

Job Aid

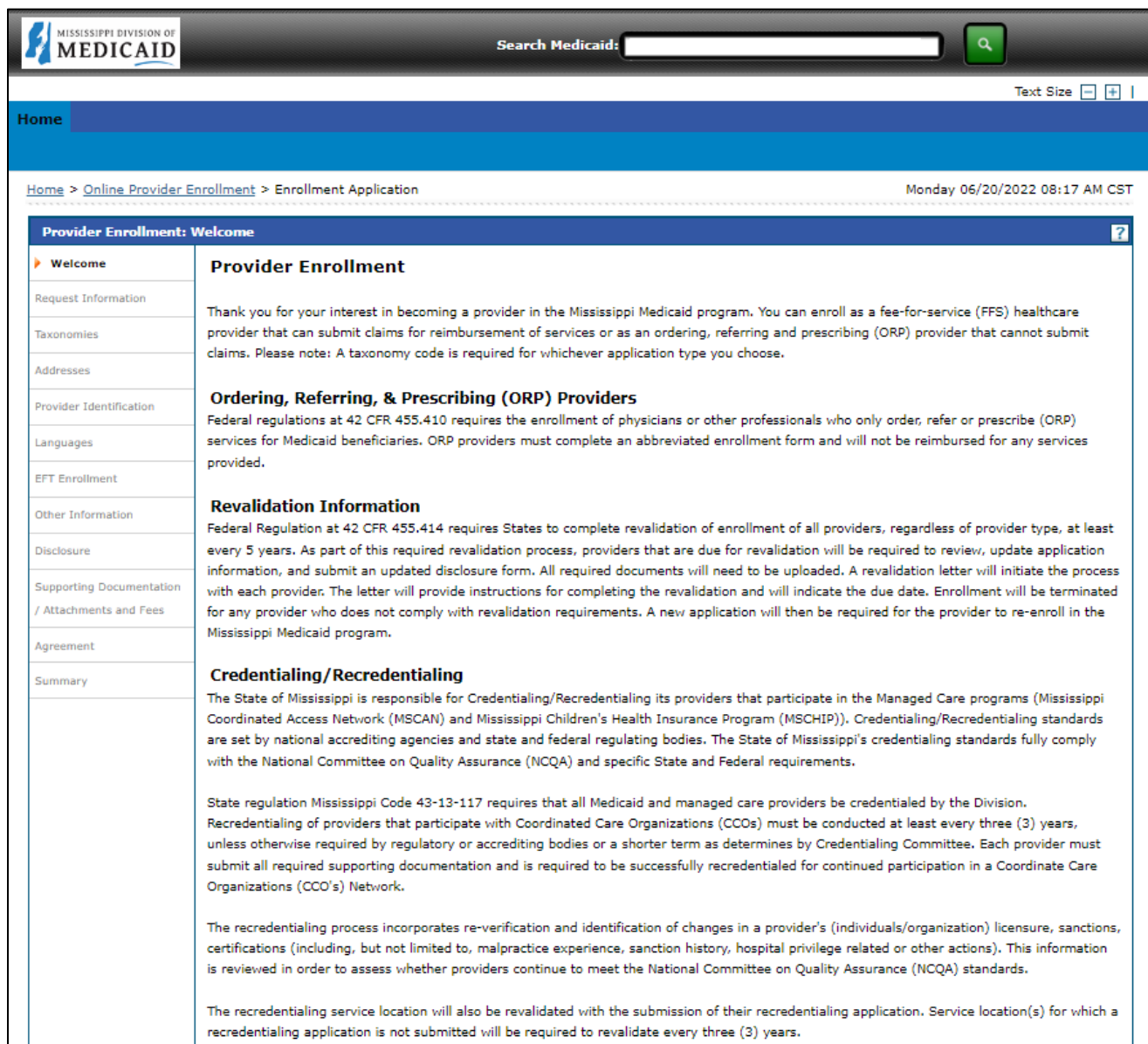
Provider Enrollment Panels

This document displays the panels presented on the Provider Portal enrollment application, as well as those in the MESA Provider area for enrollment.

Welcome Page

The **Provider Enrollment** section on the **Welcome** page discusses the enrollment process. The **Credentialing/Recredentialing** section discusses credentialing requirements and processes. See Figure 1: Welcome Page: Credentialing/Recredentialing Message.

Figure 1: Welcome Page: Credentialing/Recredentialing Message



The screenshot shows the 'Provider Enrollment: Welcome' page. It features a sidebar with a list of links: Welcome, Request Information, Taxonomies, Addresses, Provider Identification, Languages, EFT Enrollment, Other Information, Disclosure, Supporting Documentation / Attachments and Fees, Agreement, and Summary. The main content area is titled 'Provider Enrollment' and contains three sections: 'Welcome' (a thank you message), 'Ordering, Referring, & Prescribing (ORP) Providers' (information about federal regulations for ORP providers), 'Revalidation Information' (information about the revalidation process), and 'Credentialing/Recredentialing' (information about the credentialing process and requirements).

Provider Enrollment: Welcome

Welcome

Thank you for your interest in becoming a provider in the Mississippi Medicaid program. You can enroll as a fee-for-service (FFS) healthcare provider that can submit claims for reimbursement of services or as an ordering, referring and prescribing (ORP) provider that cannot submit claims. Please note: A taxonomy code is required for whichever application type you choose.

Ordering, Referring, & Prescribing (ORP) Providers

Federal regulations at 42 CFR 455.410 requires the enrollment of physicians or other professionals who only order, refer or prescribe (ORP) services for Medicaid beneficiaries. ORP providers must complete an abbreviated enrollment form and will not be reimbursed for any services provided.

Revalidation Information

Federal Regulation at 42 CFR 455.414 requires States to complete revalidation of enrollment of all providers, regardless of provider type, at least every 5 years. As part of this required revalidation process, providers that are due for revalidation will be required to review, update application information, and submit an updated disclosure form. All required documents will need to be uploaded. A revalidation letter will initiate the process with each provider. The letter will provide instructions for completing the revalidation and will indicate the due date. Enrollment will be terminated for any provider who does not comply with revalidation requirements. A new application will then be required for the provider to re-enroll in the Mississippi Medicaid program.

Credentialing/Recredentialing

The State of Mississippi is responsible for Credentialing/Recredentialing its providers that participate in the Managed Care programs (Mississippi Coordinated Access Network (MSCAN) and Mississippi Children's Health Insurance Program (MSCHIP)). Credentialing/Recredentialing standards are set by national accrediting agencies and state and federal regulating bodies. The State of Mississippi's credentialing standards fully comply with the National Committee on Quality Assurance (NCQA) and specific State and Federal requirements.

State regulation Mississippi Code 43-13-117 requires that all Medicaid and managed care providers be credentialed by the Division. Recredentialing of providers that participate with Coordinated Care Organizations (CCOs) must be conducted at least every three (3) years, unless otherwise required by regulatory or accrediting bodies or a shorter term as determines by Credentialing Committee. Each provider must submit all required supporting documentation and is required to be successfully recredentialed for continued participation in a Coordinate Care Organizations (CCO's) Network.

The recredentialing process incorporates re-verification and identification of changes in a provider's (individuals/organization) licensure, sanctions, certifications (including, but not limited to, malpractice experience, sanction history, hospital privilege related or other actions). This information is reviewed in order to assess whether providers continue to meet the National Committee on Quality Assurance (NCQA) standards.

The recredentialing service location will also be revalidated with the submission of their recredentialing application. Service location(s) for which a recredentialing application is not submitted will be required to revalidate every three (3) years.

The **Medicaid Fee-for-Service Providers** message lists information required to complete the application. This list is subject to change. The 340B Program message explains the drug pricing program for applicable providers. See Figure 2: Welcome Page: Fee-For-Service and 340B Messages.

Figure 2: Welcome Page: Fee-For-Service and 340B Messages

<p>Medicaid Fee-for-Service Providers</p> <p>Medicaid Fee for Service (FFS) providers are all health care entities including physicians or other professionals, institutions, groups, and organizations that are enrolled in the Medicaid program. FFS providers must complete the full enrollment form to submit claims for reimbursement of services provided for Medicaid beneficiaries.</p> <p>To enroll, you will need the following to complete this request:</p> <ul style="list-style-type: none"> ▶ MS Medicaid Enrollment Application ▶ Provider Disclosure Form ▶ Electronic Funds Transfer (Direct Deposit Authorization Form) <ul style="list-style-type: none"> ▶ Include verification of the bank account (such as preprinted voided check, deposit slip, or letter from bank verifying the account number and transit routing number) ▶ Medical Assistance Participation Agreement ▶ W-9 Taxpayer Identification Number Request for the enrolling provider ▶ Civil Rights Compliance Information Request for Medicaid Certification ▶ Institutional Fee or Hardship Payment Letter ▶ Medicare Certification or Enrollment in another Medicaid State <p>Additional information can be found on the following documents:</p> <ul style="list-style-type: none"> ▶ Additional Credentialing Requirements checklist which indicates any additional specific required documentation for the provider services in which you are enrolling ▶ Provider Risk Level Information ▶ Frequently Asked Questions (FAQs) ▶ Contact Information <p>To access the required documents, click here.</p> <p>Please complete each step in the enrollment process. When you have completed all steps of the application, "submit" and "confirm" the application for further processing.</p> <p>340B Program</p> <p>The 340B program is a Drug Pricing Program established by the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act (PHSA). Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes, and qualified hospitals. These providers purchase, dispense and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of these drugs makes these drugs ineligible for the Medicaid drug rebate. State Medicaid programs are mandated to ensure that rebates are not claimed on these drugs thereby preventing duplicate discounts for these drugs.</p> <p>Health Resources and Services Administration (HRSA) is specifically responsible for the enforcement of covered entity compliance with the duplicate discount prohibition. More information regarding eligibility and program logistics can be found on HRSA's website at www.hrsa.gov/opa.</p> <p>Please click the "Continue" button to start the enrollment application.</p> <div style="text-align: right;"> Continue Cancel </div>

[Privacy](#)

At the bottom of each page, users must click **Continue** to move forward in the application. If an applicant wants to go backward in the application, they can click on a page in the list on the left of the screen. To move forward again, they will have to click **Continue** and go through each page. Each time a user exits the application and returns, they must start at the Welcome page and click **Continue** to move forward through the pages.

Request Information Page

On the **Request Information** page, applicants can access lists of primary taxonomies for each application type. In the **Initial Enrollment Information** panel, they can enter a taxonomy or a description to obtain a list of matching taxonomies. See Figure 3: Request Information – Enter Primary Taxonomy.

Figure 3: Request Information – Enter Primary Taxonomy

Provider Enrollment: Request Information	
Welcome	Click the down arrow next to Enrollment Type to select the appropriate application type – Individual, Group, Facility, Other or ORP (Ordering, Referring, Prescribing).
Request Information	
Taxonomies	Individual Application Type – Individual practice. For a list of applicable Provider Types, Click Here .
Addresses	Group Application Type – Entity that has associated providers. For a list of applicable Provider Types, Click Here .
Provider Identification	Facility Application Type – Entity that does not have associated providers (example hospitals, long term care facilities, etc.). For a list of applicable Provider Types, Click Here .
Languages	Other Application Type – Entity that does not easily fit into any of the other Application Types (example DME, Pharmacy, IDD). For a list of applicable Provider Types, Click Here .
EFT Enrollment	ORP Application Type – ORP providers are individual providers that may only order, refer or prescribe services within their legal scope of practice. ORP providers will not be reimbursed for any services provided, and are not eligible for contracting with Coordinated Care Organizations (CCOs). For a list of applicable Provider Types, Click Here .
Other Information	Key the taxonomy code or description which best describes the type of service that will be provided. A list will be displayed based on the information keyed. From the list, select the appropriate taxonomy code.
Disclosure	Complete the fields on each screen and click the Continue button to move forward to the next page.
Supporting Documentation / Attachments and Fees	Click the Finish Later button to save this application.
Agreement	Enter the name of a contact person to answer any questions regarding the information in this enrollment application.
Summary	* Indicates a required field.
Initial Enrollment Information	
All required attachments must be uploaded directly to this application.	
Please retain the Application Tracking Number (ATN) provided for reference when contacting Provider Enrollment and to quickly access a saved draft of your application in the future.	
Provider may also reach a representative by phone, Monday – Friday 8:00 AM – 5:00 PM CST at 1-800-884-3222	
*Enrollment Type	Individual
*Taxonomy	hospice
*Requesting Enrollment Effective Date	207RH0002X-Internal Medicine Hospice and Palliative Medicine
*Are you enrolling only for the submission of the crossover claims? By selecting Yes, you agree that you will not be paid for any claim types other than crossover claims.	
NOTE: In accordance with the Mississippi Division of Medicaid Administrative Code found at Mississippi Division of Medicaid , providers enrolling with certain taxonomies will only be eligible for the payment of crossover claims.	
Provider Information	

After selecting a primary taxonomy, the applicant can change the date of the **Requesting Enrollment Effective Date** field, which is set to the current date (see).

The page menu on the left will update to reflect the selected enrollment type and primary taxonomy after the applicant selects **Continue** on this page. If the applicant returns and changes either of these fields, the application will be reset accordingly, and any information that has been entered will need to be re-entered.

The system asks if the applicant is enrolling only for crossover claims. If the applicant selects Yes, this constitutes an agreement that they will not be paid for claim types other than crossover claims.

Figure 4: Request Information – Provider and Program Information

Initial Enrollment Information	
All required attachments must be uploaded directly to this application.	
Please retain the Application Tracking Number (ATN) provided for reference when contacting Provider Enrollment and to quickly access a saved draft of your application in the future.	
Provider may also reach a representative by phone, Monday – Friday 8:00 AM – 5:00 PM CST at 1-800-884-3222	
*Enrollment Type	Individual
*Taxonomy	207RH0002X-Internal Medicine Hospice and Pallia
*Requesting Enrollment Effective Date	08/03/2022
*Are you enrolling only for the submission of the crossover claims? By selecting Yes, you agree that you will not be paid for any claim types other than crossover claims.	<input type="radio"/> Yes <input checked="" type="radio"/> No
NOTE: In accordance with the Mississippi Division of Medicaid Administrative Code found at Mississippi Division of Medicaid , providers enrolling with certain taxonomies will only be eligible for the payment of crossover claims.	
Provider Information	
The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.	
*NPI	1760663900
*NPI Zip + 4	386461142
*SSN	123123123
*Are you currently enrolled as a Provider?	<input type="radio"/> Yes <input checked="" type="radio"/> No
*Were you previously enrolled as a Provider?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Program Enrollment	
Please choose a selection below (at least one is required). Note: When choosing MSCAN, Fee-For-Service (FFS) must also be chosen. Click Here , to view taxonomies excluded from MSCAN and/or MSCHIP enrollments.	
Fee-For-Service (FFS)	<input checked="" type="checkbox"/>
MSCAN	<input checked="" type="checkbox"/>
MSCHIP	<input checked="" type="checkbox"/>
Application Contact Information	
Enter the name of a contact person to answer any questions regarding the information provided in this enrollment application.	
*Last Name	Jones
*First Name	John
Title	
*Phone	6015551212
Ext	
Fax Number	
*Work Email	slawrence@gainwelltechnologies.com
*Confirm Email	slawrence@gainwelltechnologies.com
Preferred Method of Communication	Email
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>	

In the **Provider Information** panel, the applicant must enter the provider's National Provider Identifier (NPI), the ZIP Code for the service location applicable to the NPI, and the Social Security Number (SSN) or Tax ID of the provider (this becomes the Login ID for the application). The applicant must also indicate whether the provider is or was enrolled in Medicaid.

In the **Program Enrollment** panel, the applicant must select at least one program to enroll in. If MSCAN and/or MSCHIP is selected, the provider is subject to credentialing.

In the **Application Contact Information** panel, the applicant should enter their contact information. Questions about the application will be addressed to this person at the provided phone, fax, or email contacts. For example, the Application Tracking Number (ATN) will be sent to the email address for this contact.

Facilities have the additional **Change of Ownership (CHOW)** panel to indicate if the applicant is taking over an existing facility (see Figure 5: Request Information – Provider and Program Information for Facility with CHOW on page 6). If the applicant indicates they are assuming ownership they must indicate whether they are assuming the previous provider's NPI. If so they must provide the NPI as part of the application.

When the applicant clicks **Continue**, the pages of the enrollment update according to the selections entered. For enrollments in MSCAN and MSCHIP, the Credentialing Information page is inserted before the Taxonomies page. The Hospital Admittance and Applicant History pages have been inserted between the Other Information and Disclosure pages. Due to credentialing requirements, the Other Information page will now include the Insurance panel.

Figure 5: Request Information – Provider and Program Information for Facility with CHOW

Summary	Initial Enrollment Information All required attachments must be uploaded directly to this application. Please retain the Application Tracking Number (ATN) provided for reference when contacting Provider Enrollment and to quickly access a saved draft of your application in the future. Provider may also reach a representative by phone, Monday – Friday 8:00 AM – 5:00 PM CST at 1-800-884-3222 <div> <div>*Enrollment Type</div> <div>Facility</div> </div> <div> <div>*Taxonomy</div> <div>261QB0400X-Clinic/Center - Birthing</div> </div> <div> <div>*Requesting Enrollment Effective Date</div> <div>08/01/2022</div> </div> <div> <div>*Are you enrolling only for the submission of the crossover claims? By selecting Yes, you agree that you will not be paid for any claim types other than crossover claims.</div> <div> <input type="radio"/> Yes <input checked="" type="radio"/> No </div> </div> <p>NOTE: In accordance with the Mississippi Division of Medicaid Administrative Code found at Mississippi Division of Medicaid, providers enrolling with certain taxonomies will only be eligible for the payment of crossover claims.</p>
	Provider Information The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required. <div> <div>*NPI</div> <div>1730594185</div> <div>*NPI Zip + 4</div> <div>386461142</div> </div> <div> <div>*Tax ID Number</div> <div>425284001</div> <div>Tax ID Type</div> <div>EIN</div> </div> <div> <div>*Are you currently enrolled as a Provider?</div> <div> <input type="radio"/> Yes <input checked="" type="radio"/> No </div> </div> <div> <div>*Were you previously enrolled as a Provider?</div> <div> <input type="radio"/> Yes <input checked="" type="radio"/> No </div> </div>
	Change of Ownership (CHOW) <div> <div>*Are you assuming ownership?</div> <div> <input checked="" type="radio"/> Yes <input type="radio"/> No </div> </div> <div> <div>*Are you assuming previous Provider's NPI?</div> <div> <input checked="" type="radio"/> Yes <input type="radio"/> No </div> </div> <div> <div>*Provider's Medicaid ID?</div> <div>000930562</div> </div> <div> <div>*Effective Date of Ownership</div> <div>08/01/2022</div> </div>
	Program Enrollment Please choose a selection below (at least one is required). Note: When choosing MSCAN, Fee-For-Service (FFS) must also be chosen. Click Here , to view taxonomies excluded from MSCAN and/or MSCHIP enrollments. <div> <div>Fee-For-Service (FFS)</div> <div><input checked="" type="checkbox"/></div> <div>MSCAN</div> <div><input checked="" type="checkbox"/></div> <div>MSCHIP</div> <div><input checked="" type="checkbox"/></div> </div>
	Application Contact Information Enter the name of a contact person to answer any questions regarding the information provided in this enrollment application. <div> <div>*Last Name</div> <div>JONES</div> </div> <div> <div>*First Name</div> <div>JOHN</div> </div> <div> <div>Title</div> <div></div> </div> <div> <div>*Phone</div> <div>6015551212</div> <div>Ext</div> <div></div> </div> <div> <div>Fax Number</div> <div></div> </div> <div> <div>*Work Email</div> <div>SLAWRENCE@GAINWELLTECHNOLOGIES.COM</div> </div> <div> <div>*Confirm Email</div> <div>SLAWRENCE@GAINWELLTECHNOLOGIES.COM</div> </div> <div> <div>Preferred Method of Communication</div> <div>Email</div> </div>
	<div>Continue</div> <div>Finish Later</div> <div>Cancel</div>

Credentialing Information Page

At the **Credentialing Information** page, individual applicants enrolling in MSCAN or MSCHIP must either select a Credentialing Delegate Agency and credentialing date, or a Council for Affordable Quality Healthcare® (CAQH) ID. See Figure 6: Individual Credentialing Information Page.

Figure 6: Individual Credentialing Information Page

Provider Enrollment: Credentialing Information	
Welcome Request Information Credentialing Information Taxonomies Addresses Provider Identification	<p>Credentialing Information</p> <p>Either enter Credentialing Delegate Agency Name and Date or your CAQH ID.</p> <p>Credentialing Delegate Agency Name <input type="text"/> Credentialing Date <input type="text"/></p> <p>OR</p> <p>CAQH ID <input type="text" value="123456789"/></p> <p>Continue Finish Later Cancel</p>

Facility applicants enrolling in MSCAN or MSCHIP only have the option to enter a Credentialing Delegate Agency. Facilities can bypass this panel if they are not contracted with a delegated credentialing agency. In this case the provider will be credential by the DOM CVO. See Figure 7: Facility Credentialing Information Page.

Figure 7: Facility Credentialing Information Page

Provider Enrollment: Credentialing Information	
Welcome Request Information Credentialing Information Taxonomies	<p>Credentialing Information</p> <p>Enter Credentialing Delegate Agency Name and Date.</p> <p>Credentialing Delegate Agency Name <input type="text"/> Credentialing Date <input type="text"/></p> <p>Continue Finish Later Cancel</p>

Additional Taxonomies Page

At the **Additional Taxonomies** page, the applicant can add other taxonomies within the same family of taxonomies. Each of these will be assigned its own Medicaid ID when the application is approved and finalized, but additional taxonomies will not change the content of the application. See Figure 8: Additional Taxonomies Page.

Figure 8: Additional Taxonomies Page

Addresses Page

At the **Addresses** page, the applicant must enter at least a service location address. They can also add a Mail-To, Pay-To, and Corporate Office address. These four addresses are required in MESA. If any addresses are missing, MESA copies the service location address to the missing address fields.

If the applicant selects Service Location from the **Address Type** drop-down list, the page updates with additional information and panels (see Figure 9: Addresses Page – Service Location).

The service location must be a physical address. The system verifies the ZIP Code as well as the State-County combination. The applicant can specify up to four phone numbers. Only one phone number is required, and the type must be Office.

In the **Service Address Information** panel, applicants must indicate hours for each day of the week. The system offers the ability to indicate if the location is open 24 hours or if it is closed all day, such as on weekends.

The applicant should also indicate here if the provider is accepting new patients, and if there are any patient restrictions. New patient information appears with provider data on the Member Portal provider search results page.

If there are any administrators at the location, they should be listed here. If a Facility or Medical Administrator is listed, an entry is required in the **License #** field.

If the service location has Telecommunication Device for the Deaf (TDD) or teletypewriter (TTY) capabilities, the applicant can indicate it here. If a check box is selected, the system requires the applicable phone number for the device. This information is also included on the Member Portal.

Figure 9: Addresses Page – Service Location

<div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Credentialed Information </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Taxonomies </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Addresses </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Provider Identification </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Languages </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> EFT Enrollment </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Other Information </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Hospital Admittance </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Applicant History </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Disclosure </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Supporting Documentation / Attachments and Fees </div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;"> Agreement </div> <div style="background-color: #f2f2f2; padding: 5px;"> Summary </div>	<div style="background-color: #e6f2ff; padding: 5px; margin-bottom: 10px;"> Provider Addresses </div> <p>The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.</p> <ul style="list-style-type: none"> The service location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered. The service location name must match the business name on the W-9. If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBAs (405 IAC 1-19.1b) as an attachment to the packet. The service location address must be a physical location. A post office box is not a valid service location address. Providers that provide services at a "place of service site", such as at a hospital or nursing facility, should enter their home/business office as their service location address. The standard NPPE/License address must be entered as the Service address for any provider that is not a billing provider. <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th>Contact Name</th> <th>Address Type</th> <th>Address</th> <th>City</th> <th>State</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6"> <div style="border: 1px solid #ccc; padding: 5px;"> <div style="display: flex; justify-content: space-between; align-items: center;"> Click to collapse. + </div> <div style="padding: 10px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>*Address Type Servicing</p> <p>*Name Type <input type="radio"/> Business Name <input checked="" type="radio"/> Personal Name</p> <p>*Last Name </p> <p>*First Name </p> <p>Middle Title </p> <p>*Address </p> <p>*City *County QUITMAN</p> <p>*State North Carolina *Zip Code 686461142</p> <p>*Contact Name </p> <p>*Primary Email *Confirm Email </p> <p>*Phone Office Ext Phone Ext </p> <p>Phone Ext Phone Ext </p> </div> </div> </div> </div></td> <td></td> </tr> </tbody> </table> <div style="background-color: #e6f2ff; padding: 5px;"> Service Address Information </div> <p>If 'Address Type' is changed from 'Servicing', the service information below will be lost upon 'Add' or 'Save' of address.</p> <p style="text-align: center;">Office Hours</p> <table style="width: 100%;"> <tr> <td>*Monday</td> <td>From 08:00 AM</td> <td>To 05:00 PM</td> <td>Open 24 hrs <input checked="" type="checkbox"/></td> <td>Closed <input type="checkbox"/></td> </tr> <tr> <td>*Tuesday</td> <td>From 08:00 AM</td> <td>To 05:00 PM</td> <td>Open 24 hrs <input checked="" type="checkbox"/></td> <td>Closed <input type="checkbox"/></td> </tr> <tr> <td>*Wednesday</td> <td>From 08:00 AM</td> <td>To 05:00 PM</td> <td>Open 24 hrs <input checked="" type="checkbox"/></td> <td>Closed <input type="checkbox"/></td> </tr> <tr> <td>*Thursday</td> <td>From 08:00 AM</td> <td>To 05:00 PM</td> <td>Open 24 hrs <input checked="" type="checkbox"/></td> <td>Closed <input type="checkbox"/></td> </tr> <tr> <td>*Friday</td> <td>From 08:00 AM</td> <td>To 05:00 PM</td> <td>Open 24 hrs <input checked="" type="checkbox"/></td> <td>Closed <input type="checkbox"/></td> </tr> <tr> <td>*Saturday</td> <td>From </td> <td>To </td> <td>Open 24 hrs <input checked="" type="checkbox"/></td> <td>Closed <input type="checkbox"/></td> </tr> <tr> <td>*Sunday</td> <td>From </td> <td>To </td> <td>Open 24 hrs <input checked="" type="checkbox"/></td> <td>Closed <input type="checkbox"/></td> </tr> </table> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <p>Accepting New Patients <input checked="" type="checkbox"/></p> <p>Sedation <input checked="" type="checkbox"/></p> <p>Services for Intellectual Disability <input checked="" type="checkbox"/></p> <p>Providing XRays <input type="checkbox"/></p> <p>Age Restrictions <input type="checkbox"/></p> </div> <div style="width: 45%;"> <p>Accepting New Patients with Special Needs <input checked="" type="checkbox"/></p> <p>Permit/Licenses# 123456789</p> <p>Providing PET and MRI <input type="checkbox"/></p> <p>Other Restrictions <input type="checkbox"/> </p> </div> </div> <p>Verify Facility Name fields as it may have been auto populated by your browser.</p> <table style="width: 100%;"> <tr> <td>Facility Administrator Last Name</td> <td></td> <td>First Name</td> <td></td> <td>License #</td> <td></td> </tr> <tr> <td>Medical Administrator Last Name</td> <td></td> <td>First Name</td> <td></td> <td>License #</td> <td></td> </tr> <tr> <td>Service Administrator Last Name</td> <td></td> <td>First Name</td> <td></td> <td></td> <td></td> </tr> </table> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <p>TDD Capability <input type="checkbox"/></p> <p>TTY Capability <input type="checkbox"/></p> </div> <div style="width: 45%;"> <p>Phone Ext </p> <p>Phone Ext </p> </div> </div>	Contact Name	Address Type	Address	City	State	Action	<div style="border: 1px solid #ccc; padding: 5px;"> <div style="display: flex; justify-content: space-between; align-items: center;"> Click to collapse. + </div> <div style="padding: 10px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>*Address Type Servicing</p> <p>*Name Type <input type="radio"/> Business Name <input checked="" type="radio"/> Personal Name</p> <p>*Last Name </p> <p>*First Name </p> <p>Middle Title </p> <p>*Address </p> <p>*City *County QUITMAN</p> <p>*State North Carolina *Zip Code 686461142</p> <p>*Contact Name </p> <p>*Primary Email *Confirm Email </p> <p>*Phone Office Ext Phone Ext </p> <p>Phone Ext Phone Ext </p> </div> </div> </div> </div>							*Monday	From 08:00 AM	To 05:00 PM	Open 24 hrs <input checked="" type="checkbox"/>	Closed <input type="checkbox"/>	*Tuesday	From 08:00 AM	To 05:00 PM	Open 24 hrs <input checked="" type="checkbox"/>	Closed <input type="checkbox"/>	*Wednesday	From 08:00 AM	To 05:00 PM	Open 24 hrs <input checked="" type="checkbox"/>	Closed <input type="checkbox"/>	*Thursday	From 08:00 AM	To 05:00 PM	Open 24 hrs <input checked="" type="checkbox"/>	Closed <input type="checkbox"/>	*Friday	From 08:00 AM	To 05:00 PM	Open 24 hrs <input checked="" type="checkbox"/>	Closed <input type="checkbox"/>	*Saturday	From 	To 	Open 24 hrs <input checked="" type="checkbox"/>	Closed <input type="checkbox"/>	*Sunday	From 	To 	Open 24 hrs <input checked="" type="checkbox"/>	Closed <input type="checkbox"/>	Facility Administrator Last Name		First Name		License #		Medical Administrator Last Name		First Name		License #		Service Administrator Last Name		First Name			
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Medical Administrator Last Name		First Name		License #																																																															
Service Administrator Last Name		First Name																																																																	

Finally, the Accessibility Options panel offers the ability to indicate if the service location offers any of these types. The applicant can add any or all of these types. They will appear in the Accessibility Type data list for the service location. See Figure 10: Addresses Page – Accessibility Options Panel.

Figure 10: Addresses Page – Accessibility Options Panel

When the applicant adds the service location, it appears in the Provider Addresses data list. They can add as many locations as applicable for the provider. If the applicant adds multiple service locations, each service location will be assigned an ATN. All non-service locations will be attached to each service location record in MESA. See Figure 11: Addresses – Provider Addresses.

Figure 11: Addresses – Provider Addresses

Provider Identification Page

At the **Provider Identification** page, the applicant must enter information about the provider, the organizational structure of the business, and add licenses, CLIA certifications, and DEA information. If the provider has already participated in Medicare, the number, type, and effective dates must be added here. See Figure 12: Provider Identification Page.

Figure 12: Provider Identification Page

[Welcome](#)
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[Credentialing Information](#)
[Taxonomies](#)
[Addresses](#)
Provider Identification
[Languages](#)
[EFT Enrollment](#)
[Other Information](#)
[Hospital Admittance](#)
[Applicant History](#)
[Disclosure](#)
[Supporting Documentation / Attachments and Fees](#)
[Agreement](#)
[Summary](#)

Provider Enrollment: Provider Identification

* Indicates a required field.

Provider Legal Name

The provider legal name and information is provided once for each enrollment.

*Last Name

*First Name

Middle Title

Individual Providers

*Gender *Birth Date

Organizational Structure

- 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.
- If you are affiliated with a Military Medical Treatment Facility (MTF), you must select the Military MTF option from the drop down.
- If you are affiliated with a Tribal Agency, you must select the Tribal Agency option from the drop down.

*Organization Type

Registered with Secretary of State ☒ Business Start Date

Incorporated ☒ Incorporation Date

Chain Affiliated ☐

Operated by Management Company ☐

*Public/Private Indicator

License

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

	License Type	License #	Effective Date	End Date	Assigning Authority	License State	Action
+	Regular	12345679	12/28/2019	12/28/2029	MS STATE DEPARTMENT OF HEALTH	Mississippi	Remove
+	Click to add license						

Medicare Participation

Medicare # Effective Date Medicare Type

CLIA Certification

Fields marked required in this section are only required if any information is entered in this section.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

	CLIA #	Effective Date	End Date	Action
-	Click to collapse.			
+	*CLIA # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

DEA #

DEA # Effective Date

Languages Page

At the **Languages** page, the applicant must indicate at least one language. The languages indicated here appears on the Member Portal and are searchable by members looking for a provider with translation options. See Figure 13: Languages Page.

Figure 13: Languages Page

Provider Enrollment: Languages							
Welcome Request Information Credentialing Information Taxonomies Addresses Provider Identification ▶ Languages	<p>Providers that have the ability to translate should select the appropriate language below.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>Language</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>ENGLISH</td> <td>Remove</td> </tr> <tr> <td colspan="2"> <input type="button" value="+"/> Click to add language. </td> </tr> </tbody> </table> <p> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </p>	Language	Action	ENGLISH	Remove	<input type="button" value="+"/> Click to add language.	
Language	Action						
ENGLISH	Remove						
<input type="button" value="+"/> Click to add language.							

EFT Information Page

At the **EFT Information** page, banking information is required. The applicant must also include EFT documentation with the attachments for the application. See Figure 14: EFT Information Page.

Figure 14: EFT Information Page

Provider Enrollment: EFT Information	
Welcome Request Information Credentialing Information Taxonomies Addresses Provider Identification Languages	<p>All providers agree to electronic direct deposit transfer payments for claims reimbursement by the Division of Medicaid and to submit, in accordance with instructions from the Division of Medicaid or its agent.</p> <p>* Indicates a required field.</p> <p> *Financial Institution Name <input type="text" value="Bank of Banks"/> </p> <p> *ABA Routing Number <input type="text" value="123456789"/> </p> <p> *Type of Account at Financial Institution <input type="text" value="Checking"/> </p> <p> *Provider's Account Number with Financial Institution <input type="text" value="123456"/> </p> <p> *Confirm Account Number <input type="text" value="123456"/> </p> <p> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </p>

Other Information Page

The **Other Information** page includes an **Insurance** panel if the application requires certification, see Figure 15: Other Information Page – Insurance Panel Entry Fields. Applicants can add multiple insurance records. See

For hospital applications, this page includes the **Facility Information** panel to indicate the administrator's name and contact information as well as bed count. See Figure 16: Other Information Page with Facility Information.

Figure 16: Other Information Page for a view of the page with a listed insurance record.

Figure 15: Other Information Page – Insurance Panel Entry Fields

Provider Enrollment: Other Information														
Welcome Request Information Credentialing Information Taxonomies Addresses Provider Identification Languages EFT Enrollment Other Information Hospital Admittance Applicant History Disclosure Supporting Documentation / Attachments and Fees Agreement Summary	<p>* Indicates a required field.</p> <p>Insurance</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p> <p>Information regarding professional (malpractice) liability insurance coverage is required.</p> <p>Please refer to the CVO Professional Liability Insurance Policy for coverage requirements.</p> <p>Note: The Provider is required to upload proof of liability insurance.</p> <table border="1"> <thead> <tr> <th>Name</th> <th>Policy #</th> <th>Effective Date</th> <th>Expiration Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="5"> <div>Click to collapse.</div> <div> <div>*Carrier or Self-Insured Name</div> <div>Aetna</div> <div>*Policy Number</div> <div>123456789</div> <div>*Address</div> <div>1900 E Woodrow Wilson Ave</div> <div>*City</div> <div>Jackson</div> <div>*County</div> <div>HINDS</div> <div>*State</div> <div>Mississippi</div> <div>*Effective Date</div> <div>01/01/2020</div> <div>*Expiration Date</div> <div>01/01/2025</div> <div>*Do you have unlimited coverage with this insurance carrier?</div> <div> <input checked="" type="radio"/> Yes <input type="radio"/> No </div> <div>*Amount of Coverage Per Occurrence</div> <div>100000000.00</div> <div>*Amount of Coverage Per Aggregate</div> <div>1000000.00</div> <div> <div>Add</div> <div>Reset</div> </div> </div> </td> </tr> </tbody> </table>				Name	Policy #	Effective Date	Expiration Date	Action	<div>Click to collapse.</div> <div> <div>*Carrier or Self-Insured Name</div> <div>Aetna</div> <div>*Policy Number</div> <div>123456789</div> <div>*Address</div> <div>1900 E Woodrow Wilson Ave</div> <div>*City</div> <div>Jackson</div> <div>*County</div> <div>HINDS</div> <div>*State</div> <div>Mississippi</div> <div>*Effective Date</div> <div>01/01/2020</div> <div>*Expiration Date</div> <div>01/01/2025</div> <div>*Do you have unlimited coverage with this insurance carrier?</div> <div> <input checked="" type="radio"/> Yes <input type="radio"/> No </div> <div>*Amount of Coverage Per Occurrence</div> <div>100000000.00</div> <div>*Amount of Coverage Per Aggregate</div> <div>1000000.00</div> <div> <div>Add</div> <div>Reset</div> </div> </div>				
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For hospital applications, this page includes the **Facility Information** panel to indicate the administrator's name and contact information as well as bed count. See Figure 16: Other Information Page with Facility Information.

Figure 16: Other Information Page with Facility Information

Provider Enrollment: Other Information																																																			
Welcome	* Indicates a required field.																																																		
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	Board Certification Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row. If board certified, please provide the board certification type, number, effective date, and expiration date of certification. <table border="1"> <thead> <tr> <th>Certification Type</th> <th>Certificate #</th> <th>Effective Date</th> <th>End Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> CLIA CERTIFICATION LETTER FROM CMS</td> <td>CL123456789</td> <td>05/01/2022</td> <td>05/01/2025</td> <td>Remove</td> </tr> </tbody> </table> <input type="checkbox"/> Click to add board certification.	Certification Type	Certificate #	Effective Date	End Date	Action	<input type="checkbox"/> CLIA CERTIFICATION LETTER FROM CMS	CL123456789	05/01/2022	05/01/2025	Remove																																								
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Hospital Admittance Page

The **Hospital Admittance** page appears for individual providers. If the page doesn't apply to the provider, the applicant selects **Neither**. If the applicant indicates there is an admitting plan or alternate arrangement, the system disables the Admitting Privileges panel and opens the Admitting Plan/Alternate Arrangement panel. Documentation of the plan or arrangement agreement must be included with the application. See Figure 17: Hospital Admittance Page.

Figure 17: Hospital Admittance Page

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Hospital Admittance
[Applicant History](#)
[Disclosure](#)
[Supporting Documentation / Attachments and Fees](#)
[Agreement](#)
[Summary](#)

Provider Enrollment: Hospital Admittance

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Admitting Type	Hospital	Address	City	State	Action
<input type="checkbox"/> Click to collapse.					
<p>*Do you have Admitting Privileges, an Admitting Plan or Neither?</p> <p> <input type="radio"/> Admitting Privileges <input checked="" type="radio"/> Admitting Plan / Alternate Arrangement <input type="radio"/> Neither </p> <div> <h4>Admitting Privileges</h4> <p>Primary Hospital <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hospital Name <input type="text"/></p> <p>Hospital Affiliation NPI <input type="text"/></p> <p>Address <input type="text"/></p> <p>City <input type="text"/></p> <p>State <input type="text"/></p> <p>Office Phone <input type="text"/></p> <p>Effective Date <input type="text"/></p> <p>Department Director Name <input type="text"/></p> <p>Full, Unrestricted Access? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Are Privileges Temporary? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Admitting Privileges Status <input type="text"/> (e.g. None, Full Unrestricted, Provisional, Temporary)</p> <p>Of Total Annual Admissions, What Percentage is to this Hospital? <input type="text"/> %</p> <p>Terminated Affiliation Information <input type="text"/></p> </div> <div> <h4>Admitting Plan / Alternate Arrangement</h4> <p>*Who will admit on your behalf? <input type="text"/></p> <p>*Admitting Physician NPI <input type="text"/></p> <p>Please submit documentation of the agreement between you and the admitting physician.</p> <p> <input type="button" value="Add"/> <input type="button" value="Reset"/> </p> </div>					

A hospital admittance record can be added for each applicable hospital.

Applicant History Page

The **Applicant History** page requires answers to several statements about the provider's history.

Figure 18: Applicant History Page for Individuals, part 1

Provider Enrollment: Applicant History	
Welcome	For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:
Request Information	<ul style="list-style-type: none"> An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals. A managing employee is defined as 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 operation of the enrolling provider. An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.
Credentialing Information	Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.
Taxonomies	
Addresses	
Provider Identification	
Languages	
EFT Enrollment	
Other Information	
Hospital Admittance	
Applicant History	Ability to Perform Job <p>*Are you NOT able to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If you answer YES, you will be asked to describe why you are NOT able to perform.</p> <p>*Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Do you currently or did you in the last two years engage in the unlawful use of drugs, including the improper use of prescription drugs? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If Yes, please explain: <input type="text"/></p>
Disclosure	
Supporting Documentation / Attachments and Fees	
Agreement	Education and Board Certification <p>*Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you even been placed on probation, disciplined, formally reprimanded, suspended, or asked to resign? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have any of your board certifications or eligibility ever been revoked? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you ever chosen not to re-certify or voluntarily surrendered your board certifications(s) while under investigation? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If Yes, please explain: <input type="text"/></p>
Summary	Training <p>*Are you and your staff annually trained on Fraud, waste, and abuse? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>If No, please explain: <input type="text"/></p>
	Hospital Privileges and Other Affiliations <p>*Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If Yes, please explain: <input type="text"/></p>
	Criminal / Civil History

Where required, the applicant must enter an explanation for their answer before continuing.

Figure 19: Applicant History Page for Individuals, part 2

Criminal / Civil History	
*In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?	<input type="radio"/> Yes <input checked="" type="radio"/> No
*Have you ever been court-martialed for actions related to your duties as a medical professional?	<input type="radio"/> Yes <input checked="" type="radio"/> No
If Yes, please explain:	<div></div>
Malpractice Claims History	
*Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?	<input type="radio"/> Yes <input checked="" type="radio"/> No
If Yes, provide information for each case using the Professional Liability Claims Information Form.	
Professional/General Liability Insurance Information and Claims History	
*Has your professional/general liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	<input type="radio"/> Yes <input checked="" type="radio"/> No
*Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional/general liability insurance carrier, based on your individual liability history?	<input type="radio"/> Yes <input checked="" type="radio"/> No
If Yes, please explain:	<div></div>
Corporate Integrity Agreements	
*Are you currently or have you ever been subject to the terms of a Corporate Integrity Agreement (CIA)?	<input type="radio"/> Yes <input checked="" type="radio"/> No
If yes, are you currently subject to the provisions of a Corporate Integrity Agreement?	<input type="radio"/> Yes <input checked="" type="radio"/> No
What date did the facility enter into the Corporate Integrity Agreement?	<div></div>
If you are currently subject to the provisions of a CIA, provide the CIA and a Compliance letter.	
Investigations	
*Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs?	<input type="radio"/> Yes <input checked="" type="radio"/> No
<div>Continue</div> <div>Finish Later</div> <div>Cancel</div>	

Figure 20: Applicant History Page for Facilities, Part 1

Provider Enrollment: Applicant History	
Welcome Request Information Credentialing Information Taxonomies Addresses Provider Identification Languages	<p>For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:</p> <ul style="list-style-type: none"> An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals. A managing employee is defined as 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 operation of the enrolling provider. An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association. <p>Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.</p> <p>Training</p>

Figure 21: Applicant History Page for Facilities, Part 2

EFT Enrollment	Training
Other Information	<p>*Are you and your staff annually trained on Fraud, waste, and abuse? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If No, please explain: <input type="text"/></p>
Applicant History	
Disclosure	
Supporting Documentation / Attachments and Fees	Hospital Privileges and Other Affiliations
Agreement	<p>*Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If Yes, please explain: <input type="text"/></p>
Summary	
	Criminal / Civil History
	<p>*In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you ever been court-martialed for actions related to your duties as a medical professional? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If Yes, please explain: <input type="text"/></p>
	Malpractice Claims History
	<p>*Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If Yes, provide information for each case using the Professional Liability Claims Information Form.</p>
	Professional/General Liability Insurance Information and Claims History
	<p>*Has your professional/general liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional/general liability insurance carrier, based on your individual liability history? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If Yes, please explain: <input type="text"/></p>
	Corporate Integrity Agreements
	<p>*Are you currently or have you ever been subject to the terms of a Corporate Integrity Agreement (CIA)? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If yes, are you currently subject to the provisions of a Corporate Integrity Agreement? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>What date did the facility enter into the Corporate Integrity Agreement? <input type="text"/> <input type="button" value="Calendar"/></p> <p>If you are currently subject to the provisions of a CIA, provide the CIA and a Compliance letter.</p>
	Investigations
	<p>*Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>

Disclosure Page

There are two versions of the **Disclosure** page. The short version is for Individual and ORP Individuals. The long version is for Facility, Group and Other enrollment types. See Figure 22: Disclosure Page – Short Version.

Figure 22: Disclosure Page – Short Version

Provider Enrollment: Disclosure									
Welcome	Final Adverse Legal Action History								
Request Information	This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspension for the enrolling provider. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.								
Credentialing Information									
Taxonomies	Convictions								
Addresses	1. Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs.								
Provider Identification	2. Has been convicted of a crime reference in Miss. Code Ann. § 43-13-121(7)(c)-(h), or								
Languages	3. Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c)-(h).								
EFT Enrollment									
Other Information	Exclusions, Revocations or Suspensions								
Hospital Admittance	1. Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,								
Applicant History	2. Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,								
Disclosure	3. Has had his/her/its license or certification revoked, or								
Supporting Documentation / Attachments and Fees	4. Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.								
Agreement									
Summary	Final Adverse Legal Action History								
	<p>*Has the enrolling provider, under any current or former name or business identity, ever had a final adverse legal action imposed? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If yes, report each final adverse legal action, when it occurred, the Federal or State Agency or the court/administrative body that imposed the action, and the resolution, if any.</p> <p>Provide a copy of the final adverse legal action documentation and resolution.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>Row</th> <th>Final Adverse Legal Action</th> <th>Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="4">Click to add Final Adverse Legal Action</td> </tr> </tbody> </table>	Row	Final Adverse Legal Action	Date	Action	Click to add Final Adverse Legal Action			
Row	Final Adverse Legal Action	Date	Action						
Click to add Final Adverse Legal Action									
	Continue Finish Later Cancel								

The long version includes the sections shown in Figure 23: Disclosure Page – Sample from Long Version, as well as:

- Section D, Relationship to Excluded, Penalized, or Convicted Persons
- Section E, Disclosure of Other Ownership and Control
- Section F, Disclosure of Subcontractor Information
- Section G, Business Transactions
- Section H, Attestation and Signature of the Disclosing Provider

Figure 23: Disclosure Page – Sample from Long Version

Provider Enrollment: Disclosure							
Welcome	Instructions for Mississippi Medicaid Provider Disclosure Form (Section C-2)						
Request Information	<input type="checkbox"/> Click to View Instructions						
Credentialing Information	SECTION B						
Taxonomies	Direct/Indirect Ownership Interest and Managing Control Identification Information						
Addresses	NOTE: ONLY REPORT ORGANIZATIONS IN SECTION B-1. INDIVIDUALS WITH OWNERSHIP/MANAGING CONTROL MUST BE REPORTED IN SECTION B-2. The disclosing entity is responsible for reporting all ownership and managing control.						
Provider Identification	SECTION B-1						
Languages	Entity with Direct/Indirect Ownership Interest and/or Managing Control Identification Information						
EFT Enrollment	Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.						
Other Information	<input type="checkbox"/>	Row	Legal Business Name as Reported to the Internal Revenue Service	Employer Identification Number (EIN)	Percent Ownership	Action	
Applicant History	<input type="checkbox"/> Click to add Organization						
Disclosure	SECTION B-2						
Supporting Documentation / Attachments and Fees	Individuals with Ownership Interest and/or Agents/Managing Control						
Agreement	<p>The following individuals must be reported in Section B-2:</p> <ul style="list-style-type: none"> ▶ All individual owners with 5% or more direct/indirect ownership ▶ All officers and directors of the disclosing provider (whether for profit or non-profit) ▶ All managing employees of the disclosing provider ▶ All authorized and delegated officials noted in the Mississippi Medicaid Enrollment application <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p>						
Summary	<input type="checkbox"/>	Row	Last Name	First Name	SSN	Birth Date	Action
	<input type="checkbox"/>	1	Jones	Robert	*****4025	05/01/1990	Remove
	<input type="checkbox"/> Click to add Individual						
	Relationships						
	<p>If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing employee, director, or shareholder and is related to each other as spouse, parent, child or sibling, please note the name and relationship:</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p>						
	<input type="checkbox"/>	Row	Owner/Managing Employee 1	Relationship	Owner/Managing Employee 2	Action	
	<input type="checkbox"/> Click to add Relationship						
	SECTION C						
	Criminal Convictions and Other Sanctions						
	<p>Provide the requested information in this section for any person who:</p> <p>(1) Has an ownership or control interest in the disclosing provider OR is an agent or managing employee of the disclosing provider AND (2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs, OR (3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c-h), (4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h), (5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program, (6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program, (7) Has had his/her/its license or certification revoked, or (8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.</p> <p>Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p>						
	<input type="checkbox"/>	Row	Name	Criminal/Sanction Info	Date	Action	

Supporting Documentation/Attachments and Fees

In addition to the **Attachments** panel, this page includes an **Application Fee** panel for providers who must pay an enrollment fee. If the applicant selects **Submitting Hardship Waiver** from the **Fee Payment Type** drop-down list, they must include supporting documentation with the attachments. See Figure 24: Supporting Documentation Page.

Figure 24: Supporting Documentation Page

[Welcome](#)
[Request Information](#)
[Credentialing Information](#)
[Taxonomies](#)
[Addresses](#)
[Provider Identification](#)
[Languages](#)
[EFT Enrollment](#)
[Other Information](#)
[Applicant History](#)
[Disclosure](#)
Supporting Documentation / Attachments and Fees

Provider Enrollment: Supporting Documentation/Attachments And Fees

Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit attachments, please follow the instructions in the Attachments panel below.

Instructions : [Privacy Notice \(Must View\)](#)

Checklist of General Provider Information Needed
[Important Check List Items can be found](#)

* Indicates a required field.

Attachments

To add an attachment, complete the required fields and click the **Add** button.
 Use the 'Other' selection to upload attachments not in the list.

Note: if you choose to "Upload" attachments by "File Transfer", a maximum of 20 MBs of information can be uploaded.
 The allowable file types are: gif, jpg, jpeg, pdf, png, tif, tiff, txt.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action
1	FT-File Transfer	Medicaid.pdf (43K)	Medicare Certification	Remove
2	FT-File Transfer	FEIN SSN W9.pdf (43K)	Copy of W9 for FEIN	Remove
3	FT-File Transfer	License.pdf (43K)	All	Remove

Click to add attachment.

Application Fee

Mississippi Medicaid has determined that your application will require you to pay an application fee.

***Fee Payment Type** Submitting Payment

Warning: If you select Hardship Waiver or Submitting Payment on the Fee Payment Type dropdown, supporting documentation must be received in 10 days or your application will be denied.

Attachment Attestation

☒ I have verified that I have uploaded all documentation for this enrollment application. I understand that any missing documentation will delay processing of the submitted application.

[Continue](#)
[Finish Later](#)
[Cancel](#)

Facility Attestation/Authorization Page

This page displays when the enrollment type is Facility or Other; MSCAN and/or MSCHIP are selected; and no delegate agency is reported on the **Credentialing Information** page.

Figure 25: Facility Attestation/Authorization and Release Page

Provider Enrollment: Facility Attestation / Authorization and Release	
Welcome Request Information Credentialing Information Taxonomies Addresses Provider Identification Languages EFT Enrollment Other Information Applicant History Disclosure Supporting Documentation / Attachments and Fees Facility Attestation / Authorization and Release Agreement Summary	<p>Mississippi Division of Medicaid / Centralized Credentialing Verification Organization (CVO) Facility Attestation / Authorization and Release</p> <p>As part of my application for credentialing submitted to the CVO (my "Application"), I hereby acknowledge, understand, consent, and agree as follows:</p> <ol style="list-style-type: none"> 1. Consistent with my Application, I have the obligation to and burden of submitting all information useful and necessary for proper evaluation of my Application. 2. I am responsible for addressing and resolving any and all issues, questions, and concerns regarding information provided to the CVO in my Application. I agree to provide information related to my Application and requested by CVO, including updated information. My failure to produce any information requested by the CVO may result in the CVO electing not to evaluate my Application or denying my Application. 3. The CVO may investigate any information included in my Application and I consent to all aspects of such investigation as part of the credentialing process. More specifically, I authorize the CVO to request, obtain, and act upon any information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health, emotional stability, utilization practices, professional licensure or certification, and other matter related to my qualifications or other information associated with my Application (my "Qualifications"). 4. I hereby authorize any and all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, corporations, agencies, licensing authorities, boards, plans, insurers, and other organizations of any type, including, but not limited to, those with which I have been associated, who have information which may bear on my Qualifications to consult with, report to, and release, exchange and share information and documents with the CVO for the purpose of the CVO's evaluation of my Application and my Qualifications. 5. I consent to and hereby authorize the CVO's inspection of records and documents (including medical records and peer review information) that may be material to the CVO's evaluation of my Application and Qualifications and my ability to carry out the services which I may perform in the event my Application is approved. I hereby authorize each and every individual and organization with custody of those records and documents to permit the CVO's inspection and copying of them as may be reasonably necessary for the CVO's evaluation of my Application. I agree to appear before the CVO for interviews regarding the CVO's evaluation of my Application. 6. I consent to and hereby authorize the CVO's release of records, documents, and related information to healthcare entities, care management organizations and interested persons on their request for such information concerning my Qualifications (including, but not limited to, peer review information), provided that the CVO's release of such information is done in good faith and without malice. I hereby release the CVO and its authorized representatives and agents from liability for any claim for damages of any nature for the good faith release of records, documents, or other related information. 7. I hereby release the CVO and its authorized representatives and agents from liability for their acts when performed in a reasonable manner with respect to the investigation and evaluation of my Application and my Qualifications, and I hereby waive any and all claims of any nature against the CVO and its authorized representatives and agents acting in good faith and without malice in connection with the evaluation of my Application and my Qualifications. 8. I acknowledge and understand that any investigations, actions, and recommendations by the CVO (including the CVO's Credentialing Committee) with respect to the evaluation of my Application and my Qualifications and any further reappraisals or evaluations will be undertaken by the CVO as a medical review and/or peer review committee are consistent with the CVO's obligations (under applicable law or otherwise) to conduct such reviews and are, therefore, entitled to application protections provided by law. 9. I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating practitioner by CVO, DCH or a Care Management Organization under contract with DCH. 10. I understand that I have the right to review and correct erroneous information obtained by the CVO to evaluate my Application. This includes information obtained from primary sources (e.g., malpractice insurance carriers, state licensing boards and National Practitioner Data Bank). The review must take place within six (6) months of the date of this Application and my proposed corrections must be submitted in writing to the CVO within thirty (30) days of commencement of the review. The CVO is not required to allow a practitioner to review references or recommendations or other information that is peer-review protected. 11. I understand that if my Application is rejected for reasons relating to my professional conduct or competence, CVO may report the rejection to the appropriate state licensing board, the National Practitioner Data Bank, and/or the Health Care Integrity and Protection Data Bank. 12. I certify that (i) the information provided in or attached to my Application is accurate and complete; (ii) I have adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state financial responsibility requirements; (iii) I hold a full, unrestricted license to practice in the state(s) in which I practice or I have indicated on this application the limitations and/or restrictions imposed; and (iv) I have reported any loss or limitation of hospital privileges or any disciplinary activity to the CVO. <p>Select the appropriate option:</p> <p><input type="checkbox"/> As a physician, I attest that I will continue to maintain active admitting and staff privileges at a CVO-participating hospital or I have otherwise indicated on this application.</p> <p><input type="checkbox"/> As a health care professional requiring a supervising physician relationship, I attest that I have a written agreement with a physician who oversees my clinical decision in compliance with the professional licensing laws in the state(s) in which I practice.</p> <p><input type="checkbox"/> I am not a physician or a health care professional who is required to have a supervising physician relationship.</p> <ol style="list-style-type: none"> 13. The CVO does not discriminate on the basis of race, color, national origin, sex, religion, age or disability. 14. I have read and fully understand this Authorization and Release, which constitutes my written authorization and request to provide and release any and all relevant information (including supportive records and documents) regarding my Application and any further reappraisals and evaluations by the CVO. I agree to execute any additional releases as may be reasonably required by the CVO in connection with any further reappraisal and evaluations. 15. By signing below, I attest that I am the duly authorized representative of the Facility and have the proper authorization to execute this attestation with the intent to fully bind Facility to the truthfulness of its answers. I attest that all the information on this entire application is complete, accurate and current. <p>*Your Signature <input type="text"/> Date 07/27/2022</p> <p>(Entering your name in the box to the right will constitute your electronic signature.)</p> <p> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </p>

Agreement Page

The **Agreement** page lists the terms of the enrollment for the applicant to accept and sign.

Figure 26: Agreement Page

Provider Enrollment: Agreement	
Welcome Request Information Credentialing Information Taxonomies Addresses Provider Identification Languages EFT Enrollment Other Information Hospital Admittance Applicant History Disclosure Supporting Documentation / Attachments and Fees Agreement Summary	<p>Instructions</p> <p>The terms of enrollment are stated below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.</p> <p>Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.</p> <p>The enrollment application terms must be accepted in order to submit the application for approval.</p> <p>Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.</p> <p>Terms of Agreement</p> <p>Provider Name John Jones Address 500 S Denver Ave Marks Mississippi, 38646-1142 Tax ID *****3123 NPI 1760663900 Contact Name JOHN JONES Contact Email SLAWRENCE@GAINWELLTECHNOLOGIES.COM</p> <p>Programs selected for application:</p> <ul style="list-style-type: none"> Fee-For-Service (FFS) MSCAN MSCHIP <p>Division of Medicaid The Office of the Governor Medical Assistance Participation Agreement (Medicaid – Title XIX Program)</p> <p>The Medicaid Provider Agrees</p> <ol style="list-style-type: none"> To provide medical services to eligible Medicaid beneficiaries without regard to race, color, religion, sex, national origin, handicap, or limited English proficiency. To abide by federal and state laws and regulations affecting delivery of services. Not to refuse to furnish services covered under the Medicaid program to an individual who is eligible for Medicaid because of potential third party liability for the services or to discriminate as to recipients served or services provided because of Medicaid eligibility or potential third party liability. In the event litigation is had concerning any part of this Agreement, whether initiated by the Provider or the Mississippi Division of Medicaid, is agreed that such litigation shall be had and conducted in either the Circuit or Chancery Courts of Hinds County, Mississippi, or the United States District Court for the Southern District of Mississippi, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue. <p>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.</p> <p>*I accept <input checked="" type="checkbox"/> I understand that my electronic signature is equivalent to written signature.</p> <p>*Your Signature <input type="text" value="John Jones"/></p> <p>(Entering your name in the box to the right will constitute your electronic signature.)</p> <p>Title <input type="text" value="Owner"/></p> <p>Submission Date 06/20/2022</p> <p>Submit Finish Later Cancel</p>

Tracking Information Page

When the application is submitted and confirmed, the system returns a page with the Assigned Tracking Number (ATN). This number is required to log in and check status and/or submit additional information.

Figure 27: Tracking Information Page

The screenshot displays the 'Tracking Information' page within the Mississippi Division of Medicaid's online provider enrollment system. The page features a dark header with the Medicaid logo and a search bar. Below the header, a blue navigation bar contains a 'Home' link. The main content area has a breadcrumb trail: 'Home > Online Provider Enrollment > Enrollment Tracking Information'. A 'Print Preview' button is located in the top right corner of the content area. The central message, titled 'Provider Enrollment: Tracking Information', states that the enrollment application has been submitted and assigned a tracking number of 16287. It provides instructions on retaining the tracking number, receiving a confirmation email at SLAWRENCE@GAINWELLTECHNOLOGIES.COM, and submitting the cover sheet with supporting documentation. A link to 'click here' is provided for saving or printing the coversheet. An 'Exit' button is located at the bottom right of the message box. The footer of the page includes a 'Privacy' link.

MESA Enrollment Panels

Information entered on the application is recorded into MESA on the applicable panels unless the information must be validated and entered by an enrollment specialist. Unless otherwise indicated, data can be added and updated by users with an appropriate security level. See Figure 28: Enrollment Tab Menu.

This table provides a brief description of each panel available from the tab menus on the Provider Enrollment Information page. See Table 1: Enrollment Panel Descriptions.

Note: Some options in the tab menus are disabled until certain requirements are met. Additionally, access to updatable fields is determined by individual security levels. See your manager if you have questions.

Figure 28: Enrollment Tab Menu

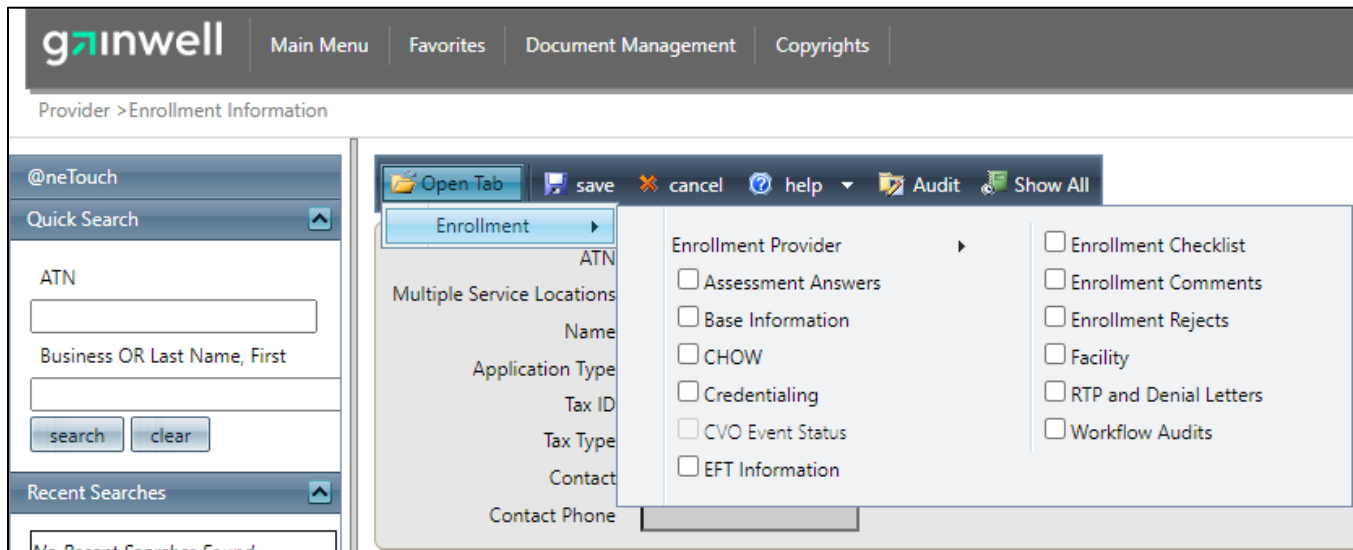


Table 1: Enrollment Panel Descriptions

Panel Name	Description
Assessment Answers	This functionality will not be used in MESA.
Base Information	This panel displays general provider information from an application and the status of the application within the approval process.
CHOW	The Change of Ownership (CHOW) panel contains change of ownership information.
Credentialing	This panel tracks whether credentialing is required and, if so, the details related to verifying the credential.
CVO Event Status	The Credential Verification Organization (CVO) Event Status panel tracks CVO events and statuses received from the CVO.
EFT Information	The Electronic Funds Transfer (EFT) Information panel displays banking information entered in the enrollment application for the purpose of electronic funds transfers.
Enrollment Checklist	This panel displays the Provider Business Rules checklist used when an analyst is screening an enrollment.
Enrollment Comments	This panel displays comments the analyst made about the provider application while rendering a decision.

Panel Name	Description
Enrollment Rejects	This functionality will not be used in MESA.
Facility	This panel displays contact and bed information for a facility.
RTP and Denial Letters	This panel is used to generate Return To Provider (RTP) and denial letters for an enrollment, and includes the reasons for the return of a provider enrollment application. Note that the Provider Enrollment Workflow process sends automatic denial letters for all but certification reasons.
Workflow Audits	This functionality will not be used in MESA.

The following panels display information submitted on the enrollment application, along with updates from processes such as the screening and background check. See Figure 29: Enrollment Provider Tab Menu.

Table 2: Enrollment Provider Panel Descriptions provides a brief description of each panel available from the tab menu on the Enrollment Provider page.

Figure 29: Enrollment Provider Tab Menu

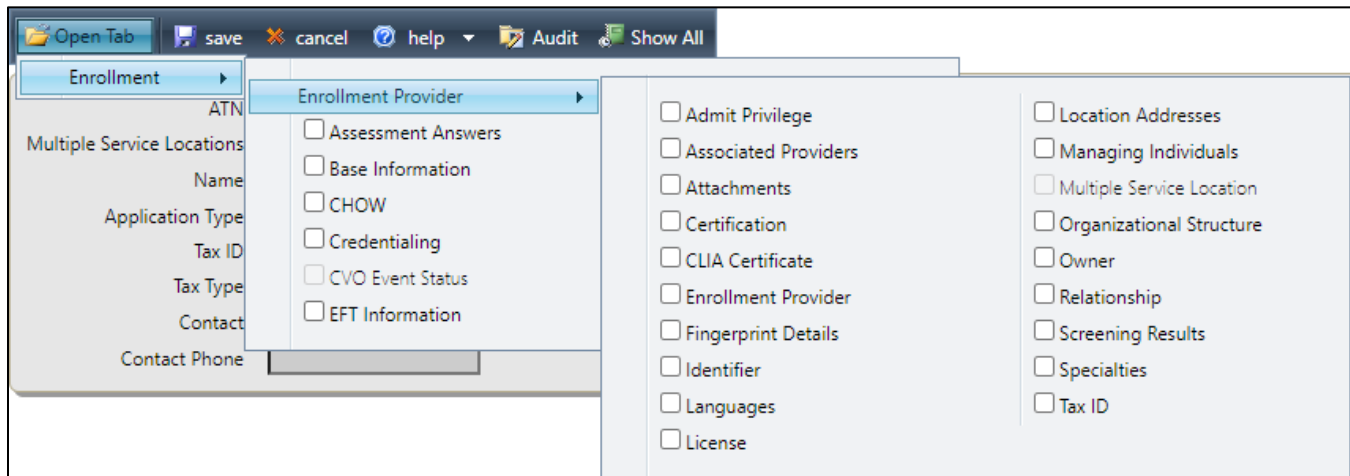


Table 2: Enrollment Provider Panel Descriptions

Panel Name	Description
Admit Privilege	This panel displays admitting privileges a provider has, with a record for each hospital. When Plan is selected as the admit type, physician information is required. When Privilege is selected as the admit type, hospital information is required.
Associated Providers	This panel displays the Medicaid Identification (ID), National Provider Identifier (NPI), Social Security Number (SSN), License Number, and other details regarding the listed associated providers. This panel is used during the Provider Enrollment Application workflow process.
Attachments	This panel displays a list of attachments the provider submitted and the screening results. It's used during the Provider Enrollment Application workflow process.
Certification	This panel displays certifications of the following type: 340B, JCAHO, ASHA Certification, and Certification of Disease Management.

Panel Name	Description
CLIA Certificate	The Clinical Laboratory Improvement Amendments (CLIA) Certificate panel displays the CLIA number, type, effective, and end date. This panel is used during the Provider Enrollment Application workflow process.
Enrollment Provider	This panel provides additional details specific to the provider. It is used during the Provider Enrollment Application workflow process.
Fingerprint Details	This panel provides details for each person who was required to submit fingerprints for enrollment. It includes their name, SSN, control number of the fingerprints submitted, outcome of the submission, comments, and status.
Identifier	This panel displays the provider's NPI, SSN, License information, and Drug Enforcement Agency (DEA) number. This panel is used during the Provider Enrollment Application workflow process.
Languages	This panel displays the languages spoken for which the provider offers an interpreter. The system requires at least one language to be added.
License	This panel records information for each provider license.
Location Addresses	This panel displays the different addresses and locations submitted by the provider. The service location address includes contact numbers, accessibility information, office hours, and other details given on the application.
Managing Individuals	This panel is used to view the managing individuals for a Provider Service location.
Multiple Service Location	This panel is enabled for enrollments that include more than one service location. The clerk works all ATNs related to the one that was submitted using the Multiple Service Location panel as a reference.
Organizational Structure	This panel displays business tax classification and state-specific information. This panel is used during the Provider Enrollment Application workflow process.
Owner	This panel displays individuals who have an ownership in the facility, along with their tax and contact information.
Relationship	This panel displays the relationships between owners and/or managing employees.
Screening Results	This panel displays the screening request submitted by the Workflow process.
Specialties	This panel displays the provider's specialty and taxonomy codes.
Tax ID	This panel displays the Tax ID submitted by the provider, along with the name the provider uses when filing tax documentation.

Change History

The following change history log contains a record of changes made to this document:

Version #	Published/ Revised	Author	Section/Nature of Change
0.1	07/xx/2022	Gainwell	Initial submission
0.2	4/10/2023	Gainwell	Updated figure 16 screenshot to remove eff and end date based on CR