provider is associated. It can be an individual location, multiple locations for the same group, or locations for two or more groups. This grid also applies to OPRs associating facilities. The grid allows the paging, sorting, and filtering of associated groups on the Provider Location ID and Names columns. Individuals may associate to groups if the state's rules allow. Individual association to a group result in both Individual and Individual within a Group provider location if the enrollment application is approved.

The Group Association list displays details about group or facility locations so the enrolling provider can see the associations being selected for this enrollment. These details include:

- Provider Location ID
- Business Name
- Location Name
- Service address: Address Line 1, City, State, and ZIP Code.
- Authorized Administrator selection for this association
- Effective Date for this association (depending on state's configuration)
- End Date for this association (depending on state's configuration; End Date is always available for Revalidations and prepopulated Re-enrollments)

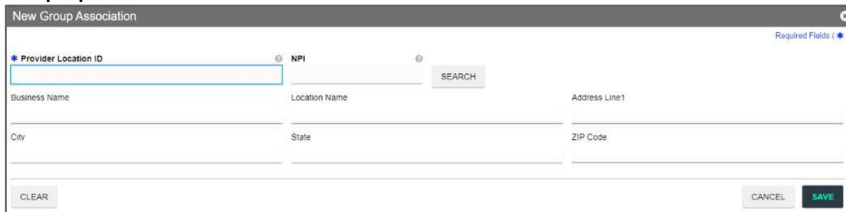
**NOTE:** If multiple service locations are added on the application, the Associations page does not display.

1. Click **CREATE NEW** to create an association.



The screenshot shows a table titled "Associations" with a "Group Association" tab. The table has columns: Provider Location ID, Business Name, Location Name, Address Line1, City, State, ZIP Code/Postal Code, Effective Date, End Date, and Edit. The table is empty, displaying "There are no records found." Below the table are buttons for "EXPORT TO EXCEL" and "EXPORT TO PDF". At the bottom right, there are buttons for "PREVIOUS" and "SAVE AND CONTINUE".

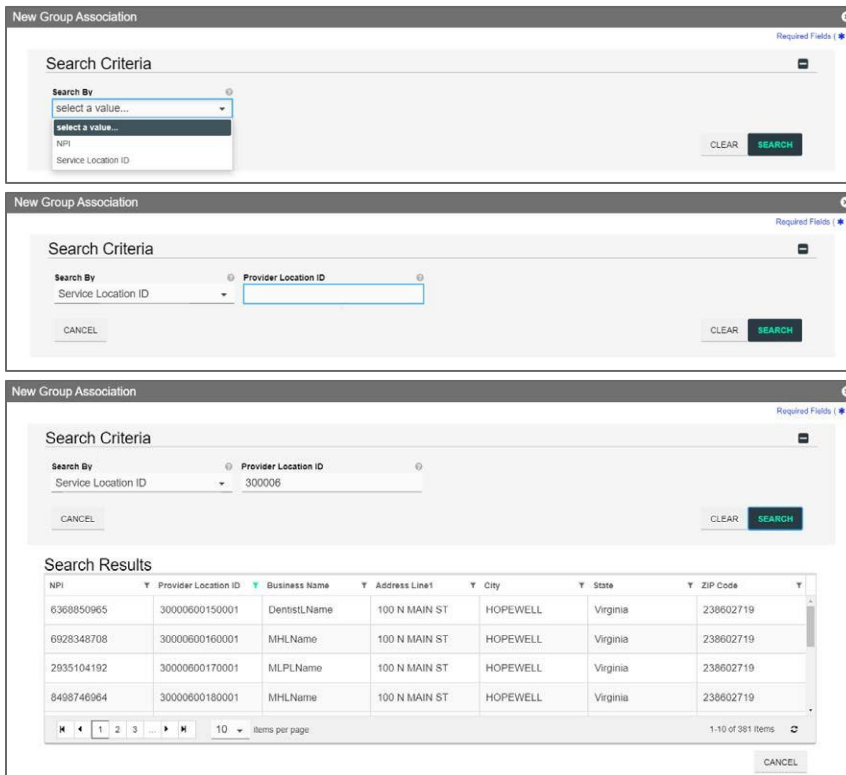
2. Select Provider Location ID or NPI and click **SEARCH**. If an exact match exists, the fields will be populated.



The screenshot shows the "New Group Association" form. It has a "Provider Location ID" field and an "NPI" field. Below these are fields for "Business Name", "Location Name", "Address Line1", "City", "State", and "ZIP Code". A "SEARCH" button is located next to the "NPI" field. At the bottom, there are "CLEAR", "CANCEL", and "SAVE" buttons.

3. Search by Service Location ID or NPI and click the search result.

**Tip!** A “starts with” search can be used if the exact location ID is not known.



The first screenshot shows the "Search Criteria" section with a dropdown menu for "Search By" set to "Service Location ID". The second screenshot shows the "Search Criteria" section with the "Search By" dropdown set to "Service Location ID" and the "Provider Location ID" field populated with "300006". The third screenshot shows the "Search Results" section with a table of results.

NPI	Provider Location ID	Business Name	Address Line1	City	State	ZIP Code
636850965	30000600150001	DentistLName	100 N MAIN ST	HOPEWELL	Virginia	238602719
6928348708	30000600160001	MHLName	100 N MAIN ST	HOPEWELL	Virginia	238602719
2935104192	30000600170001	MLPLName	100 N MAIN ST	HOPEWELL	Virginia	238602719
8498746964	30000600180001	MHLName	100 N MAIN ST	HOPEWELL	Virginia	238602719

At the bottom of the third screenshot, there is a pagination bar showing "1-10 of 381 items" and a "CANCEL" button.



- Select the desired record from the search results, search again, or click **CANCEL**.



The form is titled "New Group Association" and contains the following fields:

- Provider Location ID:** 30000600150001
- NPI:** 6928348708
- Business Name:** DentistName
- Location Name:** Loc
- Address Line1:** 100 N MAIN ST
- City:** HOPEWELL
- State:** Virginia
- ZIP Code:** 238602719
- Effective Date:** 12/31/9999
- End Date:** 12/31/9999

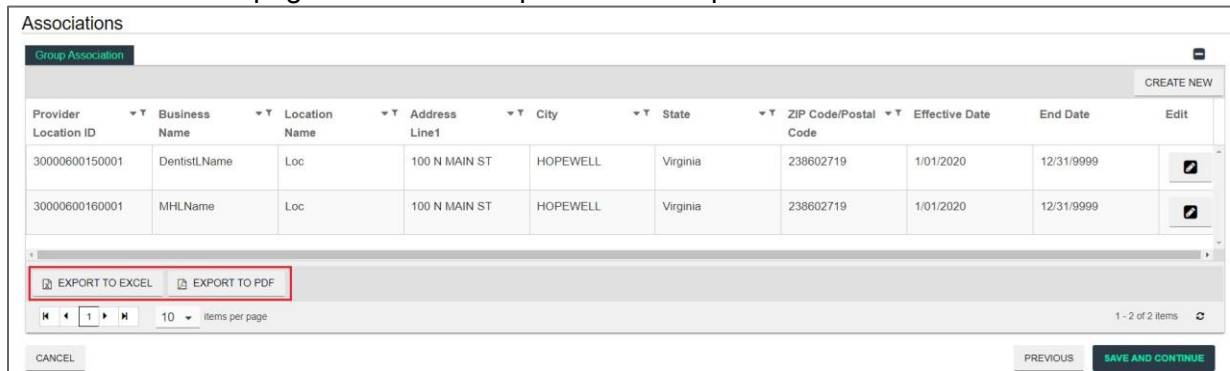
Buttons at the bottom: CLEAR, CANCEL, SAVE.

**NOTE:** Associations are limited to providers currently enrolled in the program. If the information entered for providers is not found to have an active Provider ID, an error message displays indicating the Provider number is not valid.

- Review and confirm that displayed name fields are for the expected provider, then if your state requires Effective and End dates, enter the Effective (or start) Date of the association; first date of the relationship between providers. If there is no known end date, select a distant future date (e.g., 12/31/9999).
- Click **SAVE**. The new association is added to the Associations list.

**NOTE:** Associations can be made during the enrollment process or after the process is successfully completed, but associations must exist before services for a rendering provider can be billed. Providers enrolling as Individual within a Group must associate with at least one group to submit the application.



Saved records display on the grid. **EXPORT TO EXCEL** and **EXPORT TO PDF** options are provided on the Association page. These enable providers to export associations to Excel and PDF.



The grid is titled "Associations" and contains the following columns:

- Provider Location ID
- Business Name
- Location Name
- Address Line1
- City
- State
- ZIP Code/Postal Code
- Effective Date
- End Date
- Edit

The grid displays two rows of data:

Provider Location ID	Business Name	Location Name	Address Line1	City	State	ZIP Code/Postal Code	Effective Date	End Date	Edit
30000600150001	DentistName	Loc	100 N MAIN ST	HOPEWELL	Virginia	238602719	1/01/2020	12/31/9999	
30000600160001	MHLName	Loc	100 N MAIN ST	HOPEWELL	Virginia	238602719	1/01/2020	12/31/9999	

Buttons at the bottom: EXPORT TO EXCEL, EXPORT TO PDF, CANCEL, PREVIOUS, SAVE AND CONTINUE.

**NOTE:** Only saved data is included when you click **EXPORT TO EXCEL** or **EXPORT TO PDF**. Unsaved data is **not** included. These buttons are only enabled when records exist in the list and are grayed out when there are no saved records listed.



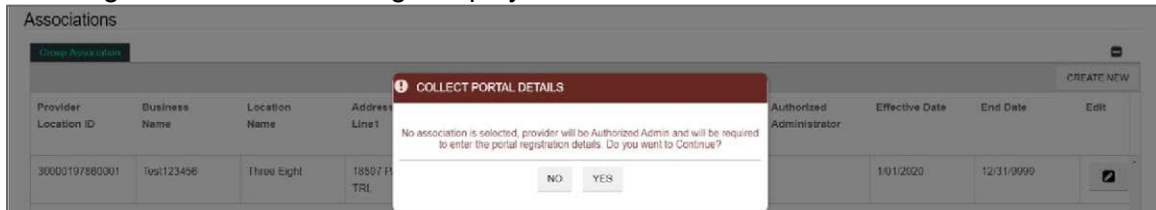
On Export To Excel, Export To PDF, and PDF reports printed via the Enrollment Application, only the End Date field displays.

**NOTE:** Display of Effective and End Date fields is based on configuration for New Enrollments, Revalidations, and Re-Enrollments. Export To Excel and Export To PDF reports only display the End Date.

Multiple Associations can be added but only one can be designated as the Authorized Administrator. A message displays with the provider's location ID of the Authorized Administrator.

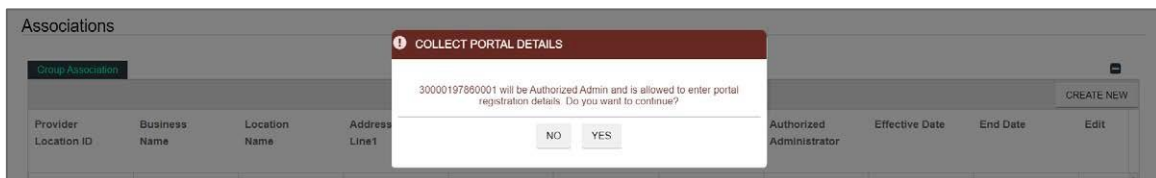
2. Click **SAVE**.

If no Authorized Administrator is selected and Provider Portal registration is enabled, the following informational message displays:



Provider Location ID	Business Name	Location Name	Address Line1	Authorized Administrator	Effective Date	End Date	Edit
30000197860001	Tos123456	Thro Eight	18597 B TRI		1/01/2020	12/31/0000	

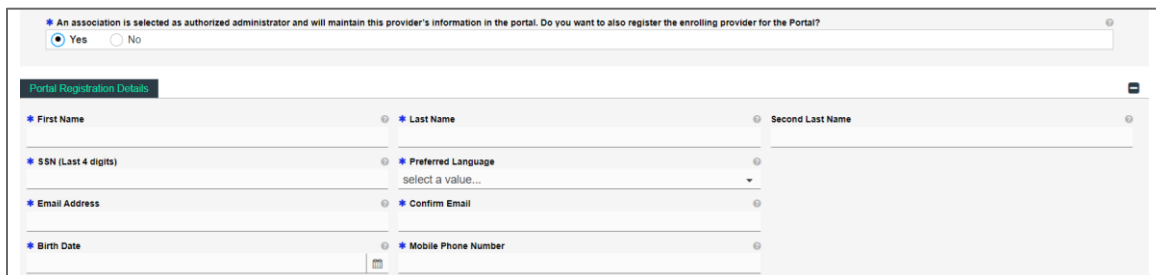
If an Authorized Administrator is selected, the following message displays to confirm the selection:



Provider Location ID	Business Name	Location Name	Address Line1	Authorized Administrator	Effective Date	End Date	Edit
30000197860001	Tos123456	Thro Eight	18597 B TRI		1/01/2020	12/31/0000	

3. Click on **YES** to continue with this Group as the administrator or **NO** to make changes.

**Tip!** If you select **YES**, it is still possible to register for the Provider Portal on the Submit page.



☒ Yes
 ☐ No

**Portal Registration Details**

\* First Name
 \* Last Name
 \* Second Last Name

\* SSN (Last 4 digits)
 \* Preferred Language (select a value...)

\* Email Address
 \* Confirm Email

\* Birth Date
 \* Mobile Phone Number

## V Credentials

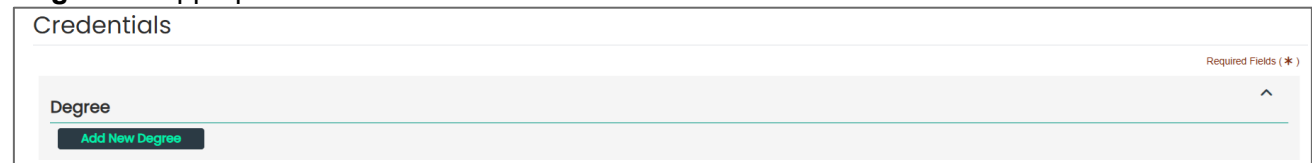
### Credentials Page Introduction

Use the Credentials page to enter all relevant licensure and Medicare participation information.

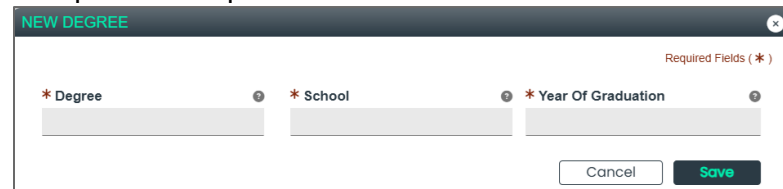
**NOTE:** PRSS uses Provider Type and Specialty to determine required credentials. If Provider Type and Specialty require no information on the page, it is not displayed. If **Yes** was selected for the Medicare participation question on the General page, Medicare Participation details are required.

### Degree

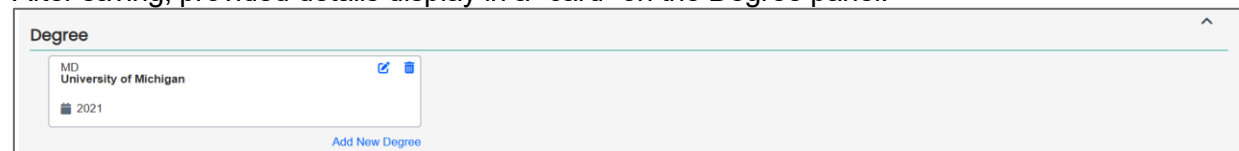
Use the Degree panel on the Credentials page to enter related educational details, click **Add New Degree** as appropriate.



Complete the required fields and click **Save**.



After saving, provided details display in a "card" on the Degree panel.



**Tip!** Use the Edit icon to change displayed information, Delete icon to remove a degree, or click the **Add New Degree** link to add another degree.

## License

License or Certification are required by provider type and specialty to hold a license in good standing in the same state as the location where services are rendered.

- You must enter accurate license or certification information including current effective and end date of license.
  - If your license information is inaccurate, it may delay your enrollment.
- License information is validated through a screening and manual process with public, state, and federal entities.
- If License lapses at any time or revoked or suspended your eligibility with one or more Virginia Medicaid Programs will be terminated.
  - If approved for enrollment it is the provider's responsibility to submit and maintain the updated license prior to the end date of the current license on the provider file.
  - If this information is not received prior to the end date in PRSS, your provider record may risk termination, and a re-enrollment will be required.

License

At least one record is required

CREATE NEW

License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit
0206009043	Virginia	DHP - Virginia Department of Health Professionals	9/03/1999	12/31/2033	

## DEA

Use the DEA panel to enter DEA license information, as appropriate.

DEA

At least one record is required

CREATE NEW

DEA Number	Effective Date	End Date	Edit
TL2384729	1/01/2010	12/31/2023	

## Medicare

Some provider types and specialties require Medicare participation.

1. Click the pencil icon and add Medicare Number, Type, Effective Date, and End Date.
2. Check the Consider for Medicare Crossover box to automatically send claims from Medicare to Medicaid.

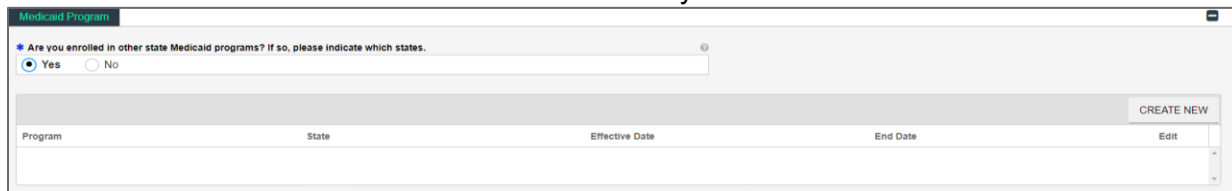


3. Click **CREATE NEW** to add any additional assigned Medicare numbers.

**NOTE:** If you answered **No** to the Enrolled in Medicare question on the General page and added a Medicare Participation record, you receive a message to confirm the response will be changed to **Yes**.

## Medicaid

Providers can add details about any other state Medicaid program in which they are actively enrolled. Click **CREATE NEW** to add each new entry.



## VI Provider Type


### Overview

PRSS uses Provider Type and Specialty specific requirements to determine which credentials are required.

**NOTE:** If Provider type and specialty combination does not require any of the information on this page, the Provider Type page is not included in the application.

### CLIA (Certified Laboratory Improvement Amendments)

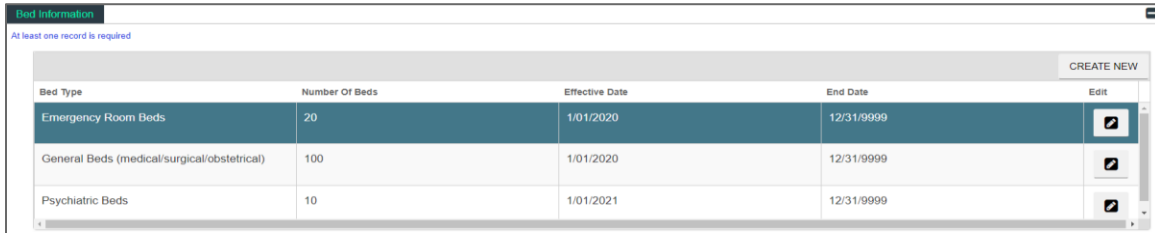
Providers who bill laboratory services must submit CLIA information. Click **CREATE NEW** and list all current CLIAs assigned to the NPI. When CLIA information is submitted in this panel, a valid CLIA certificate becomes a required attachment depending on state-specific configurations.

CLIA				
CREATE NEW				
CLIA Number	CLIA Type	Effective Date	End Date	Edit
40D0658001	3 - Accreditation	1/01/2020	12/31/2025	

## Bed Information

Hospitals, Skilled Nursing, and Intermediate Care facilities may be required to enter information about the type and number of available beds. To add that information:

1. Click **CREATE NEW**.



At least one record is required

Bed Type	Number Of Beds	Effective Date	End Date	Edit
Emergency Room Beds	20	1/01/2020	12/31/9999	
General Beds (medical/surgical/obstetrical)	100	1/01/2020	12/31/9999	
Psychiatric Beds	10	1/01/2021	12/31/9999	

2. Add one entry for each bed type on the New Bed Information window.

**NOTE:** When end dates are unknown, enter **12/31/9999**. Same Bed Type records with overlapping dates are not permitted. The following message displays if you attempt to add a record where dates overlap an existing record.



**New Bed Information**

Resolve the following form field errors and try again.  
Bed information records are not allowing overlapping dates for the same Bed Type.

Required Fields ( \* )

\* Bed Type \* Number Of Beds \* Effective Date \* End Date

Emergency Room Beds 100 05/01/2022 12/31/2022

CANCEL SAVE



## VII Other Page

### Introduction

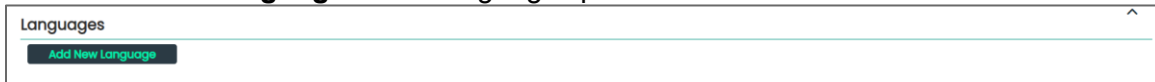
PRSS uses Provider Type and Specialty to determine required credentials on the Other page.

**NOTE:** When a Provider Type and Specialty combination does not require Languages or Malpractice information, these questions are not included in the application.

### Languages

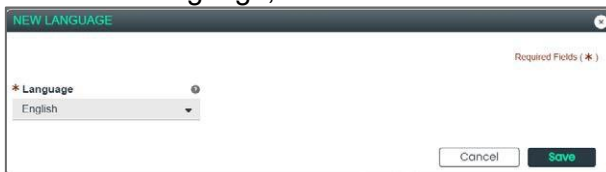
Complete the following steps to identify languages spoken at the service location.

1. Click **Add New Language** in the Languages panel.



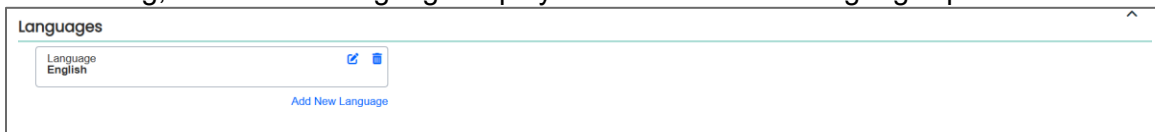
The screenshot shows a panel titled 'Languages' with a search bar and a button labeled 'Add New Language'.

2. Select the Language, then click **Save**.



The screenshot shows a 'NEW LANGUAGE' dialog box with a dropdown menu for 'Language' set to 'English'. There are 'Cancel' and 'Save' buttons at the bottom right. A note 'Required Fields (\*)' is visible in the top right corner.

After saving, the selected language displays in a "card" on the Languages panel.



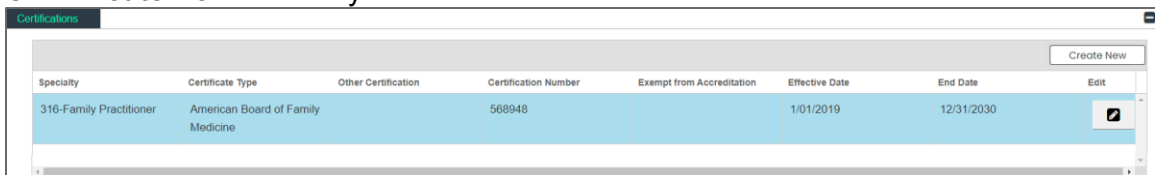
The screenshot shows the 'Languages' panel with a card for 'English' language. There are edit and delete icons next to the card, and an 'Add New Language' link at the bottom.


**Tip!** Use the Edit icon to select a different language, Delete icon to remove the selected language, or the **Add New Language** link to add another language.

### Certifications

Complete the following steps to add certification details.

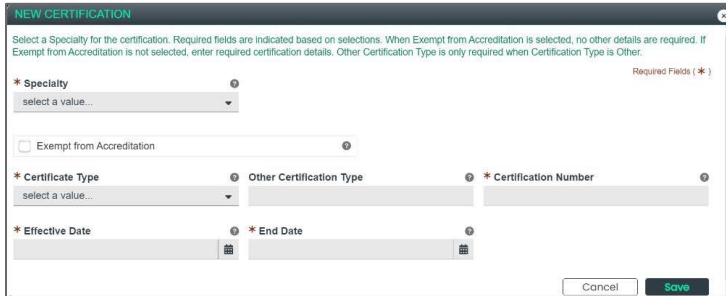
1. Click **Create New** to identify certifications held.



Specialty	Certificate Type	Other Certification	Certification Number	Exempt from Accreditation	Effective Date	End Date	Edit
316-Family Practitioner	American Board of Family Medicine		568948		1/01/2019	12/31/2030	

The screenshot shows a 'Certifications' table with a 'Create New' button in the top right corner. The table has columns for Specialty, Certificate Type, Other Certification, Certification Number, Exempt from Accreditation, Effective Date, End Date, and an Edit icon.

2. Select and enter required details that vary based on the following:
  - Selection of a Specialty with an unchecked Exempt from Accreditation box, causes Certification Type, Certification Number, Effective Date, and End Date to be required.
  - Selection of Certification Type **Other**, causes Other Certification Type to be required.
  - Checking the Exempt from Accreditation box causes **only** the Specialty to be required.



**NEW CERTIFICATION**

Select a Specialty for the certification. Required fields are indicated based on selections. When Exempt from Accreditation is selected, no other details are required. If Exempt from Accreditation is not selected, enter required certification details. Other Certification Type is only required when Certification Type is Other.

**\* Specialty** Required Fields ( \* )

select a value...

☐ Exempt from Accreditation

**\* Certificate Type** Other Certification Type \* Certification Number

select a value...

**\* Effective Date** \* End Date

Cancel Save

3. Click **Save**.

## Facility Accreditations

This panel only displays if applicable for certain Provider type and specialty combinations.

1. Click **Create New** and identify any Long-Term Care (LTC) certifications held, along with required information for each.

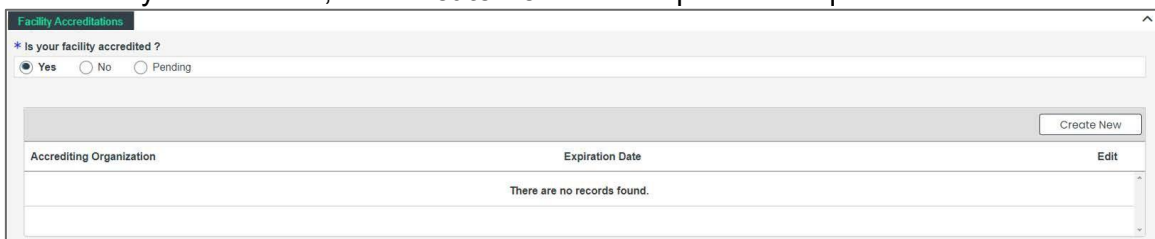


**LTC Certification**

Create New

Specialty	Certificate Type	Effective Date	End Date	Facility Inspection Date	Edit
035-Skilled Nursing Facility	Skilled nursing	01/01/2000	12/31/2020	04/05/2000	

2. If the facility is accredited, click **Create New** and complete the required information.



**Facility Accredited**

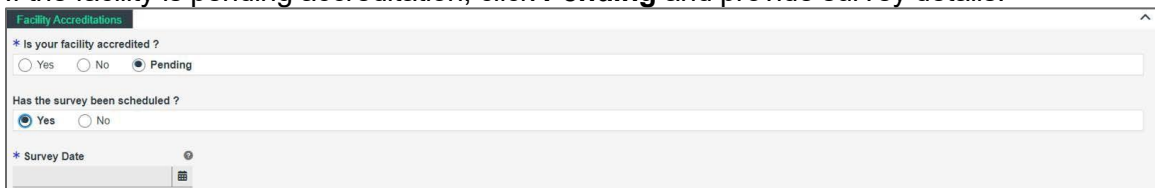
\* Is your facility accredited ?

☒ Yes ☐ No ☐ Pending

Create New

Accrediting Organization	Expiration Date	Edit
There are no records found.		

3. If the facility is pending accreditation, click **Pending** and provide survey details.



**Facility Accredited**

\* Is your facility accredited ?

☐ Yes ☐ No ☒ Pending

Has the survey been scheduled ?

☒ Yes ☐ No

\* Survey Date



## Telehealth Information

Telehealth question displays.

**NOTE:** The provider website address is optional and may be used in the Provider directory.

Other

Required Fields ( \* )

Additional Information ^

\* Do you offer telehealth services? ⓘ  
☐ Yes ☒ No

Please enter the provider website address below. It must begin with "http:" or "https:" followed by a valid address.

Provider Website URL ⓘ



## Electronic Claims Submission Participation and Claims Waiver Signature

Virginia Medicaid providers are required to indicate whether they will submit claims by EDI (Electronic Data Interchange) or DDE (Direct Data Entry), and whether there are signatures on file.

Electronic Claims Submission Participation

I will submit claim(s) through Electronic Data Interchange (EDI) or Direct Data Entry (DDE) on the Medicaid Web Portal as part of my enrollment with Medicaid. ⓘ

☒ Yes ☐ No

If you answered "No" above, please provide documentation supporting your exemption request. It can be uploaded on the Attachments page of this application.

Claims Signature Waiver

I certify that I have authorized submission of claims to Medicaid, which contain my typed, computer generated, or stamped signature. ⓘ

☒ Yes ☐ No

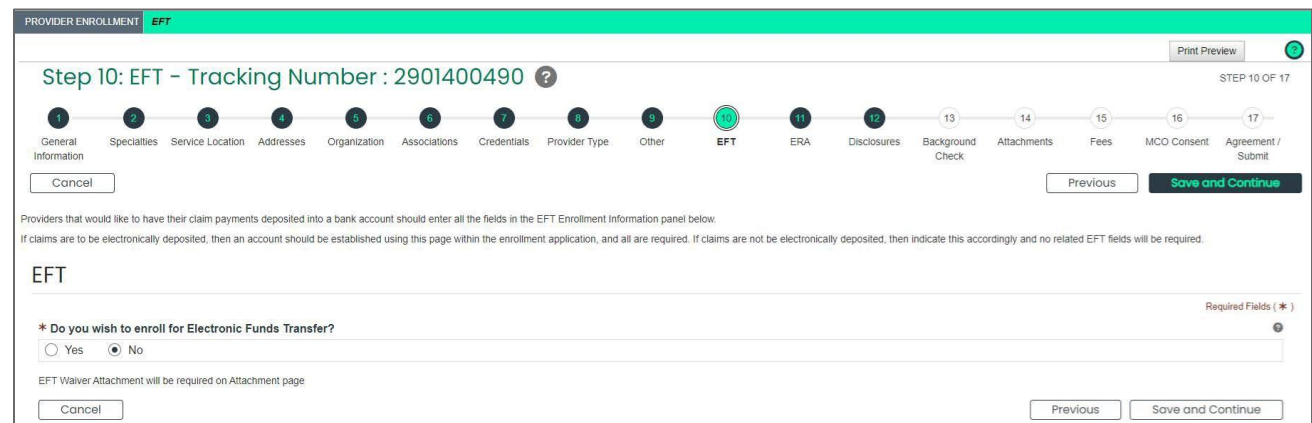
## VIII EFT (Electronic Funds Transfer)

### EFT Overview

PRSS uses enrollment type to determine if the EFT page displays during the application process.

Virginia Medicaid requires an EFT waiver when EFT information is not provided. In these cases, additional instructions may appear when No is selected, and additional attachments are required.

**NOTE:** If the enrollment type does not require EFT information or an existing NPI or API has EFT information, the EFT information does not display.



PROVIDER ENROLLMENT **EFT**

Step 10: EFT - Tracking Number : 2901400490 ? STEP 10 OF 17

Providers that would like to have their claim payments deposited into a bank account should enter all the fields in the EFT Enrollment Information panel below.  
If claims are to be electronically deposited, then an account should be established using this page within the enrollment application, and all are required. If claims are not be electronically deposited, then indicate this accordingly and no related EFT fields will be required.

**EFT**

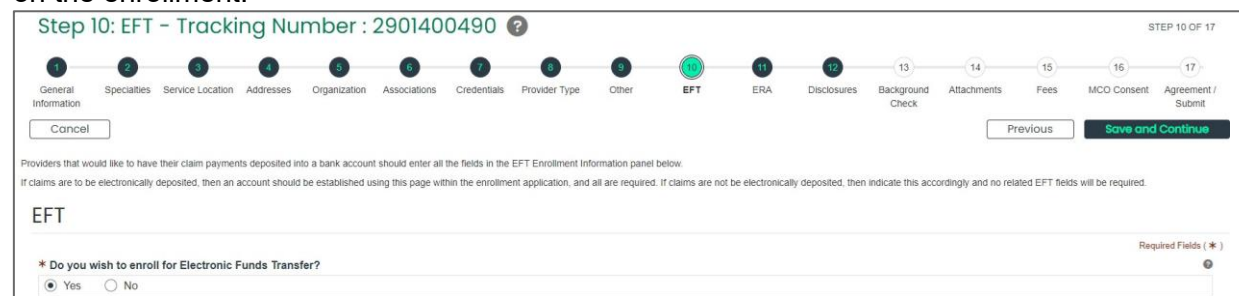
\* Do you wish to enroll for Electronic Funds Transfer?

☐ Yes ☒ No

EFT Waiver Attachment will be required on Attachment page

Previous Save and Continue

If a Provider selects **Yes** on the EFT page, the following eight panels are presented to be completed on the enrollment.



Step 10: EFT - Tracking Number : 2901400490 ? STEP 10 OF 17

Providers that would like to have their claim payments deposited into a bank account should enter all the fields in the EFT Enrollment Information panel below.  
If claims are to be electronically deposited, then an account should be established using this page within the enrollment application, and all are required. If claims are not be electronically deposited, then indicate this accordingly and no related EFT fields will be required.

**EFT**

\* Do you wish to enroll for Electronic Funds Transfer?

☒ Yes ☐ No

EFT Waiver Attachment will be required on Attachment page

Previous Save and Continue



## Provider Information

Provider Information				
Provider Name	Doing Business As Name			
Medical Supply Inc	Hospital			
PROVIDER ADDRESS				
Address Line 1	Address Line 2			
3000 Hanover St				
City	State	ZIP Code/ Postal Code	Country	
Kansas	Kansas	943041112	UNITED STATES	

## Provider Identifier Information

Provider Identifier Information					
Tax Identification Number (TIN / EIN)	National Provider Identifier (NPI)				
***-**-6789	3297577322				
Other Identifier	Assigning Authority	Trading Partner ID	License Number	License Issuer	
	select a value...				
Provider Type					
25 - DME-Medical Supply Dealer					
Provider Taxonomy Code					
332B00000X - Durable Medical Equipment & Medical Supplies					

## Provider Contact Information

Provider Contact Information					
Contact Last Name	Contact First Name	Contact Middle Name			
Title					
Telephone Number	Telephone Number Extension	Email Address	Fax Number		



## Provider Agent Information

Provider Agent Information

Provider Agent Name

PROVIDER AGENT ADDRESS

Address Line 1

Address Line 2

City

State

select a value...

ZIP Code/ Postal Code

Country

select a value...

PROVIDER AGENT CONTACT

Agent Contact Last Name

Agent Contact First Name

Agent Contact Middle Name

Title

Telephone Number

Telephone Number Extension

Email Address

Fax Number

## Federal Agency Information

Federal Agency Information

Federal Program Agency Name

Federal Program Agency Identifier

Federal Agency Location Code

## Retail Pharmacy Information

Retail Pharmacy Information

Pharmacy Name

Chain Number

Parent Organization ID

Payment Center ID

NCPDP Provider ID Number

Medicaid Provider Number

## Financial Institution Information

### Financial Institution Information

\* Financial Institution Name ⓘ  
North Central

---

**FINANCIAL INSTITUTION ADDRESS**

Address Line 1 ⓘ Address Line 2 ⓘ  
3000 Hanover St

City ⓘ State ⓘ ZIP Code/ Postal Code ⓘ Country ⓘ Financial Institution Teleph... ⓘ Telephone Number Extension ⓘ  
Kansas Kansas 94304-1112 UNITED STATES 555-555-5555

\* Financial Institution Routing Number ⓘ \* Type of Account at Financial Institution ⓘ \* Provider's Account Number with Financial Institution ⓘ  
111111111 Checking 222222222

---

**ACCOUNT NUMBER LINKAGE TO PROVIDER IDENTIFIER**

\* Preferred ID ⓘ  
☒ Tax ID Number ☐ NPI

Tax ID Number ⓘ  
● ● ● - 6789

## Submission

Submission

Reason For Submission

New Enrollment

● Include with Enrollment Submission

select a value...

● Authorized Signature Type

Electronic Signature of Person Submitting Enrollment

\* Electronic Signature of Person Submitting Enrollment

T Smith

● Submission Date

3/13/2024

● Requested EFT Start/Chan...

Cancel

Previous

Save and Continue

*Note: For guidance on updating EFT information, please consult the Provider Portal User Guide.*



## IX Disclosures

PRSS presents five disclosure forms. OPR and Individual Within Group (IG) enrollments require only a Self-disclosure form. All others require providers to complete each form.

Disclosures

Disclosure Details

PRIVACY ACT NOTICE STATEMENT

This statement explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs) and dates of birth (DOB), may be requested and used.

Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the State Medical Assistance Program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation. Any information may also be provided to the U.S. DHHS Centers for Medicare and Medicaid Services, the Internal Revenue Service, State Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state or logical agencies as appropriate.

Providing this information is mandatory to be eligible to enroll as a provider with the State Medical Assistance Program, pursuant to 42 CFR § 455 and CFR § 438. Failure to submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the State Medical Assistance Program.

OWNERSHIP/CONTROLLING INTEREST

Federal law requires individuals and entities with ownership, control, management or a business relationship to submit a separate disclosure form for each entity or person affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 106, 42 CFR § 455.436, 42 CFR § 1002.3, and CFR § 438.602 (b)

1. Click **Create New** next to each form to open it.

DISCLOSURE FORMS

**Answer all questions:** If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please provide the additional information that may be requested.

Disclosure Form	Status	Create New
Provider Self Disclosure	New	<button>Create New</button>
Sub-Contractor Disclosure	New	<button>Create New</button>
Ownership and Control Interest	New	<button>Create New</button>
Managing Employees	New	<button>Create New</button>
Business Transaction	New	<button>Create New</button>

Cancel

Previous

Save and Continue

**Tip!** PRSS does not allow you to **Save and Continue** until every form shows a **Completed** status.

2. To confirm the forms are completed correctly, click once on the disclosure form type, and another window opens that displays disclosure names. The example below displays two completed ownership and control interest forms.

The requested information may result in a provider to obtain reimbursement from the

**OWNERSHIP/CONTROLLING INTEREST**

Federal law requires individuals and entities with the provider. For more information on

**DISCLOSURE FORMS**

Answer all questions. If you do not believe that may be requested.

Disclosure Form

Provider Self Disclosure

VIEW OWNERSHIP AND CONTROL INTEREST

Disclosures NameEdit

Smith, T

Hospital

Create New

Close

Provider Self Disclosure

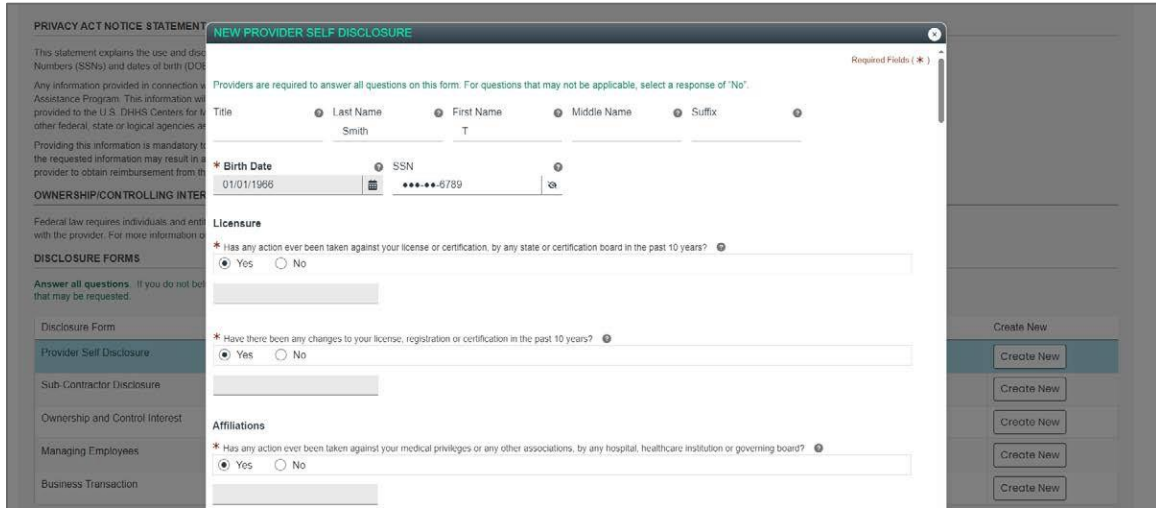
3. Click the Edit (pencil) icon to open each form.

## Provider Self-Disclosure

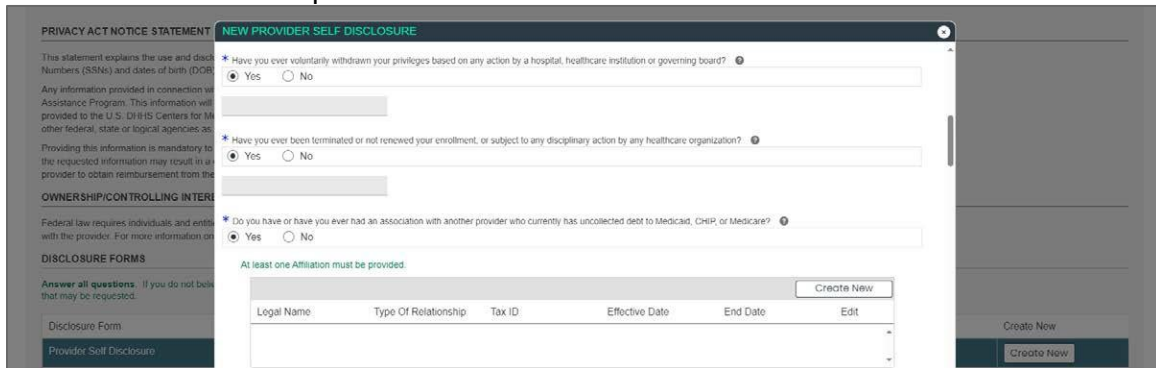
Every enrolling and revalidating provider must complete the self-disclosure form in its entirety. Provider Name, Tax ID, and DOB (for individuals) are populated from the General page.

1. Select Yes / No responses to questions as appropriate.

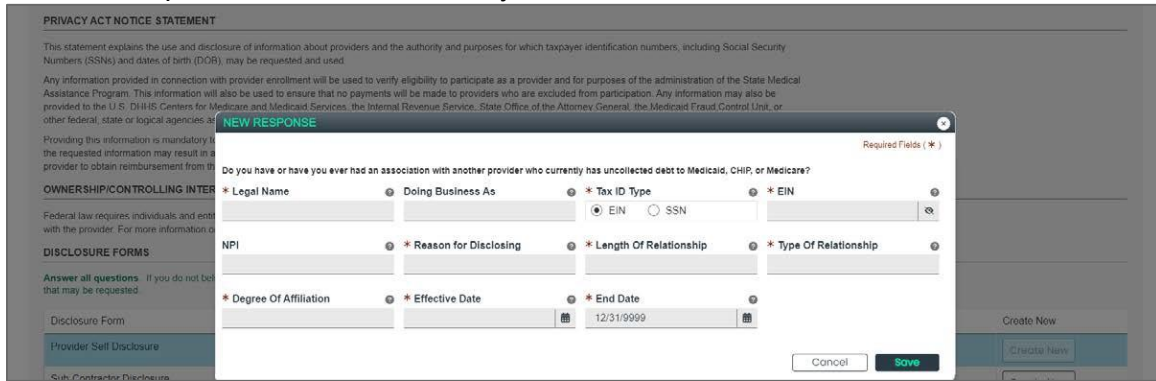
**NOTE:** Additional required fields display when you respond **Yes** to any question. If any question is not applicable, click **No**.



2. For responses that require additional details, enter a value in the text field, or click **Create New** where affiliations are required.



### 3. Enter the required details for each entity and click **Save**.



**NEW RESPONSE**

Do you have or have you ever had an association with another provider who currently has uncollected debt to Medicaid, CHIP, or Medicare?

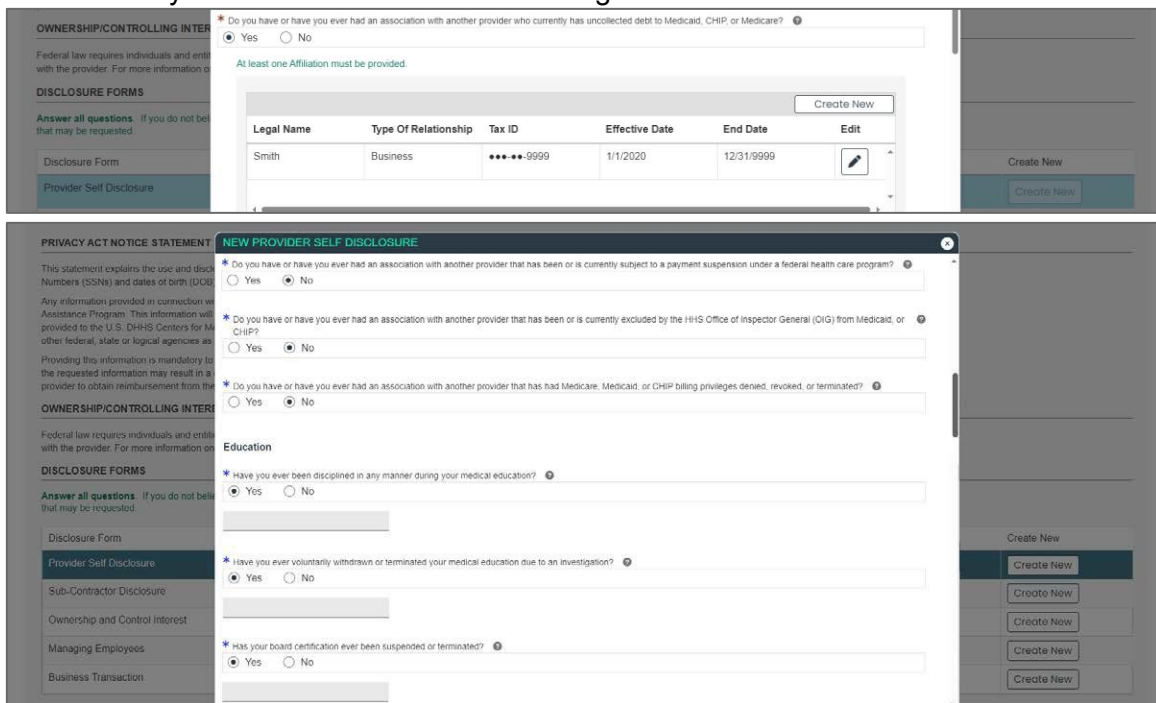
☐ Yes ☒ No

At least one Affiliation must be provided.

Legal Name	Doing Business As	Tax ID Type	EIN	SSN	NPI	Reason for Disclosing	Length Of Relationship	Type Of Relationship	Degree Of Affiliation	Effective Date	End Date
Smith		Business	***-**-9999				1/1/2020			12/31/9999	

**Save**

The summary of the details will be listed in the grid.



**NEW PROVIDER SELF DISCLOSURE**

Do you have or have you ever had an association with another provider who currently has uncollected debt to Medicaid, CHIP, or Medicare?

☐ Yes ☒ No

Do you have or have you ever had an association with another provider that has been or is currently subject to a payment suspension under a federal health care program?

☐ Yes ☒ No

Do you have or have you ever had an association with another provider that has been or is currently excluded by the HHS Office of Inspector General (OIG) from Medicaid, or CHIP?

☐ Yes ☒ No

Do you have or have you ever had an association with another provider that has had Medicare, Medicaid, or CHIP billing privileges denied, revoked, or terminated?

☐ Yes ☒ No

**Education**

Have you ever been disciplined in any manner during your medical education?

☐ Yes ☒ No

Have you ever voluntarily withdrawn or terminated your medical education due to an investigation?

☐ Yes ☒ No

Has your board certification ever been suspended or terminated?

☐ Yes ☒ No

**Create New**

**PRIVACY ACT NOTICE STATEMENT**

This statement explains the use and disclosure of your personal information (SSNs) and dates of birth (DOB). Any information provided in connection with the Assistance Program. This information will be provided to the U.S. DHHS Centers for Medicare & Medicaid Services for all other federal, state or logical agencies as requested.

Providing this information is mandatory to the requested information may result in a provider to obtain reimbursement from the program.

**OWNERSHIP/CONTROLLING INTEREST**

Federal law requires individuals and entities with the provider. For more information on this, please see the Privacy Act Notice.

**DISCLOSURE FORMS**

Answer all questions. If you do not believe that may be requested.

- Disclosure Form
- Provider Self Disclosure**
- Sub-Contractor Disclosure
- Ownership and Control Interest
- Managing Employees
- Business Transaction

**NEW PROVIDER SELF DISCLOSURE**

\* Have you ever chosen to terminate your board certification while under investigation? <sup>?</sup>

☒ Yes ☐ No

**Substance Registration**

\* Has any action ever been taken against your federal or state controlled substance certifications or authorizations? <sup>?</sup>

☒ Yes ☐ No

\* Has any action ever been taken against you during your participation in, or have you been debarred from, any federal or state governmental healthcare program? <sup>?</sup>

☒ Yes ☐ No

**Investigations**

\* Have you ever been the subject of investigation by any healthcare organization or military agency, related to your performance of medical duties, for any action that qualifies as fraudulent activities? <sup>?</sup>

☒ Yes ☐ No

\* Are you aware of any information being reported regarding your performance as a medical practitioner, to any public medical malpractice reporting agency? <sup>?</sup>

☒ Yes ☐ No

Create New

Create New

Create New

Create New

Create New

Create New

**PRIVACY ACT NOTICE STATEMENT**

This statement explains the use and disclosure of your personal information (SSNs) and dates of birth (DOB). Any information provided in connection with the Assistance Program. This information will be provided to the U.S. DHHS Centers for Medicare & Medicaid Services for all other federal, state or logical agencies as requested.

Providing this information is mandatory to the requested information may result in a provider to obtain reimbursement from the program.

**OWNERSHIP/CONTROLLING INTEREST**

Federal law requires individuals and entities with the provider. For more information on this, please see the Privacy Act Notice.

**DISCLOSURE FORMS**

Answer all questions. If you do not believe that may be requested.

- Disclosure Form
- Provider Self Disclosure**
- Sub-Contractor Disclosure
- Ownership and Control Interest
- Managing Employees
- Business Transaction

**NEW PROVIDER SELF DISCLOSURE**

\* Have you ever been under investigation by any state or federal regulatory agencies in the past 10 years? <sup>?</sup>

☒ Yes ☐ No

\* Have you ever been convicted, or are you currently under investigation, for sexual harassment or any other legal misconduct in the past 10 years? <sup>?</sup>

☒ Yes ☐ No

**Liability**

\* Has any action ever been taken against your professional liability coverage based on your history of medical practice? <sup>?</sup>

☒ Yes ☐ No

\* Have you had an adverse professional liability action within the past 10 years? <sup>?</sup>

☒ Yes ☐ No

**Legal History**

\* Have you ever been convicted or plead guilty of a felony or misdemeanor (excluding traffic violations)? <sup>?</sup>

☒ Yes ☐ No

Create New

Create New

Create New

Create New

Create New

Create New

**PRIVACY ACT NOTICE STATEMENT**

This statement explains the use and disclosure of your personal information (SSNs) and dates of birth (DOB). Any information provided in connection with the Assistance Program. This information will be provided to the U.S. DHHS Centers for Medicare & Medicaid Services for all other federal, state or logical agencies as requested.

Providing this information is mandatory to the requested information may result in a provider to obtain reimbursement from the program.

**OWNERSHIP/CONTROLLING INTEREST**

Federal law requires individuals and entities with the provider. For more information on this, please see the Privacy Act Notice.

**DISCLOSURE FORMS**

Answer all questions. If you do not believe that may be requested.

- Disclosure Form
- Provider Self Disclosure**
- Sub-Contractor Disclosure
- Ownership and Control Interest
- Managing Employees
- Business Transaction

**NEW PROVIDER SELF DISCLOSURE**

**Job Performance**

\* Are you currently engaged in the use of illegal drugs or any other chemical substances that would in any way impair your performance? <sup>?</sup>

☒ Yes ☐ No

\* Do you have reason to believe that you pose a risk to the safety of any individual under your medical care, or are you unable to perform the functions of a healthcare practitioner in any way? <sup>?</sup>

☒ Yes ☐ No

**General**

\* Provide the following information for the contact person for audit purposes:

Title <sup>?</sup> \* Last Name <sup>?</sup> Second Last Name <sup>?</sup> \* First Name <sup>?</sup> Middle Name <sup>?</sup>

Suffix <sup>?</sup> \* Address Line 1 <sup>?</sup> Address Line 2 <sup>?</sup>

\* City <sup>?</sup> \* State <sup>?</sup> select a value... \* Country <sup>?</sup> select a value... \* ZIP Code <sup>?</sup>

\* Phone Type <sup>?</sup> select a value... \* Telephone Number <sup>?</sup>

Create New

Create New

Create New

Create New

Create New

Create New

**NEW PROVIDER SELF DISCLOSURE**

\* Provide the address for the physical location of the records to be kept.  
 P.O. Boxes and drop boxes are not acceptable.

\* Address Line 1 \* Address Line 2

\* City \* State \* Country \* ZIP Code

\* Phone Type \* Telephone Number

\* Is the provider part of a provider or entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act? \*  
☒ Yes ☐ No

\* Is the provider out of compliance with the requirement? \*  
☒ Yes ☐ No

Sub-Contractor Disclosure  
 Ownership and Control Interest  
 Managing Employees  
 Business Transaction

Conventions Of Criminal Offense

\* Has the provider been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs?  
☒ Yes ☐ No

\* Offense Description \* Conviction Date \* Jurisdiction

Cancel Save

- Click **Save** when the form is complete. The disclosure form status changes from **New** to **Completed**.

**NOTE:** User cannot advance to the next step until all required disclosures have a Completed status.

**DISCLOSURE FORMS**

Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please provide the additional information that may be requested.

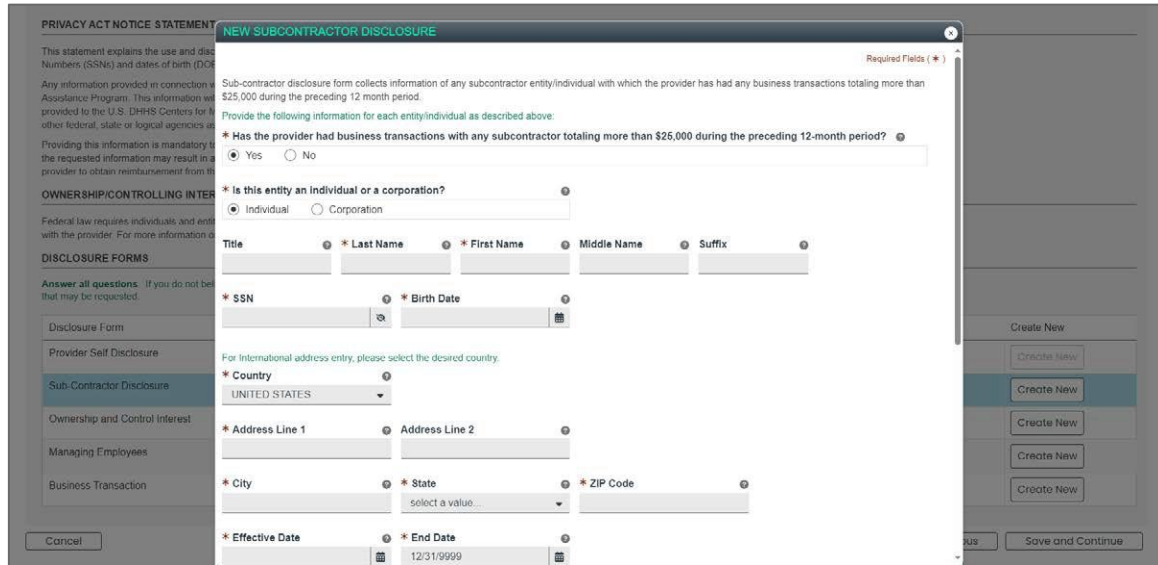
Disclosure Form	Status	Create New
Provider Self Disclosure	Completed	Create New
Sub-Contractor Disclosure	New	Create New
Ownership and Control Interest	New	Create New
Managing Employees	New	Create New
Business Transaction	New	Create New

Cancel Previous Save and Continue

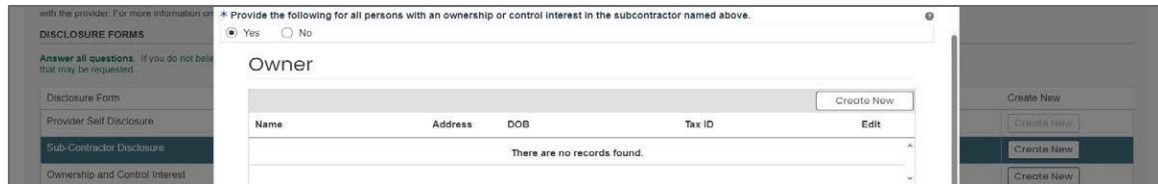
## Sub-Contractor

Sub-contractors may be subject to screening against federal databases depending on configuration.

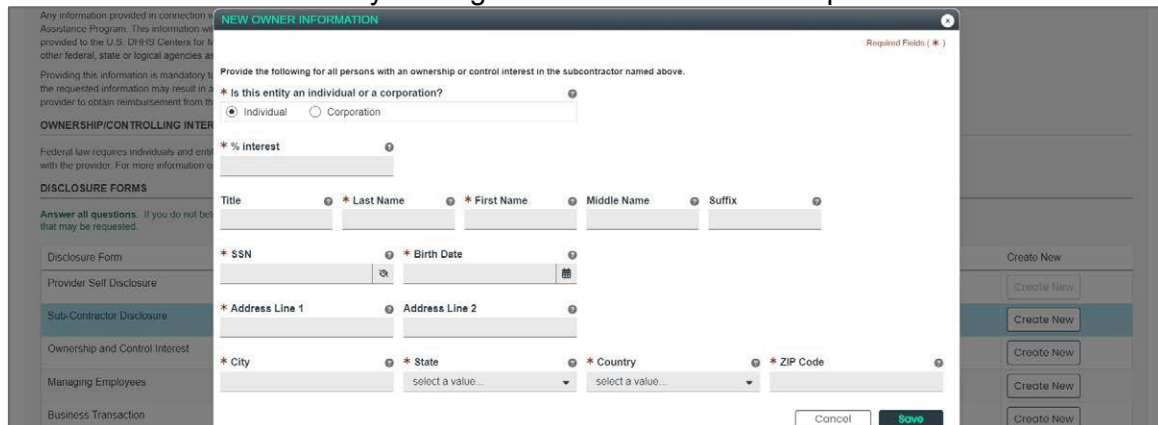
1. Click **Create New** to open the window. When the user answers **No** and clicks **Save**, the status of the form changes to **Completed**. When the user answers **Yes**, the following data is collected:



2. Indicate if there are owners or control interests for the subcontractor named.



3. Name one or more owners by clicking **Create New** in the Owner panel.



The Disclosure Panel summarizes the owner's data as shown in the following example.



The screenshot shows the 'Owner' disclosure panel. On the left is a sidebar with navigation links: 'Disclosure Form', 'Provider Self Disclosure', 'Sub-Contractor Disclosure' (highlighted), 'Ownership and Control Interest', 'Managing Employees', and 'Business Transaction'. The main area is titled 'Owner' and contains a table with columns: Name, Address, DOB, Tax ID, and an 'Edit' button. A 'Create New' button is at the top right. The table has one row for 'Smith, L' with address '3000 Hanover St, Kansas AR, US' and DOB '1/1/1970'. The Tax ID is masked as '\*\*\*-\*\*-5789'. At the bottom are 'Cancel' and 'Save' buttons. On the right side of the panel, there is a vertical stack of 'Create New' buttons for each disclosure type, and a 'Save and Continue' button at the bottom.

Name	Address	DOB	Tax ID	Edit
Smith, L	3000 Hanover St Kansas AR US	1/1/1970	***-**-5789	

- Continue adding records until all owners have been named, then click **Save**.

The status of the Sub-Contractor Disclosure form is now **Completed**.



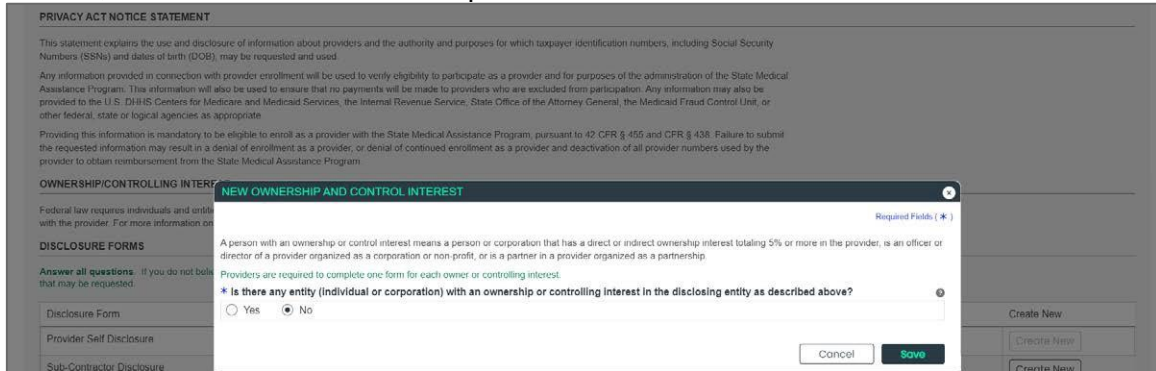
The screenshot shows the 'Disclosure Form' summary panel. It has a table with columns: 'Status' and 'Create New'. The rows represent different disclosure types: 'Provider Self Disclosure' (Completed), 'Sub-Contractor Disclosure' (Completed, highlighted with a red box), 'Ownership and Control Interest' (New), 'Managing Employees' (New), and 'Business Transaction' (New). At the bottom are 'Cancel', 'Previous', and 'Save and Continue' buttons.

Status	Create New
Completed	<a href="#">Create New</a>
Completed	<a href="#">Create New</a>
New	<a href="#">Create New</a>
New	<a href="#">Create New</a>
New	<a href="#">Create New</a>

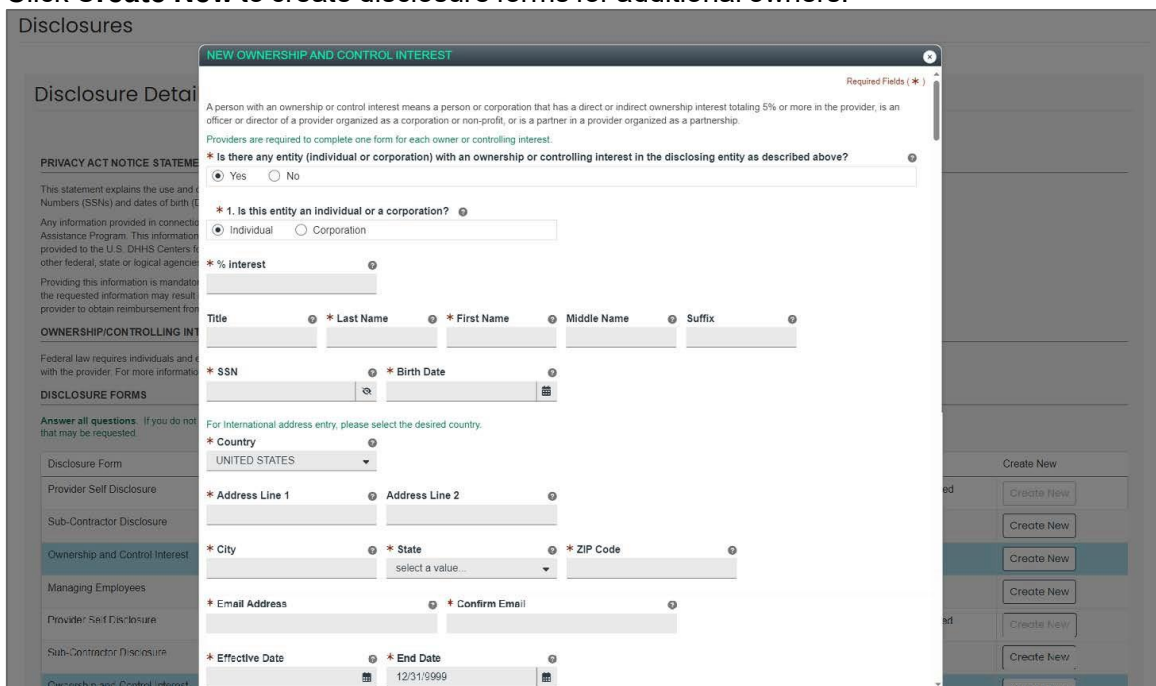


## Ownership and Control Interest

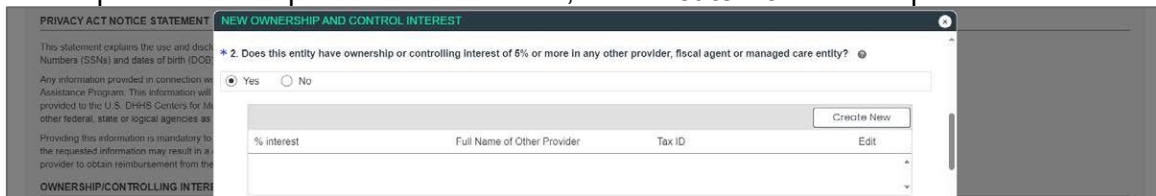
1. Click **Create New** to open the Ownership and Control Interest form. If the response to question 1 is **No**, the form is considered complete.



2. If the provider is an owner or has a controlling interest, click **Yes** and complete the form in its entirety for that entity. The status for the Control and Ownership form displays as **Completed**.
3. Click **Create New** to create disclosure forms for additional owners.

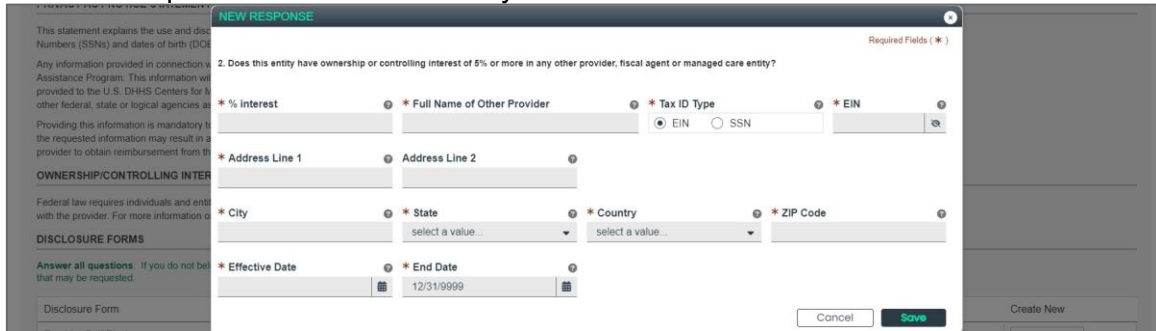


4. For responses that require additional details, click **Create New** for multiple entries.





## 5. Enter the required details for each entity and click **Save**.



**NEW RESPONSE**

2. Does this entity have ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity?

\* % interest  \* Full Name of Other Provider  \* Tax ID Type ☒ EIN ☐ SSN \* EIN

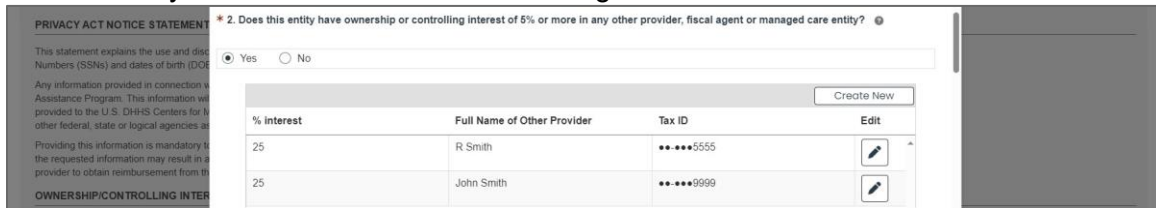
\* Address Line 1  \* Address Line 2

\* City  \* State  select a value... \* Country  select a value... \* ZIP Code

\* Effective Date  \* End Date  12/31/9999

Cancel Save

The summary of the details will be listed in the grid.



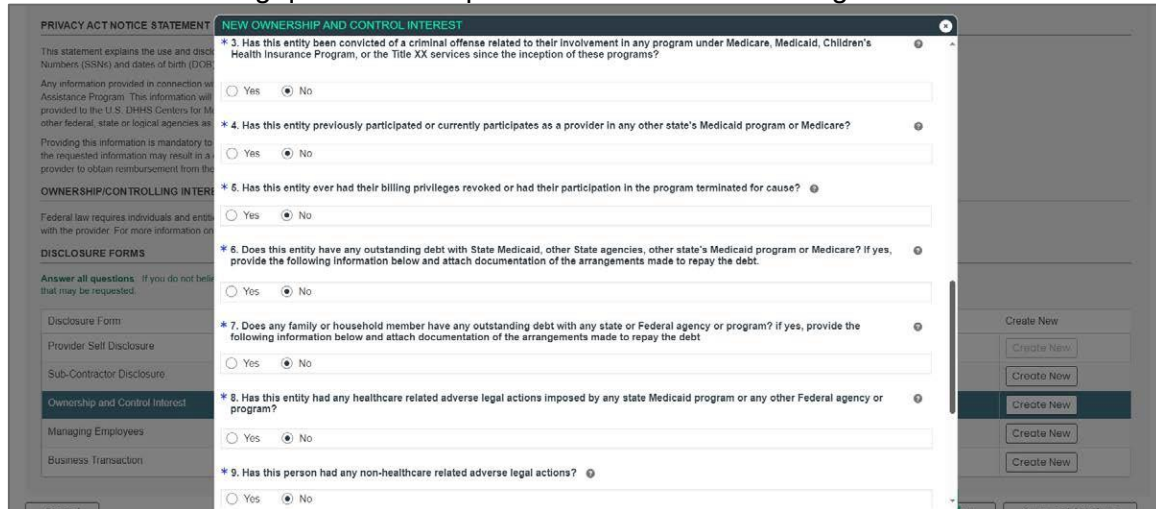
**2. Does this entity have ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity?**

☒ Yes ☐ No

% interest	Full Name of Other Provider	Tax ID	Edit
25	R Smith	***5555	
25	John Smith	***9999	

Create New

## 6. Answer all remaining questions and provide details when selecting **Yes**.



**NEW OWNERSHIP AND CONTROL INTEREST**

3. Has this entity been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, Children's Health Insurance Program, or the Title XX services since the inception of these programs?

☐ Yes ☒ No

4. Has this entity previously participated or currently participates as a provider in any other state's Medicaid program or Medicare?

☐ Yes ☒ No

5. Has this entity ever had their billing privileges revoked or had their participation in the program terminated for cause?

☐ Yes ☒ No

6. Does this entity have any outstanding debt with State Medicaid, other State agencies, other state's Medicaid program or Medicare? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.

☐ Yes ☒ No

7. Does any family or household member have any outstanding debt with any state or Federal agency or program? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.

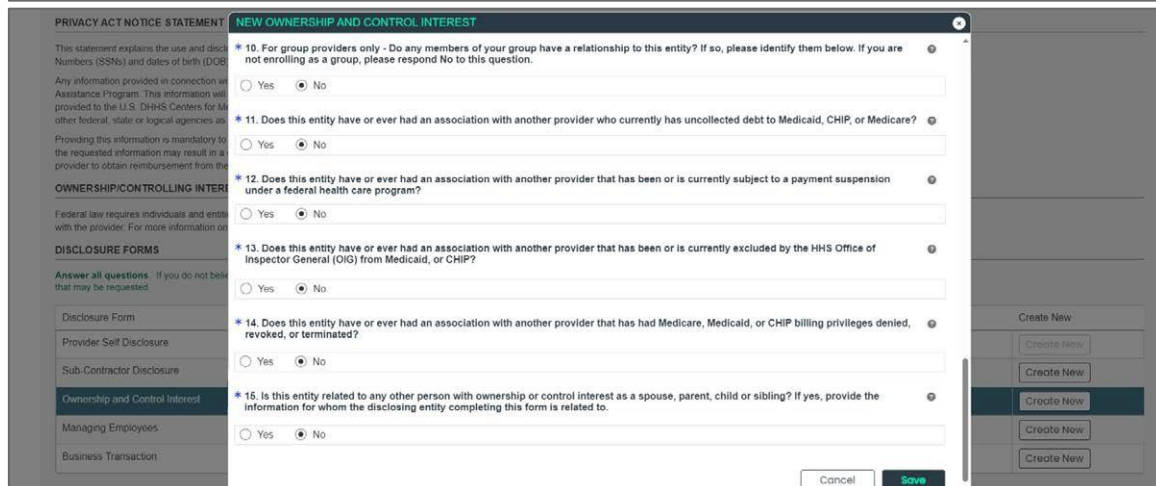
☐ Yes ☒ No

8. Has this entity had any healthcare related adverse legal actions imposed by any state Medicaid program or any other Federal agency or program?

☐ Yes ☒ No

9. Has this person had any non-healthcare related adverse legal actions?

☐ Yes ☒ No



**NEW OWNERSHIP AND CONTROL INTEREST**

10. For group providers only - Do any members of your group have a relationship to this entity? If so, please identify them below. If you are not enrolling as a group, please respond No to this question.

☐ Yes ☒ No

11. Does this entity have or ever had an association with another provider who currently has uncollected debt to Medicaid, CHIP, or Medicare?

☐ Yes ☒ No

12. Does this entity have or ever had an association with another provider that has been or is currently subject to a payment suspension under a federal health care program?

☐ Yes ☒ No

13. Does this entity have or ever had an association with another provider that has been or is currently excluded by the HHS Office of Inspector General (OIG) from Medicaid, or CHIP?

☐ Yes ☒ No

14. Does this entity have or ever had an association with another provider that has had Medicare, Medicaid, or CHIP billing privileges denied, revoked, or terminated?

☐ Yes ☒ No

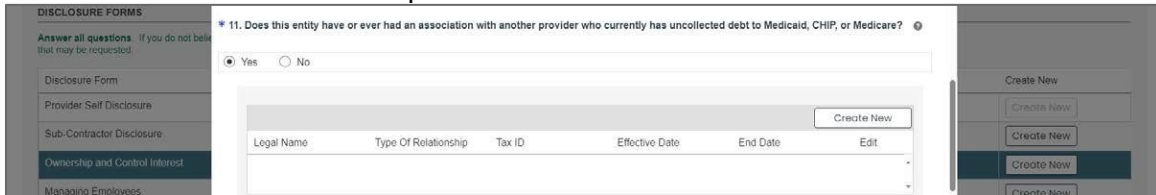
15. Is this entity related to any other person with ownership or control interest as a spouse, parent, child or sibling? If yes, provide the information for whom the disclosing entity completing this form is related to.

☐ Yes ☒ No

Cancel Save

7. Additional information is required for questions where **Yes** is selected, click **Create New**.

At least one Affiliation must be provided.



DISCLOSURE FORMS

Answer all questions. If you do not believe the information is correct, you may be requested to provide additional information.

Disclosure Form

Provider Self Disclosure

Sub-Contractor Disclosure

Ownership and Control Interest

Managing Employees

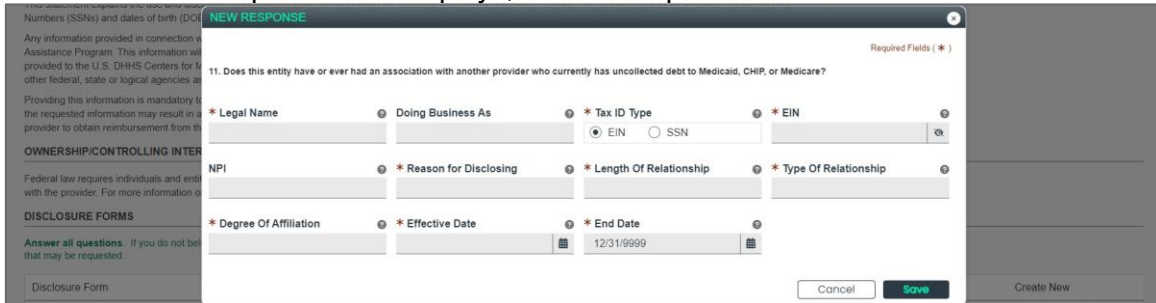
11. Does this entity have or ever had an association with another provider who currently has uncollected debt to Medicaid, CHIP, or Medicare?

☒ Yes ☐ No

Create New

Legal Name	Type Of Relationship	Tax ID	Effective Date	End Date	Edit

8. When the New Response form displays, enter all required fields and click **Save**.



NEW RESPONSE

Required Fields (\*)

11. Does this entity have or ever had an association with another provider who currently has uncollected debt to Medicaid, CHIP, or Medicare?

\* Legal Name

Doing Business As

\* Tax ID Type

☒ EIN ☐ SSN

\* EIN

NPI

\* Reason for Disclosing

\* Length Of Relationship

\* Type Of Relationship

\* Degree Of Affiliation

\* Effective Date

\* End Date

12/31/9999

Cancel Save

A summary of the details displayed in a grid.



OWNERSHIP/CONTROLLING INTEREST

☒ Yes ☐ No

Create New

Legal Name	Type Of Relationship	Tax ID	Effective Date	End Date	Edit
Dr Smith	Business	*****4444	3/1/2024	12/31/9999	

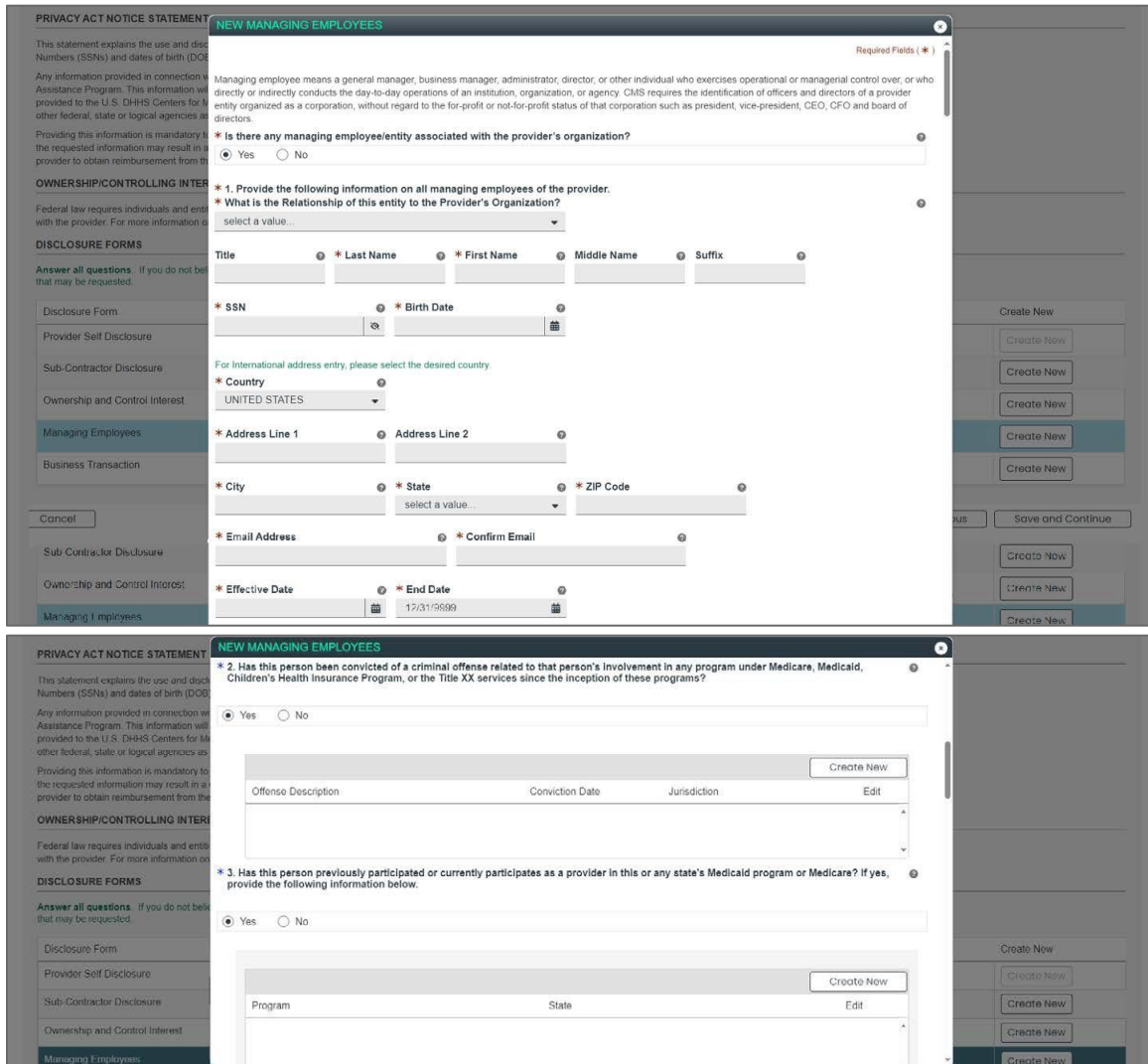
9. When all the responses are complete, click **Save**. The form closes and the status for the Control and Ownership form displays as **Completed**.
10. Click **Create New** and repeat these steps to create disclosure forms for additional owners.

## Managing Employees

The Managing Employee form must be completed for every provider enrolling, except OPR or IG enrollment types.

1. Complete one form for each Managing Employee. To create multiple entries, click **Create New** under all questions except the first.

**NOTE:** Configuration may cause Yes / No answers to display for "1. Provide the following information on all managing employees of the provider."



**NEW MANAGING EMPLOYEES**

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation such as president, vice-president, CEO, CFO and board of directors.

\* Is there any managing employee/entity associated with the provider's organization?

☒ Yes ☐ No

\* 1. Provide the following information on all managing employees of the provider.

\* What is the Relationship of this entity to the Provider's Organization?

select a value...

Title \* Last Name \* First Name \* Middle Name \* Suffix \*

\* SSN \* Birth Date

For International address entry, please select the desired country.

\* Country

UNITED STATES

\* Address Line 1 \* Address Line 2 \*

\* City \* State \* ZIP Code \*

select a value...

\* Email Address \* Confirm Email \*

\* Effective Date \* End Date

12/31/2099

\* 2. Has this person been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program, or the Title XX services since the inception of these programs?

☒ Yes ☐ No

Offense Description	Conviction Date	Jurisdiction	Edit
			Create New

\* 3. Has this person previously participated or currently participates as a provider in this or any state's Medicaid program or Medicare? If yes, provide the following information below.

☒ Yes ☐ No

Program	State	Edit
		Create New

**PRIVACY ACT NOTICE STATEMENT**

This statement explains the use and disclosure of your personal information (SSNs) and dates of birth (DOB).

Any information provided in connection with this program is mandatory to the requested information may result in a provider to obtain reimbursement from the program.

Providing this information is mandatory to the requested information may result in a provider to obtain reimbursement from the program.

Federal law requires individuals and entities with the provider. For more information on this statement, please visit the U.S. DHHS Centers for Medicare & Medicaid Services website.

**OWNERSHIP/CONTROLLING INTEREST**

Federal law requires individuals and entities with the provider. For more information on this statement, please visit the U.S. DHHS Centers for Medicare & Medicaid Services website.

**DISCLOSURE FORMS**

**Answer all questions.** If you do not believe that may be requested.

Disclosure Form

Provider Self Disclosure

Sub-Contractor Disclosure

Ownership and Control Interest

**Managing Employees**

**NEW MANAGING EMPLOYEES**

**\* 4. Has this person ever had their billing privileges revoked or had their participation in the program terminated for cause?**

☒ Yes ☐ No

Program	State	Date of Revocation	Edit
<a href="#">Create New</a>			

**\* 6. Does this person have any outstanding debt with Medicaid, other State agencies, other state's Medicaid program or Medicare? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.**

☒ Yes ☐ No

Program	State	Amount Of Debt	Date	Edit
<a href="#">Create New</a>				

**\* 6. Does any family or household member have any outstanding debt with any State or Federal agency or program? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.**

☒ Yes ☐ No

Name	SSN	DOB	Amount Of Debt	Program	Edit
<a href="#">Create New</a>					

**\* 7. Has this person had any healthcare related adverse legal actions imposed by any state Medicaid program or any other Federal agency or program?**

☒ Yes ☐ No

Program	State	Action Imposed	Date of Action	Edit
<a href="#">Create New</a>				

**\* 8. Has this person had any non-healthcare related adverse legal actions?**

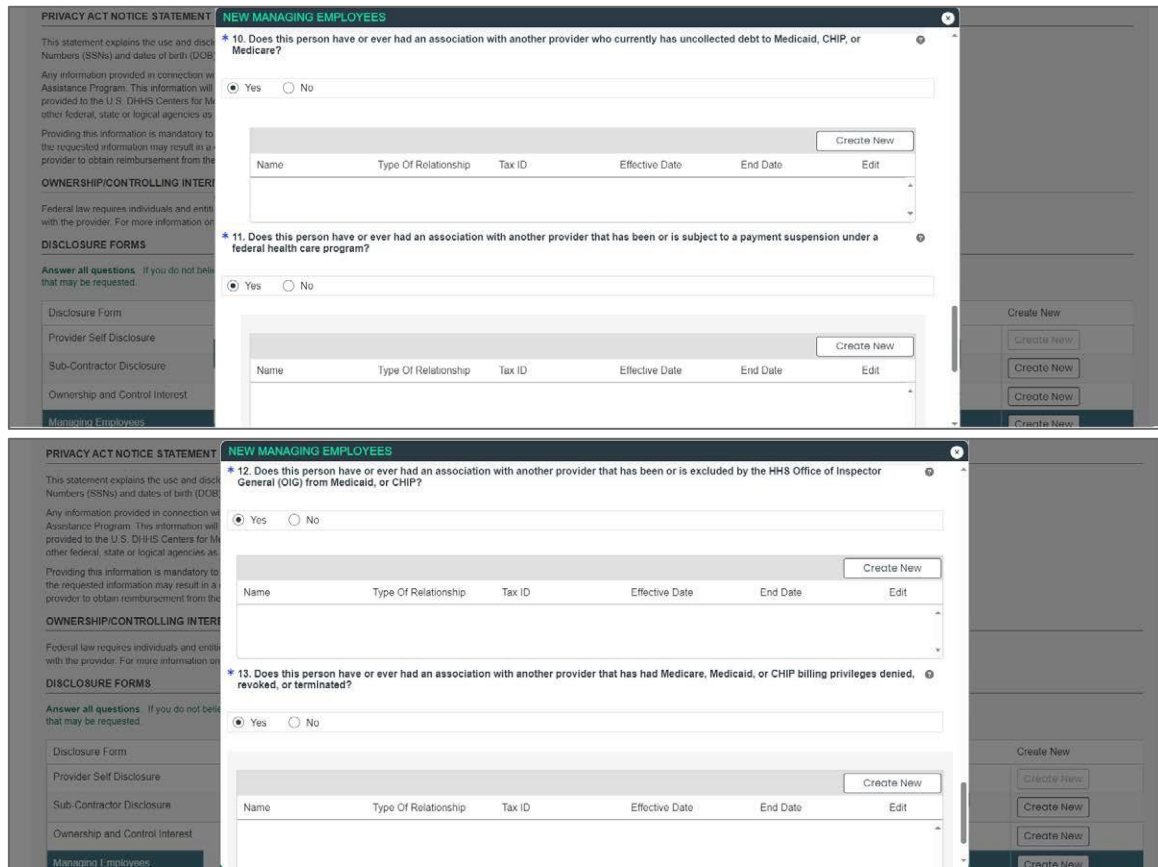
☒ Yes ☐ No

Program	State	Action Imposed	Date of Action	Edit
<a href="#">Create New</a>				

**\* 9. Is this person related to the provider or any other disclosing entity as a spouse, parent, child or sibling?**

☒ Yes ☐ No

Name	Relationship	SSN	Edit
<a href="#">Create New</a>			



**NEW MANAGING EMPLOYEES**

\* 10. Does this person have or ever had an association with another provider who currently has uncollected debt to Medicaid, CHIP, or Medicare?

☒ Yes ☐ No

**Create New**

Name	Type Of Relationship	Tax ID	Effective Date	End Date	Edit

\* 11. Does this person have or ever had an association with another provider that has been or is subject to a payment suspension under a federal health care program?

☒ Yes ☐ No

**Create New**

Name	Type Of Relationship	Tax ID	Effective Date	End Date	Edit

\* 12. Does this person have or ever had an association with another provider that has been or is excluded by the HHS Office of Inspector General (OIG) from Medicaid, or CHIP?

☒ Yes ☐ No

**Create New**

Name	Type Of Relationship	Tax ID	Effective Date	End Date	Edit


\* 13. Does this person have or ever had an association with another provider that has had Medicare, Medicaid, or CHIP billing privileges denied, revoked, or terminated?

☒ Yes ☐ No

**Create New**

Name	Type Of Relationship	Tax ID	Effective Date	End Date	Edit

2. Additional information is required for questions where **Yes** is selected, click **Create New**.



**ADD RESPONSE**

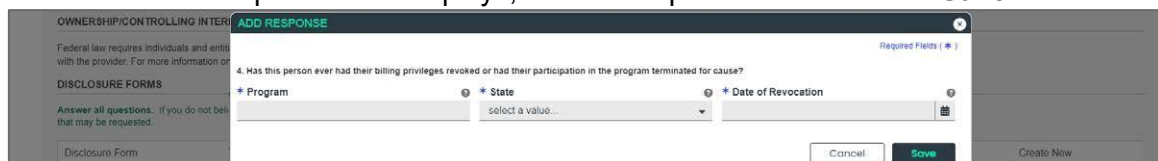
4. Has this person ever had their billing privileges revoked or had their participation in the program terminated for cause?

☒ Yes ☐ No

**Create New**

Program	State	Date of Revocation	Edit

3. When the New Response form displays, enter all required fields and click **Save**.



**ADD RESPONSE**

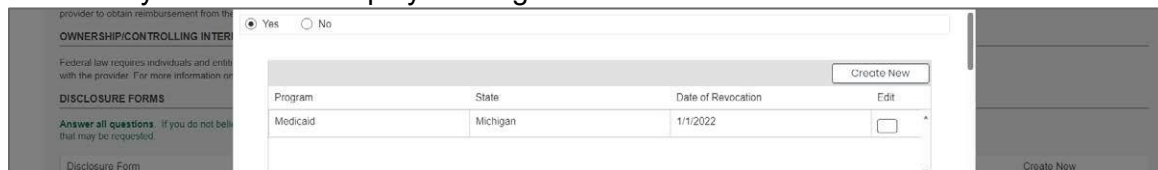
4. Has this person ever had their billing privileges revoked or had their participation in the program terminated for cause?

☒ Yes ☐ No

**Program** **State** **Date of Revocation**

**Save**

A summary of the details displayed in a grid.



**ADD RESPONSE**

4. Has this person ever had their billing privileges revoked or had their participation in the program terminated for cause?

☒ Yes ☐ No

**Create New**

Program	State	Date of Revocation	Edit
Medicaid	Michigan	1/1/2022	

4. When all the responses are complete, click **Save**. The form closes and the status for the Managing Employees form displays as **Completed**.



## New Business Transaction Disclosure

Use the last disclosure form to report significant business transactions. Create one form for each wholly-owned supplier or subcontractor.

**PRIVACY ACT NOTICE STATEMENT**

This statement explains the use and disclosure of your personal information (Social Security Numbers (SSNs) and dates of birth (DOB)) in connection with the Medicare and Medicaid Assistance Program. This information was provided to the U.S. DHHS Centers for Medicare and Medicaid Services (CMS) and other federal, state or local agencies as required by law.

Providing this information is mandatory to the requested information may result in a provider to obtain reimbursement from the Medicare and Medicaid programs.

**OWNERSHIP/CONTROLLING INTEREST**

Federal law requires individuals and entities to disclose ownership and controlling interest with the provider. For more information on this requirement, please visit the CMS website.

**DISCLOSURE FORMS**

Answer all questions. If you do not believe that may be requested.

Disclosure Form

Provider Self Disclosure

Sub-Contractor Disclosure

Ownership and Control Interest

Managing Employees

**Business Transaction**

Cancel

**NEW BUSINESS TRANSACTION**

Business Transaction means any significant business transaction, the provider entity had with any wholly owned supplier or with any subcontractor during the preceding five year period.

Provide the following information for each transaction as described above:

**\* Has the provider entity had any significant business transaction with any wholly owned supplier or with any subcontractor during the preceding five year period?**

☒ Yes ☐ No

**\* Is this entity an individual or a corporation?**

☒ Individual ☐ Corporation

**Title** **\* Last Name** **\* First Name** **Middle Name** **Suffix**

**\* SSN** **\* Birth Date**

**\* Effective Date** **\* End Date**

**\* Address Line 1** **Address Line 2**

**\* City** **\* State** **\* Country** **\* ZIP Code**

**\* Description**

Cancel Save

**VIEW BUSINESS TRANSACTION**

Disclosure Name

Smith, T

Edit

Close

## Background Check

High-risk providers are subject to additional screening checks, including fingerprinting. The Background Check panel displays owners with 5% or greater ownership who may be required to submit prints.

This information is populated from the ownership disclosure forms. If the information is incorrect, return to the Disclosures page, update, and save. Click the check box to see if fingerprints have been submitted within the past five years.

## Background Check – Collect Fingerprint Details

If you are considered a High-Risk Provider and are enrolling, re-enrolling, or revalidating you may be subject to submit fingerprint and criminal background checks.

Background Check

Background Check Details

The Affordable Care Act requires that providers with an ownership of 5% or more and are considered a high category of risk, submit fingerprint and background checks. This page is being displayed based on the provider type/primary specialty you selected earlier in the enrollment process.

If you are assigned to the high-risk category, the information below identifies those individuals required to submit fingerprints. You will receive additional instructions after you submit the application.

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Smith	L	•••••-1111	1/1/1970	<input type="checkbox"/> Check if Yes	Completed	

Cancel

Previous

Save and Continue

According to the ACA Provider Screening Regulations § 455.434, the State Medicaid Agency (SMA):

- As a condition of enrollment, re-enrollment, or revalidation must require providers consent to criminal background checks (including fingerprinting) when required to do so under state law or by the applicable level of screening. (§ 455.434(a))
- Must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste, or abuse to the State Medicaid Program. (§ 455.434(b))
- Upon the SMA determining that a provider, or a person with a 5 percent or more direct or indirect ownership interest in the provider, meets the SMA's criteria for criminal background checks as a “high” risk to the State Medicaid Program, the SMA will require that each such provider or person submit fingerprints. (§ 455.434(b)(1))
- The SMA must require a provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, to submit a set of fingerprints, in a form and manner to be determined by the SMA, within 30 days upon request from CMS or the SMA. (§ 455.434(b)(2))

PROVIDER ENROLLMENT **Background Information**

Step 13: Background Check – Tracking Number : 2901400490 ? STEP 13 OF 17

1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization 6 Associations 7 Credentials 8 Provider Type 9 Other 10 EFT 11 ERA 12 Disclosures 13 **Background Check** 14 Attachments 15 Fees 16 MCO Consent 17 Agreement / Submit


Cancel Previous Save and Continue

### Background Check

#### Background Check Details

The Affordable Care Act requires that providers with an ownership of 5% or more and are considered a high category of risk, submit fingerprint and background checks. This page is being displayed based on the provider type/primary specialty you selected earlier in the enrollment process.

If you are assigned to the high-risk category, the information below identifies those individuals required to submit fingerprints. You will receive additional instructions after you submit the application.

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Smith	L	***-**-1111	1/1/1970	<input type="checkbox"/> Check if Yes	Completed	

Cancel Previous Save and Continue

If you have checked Yes, the Status changes from **Completed** to **Incomplete**. After required fields are completed in the Medicare/Medicaid Fingerprints Submission panel is completed, the Status in the list changes to **Completed**.

Click **Edit** to enter details for fingerprints submission to Medicare/Medicaid.

PROVIDER ENROLLMENT **Background Information**

Step 13: Background Check – Tracking Number : 2901400490 ? STEP 13 OF 17

1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization 6 Associations 7 Credentials 8 Provider Type 9 Other 10 EFT 11 ERA 12 Disclosures 13 **Background Check** 14 Attachments 15 Fees 16 MCO Consent 17 Agreement / Submit


Cancel Previous Save and Continue

### Background Check

#### Background Check Details

The Affordable Care Act requires that providers with an ownership of 5% or more and are considered a high category of risk, submit fingerprint and background checks. This page is being displayed based on the provider type/primary specialty you selected earlier in the enrollment process.

If you are assigned to the high-risk category, the information below identifies those individuals required to submit fingerprints. You will receive additional instructions after you submit the application.

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Smith	L	***-**-1111	1/1/1970	<input type="checkbox"/> Check if Yes	InComplete	

#### MEDICARE/MEDICAID FINGERPRINTS SUBMISSION

Required Fields ( \* )

\* 1. Have you submitted prints to Medicare within the last five years?

☒ Yes ☐ No

\* Submitted Date

\* 2. Have you submitted prints to another state Medicaid agency within the last five years?

☒ Yes ☐ No

\* State

select a value...

\* Submitted Date

Cancel Save

Cancel Previous Save and Continue



Click **Save** to close the window and save submission information.

Background Check

Background Check Details

The Affordable Care Act requires that providers with an ownership of 5% or more and are considered a high category of risk, submit fingerprint and background checks. This page is being displayed based on the provider type/primary specialty you selected earlier in the enrollment process.

If you are assigned to the high-risk category, the information below identifies those individuals required to submit fingerprints. You will receive additional instructions after you submit the application.

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Smith	L	***-**-1111	1/1/1970	<input checked="" type="checkbox"/> Check if Yes	Completed	

Cancel

Previous

Save and Continue

An error displays when answers are **No**.

Background Check

Background Check Details

The Affordable Care Act requires that providers with an ownership of 5% or more and are considered a high category of risk, submit fingerprint and background checks. This page is being displayed based on the provider type/primary specialty you selected earlier in the enrollment process.

If you are assigned to the high-risk category, the information below identifies those individuals required to submit fingerprints. You will receive additional instructions after you submit the application.

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Smith	L	***-**-1111	1/1/1970	<input type="checkbox"/> Yes <input checked="" type="radio"/> No	InComplete	

Cancel

Save

**NOTE:** If an owner is required to submit fingerprints but does not submit fingerprints within 30 calendar days of the fingerprint notification the enrollment application will be denied, and provider must submit a new application.

## Attachments

The Attachments page displays supporting documentation required for your Provider type and specialty. Under Additional Information, instructional text may populate based on the Business Rules defined.

Attachments	
Provider Type Physician	Specialty Family Practitioner

Attachments will be different for a new/re-enrollment, revalidation, provider, specialty, and enrollment type.

## Example of Required Attachments

The example below is required attachments for an enrollment for a Physician.

Provider/Specialty Type	Enrollment Scenario	Required Attachments
Physician (PT 020), Anesthesiologist (PS 057)	IG New Enrollment	PS 057 - No required attachments unless physician is 50 miles from the VA Border
Physician (PT 020), Anesthesiologist (PS 057), and Substance Abuse – Anesthesiology (PS 047)	IG New Enrolment	PS 057 – No required attachments PS 047 – Substance Abuse Certification
Physician (PT 020), Anesthesiologist (PS 057), and Substance Abuse – Anesthesiology (PS 047)	IG Revalidation	No required attachments
Physician (PT 020), Anesthesiologist (PS 057)	Individual New Enrollment	PS 057 <ul style="list-style-type: none"> <li>CV</li> <li>IRS Document/W-9</li> <li>Liability Insurance</li> <li>License</li> <li>Board Certification</li> </ul>
Physician (PT 020), Anesthesiologist (PS 057)	Individual Revalidation	No required attachments

The Attachment Type indicates the expected document type on the Required Attachments panel. The Requirement Met status changes from **NO** to **YES** as the documents are attached in the Attachment Details panel below. The panel is informational only.

### Required Attachments

The list below contains the attachments required for your application.

For each of the Attachment Types listed in the Required Attachments panel, in the Attachment Details section, select **CREATE NEW** to display New Attachment panel.

On the New Attachment panel, select a Transmission Method (e.g. File Transfer) and then select an Attachment Type from the required list. The most common attachment types should be at the top of the list. However, attachment types can be quickly found by typing part of the attachment type name (e.g. fed).

Use **SELECT FILES** to browse and select the corresponding file from your computer. You can also drag and drop the file anywhere within the Upload File box. Note: If you happen to select the wrong file, click the X icon to remove it and then add the correct file. Select **SAVE** to securely attach the file to your application.

After each attachment is added, the Required Attachments Requirement Met status will change to YES. Once all required attachments have changed to YES and all required fields are complete, select **SAVE AND CONTINUE** to save your information and move to the next step of the enrollment process.

Attachment Type	Requirement Met
Federal W-9 Form	Generated on Approval
Liability Insurance Declaration Page	NO
License	NO

### Attachment Details

Create New

Transmission Method	Attachment Type	File Name	Edit
There are no records found.			

Cancel

Previous

Save and Continue

1. Click **Create New** to display the New Attachment panel where you will attach documents.

New Attachment

Transmission Method

File Transfer

Attachment Type

License

Upload File

SELECT FILES...

✓ Done

License example.docx

File(s) uploaded successfully.

Cancel

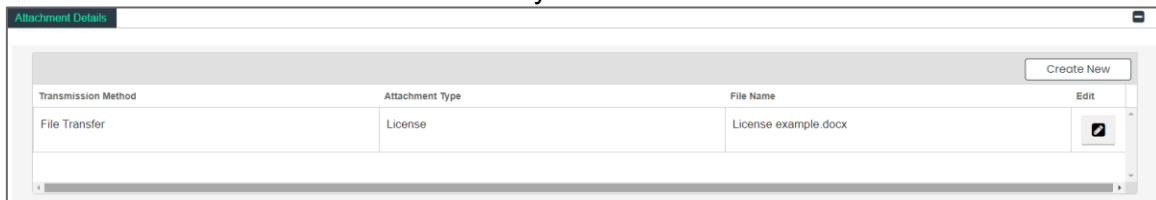
Save

2. Select Electronic Only as Transmission Method to use to attach documents. Available options are based on state-specific configuration and include:
  - **Select Files** button so files can be uploaded and included in the enrollment.
3. Select the Attachment Type to match the required attachment type or additional attachment types.

**Tip!** Use the predictive search option by typing in the search field of the selection list as shown below.



4. Click **SELECT FILES** to select a file from your file locations to attach to the enrollment.



Transmission Method	Attachment Type	File Name
File Transfer	License	License example.docx

As documents are attached, the Requirements Met status changes from **NO** to **YES**. Users cannot save and continue until the status for all attachments is **YES**.

5. Confirm all attachments are legible and complete. Licenses and other credentials must be current.

Attachment Type	Requirement Met
Federal W-9 Form	YES
Liability Insurance Declaration Page	YES
License	YES

6. If a W9 Form is required for enrollment, complete the W9 Verification panel.

---

## XII Additional Information

### Overview

Additional information, such as Application Fees and Participation Agreement acknowledgement, may be applicable during the enrollment process.

### Application Fee

The Affordable Care Act requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidations, and change of ownership, as required, and is assessed in full for each service location enrolled in a State Medical Assistance Program.

**\*Fee effective January 1, 2025\***

Per CMS final rule 6028-F, State Medicaid Agency programs must collect an application fee for new provider applications, revalidation, and reactivations due to being terminated for any reason. The following providers are exempt from the application fee:

- Individual providers or non-physician practitioners.
- Providers who are enrolled with Medicare
- Providers who paid the application fee to either Medicare or another state Medicaid plan after March 25, 2011

Payment can be made online or in the form of a bank-certified check made out to the Department of Medical Assistance Services.

**NOTE:** The application fee is not required for providers who have already paid their fee to Medicare or another state's Medicaid program. CMS may agree to waive the application fee based on proof of financial hardship for a provider.

If an application is received and deemed to require an application fee and one is not attached or payment is not in an acceptable format, the entire application will be returned to the provider requesting proper payment.

### Application Fee Hardship Waiver

Requests for Application Fee Hardship Waivers must be submitted with your enrollment application. It should include the following:

- Explanation on company letterhead of the financial hardship.
- 3 years of tax returns, profit/loss report and/or any documents to validate your reason for hardship.

PRSS will send the request to DMAS who will review and send your request to CMS for review and approval pursuant to Section 1866(j)(2)(C)(ii) of the Social Security Act.

## Application Fee Determination

PRSS collects additional details to determine if an application fee will be required.

### Application Fee Questions

1. Is the service location enrolled in Medicare?
  - a. Select Yes, if you are enrolling with Virginia Medicaid with the same NPI, EIN, Provider and Risk Type, Service Location, and Ownership structure as Medicare.
    - i. Provide the date you were approved with Medicare.
    - ii. This information will be validated through the Provider Enrollment, Chain, and Ownership System (PECOS). If it cannot be validated or is not an exact match the enrollment may be returned and the application fee required.
  - b. Select No if you are not enrolled in Medicare.
2. Have you paid an application fee to another state's Medicaid program for the service location?
  - a. Select Yes, if you have paid an application fee to another SMA for the same Service Location as indicated on your Virginia Medicaid Enrollment application.
    - i. Enter the State and date paid.
    - ii. Also, attach a copy of the application fee receipt from the other SMA. If this information is not submitted the enrollment application will be returned and you will be required to pay the application fee.
  - b. Select No if you are not enrolled in Medicare.
3. Have you received a waiver of the application fee from Medicare or another SMA program because of a financial hardship?
  - a. Select Yes if you have received a waiver of the application fee.
    - i. Attach a copy of the application fee waiver from Medicare or SMA. If this information is not submitted the enrollment application will be returned and you will be required to pay the application fee.
  - b. Select No if you have not received a waiver of the application fee.
4. Are you requesting a hardship waiver of the application fee from Virginia Medicaid because of a financial hardship?
  - a. Select Yes if you are requesting a waiver of the application fee.
    - i. Attach a copy of the request and include the following:
      1. Past 3 years of tax returns, profit/loss report and/or any documents to validate your reason for hardship.
      2. Past 3 months of banking statements.
      3. If this information is not submitted the enrollment application will be returned and you will be required to pay the application fee.
  - b. Select No if you are not requesting a waiver of the application fee.



If applicable, fee details which include the total amount due to be paid by the provider will display on the lower right side of the application fee panel.

1. Is the service location enrolled in Medicare? ?  
☐ Yes ☒ No

If the service location has paid an application fee to another Medicaid program then a fee payment is not required.

2. Have you paid an application fee to another state's Medicaid program for the service location? ?  
☐ Yes ☒ No

If you have received a waiver from the programs mentioned below a fee payment is not required.

3. Have you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship? ?  
☐ Yes ☒ No

If you are requesting a waiver for financial hardship, please submit a letter explaining the financial hardship along with your enrollment application, include 3 years of tax returns, profit/loss report and/or any documents to validate your reason for hardship.

4. Are you requesting a waiver of the application fee because of financial hardship? ?  
☐ Yes ☒ No

Enrollment Application Fee \$730.00

Total Amount Due \$730.00

Click Make Payment button to pay now with credit card or Save and Continue to send check payment. After credit card payment is complete, click Save and Continue to complete application. If you have elected to pay by check, follow the instructions on the Application Fee Form to submit payment.

\* Payment Mode ?  
☐ Online ☐ Check

## Fee Payment Processing

Select your method of payment.

1. Online Credit Card payment– User will be directed to an external Commonwealth of Virginia payment processor. PRSS will be notified of payment approved.
  - a. URL opens in a new window.
  - b. Enter Provider and payment information.
  - c. When complete, you will be directed to close the window and navigate back to your enrollment application.
2. Pay by Check - When your enrollment application is submitted you will have the option to download an Application Fee Form.
  - a. Your enrollment application will pend until the Check has been cleared.

## XIII Agree/Submit

### Overview

The last step before submitting the application requires that users accept the terms and conditions in the Provider Agreement. Legal Name, Contact Name, Contact Email, Tax ID, and Tax ID Number are populated from the General page. Service Location information is populated from the Service Location page. If any information is incorrect, return to those pages and update information.

**NOTE:** Individual Within a Group enrollment do not include a service location address, so the Service Location will be blank.

The Terms of Agreement may contain a hyperlink that enables providers to specify special provisions for the Provider Type selected during enrollment.

### Agreement/Submit

Required Fields (\*)

The terms of the enrollment are stated below. You must accept these terms in order to submit the enrollment application for approval. Failure to accept these terms means that no enrollment application is retained or submitted.

Access the links above to review all data that has been entered into the application. Changes can be made, except for enrollment type, by navigating back to the appropriate screen using the links in the table of contents. If the enrollment type selected is incorrect, do not submit the application. You must complete a new application for the appropriate provider type.

Once the application is confirmed and submitted, a cover sheet can be printed for submission with any hard copy materials sent to the enrollment office.

If you are interested in contracting with one of our Managed Care Organizations, please click on the appropriate link below. You will be redirected to the plan's website in another browser window. Please return to this page, complete the electronic signature process and submit your application.

820\_MCE125A - <http://www.service.com/>

#### Terms of Agreement

Legal Business Name Group Inc	Contact Name J Smith	Contact Email @gainwelltechnologies.com
NPI 3297577322	Tax ID Type EIN	Tax ID Number 6789
Service Location 3000 Hanover St Palo Alto CA, 943041112		

The above provider agrees to participate in the Medicaid Program, hereinafter referred to as the Title XIX Program.

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the State Medical Assistance Program.

I understand that I should be enrolled as a provider of services under the State Medical Assistance Program, that it is my responsibility to notify the State Medical Assistance Program fiscal agent of any change to the information on this application including but not limited to address, group affiliation, change of ownership, or tax identification number.

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

Proceed


Cancel

Previous

Finish Later



1. Click **Proceed** to continue with the agreement.



**COMMONWEALTH of VIRGINIA**  
Department of Medical Assistance Services  
Provider Enrollment Services

The provider agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid, in accordance with the terms below.

1. The provider is authorized to practice under the laws of the state in which they are licensed and is not, as a matter of state or federal law, disqualified from participating in the Program.

2. Click the Print icon to display and print the Provider Agreement.
3. Check **I Accept** below the agreement to continue with submission.
4. If Portal Registration Details display, enter information from the Provider/Enroller required for the registration process. This provides access to information on the External Portal.

Portal Registration Details

\* First Name

isa

\* Last Name

w

\* Second Last Name

\* Email Address

@gainwelltechnologies.com

\* Confirm Email

@gainwelltechnologies.com

\* Preferred Language

English

\* Mobile Phone Number

555-555-5555

5. Check **I Accept** in the Signature panel, then enter name details and the email address to use for verification.

Signature

The Provider Agreement is now fully electronic. By selecting the "I Accept" box below you acknowledge that you understand your electronic signature binding to the same extent as your written signature.

☒ I Accept

Title

\* Last Name

Second Last Name

\* First Name

Middle Name

Suffix

W

Lisa

Mary

Comments

Submit Enrollment.

Click on "Request Verification Code" button. An email will be sent to the registered email address. Check your email and enter the code immediately before you leave the application or Submit page. The verification code will expire when the page is closed.

**DO NOT NAVIGATE AWAY FROM PAGE**

Once you receive the code in the email, please enter the verification code and click Submit.

Request Verification Code

Verification Code

Submission Date

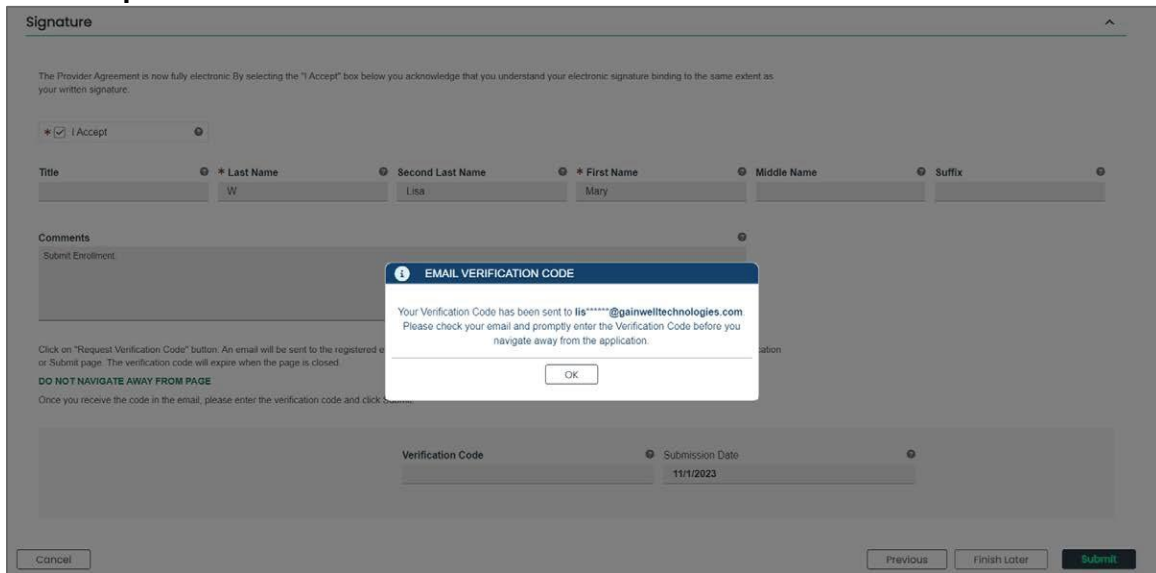
11/1/2023

Cancel

Previous

Finish Later

## 6. Click **Request Verification Code**.



The Signature page shows a form for provider enrollment. A pop-up window titled "EMAIL VERIFICATION CODE" is displayed in the center. The pop-up contains the following text:

**EMAIL VERIFICATION CODE**

Your Verification Code has been sent to lis\*\*\*\*\*@gainwelltechnologies.com. Please check your email and promptly enter the Verification Code before you navigate away from the application.

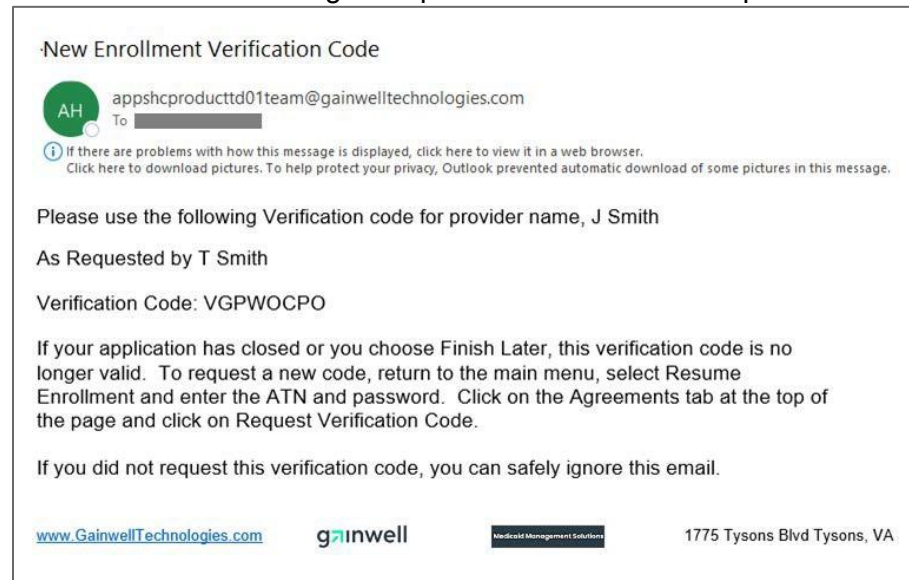
OK

The background form includes fields for Title, Last Name (W), Second Last Name (Lisa), First Name (Mary), Middle Name, and Suffix. There is also a "Comments" section with a "Submit Enrollment" button. At the bottom, there are fields for "Verification Code" and "Submission Date" (11/1/2023), along with "Cancel", "Previous", "Finish Later", and "Submit" buttons.

**IMPORTANT:** The code is emailed to the address provided. **Do not** close the application or navigate back through the application until the code is entered.

## Verification Code Email

An email like the following example is sent to the address provided.



**New Enrollment Verification Code**

appshcproducttd01team@gainwelltechnologies.com  
To: [Redacted]

If there are problems with how this message is displayed, click here to view it in a web browser.  
Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

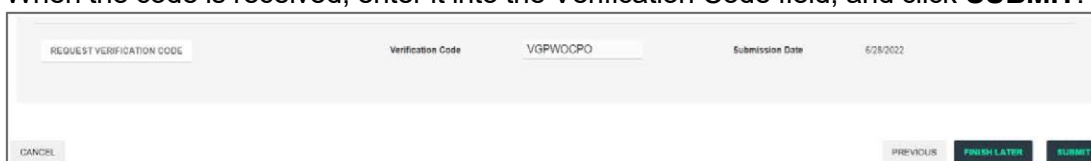
Please use the following Verification code for provider name, J Smith  
As Requested by T Smith  
Verification Code: VGPWOCPO

If your application has closed or you choose Finish Later, this verification code is no longer valid. To request a new code, return to the main menu, select Resume Enrollment and enter the ATN and password. Click on the Agreements tab at the top of the page and click on Request Verification Code.

If you did not request this verification code, you can safely ignore this email.


[www.GainwellTechnologies.com](http://www.GainwellTechnologies.com) gainwell Medisafe Management Solutions 1775 Tysons Blvd Tysons, VA

## 1. When the code is received, enter it into the Verification Code field, and click **SUBMIT**.



The Signature page shows the "Verification Code" field filled with "VGPWOCPO". The "Submission Date" is "6/28/2022". The "REQUEST VERIFICATION CODE" button is disabled. The "Cancel", "Previous", "Finish Later", and "Submit" buttons are visible at the bottom.

**NOTE:** If you click **SAVE**, the system re-checks the validations on various pages and displays error messages if anything is missing. After submission, applications cannot be viewed or modified until the provider enrollment returns the application.


**ALERT CONFIRMATION**

Do you want to submit this application?

NO

YES

2. Click **YES** to submit.

Signature

The Provider Agreement is now fully electronic. By selecting the "I Accept" box below you acknowledge that you understand your electronic signature binding to the same extent as your written signature.

☒ I Accept

Title

\* Last Name

\* First Name

Middle Name

Suffix

LTEST

FTEST

Comments

Processing The application is being validated. This may take several seconds.

Click on "Request Verification Code" button. An email will be sent to the registered email address. Check your email and enter the code immediately before you leave the application or Submit page. The verification code will expire when the page is closed.

**DO NOT NAVIGATE AWAY FROM PAGE**

Once you receive the code in the email, please enter the verification code and click Submit.

Verification Code

Submission Date

ISMT28PU

12/24/2024

Cancel

Previous

Finish Later

Submit

## Enrollment Submission Notification

When the application is submitted, a confirmation message is generated like the following example.

Submit Confirmation

Congratulations! You have successfully submitted your provider enrollment application. Please reference the tracking number below for all inquiries related to this application.

Tracking Number: 3873168831

[Coveredlink](#)

Sincerely,  
State Medical Assistance Program  
apps@pcproduct.com  
Contact us: 1-800-999-9999

Print Preview



### Example of Email notifications that are generated.

Congratulations! You have successfully completed your provider enrollment application with the State Medical Assistance Program. Below is your tracking number that has been associated with your enrollment application.

Tracking Number: 3873188831

Password: \*\*\*\*\*

Download the coversheet and remit it with the following, as appropriate:

- Required documentation that you indicated would be submitted by mail
- The application fee, if one is owed. Payment must be made by bank-certified check or money order, payable to State Medicaid.

<https://tenant1foraks.test.mapshc.com/ProviderEnrollment/EnrollmentStatus/>

We cannot process your application until all documentation and fee payment (if required) has been received.

Our mailing address is:

Provider Enrollment  
P.O. Box 9999  
Anywhere, ZZ 99999

State Medical Assistance Program  
Provider Enrollment  
[appshcproducttd01team@gainwelltechnologies.com](mailto:appshcproducttd01team@gainwelltechnologies.com)  
Contact us: 1-888-555-1212

<http://www.GainwellTechnologies.com>

**gainwell**

Medicaid Management Solutions

1775 Tysons Blvd Tysons, VA

## XIV Other PRSS Features

PROVIDER ENROLLMENT
Enrollment Status

Enrollment Status

Please enter your Tracking Number and Password that was used on the Provider Enrollment application to verify the current status.  
If you have questions or concerns, please reach out to the Gainwell Technologies Customer Service Account Team: [agoshcux@gainwelltechnologies.com](mailto:agoshcux@gainwelltechnologies.com)

\* Tracking Number

\* Password

[Forgot Password?](#)

CANCEL
SUBMIT

**NOTE:** Click the Coversheet link (shown in the following example) and print it to accompany any attachments or other documentation required to complete your enrollment. The Coversheet contains the ATN that makes it faster to match the documents to the application.

PROVIDER ENROLLMENT
Enrollment Status

Enrollment Status

This is your current Enrollment Application Status. If you have any questions or concerns, please contact Customer Service.  
Gainwell Technologies Customer Service Account Team: [agoshcux@gainwelltechnologies.com](mailto:agoshcux@gainwelltechnologies.com)

Tracking Number  
4968500998

Application Type  
New Enrollment

Status  
Partial

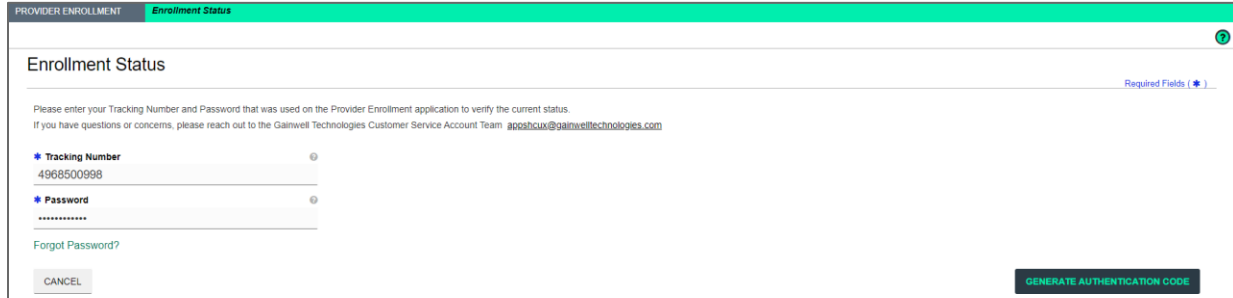
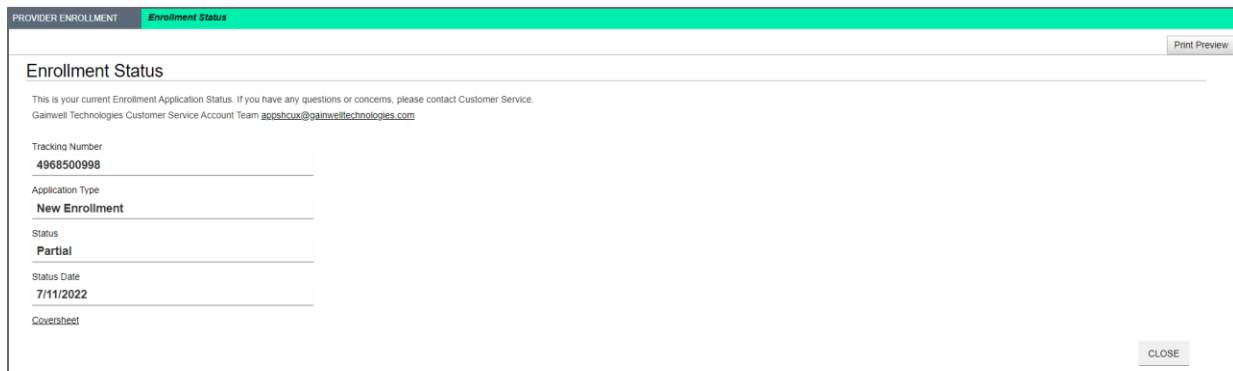
Status Date  
7/8/2022

[Coversheet](#)

Print Preview
CLOSE

## Enrollment Status

This feature enables applicants to check the status of an application. Enter the ATN and self-selected password to access the application. You may be required to enter an authentication code based on configuration.

## Status Descriptions

Status	Description
Partial	Application has not yet been submitted.
Started	Re-enrollment application has been generated. (A pre-populated re-enrollment application has been requested by the provider and has been created.)
Awaiting Attachments	Application was submitted but is waiting for required attachments/documents. Submit the required documents within the time limit indicated in the notification so the application can proceed to screening.
Submitted	The application has been submitted and sent to the screening service.
Pending	Application has been processed by the screening service and has been queued for the enrollment team for review.
RTP (Returned to Provider)	Application requires corrections. (You receive a separate notification identifying the specific issues requiring attention.)

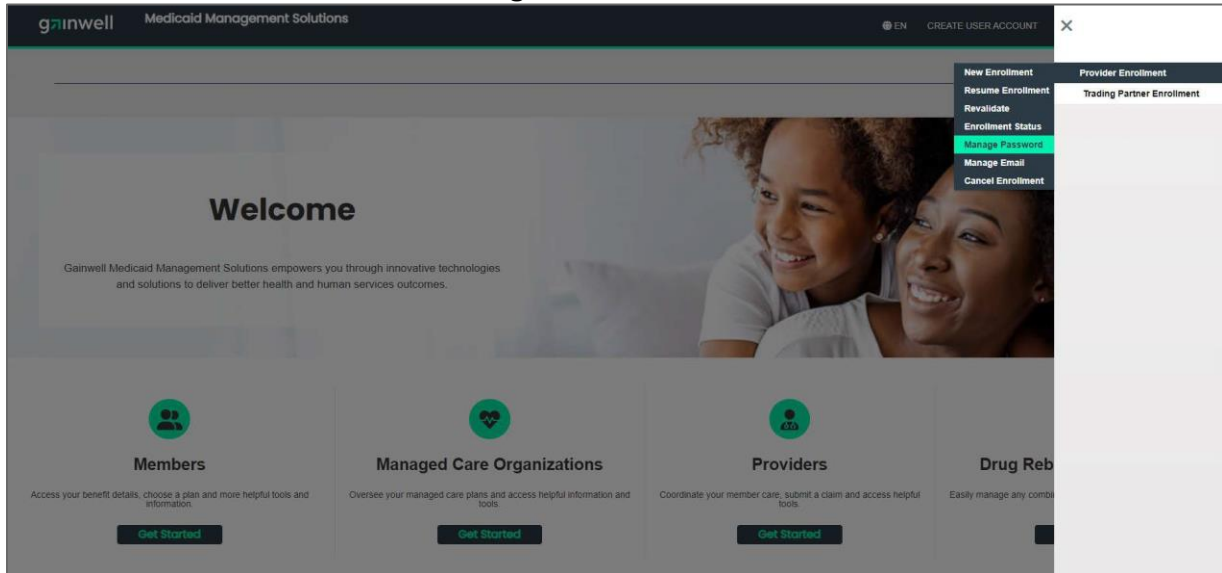


Status	Description
Approved	Application was approved. (You receive written confirmation that the application has been approved. For newly-enrolling Providers, the Welcome Packet includes the Provider number and other program participation information.)
Rejected	Application was denied. (You are sent a notification identifying the reasons the state declined your application.) The application may also be rejected if there is no response to the RTP request within the time allowed.
Expired	Application was not submitted within the allowable time.
Submitted to Managed Care	Application has been forwarded to MCOs for contracting. (This status is used for post-enrollment requests to participate with additional managed care organizations only and available if configured.)
Requested	Application has been requested.

## Managing/Changing Your Password

This feature enables applicants to change the password of an application that has not yet been submitted. Enter the ATN and self-selected password to access the application. If configured, an authentication code popup displays and a corresponding email is sent to the provider with the Authentication code. If the correct Authentication code is entered, the password will be changed.

1. Click **Provider Enrollment**, then **Manage Password** on the menu.



2. Enter the Application Tracking Number, existing password, and a new password.

### Change Password

Please enter your Tracking Number and Password that was used on the Provider Enrollment application to verify the current status.  
If you have questions or concerns, please reach out to the Gainwell Technologies Customer Service Account Team: [apoc@tcu@gainwelltechnologies.com](mailto:apoc@tcu@gainwelltechnologies.com)

Required Fields ( )

- Tracking Number
- Enter your existing Password
- New Password
- Confirm New Password

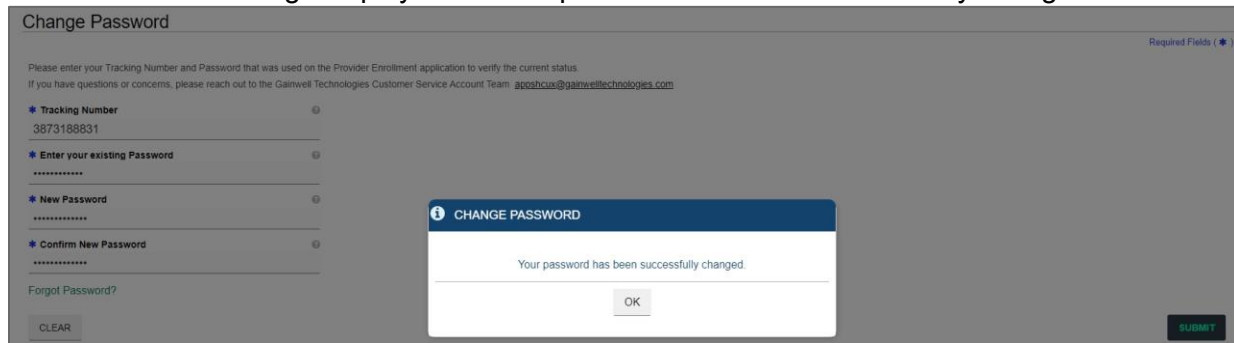
[Forgot Password?](#)

[CLEAR](#) [SUBMIT](#)

**NOTE:** Passwords must be between 8 and 20 characters and include one number, one upper-case letter, and one special character.



A confirmation message displays when the password has been successfully changed.

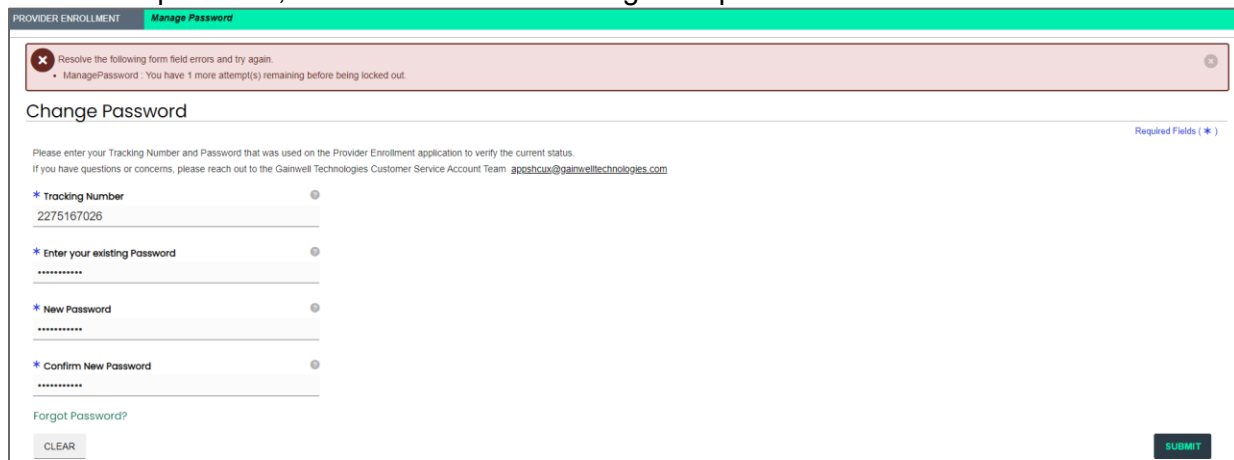


The screenshot shows the 'Change Password' form with the following fields: Tracking Number (3873188831), Enter your existing Password, New Password, and Confirm New Password. A confirmation message box in the center states: 'CHANGE PASSWORD' and 'Your password has been successfully changed.' with an 'OK' button. A 'SUBMIT' button is visible at the bottom right.

## Manage Password - Incorrect Attempts Limit

Users are allowed a limited number of attempts to change a password. If invalid information is entered for any of the required fields (ATN, Password, New Password, Confirm New Password) the user is presented with a message indicating the number of attempts remaining.

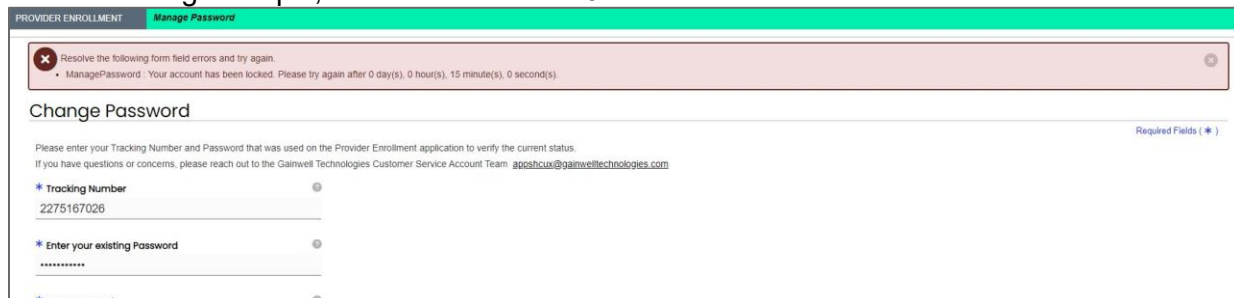
In the example below, the user has one remaining attempt.



The screenshot shows the 'Change Password' form with a warning message at the top: 'Resolve the following form field errors and try again.' and 'ManagePassword: You have 1 more attempt(s) remaining before being locked out.' The form fields are: Tracking Number (2275167026), Enter your existing Password, New Password, and Confirm New Password. A 'SUBMIT' button is visible at the bottom right.

After the number of invalid attempts is reached, the user's account is locked for a configured period. After the lockout time has elapsed, the user can try again.

In the following example, the user must wait 15 minutes for the account to be unlocked.



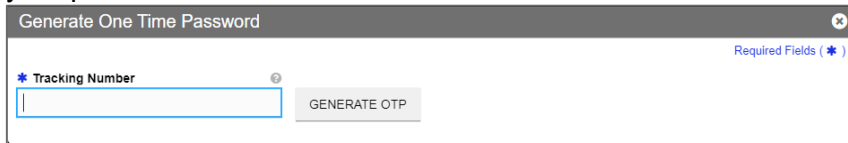
The screenshot shows the 'Change Password' form with a warning message at the top: 'Resolve the following form field errors and try again.' and 'ManagePassword: Your account has been locked. Please try again after 0 day(s), 0 hour(s), 15 minute(s), 0 second(s).' The form fields are: Tracking Number (2275167026), Enter your existing Password, and New Password. A 'SUBMIT' button is visible at the bottom right.

## Resetting Your Password

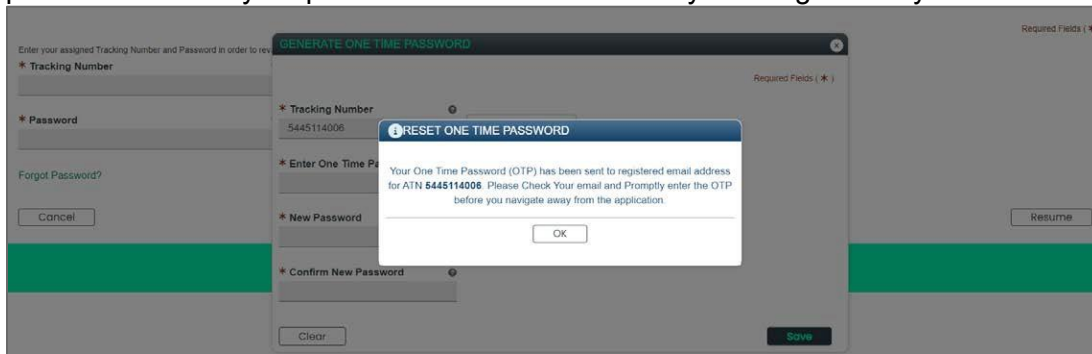
- From the Resume Enrollment or Revalidate Enrollment page, click **Forgot Password?**

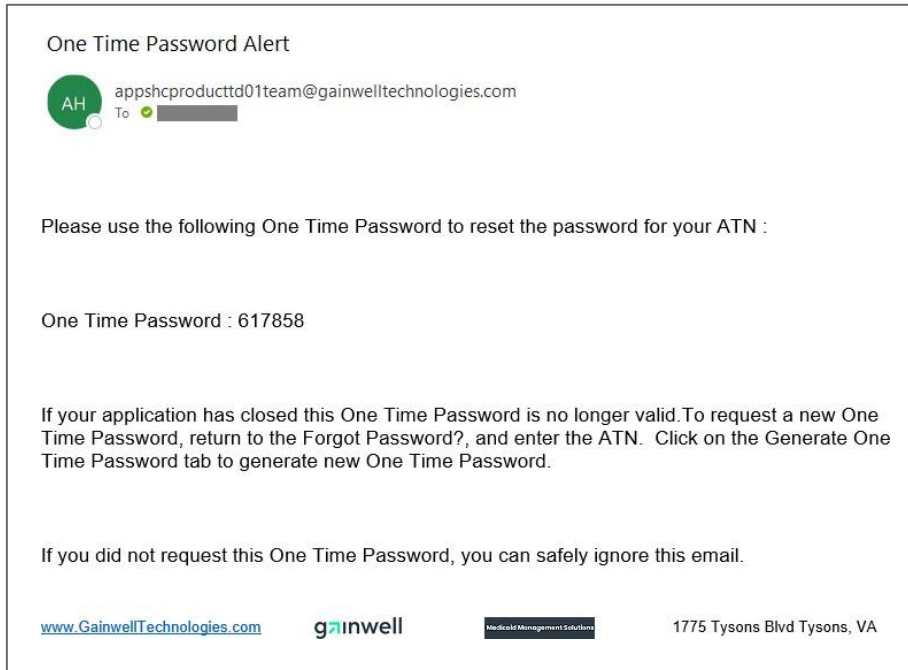



- A popup window prompts you to enter your Application Tracking Number (ATN). Enter your ATN and click **GENERATE OTP** to generate a one-time password that can be used to reset your password.

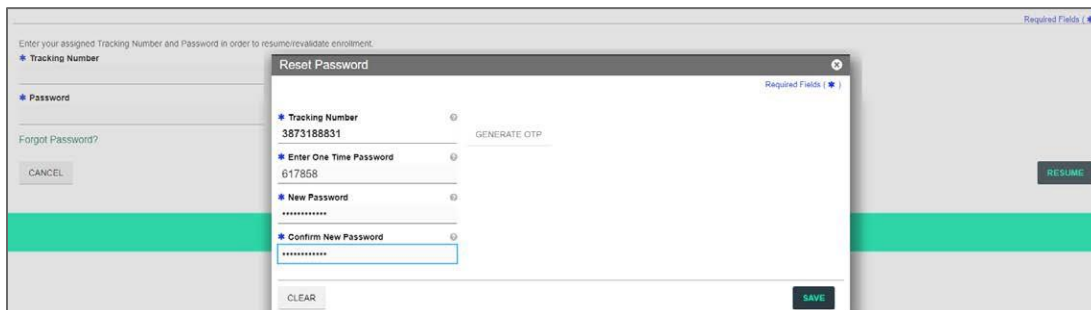


- A message with the one-time password (OTP) is sent to the email address on file. Use this password to reset your password for this ATN before you navigate away from this screen.





4. Enter the OTP provided in the message in Enter One Time Password, then enter and confirm a New Password and click **SAVE**.



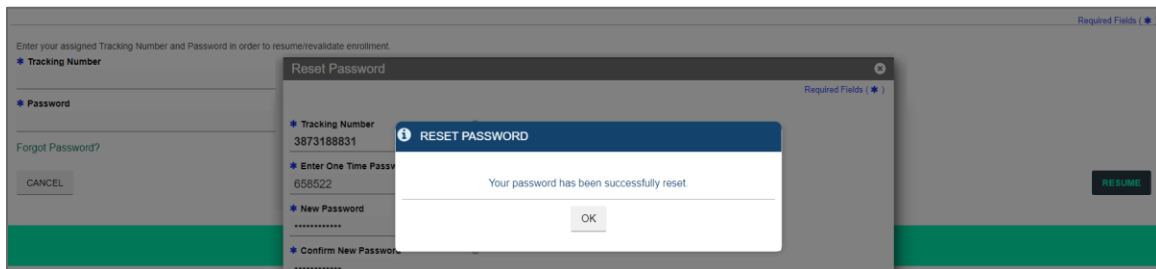
The screenshot shows a 'Reset Password' dialog box with the following fields:

- Tracking Number: 3873188831
- Enter One Time Password: 617858
- New Password: (masked with dots)
- Confirm New Password: (masked with dots)

Buttons: GENERATE OTP, RESUME, CLEAR, SAVE.

**NOTE:** Passwords must be between 8 and 20 characters and include one number, one upper-case letter, and one special character.

5. A message that the Password was successfully reset is received. Use the New Password to resume the enrollment.



The screenshot shows the 'Reset Password' dialog box with a success message overlay:

**RESET PASSWORD**

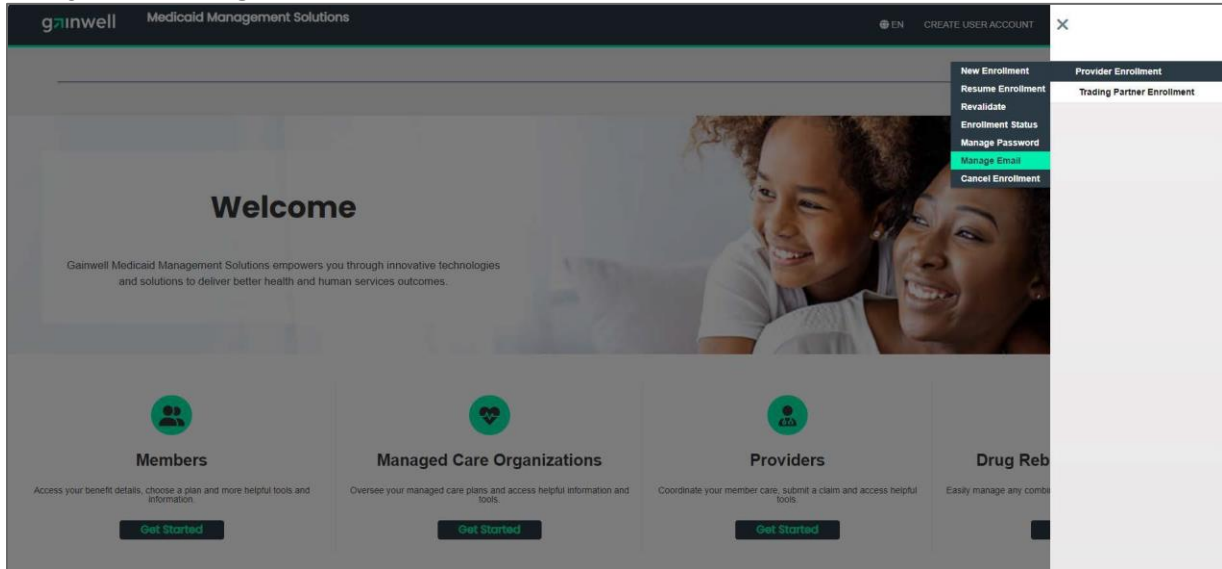
Your password has been successfully reset.

OK

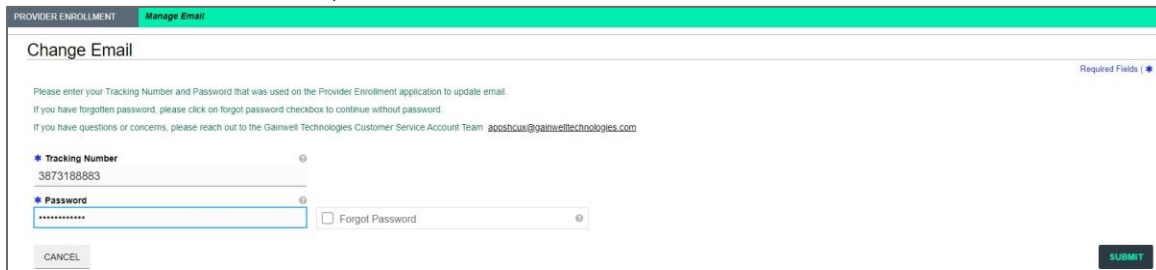
## Manage Email

This functionality allows users to change the application registration email address.

1. Navigate to **Manage Email**.



2. Enter ATN and Password, then click **SUBMIT**.



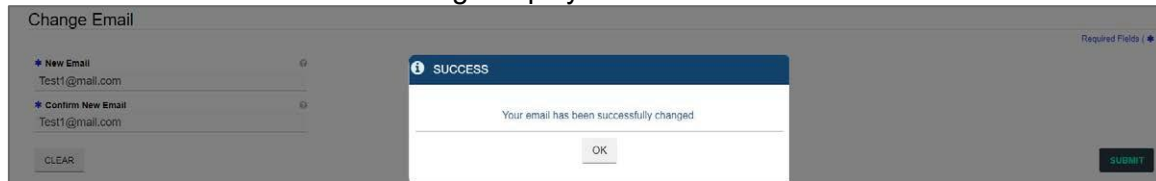
The 'Change Email' form is displayed. It includes instructions: 'Please enter your Tracking Number and Password that was used on the Provider Enrollment application to update email. If you have forgotten password, please click on forgot password checkbox to continue without password. If you have questions or concerns, please reach out to the Gainwell Technologies Customer Service Account Team: [apocbcus@gainwelltechnologies.com](mailto:apocbcus@gainwelltechnologies.com)'. The form has two required fields: 'Tracking Number' (filled with '387318883') and 'Password' (filled with '\*\*\*\*\*'). There is a 'Forgot Password' checkbox which is unchecked. A 'SUBMIT' button is at the bottom right.

3. Enter and confirm the new email address, then click **SUBMIT**.



The 'Change Email' form is displayed. It includes two required fields: 'New Email' (filled with 'Test1@mail.com') and 'Confirm New Email' (filled with 'Test1@mail.com'). A 'CLEAR' button is at the bottom left, and a 'SUBMIT' button is at the bottom right.



4. Click **OK** when the Success message displays.




The 'Change Email' form is displayed. A success message is shown: 'SUCCESS: Your email has been successfully changed'. There is an 'OK' button to dismiss the message. The form fields 'New Email' and 'Confirm New Email' are still visible and filled with 'Test1@mail.com'. A 'SUBMIT' button is at the bottom right.

A notification is sent to the new email address indicating it will be used for future communications.

New Enrollment - Application Registration Email Changed ATN: 3657769625

 appshcproducttd01team@gainwelltechnologies.com  
To: Test@mail.com; 

 If there are problems with how this message is displayed, click here to view it in a web browser.

Dear John Smith,

The registered email address for the provider enrollment application with the State Medical Assistance Program has been changed from [Bea\\*\\*\\*\\*\\*@GainwellTechnologies.com](mailto:Bea*****@GainwellTechnologies.com) to the following email address [Tes\\*@mail.com](mailto:Tes*@mail.com).  
This email address will be used going forward for any further communications with your enrollment application.



Tracking Number: 3657769625

If you did not make this or approve this change, please contact Provider Enrollment service representative.

**If you have any questions or concerns, please contact the State Provider Enrollment Unit at 1-888-555-1212.**

Sincerely,


State Medical Assistance Program  
Provider Enrollment  
[appshcproducttd01team@gainwelltechnologies.com](mailto:appshcproducttd01team@gainwelltechnologies.com)  
Contact us: 1-888-555-1212



[www.GainwellTechnologies.com](http://www.GainwellTechnologies.com)   1775 Tysons Blvd Tysons, VA




5. Enter the Password or check the Forgot Password box if you have forgotten the password and click **SUBMIT**.

Change Email

Please enter your Tracking Number and Password that was used on the Provider Enrollment application to update email.  
If you have forgotten password, please click on forgot password checkbox to continue without password.  
If you have questions or concerns, please reach out to the Gainwell Technologies Customer Service Account Team: [appshc@gainwelltechnologies.com](mailto:appshc@gainwelltechnologies.com)

 Required Fields ( \* )

 Tracking Number   
6653427549


Password   
☐  Forgot Password 





**NOTE:** Checking Forgot Password causes the Password field to become optional, so you can continue to the next page to enter additional information.

6. Take one of the following actions based on type of enrollment:

- Enter the last 4 digits of the SSN and Birth Date for **Individual** enrollments.

Change Email

 Required Fields ( \* )

 SSN (Last 4 digits)   Birth Date   
6789 01/01/1966

or

- Enter the Business Name and the last 4 digits of the Tax ID (EIN) exactly as it is in the application for **Group** or **Facility** enrollments.

Change Email

Required Fields ( )

Business Name

Gainwell

Tax ID (Last 4 digits)

0595

CLEAR

PREVIOUS

SUBMIT

or

- Enter the Business Name and last 4 digits of the Tax ID (SSN) exactly as it is in the application for **Group** or **Facility** enrollments.

**NOTE:** Configuration determines use an SSN instead of EIN for Group or Facility enrollments.

Change Email

Required Fields ( )

Business Name

Gainwell

SSN (Last 4 digits)

6789

CLEAR

PREVIOUS

SUBMIT

- Enter and confirm the New Email, then click **SUBMIT**.

Change Email

Required Fields ( )

New Email

Test1@mail.com

Confirm New Email

Test1@mail.com

CLEAR

SUBMIT

- Click **OK** to acknowledge the Success message indicating the email was successfully changed.

Change Email

Required Fields ( )

New Email

Test1@mail.com

Confirm New Email

Test1@mail.com

CLEAR

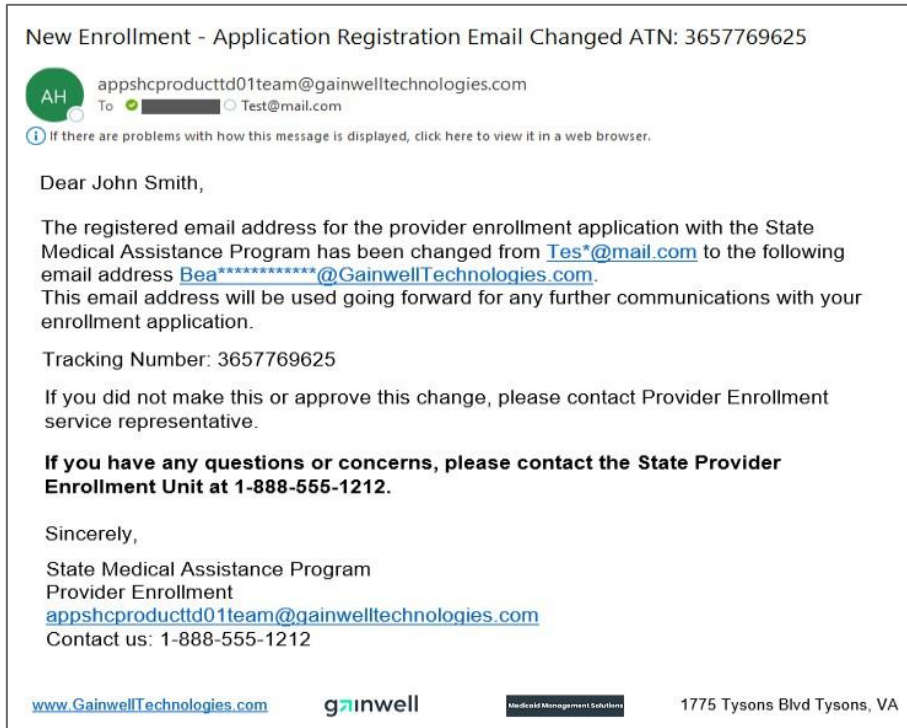
SUBMIT

SUCCESS

Your email has been successfully changed

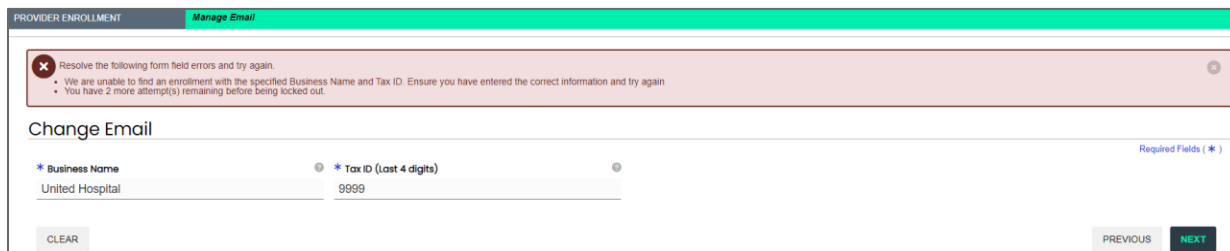
OK

A notification is sent to the new email address indicating it will be used for future communications.



## Manage Email - Incorrect Attempts Limit

Users are allowed a limited number of attempts to change or update email information. If invalid information is entered for any required field (ATN, Password, SSN, DOB, Business Name, or Tax ID), the user is presented with a message, like the following example, indicating number of attempts remaining.



PROVIDER ENROLLMENT **Manage Email**

**×** Resolve the following form field errors and try again.  
• We are unable to find an enrollment with the specified Business Name and Tax ID. Ensure you have entered the correct information and try again.  
• You have 2 more attempt(s) remaining before being locked out.

**Change Email**

\* Business Name United Hospital \* Tax ID (Last 4 digits) 9999

Required Fields ( \* )

CLEAR PREVIOUS NEXT

After reaching the number of invalid attempts, the user's account is locked for a configured period. After the lockout time has elapsed, the user can try again. The following example indicates the user must wait 15 minutes before another attempt to unlock the account.



PROVIDER ENROLLMENT **Manage Email**

**×** Resolve the following form field errors and try again.  
• Your account has been locked. Please try again after 0 day(s), 0 hour(s), 15 minute(s), 0 second(s).

**Change Email**

\* Business Name United Hospital \* Tax ID (Last 4 digits) 1234

Required Fields ( \* )

CLEAR PREVIOUS NEXT

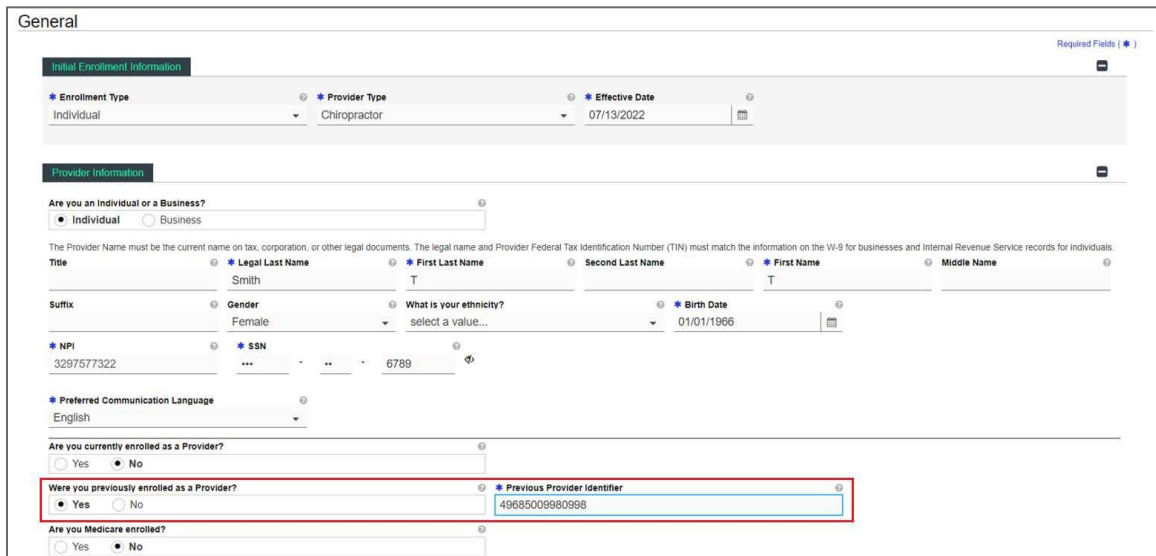


## Re-enrollment

Providers enrolled in the network with contracts that have been terminated or inactivated can re-enroll by completing the following process.

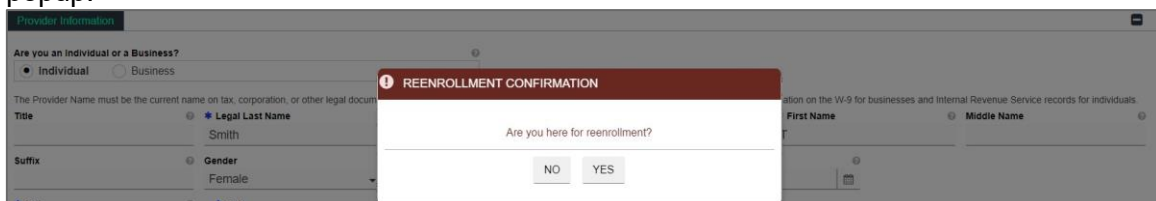
1. Select **New Enrollment** from the Provider Enrollment menu.
2. Start a new enrollment application using the same information currently in the Provider Management system. The following fields should match the previous enrollment information on the General page:
  - Enrollment Type
  - Provider Type
  - NPI
  - Tax ID or EIN
  - Tax ID Type
3. Select **Yes** for Were you previously enrolled as a Provider? and enter the Previous Provider Identifier.

**Tip!** This identifier is the 14-digit service location number. Contact Provider Enrollment Services if the number is unknown or incorrect.



The screenshot shows the 'General' enrollment form. The 'Initial Enrollment Information' section includes fields for Enrollment Type (Individual), Provider Type (Chiropractor), and Effective Date (07/13/2022). The 'Provider Information' section includes fields for Are you an Individual or a Business? (Individual), Title (Smith), Suffix, Gender (Female), What is your ethnicity? (select a value...), Birth Date (01/01/1966), NPI (3297577322), SSN (\*\*\*-\*\*-6789), Preferred Communication Language (English), Are you currently enrolled as a Provider? (No), Were you previously enrolled as a Provider? (Yes), and Previous Provider Identifier (4968500980998). The 'Previous Provider Identifier' field is highlighted with a red box.

4. After entering the Previous Provider Identifier, select **YES** on the Reenrollment Confirmation popup.

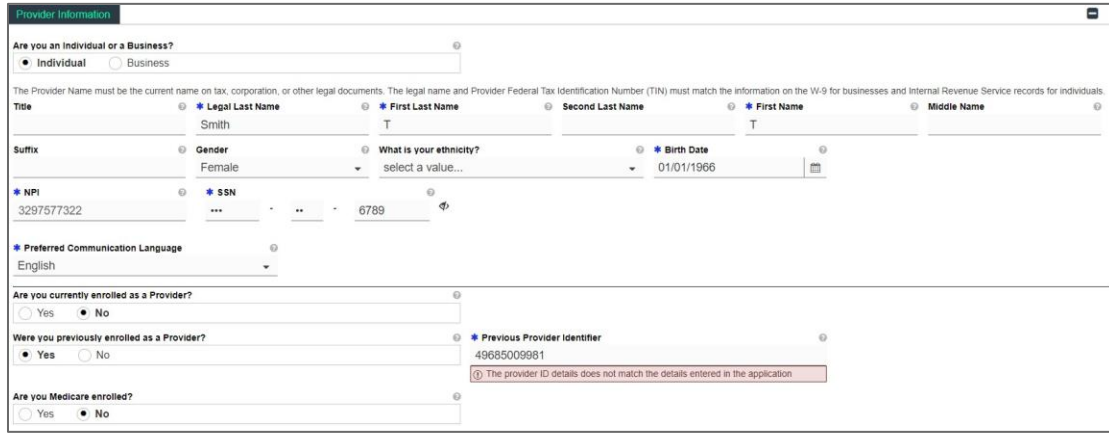


The screenshot shows the 'Reenrollment Confirmation' popup. The popup has a title bar that says 'REENROLLMENT CONFIRMATION' and a message that says 'Are you here for reenrollment?'. There are two buttons: 'NO' and 'YES'. The 'YES' button is highlighted, indicating it has been selected.



The Previous Provider Identifier is validated.

- If Provider ID details do not match the previous enrollment information, the message “The provider ID details do not match the details entered in the application” displays, as shown below.



The screenshot shows the 'Provider Information' form. At the bottom, there is a red error message box that reads: "The provider ID details do not match the details entered in the application". The form includes fields for:
 

- Are you an individual or a business? (Individual selected)
- Title, Legal Last Name (Smith), First Last Name (T), Second Last Name, First Name (T), Middle Name
- Suffix, Gender (Female), What is your ethnicity? (select a value...), Birth Date (01/01/1966)
- NPI (3297577322), SSN (\*\*\*-\*\*-6789)
- Preferred Communication Language (English)
- Are you currently enrolled as a Provider? (No selected)
- Were you previously enrolled as a Provider? (Yes selected)
- Previous Provider Identifier (4968500981)
- Are you Medicare enrolled? (No selected)

- If the provider’s detailed information is accepted, complete the additional information on the page and click **SAVE AND CONTINUE**.

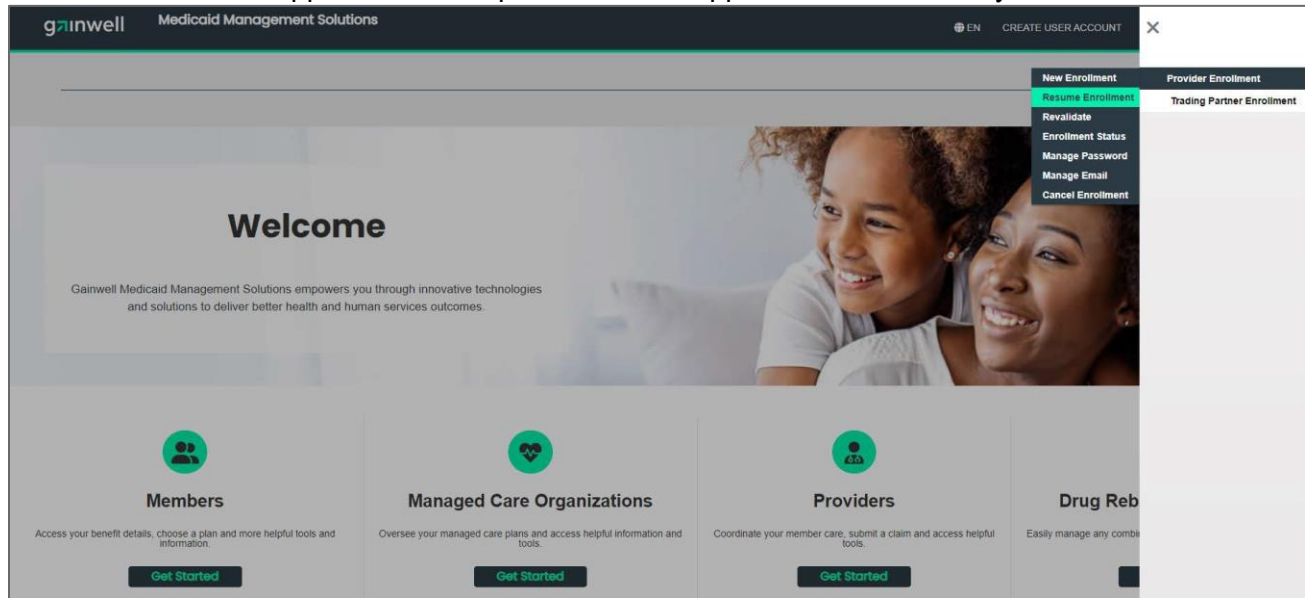
#### 5. If the system is...

- configured to prepopulate re-enrollment applications with details from the Provider Management system, resume and submit the prepopulated application. You will receive an Enrollment Request Confirmation indicating the re-enrollment request was successfully placed with a tracking number and password to resume the enrollment application. After the application is submitted, you will receive notification of the enrollment's successful completion.
- not configured for prepopulating re-enrollment applications, the Enrollment Request Confirmation is not generated, and the application is not prepopulated. You will need to:
  - Answer **Yes** to Were you previously enrolled as a Provider? **and** enter the previous Provider Identifier, then complete and save the General page.
  - Navigate to the Specialty page, provide required information, and submit the application.

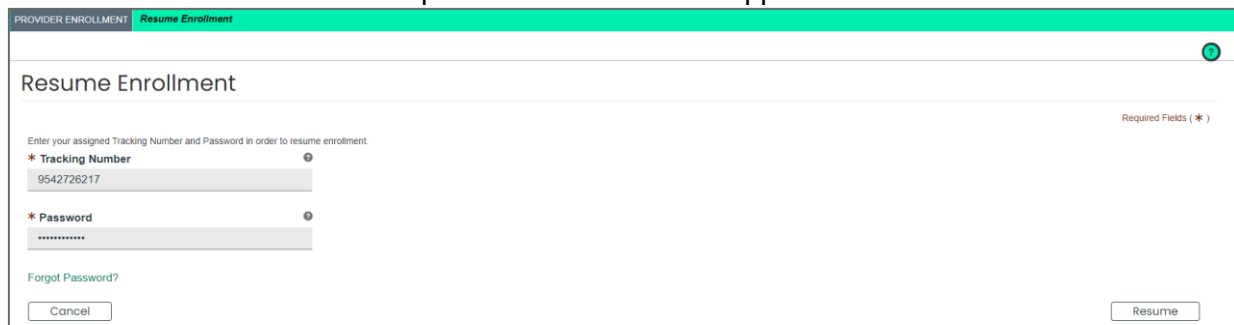
The enrollment team will contact you if the application requires corrections or is incomplete. Otherwise, you are notified after an enrollment decision has been made.

## Resume Enrollment

This feature enables applicants to complete or edit an application that has not yet been submitted.



Enter the ATN and self-selected password to access the application.



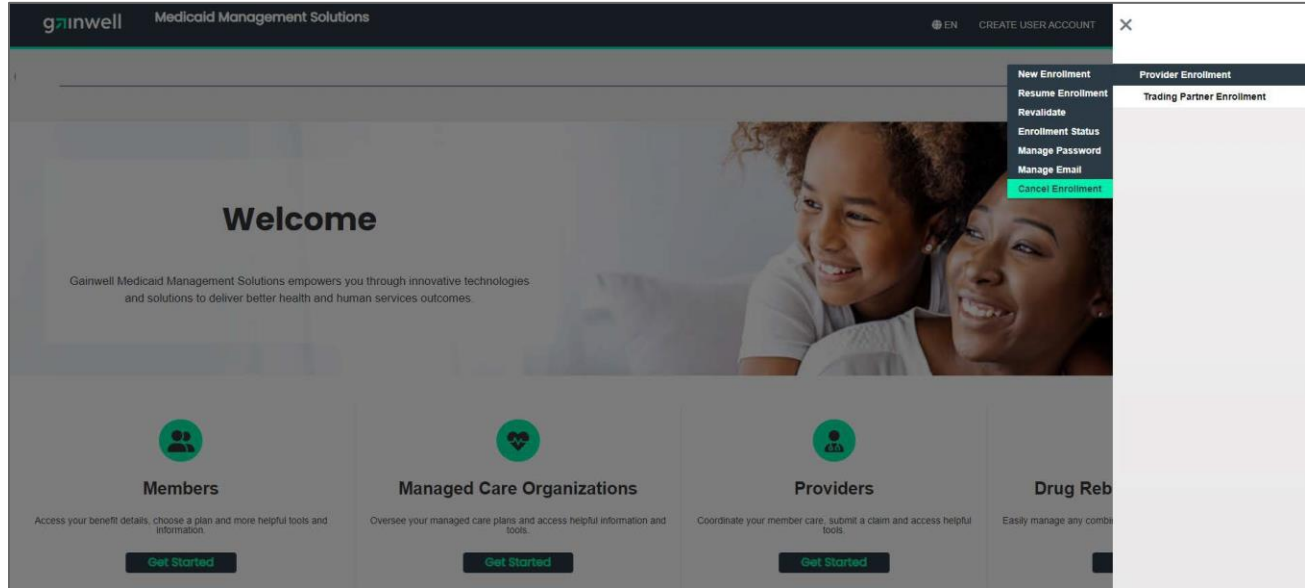
**NOTE:** The system may be configured to require an Authentication code. If one is required, enter the code provided and click **SUBMIT**.



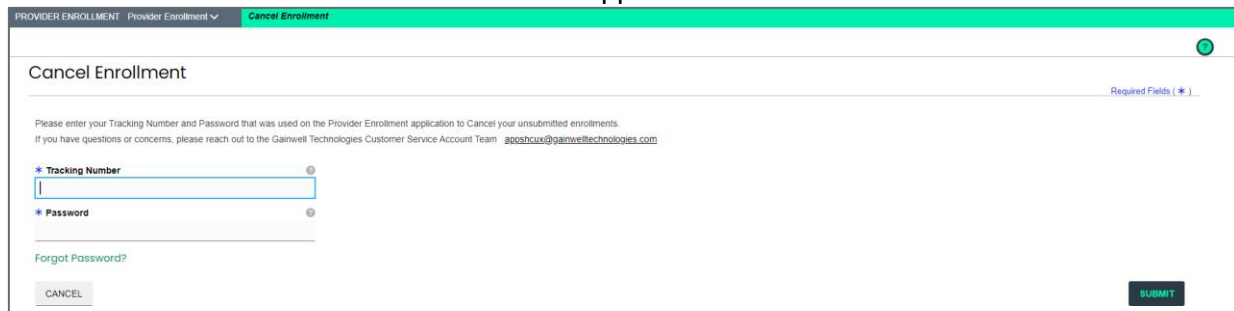
User will return to the last page from which the user clicked **SAVE AND CONTINUE**.

## Cancelling Enrollment

This feature enables applicants to cancel enrollments in a non-finalized status, including enrollments in Workflow. A notification email is sent to the applicant's registered email address notifying the provider that the enrollment has been canceled.



1. Enter the ATN and Password to cancel the application.



2. Click **SUBMIT** to return to the Home page.

**NOTE:** Applications in a finalized status (**Approved** or **Denied**) cannot be cancelled.

## Return to Provider

When the enrollment team determines corrections are required, the provider will receive a Return to Provider (RTP) notification identifying the incomplete or incorrect information. Return to the application using **Resume Enrollment**, and make all corrections specified in the notification. Sign the provider's agreement before resubmission.

**NOTE:** Returned applications are available for a limited time as outlined in the notification. After the RTP time limit has elapsed, the ATN expires, and a new enrollment application must be completed.

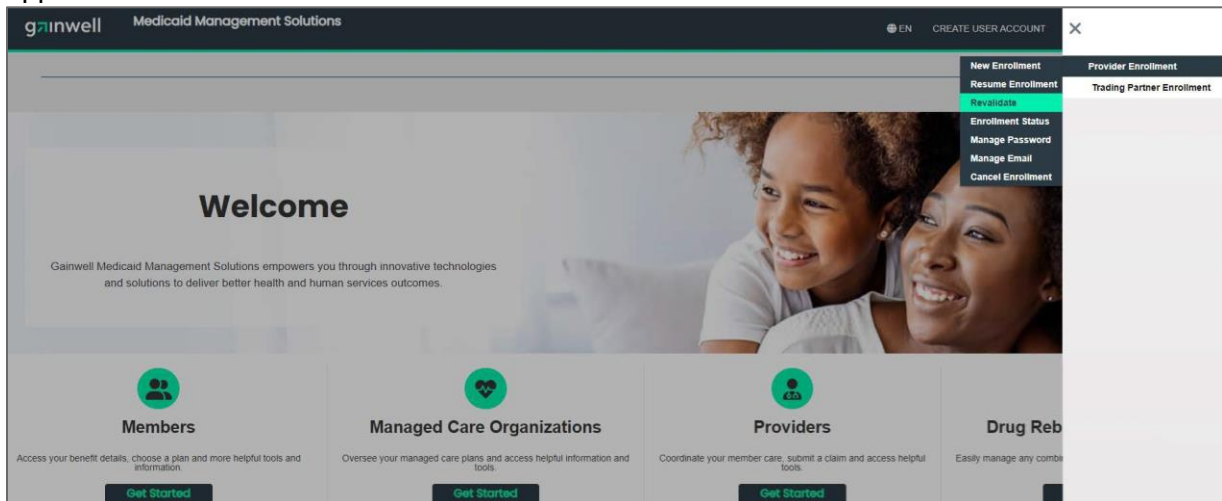
## XV Revalidate

The Federal Law, known as the 21st Century Cures Act, requires all providers to enroll and revalidate every 5 years directly with DMAS through PRSS portal. This requirement includes billing, servicing, ordering, referring, or prescribing (ORP) providers who serve members through managed care organizations (MCOs) or Fee-For-Service (FFS), or both.

Providers will receive a notice to begin their revalidation 90 days before their revalidation is due. The notice is sent via email or U.S. Mail depending on the provider's communications preferences recorded in PRSS. Reminder notices are also sent at 60 and 30 days prior to the revalidation deadline. Notification letters are sent via email from: [appshcproductNoReply@gainwelltechnologies.com](mailto:appshcproductNoReply@gainwelltechnologies.com). Providers are encouraged to add this email to their contacts, so the email is not marked as spam. DMAS encourages providers to begin the revalidation application upon receipt of the notification to allow for sufficient processing time and if needed corrections made prior to the expiration date. Providers can access their revalidation date in the provider portal or using the provider extract located at the following link <https://vamedicaid.dmas.virginia.gov/provider/mco>.

When revalidation is needed, a notification containing an Application Tracking Number (ATN) and password is received. Once received complete the steps in this section.

1. Logon and change the received password to continue with the revalidation application.
2. Click **Provider Enrollment**, then **Revalidate** on the menu to launch the revalidation application.



**NOTE:** The system may be configured to require an Authentication code. If one is required, enter the code provided and click **SUBMIT**.



3. The application pre-populates values on the following pages and fields:
  - General page (Initial Enrollment Information and Provider Information panels)
  - Specialty or Specialties
  - Addresses
  - Organization
  - Associations
  - Credentials
  - Provider Type
  - Other (Malpractice Insurance from original enrollment is not pre-populated)
  - Subcontractors (basic information only: Name, DOB, Tax ID)
  - Managing Employee and Controlling Interest names, addresses and tax IDs
  - Ownership and Control Interest names, addresses and tax IDs
4. If modification is needed in any read-only field, contact customer service. Fields include the following:
  - Enrollment Type
  - Provider Type
  - Birth Date (if applicable)
  - NPI
  - SSN (if applicable)
  - EIN (if applicable)
  - Legal Name
  - Tax Name



The screenshot shows a web interface titled "General". It contains two main panels: "Initial Enrollment Information" and "Provider Information". In the "Initial Enrollment Information" panel, the "Enrollment Type" is set to "Facility". In the "Provider Information" panel, the "Provider Type" is set to "Laboratory". There is a "Required Fields (\*)" link in the top right corner of the "Provider Information" panel.

5. Update the following editable fields as needed. Remember to select the programs into which patients will be accepted. (**FFS** and **MCO** is shown in the following example.)
  - Name (Last, Second Last, First, Title, Middle, Legal, Tax, and Doing Business As)
  - Birth date
  - NPI – only editable if invalid NPI
  - SSN – only editable if blank/Invalid
  - EIN – only editable if blank/Invalid

**NOTE:** A valid SSN, EIN, or NPI must be provided to be able to save and continue.

Provider Information

The Provider Name must be the current name on tax, corporation, or other legal documents. The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9 for businesses and Internal Revenue Service records for individuals.

\* Legal Business Name

Test Lab

Tax Name

Test Lab

Doing Business As Name

NPI

8638728153

Tax ID Type

EIN

64

746

3745

\* IRS Effective Date

10/26/2021

Provider ID

30000388000002

\* Preferred Communication Language

English

Are you Medicare enrolled?

☐ Yes
 ☒ No

If you choose "FFS and MCO" or "MCO (s) only", your information will be shared with the selected MCO programs. This application does not guarantee participation with the Managed Care Organizations. Each organization is independent. Please select the appropriate option.

\* I will accept patients in the following programs:

FFS only

Are you registered with CAQH?

☐ Yes
 ☒ No

- Review each page of the enrollment, updating out-of-date information and adding required data that was not available for pre-population.

## Key Factors for Successful Revalidation

**IMPORTANT:** Do not risk termination; revalidate as soon as possible. The time limit in which to complete the revalidation process, including submitting required corrections, is limited.

- Keep your email address updated as this will direct your notifications for Revalidation.
- Begin the revalidation process upon receipt of the notification. The application must be received and approved before the revalidation due date.
- Verify that the pre-populated information is correct.
- Complete all required information that was not pre-populated.
- Make sure all required attachments are uploaded for faster processing.
- Send the application fee immediately if one is required.
- Respond promptly if the application is returned for corrections.
- For additional information see the Appendix A FAQs

**NOTE:** Revalidation for "Provider terminated for Cause" within the grace period is not permitted.

## XVI Provider Maintenance

### Manage Provider Information

Providers are responsible for updating their provider information such as license effective and end dates and updates to demographic information. Timely updates to your provider's information will keep the provider eligible and will not run the risk of termination.

### Provider Self-Service

The following information can be managed through Self-Service via the PRSS Provider Portal. Please see the Provider Portal User Guide Located here [Provider Portal User Guide](#) for additional information on how to log in, becoming or updating Primary Account Holder (PAH) and how to manage additional users.

- License Updates
- Pay, Mail, Remit, and IRS address updates
- Add/Remove/Update Affiliation for Group, Facility, IGs and OPRs
- Manage Users
- Initiate/View Revalidations
- Navigate to external systems such as Claims Payment, Claims DDE, Service Authorization and Member Eligibility

### Other Maintenance Items

The maintenance items below require a form to be completed. The forms must be updated electronically, saved to your computer and emailed to [VAMedicaidProviderEnrollment@gainwelltechnologies.com](mailto:VAMedicaidProviderEnrollment@gainwelltechnologies.com) for efficient processing of your request.

Download form here [Forms & Downloads | MES](#)

- Primary Account Holder Updates
- Electronic Funds Transfer (EFT)
- Adding VA FFS or other contracts not available through self-service
- Provider Termination Requests
- Application Fee Refund Requests
- Duplication 1099s



# Appendix A: Common Reasons Enrollment Application are Returned to Providers

Did you know that half of all enrollment applications are returned to providers for the following errors? Providers are encouraged to review the information below for faster approval.

## 1. Duplicate Enrollment Provider is already enrolled

1. Individuals within a Group only need one 14-digit service location id for each PT.
2. If a provider is enrolled as an Individual or Individual within a group a separate enrollment as an OPR is not needed.
3. For Group and Facility enrollments, each individual site where services are rendered. An administrative site or main site is not needed.

## 2. Missing or Non-Matching License or Certification Attachment –

1. License attachment is missing.
2. Effective or end dates provided on the application do not match the documents provided as proof of licensure/certification.
3. License or certification does not match the PTPS of the enrolling provider.
4. License or certification does not match the service address on the enrolment application.

## 3. National Plan and Provider Enumeration System NPPES Address Mismatch - The address in the National Plan and Provider Enumeration System (NPPES) does not match the service location address on the application.

## 4. W9 Issue –

1. The address entered on the W9 attachment is required to match the mail to pay to, or service location address in the application.
2. W-9 is not signed.

## 5. MOU was not received for PS 902 or 920.- Providers who do not have a Memorandum of Understanding for Crisis Services.

## 6. CMS Certification - When the Medicare information is searched in the Provider Enrollment, Chain, and Ownership System (PECOS), nothing came up for the provider.

## 7. Tax Identification Numbers: Social Security Number (SSN) and Federal Employer Identification Number (FEIN) - Individuals are required to use a personal SSN as a form of valid Tax ID. Facilities and groups will input a FEIN available to use as a Tax ID.

## 8. Disclosures - Business ownership information is required when completing the Disclosures section of the application. Ownership and Control Interest is submitted for the enrolling entity. If the enrolling entity is an Individual practitioner, Ownership and Control information of the billing provider is not required, so the response to Section A is generally "No".

A Social Security Number (SSN) is required for each owner when disclosing information to individual owners of the business. A secondary question, "Is this entity an individual?" must be answered "Yes" when disclosing information for individual owners of the business. An additional question, "Date of Birth" will be populated and must be answered when disclosing information for individual owners of the business.

If there is no ownership of 5%, the board of directors' information should be entered, including addresses, dates of birth, and social security numbers for everyone listed.

## Appendix B: FAQs

**Q. I was reviewing my new enrollment application and noticed some data is incorrect. The field is grayed out and I cannot edit it. What should I do?**

**A.** When a field is grayed out in a new enrollment application, it is because it was copied from another area within the application. Return to the first place that you entered the information, change it there, click **Save and Continue**, and navigate back to the page you were on. The data will be updated.

**Q. Can my effective date be greater than the 1st date of the month of my enrollment submission?**

**A.** Any requests for an effective date prior to the 1st date of the month of your enrollment must meet specific criteria and will be reviewed by DMAS.

**Q. I submitted my new, re-enrollment or revalidation application. Now what happens?**

**A.** PRSS has 10 business days to process a complete and accurate enrollment. Upon submission PRSS performs screening checks on the provider, and all named disclosed entities against state and federal databases, as required under the ACA.

The screening results are then sent to provider enrollment services for review. If the enrollment application is clean and can be approved a notification will be sent with your 14-digit Service Location Id and Effective Date

The application may be returned to you for corrections or additional information. If you are a moderate risk Provider type, you are subject to an unscheduled site visit. If you are a high-risk Provider type, you are subject to a site visit and a criminal background check. The state renders its enrollment decision after all data has been reviewed.

**Q. I received notification that my application is being returned to me for corrections. What do I need to do?**

**A.** Return to PRSS and use the Resume Enrollment feature. Enter the ATN and your password. Make appropriate updates in the application, remembering to **Save and Continue** as you navigate through the pages.

After 30 days the ATN expires and is not eligible for resumption. If this is for a Revalidation your 14-digit SL ID will terminate, and you will have a 45-day grace period to resume your revalidation.

**Q. How often do I need to complete a revalidation?**

**A.** In accordance with the ACA Provider Enrollment and Screening Regulations, all Virginia Medicaid Providers are required to revalidate their enrollment information at least every 5 years.

**Q. When can I revalidate?**

**A.** You will receive a notification 90 days prior to your revalidation date. It is suggested you submit your revalidation as soon as you receive notification to allow for processing time and time to submit any corrections, if needed, prior to your contract's expiration date.

**Q. How long will it take to hear back on my revalidation status?**

**A.** The screening process can take 10 business days to process. Additional screening requirements (Fee, Site Visit, and Background Check) may extend the handle time for the enrollment decision.

**Q. Why am I unable to access and submit my revalidation; the application status is expired?**

**A.** If your revalidation is not submitted within 45 days of the service locations compliance due date for revalidation and termination, you will need to submit a new enrollment application and select yes to previously enrolled and indicate the service location ID for the service location terminated. A Grace Period of up to 45 days is allowed on any provider revalidation that has not been submitted. If the provider revalidation is returned to provider, the grace period is not allowed. The provider will need to access and submit their application before the 30-day expiration requirements.

**Q. How can I determine my revalidation applications status?**

**A.** Navigate to: <https://virginia.hppcloud.com/> and select Enrollment Status. Enter your ATN and password that was entered when the enrollment application was started. Note: To review your submitted application, click *Print Preview* to open a copy of the application in a new window to view, download, or print.

**Q. How can I change my enrollment details selected?**

**A.** Depending on the change, the details entered can be edited using the edit icon. The Enrollment Type and Provider Type selections, however, determine the information required throughout the application. Depending on your selections, you may receive a message indicating your provider risk-level; limited, moderate, or high, which may modify your requirements for enrollment. If the Enrollment and Provider Type needs to be updated, cancel the current partial enrollment and register to start a new enrollment application.

**Q. When do I select yes to Are you currently enrolled as a Provider?**

**A.** If you are not revalidating, select No and continue as a new enrollment. If you receive your revalidation letters, select Yes then click Yes on the message window asking if you wish to revalidate your existing enrollment. You will be redirected to the Resume/Revalidate page.

**Q. When do I select yes to Were you previously enrolled as a Provider?**

**A.** Only select Yes, if you are no longer active in the Virginia Medicaid program and wish to apply for re-enrollment. You must enter a 14-digit service location. Once entered you will have the option to say yes, re-enrolling and a pre-filled application will be created. This will require you to close current enrollment and respond to email with instructions on how to re-enroll.

**Q. When do I select yes to Are you Medicare Enrolled?**

**A** yes response is used to trigger a fee waiver request for Medicaid participation as fees already paid to Medicare may be applied. Additionally, it may be used for post-enrollment activities such as processing crossover claims.

**Q. Do I need to pay an application fee on my revalidation application?**

**A.** Based on your selections, the Amount Due displays either No Fee or the amount due. Note: If an enrollment application for the Virginia Medicaid program is received and deemed to require an application fee but one is not submitted or payment is not in an acceptable format, the entire application will be returned to the Provider requesting proper payment. The Provider has 30 days to complete the payment and resubmit the application before the entire application is denied.

**Q. What are my next steps if my revalidation is returned for corrections?**

**A.** After submission, applications cannot be viewed or modified unless a PRSS Enrollment and Management Clerk returns it for corrections. If your application is returned for corrections, you will receive a notification with changes that need to be made. This includes providing an additional attachment or editing responses. You have 30 days to make the corrections and resubmit your application: if not completed by the deadline, your applications status will update to expired and will not be accessible.

**Q. What if I do not submit by the revalidation compliance date?**

**A.** If your revalidation is not submitted by the compliance date, the provider will have up to 45 days to submit the revalidation application as part of the revalidation grace period implementation. Select the resume revalidation option as normal to complete the revalidation. Providers who submit the revalidation will not qualify for a grace period.

**Q. What are my next steps if my revalidation is denied?**

**A.** You will receive a notification with reasons that your revalidation was denied. The provider will be terminated as of the revalidation compliance date if the revalidation application is denied. If you can address the denial reasons by the compliance date, you may submit a re-enrollment application.

**Q. What are my next steps if my revalidation is approved?**

**A.** If your revalidation is approved, you will receive notification of your approval and ongoing provider maintenance will be conducted in Provider Portal. Refer to the Virginia Provider Portal User Guide for functionality.

- If you selected any MCO program(s) in the General Information section of your application, your application and participation request is submitted to the MCO(s).
- Any allowed changes made via the revalidation will be applied to the associated service location.