

Provider Revalidation

gainwell

- ❑ Title 42 CFR 455.414 of the Federal Regulations requires all providers, regardless of provider type, to revalidate their enrollment with the Mississippi Division of Medicaid (DOM) at least every 5 years.
- ❑ Revalidation is the process of validating the current enrollment information on your provider file is accurate and up to date and to collect updated disclosures.
- ❑ Providers will receive a revalidation notification letter 180 days prior to their next revalidation due date.
- ❑ Providers revalidation link will be available on their MESA Provider Portal Home Page.
- ❑ **You will have 60 days to submit your revalidation application from the due date.**
- ❑ Once the provider's revalidation due date has passed, or the application has been completely submitted, the revalidation link is no longer available on the Provider Portal.
- ❑ **Providers that fail to revalidate or submit supporting documentation by the deadline will be terminated and must re-enroll.**

Application Tips

- Fields that are **grayed-out cannot** be updated. If any updates are needed for the grayed-out fields you can send a **Secure Correspondence** with proof of changes needed or contact Customer Service at 1-800-884-3222.
- By selecting the “+” sign, you can view or update that specified row.
- To remove a row, select the **Remove** link located in that specific row.
- The red asterisk signifies fields that must be filled out.
- If the disclosing provider is an **individual** or **sole proprietor**, the application must be signed by the individual or sole proprietor.
- If the disclosing provider is a **group/organization**, the signature should be by the person legally authorized to sign on behalf of the group/organization.
- All application attachments must be in PDF format.



Sample Revalidation Notice

- You will receive a letter 180 days prior to your revalidation due date.
- The submission date noted in the body of the letter is the **recommended submission date** to allow time for processing before the deadline date. This date is the date you will see on the Provider Portal.
- The **final due date** is shown at the top of this letter.
- The letter contains important information about revalidating.
- Also, the letter includes a link to the secure Provider Portal.



Medicaid Provider Enrollment Unit
Gainwell Technologies
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<https://medicaid.ms.gov>



September 18, 2023



Mississippi Medicaid Provider Revalidation
Deadline: 03/17/2024

Dear Provider:

Our records indicate that [REDACTED] is due to revalidate enrollment with Mississippi Division of Medicaid (DOM) on 03/17/2024. 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, States must revalidate the enrollment information and collect updated disclosures from all providers.

You are encouraged to begin the revalidation as soon as possible. To allow processing time, the revalidation must be submitted by 11/18/2023.

To expedite the process, follow the instructions below to access the provider revalidation page through the web portal on or before 11/18/2023. If you are not a registered user, you can find the registration instructions for becoming a web portal user by clicking the "Web Registration" link on the site.

To submit the revalidation, providers should do the following:

- Log onto the secure Portal at <https://portal.MS-Medicaid-MESA.com/MS/Provider>
- Select the "Revalidate Your Provider Enrollment" link under the 'Upcoming Actions' section on the left side of the secure log-in Home page.
- Follow the instructions to complete the Revalidation application.

Current provider information allows the Medicaid Program to send appropriate communications, make accurate and timely payments on your Medicaid claims, as well as ensure that correct information is included in the provider directory. By complying with the revalidation process prior to your due date, there will not be a disruption in the processing of claims filed.

Failure to submit all the information required in the revalidation by the due date above may cause your enrollment to be terminated and your claims to be denied. A new application will be required to re-enroll in the Mississippi Medicaid program.

In accordance with Federal Regulation at 42 CFR 455.460 and 42 CFR 424.514, certain providers applying to participate in the Medicaid program are required to pay an application fee unless you meet one of the exemptions.

Additionally, if the revalidation is not completed in the allotted time and the provider is also enrolled with one or all MississippiCAN Coordinated Care Organizations (CCO), Magnolia Health, United Healthcare Community Plan, and Molina Healthcare, enrollment with the CCO(s) will be terminated.

Providers are able to track the status of their revalidation application after the materials are submitted by doing the following:

- Access Provider Portal at <https://portal.MS-Medicaid-MESA.com/MS/Provider>
- Select Provider Enrollment Access link from the left-hand side of the page.
- Select Enrollment Status link under the Online Provider Enrollment section on the left-hand side of the Provider Enrollment page.
- Enter Application Tracking Number (provided after submitting the revalidation application) to view the status of the application.

Thank you for your prompt response to this request. Please contact Provider Services staff at 1-800-884-3222 with any inquiries between the hours of 8:00 a.m. and 5:00 p.m. CST, Monday through Friday.

Sincerely,

Provider Services

Sample Revalidation Notice cont'd

Submitting a Revalidation Application

- You have received your letter and now you are ready to log onto the MESA Provider Portal.
- To access the MESA Provider Portal use the link on DOM's website. Home > Provider Portal > Provider Log in.
[MESA Portal for Providers ms.gov](https://www.ms.gov/mesa-portal-for-providers)
- On the MESA Provider portal homepage, enter your User ID and select "Log In".

Home | [Contact Us](#)

Home Friday 08/04/2023 01:49 PM CS

Login ?

*User ID

Log In

[Forgot User ID?](#)
[Register Now](#)
[Where do I enter my password?](#)

What you can do in the Medicaid Portal for Providers
Through this secure and easy to use internet portal, health care providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files, and search for other providers. In addition, health care providers can use this site to locate claim forms, provider participation materials and other Medicaid information and resources.

Call Center Hours!
8:00 a.m. - 5:00 p.m.
1-800-884-3222

Protect Your Privacy!
Always log off and close all of your browser windows
[Privacy Policy](#)

[Provider Enrollment Access](#)
[Enrollments Forms](#)
[340B Program Information](#)
[Trading Partner Enrollment](#)

[Late Breaking News](#)
[Provider Bulletins](#)

[UM/QIO](#)
[Provider Rates](#)

[Report Fraud](#)

[Search Providers](#)
[Search Fee Schedule](#)

Did you know?

Submitting a Revalidation Application cont'd

- Enter your **password** and select **“Sign In”**.
- Make sure your site key picture and passphrase are correct.

 **Confirm Site Key Token and Passphrase**

Confirm that your site key token and passphrase are correct.

If you recognize your site key token and passphrase, you can be more comfortable that you are at the valid HealthCare Portal site and therefore is safe to enter your password.

Make sure your site key token and passphrase are correct.

If the site key token and passphrase are correct, type your password and click **Sign In**.
If this is not your site key token or passphrase, do not type your password.
Call the customer help desk to report the incident using the appropriate number below:

Member Services - 1-800-884-3222.
Provider Services - 1-800-884-3222.

Site Key:



Passphrase Password07242023!

*Password

Sign In

[Forgot Password?](#)

Submitting a Revalidation cont'd

- ❑ After logging in, select the “Revalidate your Provider Enrollment” link on the Home page.
- ❑ Reminder, if you have already submitted or you are past the due date this link will no longer be available.

Home Eligibility Claims Care Management Patient Health History Files Exchange Resources Contact Us

Home Thursday 08/31/2023 09:22 AM CST

Provider Name Role IDs

Location Taxonomy

Eligible Programs and CCO Affiliations

User Details

Welcome

- ▶ [My Profile](#)
- ▶ [Manage Accounts](#)

Provider

Name

Provider ID

Location ID

- ▶ [Characteristics](#)

Upcoming Actions

Revalidation	05/05/2023
Start Date	
Revalidation	07/04/2023
Due Date	

 [Revalidate your Provider Enrollment](#)



MESA

MEDICAID ENTERPRISE SYSTEM ASSISTANCE

Welcome Health Care Professional!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Broadcast Messages

The Pharmacy Drug Coverage Inquiry functionality is currently under construction and is not available at this time. Please check back later for updates.

- ▶ [Sign Up to Receive News](#)
- ▶ [Secure Correspondence](#)
- ▶ [Latest News](#)
- ▶ [Late Breaking News](#)
- ▶ [Provider Bulletins](#)
- ▶ [UM/QIO](#)
- ▶ [Report Fraud](#)

Request Information Page

- ❑ Update the **Application Contact Information** and Select “Continue” to the Provider Identification Page.
- ❑ This is the only portion on this page that must be updated.
- ❑ Next, are the steps to show you how to save the application before you finish, if needed.

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 Facility
Taxonomy [Redacted]

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. 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 [Redacted] **NPI Zip + 4** [Redacted]

Tax ID Number [Redacted] **Tax ID Type** EIN

Are you currently enrolled as a Provider? Yes
Current Provider Identifier [Redacted]

Were you previously enrolled as a Provider? 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) **MSCAN** **MSCHIP**

Application Contact Information

Enter the name of a contact person to answer any questions regarding the information provided in this enrollment application.

***Last Name** [VER] [Redacted]

***First Name** [AKANI] [Redacted]

Title [Redacted]

***Phone** [Redacted] **Ext** [Redacted]

Fax Number [Redacted]

***Work Email** [Redacted]

***Confirm Email** [Redacted]

Preferred Method of Communication [Email] [v]

Continue **Finish Later** **Cancel**

Saving the Application

Finish Later
= Save

The screenshot shows a web application interface with a navigation menu on the left and a main content area. At the top, there are three buttons: 'Continue', 'Finish Later' (highlighted in red), and 'Cancel'. Below the buttons, an error message is displayed: 'Error: A failure occurred during a database insert. Contact Name is required. Ownership Type Code is required. Percent Ownership must be greater than or equal to 5.00.' The main content area is titled 'Provider Enrollment: Credentials' and contains a 'Password Assistance' section with a list of password requirements. Below this, there are fields for 'Tax ID', 'Password', and 'Confirm Password', each with a red asterisk indicating it is a required field. At the bottom right, there are 'Submit' and 'Cancel' buttons. A callout box points to the 'Finish Later' button with the text 'Finish Later = Save'.

Continue **Finish Later** **Cancel**

Error
A failure occurred during a database insert.
Contact Name is required.
Ownership Type Code is required.
Percent Ownership must be greater than or equal to 5.00.

Provider Enrollment: Credentials

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

Password Assistance

1. A password cannot be reset more than once in a 24 hour period.
2. Passwords will expire every 60 days.
3. The minimum password length is 14.
4. The password cannot repeat any of the previous 24.
5. Passwords must be complex, containing 3 of the following 4 items:
 - Upper case letters (A, B, C...)
 - Lower case letters (a, b, c...)
 - Numbers (1, 2, 3...)
 - Special characters (!, \$, *...)
6. User ID cannot be part of your

Your enrollment application will be suspended for ## days, pending completion. Upon expiration, you will need to reinitiate a new enrollment application.

Please provide the following information, which will be required to resume your application at a later date. Your password must follow the criteria documented in the 'Password Assistance' section which is listed on the left hand side of this page. Your tax id is provided, if already contained within your provider enrollment application.

Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number along with the following information, will be used as your credentials to resume your suspended enrollment application.

* Indicates a required field.

Tax ID [XXXXXXXXXX]

* Password []

* Confirm Password []

Submit **Cancel**

- Because of the system change, Providers Profile is missing some of the required data in the new system that was not collected in the previous system. which, the application cannot be saved partially (finish later) until all the required data is provided. There could be some circumstances which might call for suspending an application midway because some information needs to be gathered or the person filling out the application needs to step away. If the missing data is not provided, then all the information filled in so far will get lost.
- Therefore, to avoid those situations it is recommended that providers should try to click on Finish Later as soon as they are in their application and once all the missing information has been saved, they can take time filling in and updating the remainder of the application.
- Upon clicking on Finish Later, the Credentials page will display, then you will create a password and select Submit. If any information is missing it will be shown in the top left corner. You will go through each page correcting/updating the required data, the error is also displayed on the top of the respective page. The application is not saved until the errors are corrected.
- Once all of the missing data is provided, create a password to save the application and select the Submit button.
- If no errors are displayed, then all of the required information is present, and you can log in and continue with the revalidation application.

Saving the Application cont'd

Once you have corrected those errors you can now save it. Select **Finish later**.

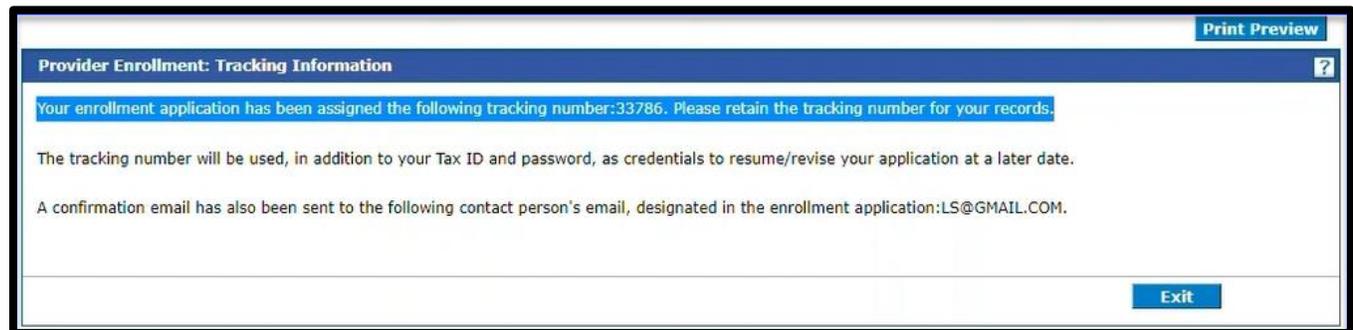
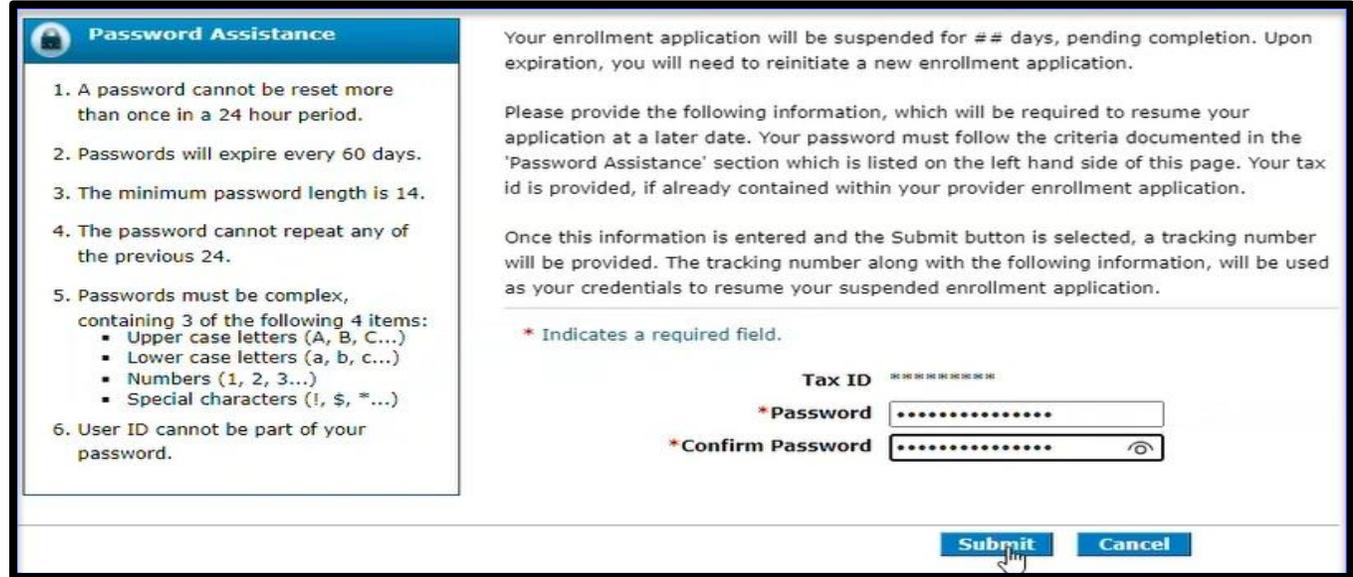
Select **Yes** to suspend the application.

Create and enter a **Password**.

Enter the Password again to confirm it's accurate.

Select **Submit**.

Your application has been saved. Take note of your **ATN – Application Tracking Number**. The ATN does not mean that the application is submitted, you still need to completely submit the application (see submission steps on page 25). You will also receive an email with the ATN. You can select **Print Preview** to print this information.



Provider Identification Page

Make sure all the information is correct in each section and make any necessary updates.

If a license has been extended, please update the **End Date** for that License. Select “+” to expand that field and update the end date.

If you have a new license, make sure to add it in the license section. You must select “**Add**” after you have entered the required information.

To remove a specific license, you will expand the section by clicking “+” and select the “**Remove**” link and that license will be removed.

Once all updated information has been entered, select **Continue** to the **Address** page.

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

Legal Tax Name

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

*Legal Tax Name
*DBA Name

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
<input type="checkbox"/>	Click to collapse.						
*License Type	<input type="text" value=""/>	*License #	<input type="text" value=""/>	*License State	<input type="text" value=""/>		
*Assigning Authority	<input type="text" value=""/>	*Effective Date	<input type="text" value=""/>	*End Date	<input type="text" value=""/>		
		<input type="button" value="Add"/>	<input type="button" value="Reset"/>				

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
<input type="checkbox"/>	Click to collapse.						
<input checked="" type="checkbox"/>	Regular	<input type="text" value=""/>	01/01/2020	12/31/2023	MS BOARD OF CHIROPRACTIC EXAMINERS	Mississippi	<input type="button" value="Remove"/>

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

DEA #

DEA # Effective Date

Address Page

- Make all updates to each section but the **Pay To** and **Servicing Address** cannot be updated on the application. If you need to update the **Pay To** or **Servicing Address**, please submit the filled-out Change of Address Form, using the “Secure Correspondence” link on the right-hand side of the Home page.
- Change of Address Form can be found here: medicaid.ms.gov/resources/forms
- The **primary contact information** for the **Servicing Address** can be updated as well as the other addresses, if applicable.
- After all updates have been made, you **must** select “**Save**” otherwise the data will not be saved.
- Select **Continue** to the Language page.

Provider Addresses

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

	Contact Name	Address Type	Address	City	State	Action
+	ANKS	Corporate Office			Tennessee	NA
+	ANKS	Mail To			Arizona	NA
+	JESSI GALINDO	Pay To			Tennessee	NA
-	MISTY CLARK	Servicing			Mississippi	NA

*Address Type

*Name

*Address

*City

*State

*Contact Name

*Primary Email

*Phone

*Confirm Email

*County

*Zip Code

*Phone

Service Address Information

Office Hours

Day	From	To	Open 24 hrs	Closed
*Monday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Tuesday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Wednesday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Thursday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Friday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Saturday	From <input type="text" value=""/>	To <input type="text" value=""/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
*Sunday	From <input type="text" value=""/>	To <input type="text" value=""/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Service Provided Within State

Accepting New Patients

Sedation

Services for Intellectual Disability

Providing XRays

Age Restrictions

Accepting New Patients with Special Needs

Permit/Licenses#

Providing PET and MRI

Other Restrictions

Providing PET CT

Verify Facility Name fields as it may have been auto populated by your browser.

Facility Administrator Last Name First Name License #

Medical Administrator Last Name First Name License #

Service Administrator Last Name First Name

TDD Capability

TTY Capability

Phone

Phone

Accessibility Options

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

	Accessibility Type	Action
+	Click to add a Option	

User Details

Welcome Mod_009320839_Anks

My Profile

Manage Accounts

Provider

MESA
MEDICAID ENTERPRISE SYSTEM ASSISTANCE

Welcome Health Care Professional!

Sign Up to Receive News

Secure Correspondence

Latest News

Languages Page

- ☐ Make any necessary updates and select **Continue**, to the Other Information page.

Providers that have the ability to translate should select the appropriate language below.

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

Language	Action
ENGLISH	Remove
+ Click to add language.	

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

Other Information

- Make any updates needed to each section.
- If you have a certification type noted in the dropdown list that needs to be added, complete the fields, then select **Add**.
- **Facility Information** will only populate if you are facility provider.
- Select **Continue** to the Disclosure page.

Provider Enrollment: Other Information

[Welcome](#)

[Request Information](#)

[Provider Identification](#)

[Addresses](#)

[Languages](#)

Other Information

[Disclosure](#)

[Supporting Documentation / Attachments and Fees](#)

[Agreement](#)

[Summary](#)

Certification required when no license information provided.

* Indicates a required field.

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.

	Certification Type	Certificate #	Effective Date	End Date	Action
<input type="checkbox"/>	Click to collapse.				
	*Certification Type <input type="text"/>	*Certificate # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
	<input type="button" value="Add"/> <input type="button" value="Reset"/>				

Facility Information

*Administrator First Name MI

*Administrator Last Name

*Phone

*Fax Number

*Email

*Number Medicaid Beds *Dually-Certified Beds

*Number Medicare Beds *Total Beds

Disclosure Page, Section B-1

- Check each section and make any necessary updates.
- To view or update a row select the + sign.
- To remove a row, select the **Remove** link.
- If any updates are required for the fields in the red highlighted box, then a PDF attachment is required. You must fill out the B-1 section of the Disclosure Form, as applicable, and upload the PDF document. The form can be found on the MS Division of Medicaid's website: [Forms - Mississippi Division of Medicaid](#)
- Gainwell is working on a solution, so the providers do not have to upload a PDF document for changes in the mentioned fields. Providers will be notified through Late Breaking News as soon as the change is implemented.
- **Save** must be selected after the updates have been made.

SECTION B-1
Entity with Direct/Indirect Ownership Interest
and/or Managing Control Identification Information

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

Row	Legal Business Name as Reported to the Internal Revenue Service	Employer Identification Number (EIN)	Percent Ownership	Action
[-] 1			5	Remove

***Legal Business Name as Reported to the Internal Revenue Service**

DBA Name

***Effective Date**
01/01/1900

Percent Ownership
5

***Employer Identification Number (EIN)**

***Owner/Partner**
5 Percent (5%) or More Ownership Inter

Ownership Type
Direct

Addresses

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

Row	Address	Primary	Action
[-] 1		Yes	Remove

***Address**

***City**

***State**

***Country** UNITED STATES

Primary Address

***Zip Code**

+ Click to add address.



Disclosure Page, Section B-2

- Check each section and make any necessary updates.
- If any updates are required for the fields in the red highlighted box, then a PDF attachment is required. You must fill out the B-2 section of the Disclosure Form, as applicable and upload the PDF document. The form can be found on the MS Division of Medicaid's website: [Forms - Mississippi Division of Medicaid](#)
- Gainwell is working on a solution, so the providers do not have to upload a PDF document for changes in the mentioned fields. Providers will be notified through Late Breaking News as soon as the change is implemented.
- Save must be selected after the updates have been made.

SECTION B-2

Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported in Section B-2:

- ▶ 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

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

Row	Last Name	First Name	SSN	Birth Date	Action
1					Remove

*Last Name *First Name MI

*Birth Date *Gender Title

*SSN *Owner/Managing Employee

*Home Address

*City

*State *Zip Code

*Country

If the above noted individual is an owner, please select one of the following options and give the effective date:

*Owner/Partner *Effective Date

Percent Ownership Ownership Type

If the above noted Individual is a managing employee, please select all that apply and give the effective date:

Director/Officer Managing Employee(W-2)

Contracted Managing Employee Agent

If the above noted Individual is an authorized or delegated official, please select one of the following options and give the effective date:

Official Type Official Effective Date

Relationships

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:

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

Row	Owner/Managing Employee 1	Relationship	Owner/Managing Employee 2	Action
Click to add Relationship				

Disclosure Page, Sections C and D

Check each section and make any necessary updates.

Save must be selected after the updates have been made.

SECTION C Criminal Convictions and Other Sanctions

Provide the requested information in this section for any person who:

- (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.

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.

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

Row	Name	Criminal/Sanction Info	Date	Action
<input type="button" value="+"/> Click to add Conviction/Sanction				

SECTION D Relationships to Excluded, Penalized, or Convicted Persons in Accordance with 42 CFR § 1002.3

Identify and provide the requested information in this section regarding any person who:

- (1) has been convicted of a criminal offense as described in Sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;
- (2) has had civil money penalties or assessments imposed under Section 1128A of the Social Security Act OR
- (3) has been excluded from participation in Medicare or any of the state health programs AND
- (4) also has one or more of the following relationships to the disclosing provider:
 - i. has a direct or indirect ownership interest (or any combination thereof) of five percent (5%) or more in the group/organization;
 - ii. is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the group/organization or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets of the group/organization;
 - iii. is an officer or director of the group/organization, if the group/organization is organized as a corporation;
 - iv. is a partner in the group/organization, if the group/organization is organized as a partnership;
 - v. is an agent of the group/organization;
 - vi. is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the group/organization or part thereof, or directly or indirectly conducts the day-to-day operations of the group/organization or part thereof; or
 - vii. was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer or ownership or control interest to an immediately family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

NOTE: Please refer to the Instructions for Provider Disclosure Form for applicable definitions.

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

Row	Name	Relationship	Action
<input type="button" value="+"/> Click to add Relationship			

Disclosure Page, Sections E, F and G

Check each section and make any necessary updates.

Save must be selected after the updates have been made.

SECTION E				
Disclosure of Other Ownership and Control				
Identify individuals or legal entities as having an ownership or control interest who also have an ownership or control interest in any other disclosing group/organization.				
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.				
	Row	Name of the Individual/Legal Entity	Action	
<input type="button" value="⊕"/> Click to add Relationship				
SECTION F				
Disclosure of Subcontractor Information				
Identify any person (individual or legal entity) with an ownership or control interest in any subcontractor in which the disclosing group/organization has a direct or indirect ownership of five percent (5%) or more.				
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.				
	Row	Name of the Individual/Legal Entity	Action	
<input type="button" value="⊕"/> Click to add Relationship				
SECTION G				
Business Transactions (This section should only be completed at the direction of Division of Medicaid (DOM))				
Identify the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period before the date of this request. If there are multiple owners or shareholders, list only those with direct or indirect ownership of five percent (5%) or more.				
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.				
	Row	Name of the Subcontractor	Name of Owner	Action
<input type="button" value="⊕"/> Click to add Transaction				

Disclosure Page, Section H

Read

Once all updates are made in each section, read instructions and select “ I accept”.

Enter

Enter the required signature and title.

Select

Select Continue.

SECTION H

Attestation and Signature of the Disclosing Provider

I certify that the information on this form, and any submitted statement(s) that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I sign under penalty of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

In addition, I understand that:

- In accordance with 42 CFR § 455.104(e), federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required.
- In accordance with 42 CFR § 455.106(c), DOM may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid or the Title XX Services Program. Further, DOM may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under 42 CFR § 455.106(a).
- In accordance with Miss. Code Ann. § 43-13-121, Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These circumstances include failure to truthfully or fully disclose any and all information required on this form, or making a false or misleading statement to DOM relative to the Medicaid program.
- In accordance with 42 CFR § 455.436, the State Medicaid agency and all Medicaid contractors shall do the following:
 1. Confirm the identity and determine the exclusion status of providers and contractors/subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the provider or contractor/subcontractor through routine checks of federal databases; and,
 2. Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, revalidation, and no less frequently than monthly thereafter, to ensure that the State does not pay federal funds to excluded persons or entities.

NOTE: If the disclosing provider is an individual or a sole proprietor, the application must be signed by the individual provider or sole proprietor. If the disclosing provider is a group/organization, the signature should be that of the person legally authorized to sign on behalf of the group/organization.

*I accept I have read and agree to the terms stated above

*Your Signature

d

Title

d

Date 03/22/2023

[Continue](#)

[Finish Later](#)

[Cancel](#)

Supporting Documentation/Attachment and Fees Page

The [Privacy Notice](#) link must be selected in order to continue to the next page. The link directs you to the Division of MS Medicaid page.

If all your documents are combined into one file, select **Attachment Type "All"** to add as one PDF document. When adding each document separately, choose the appropriate **Attachment Type** for each document. Select **"Other"** if adding Disclosure Forms.

Add must be selected to attach documents to the application.

All forms can be located at [Forms - Mississippi Division of Medicaid](#)

Select the appropriate **Fee Payment Type**. *Application Fee section will only be visible to providers taxonomies that are required to pay the fee to Medicare or Medicaid.*

This link, [Provider Enrollment Application Fee](#) can be utilized to verify if your taxonomy code is required to pay an application fee.

Select the **Attestation Statement**, then **Continue** to the Agreement page.

Supporting Documentation

The following actions need to be taken to complete the 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.

Individual providers are required to upload a proof of Professional Liability Insurance and Facility/Other Providers are required to upload a proof of General Liability Insurance when enrolling/adding Managed Care Program(s) MSCAN and/or MSCHIP) and requiring credentialing by the DOM CVO.

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
<input type="checkbox"/> Click to collapse.				
	*Transmission Method	FT-File Transfer		
	*Upload File	Choose File No file chosen		
	*Attachment Type			
	Add	Cancel		

Application Fee

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

*Fee Payment Type

Warning: If you select Hardship Waiver or Submitting Payment on the Fee Payment Type dropdown, you will be required to pay the fee 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**

This is only visible to providers taxonomies that are required to pay the fee to Medicare or Medicaid.

Agreement Page

- ✓ Read all the instructions until you reach the bottom of the page.
- ✓ Select “I Accept”.
- ✓ Enter the **Signature** of the **Provider or Authorized Representative**. Enter the **Title** (if applicable).
- ✓ Select **Submit** to advance to the **Summary** page.

Instructions

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.

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.

The enrollment application terms must be accepted in order to submit the application for approval.

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.

Terms of Agreement

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.

***I accept** I understand that my electronic signature is equivalent to written signature.

***Your Signature**

(Entering your name in the box to the right will constitute your electronic signature.)

Title

Submission Date 08/14/2023

Submit

Finish Later

Cancel

Summary Page

- After reading all the Instructions and Terms of Agreement, Select “I accept” stating you agree with the terms of the enrollment application.
- Enter the **Signature of the Provider or Authorized Representative**. Enter the **Title** (if applicable).
- Select **Submit**.

Instructions

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.

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.

The enrollment application terms must be accepted in order to submit the application for approval.

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.

Terms of Agreement

Provider Name [REDACTED]
Address [REDACTED]
Tax ID [REDACTED]
NPI [REDACTED]
Contact Name [REDACTED]
Contact Email [REDACTED]

Division of Medicaid The Office of the Governor Medical Assistance Participation Agreement
(Medicaid – Title XIX Program)

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.

***I accept** I understand that my electronic signature is equivalent to written signature.

***Your Signature** [LD] [REDACTED]

(Entering your name in the box to the right will constitute your electronic signature.)

Title [REDACTED]

Submission Date 08/14/2023

Summary Page cont'd

- Select **Print Preview** to review the content of the entire application before submitting. Also, Print Preview allows the chance to save or print the application for your record keeping before completing the submission.
- Select **Print** (blue box) on the right-hand side, change the Printer drop-down to a physical printer and print a physical copy. Or select "Microsoft Print to PDF" to save an electronic copy.
- To finish printing or saving a copy of the application, select **Print** (red box) at the bottom.
- It's imperative to select **Confirm** in order to submit the application completely so that the application can be processed.
- An ATN (Application Tracking Number) will be generated and provided. If you partially saved the application earlier, you will not see the ATN here. Also, an email will be sent with the ATN.

Instructions for Summary Page

If changes are required after reviewing the Summary Page, click the appropriate link on the Table of Contents panel for the section and make the needed corrections. When completed, you will be given the opportunity to review the Summary Page again. Once you have reviewed the contents of the application, click 'Confirm' to submit for processing. Please print a copy of this Summary Page for your records.

Note: If the enrollment type or taxonomy code is changed on the Request Information Panel, you will be required to re-enter all fields on the application.

Print Preview **Confirm** **Finish Later** **Cancel**

Provider Enrollment: Summary

Request Information

Initial Enrollment Information

Print

Print ?

Total: 16 sheets of paper

Printer

Microsoft Print to PDF

Copies

1

Layout

Portrait

Landscape

Pages

All

Odd pages only

Even pages only

e.g. 1-5, 8, 11-13

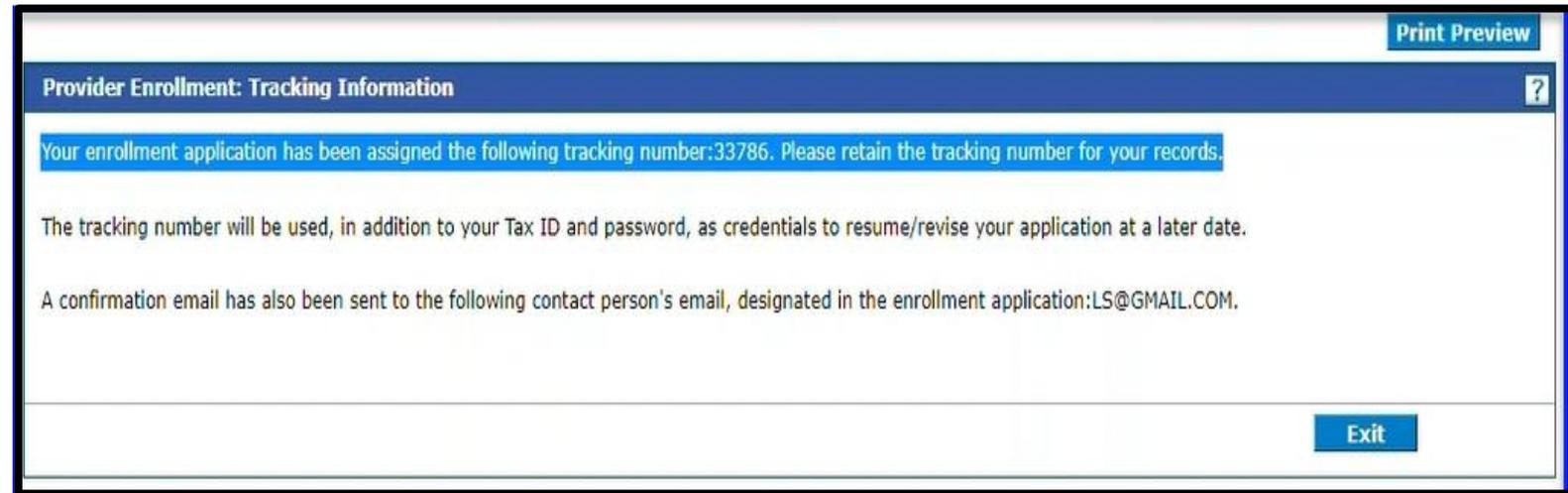
Color

Black and white

Print Cancel

Summary Page cont'd

- Your application has been submitted and you have been provided an **ATN, Application Tracking Number**.
- Take note of your **ATN, Application Tracking Number**. You will also receive an email with the ATN.
- Select **Print Preview** to save or print this information.
- Your **ATN** can be used to check the status of your application and make updates requested from Gainwell through the Portal. Also, any documents you fax or mail to Gainwell in reference to your application should include your **ATN**.
- Select **Exit**.



Sample Revalidation Approval Letter

- Once your Revalidation Application has been approved, you will receive an approval letter with the date you are approved through.



Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 23078
Jackson, MS 39225
<https://medicaid.ms.gov>



June 05, 2023



Dear Provider:

Mississippi Division of Medicaid (DOM) has approved the provider revalidation for [REDACTED], provider ID [REDACTED] through 05/10/2026.

If you have questions or need assistance, contact Provider Services staff at 1-800-884-3222 with any inquiries between the hours of 8:00 a.m. and 5:00 p.m. CST, Monday through Friday.

Sincerely,

Provider Services