Provider Revalidation



- 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.

Revalidation Facts

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 P.O. Box 23078 Jackson, MS 39225 https://medicaid.ms.gov



September 18, 2023



Mississippi Medicaid Provider Revalidation Deadline: 03/17/2024

Dear Provider:

Our records indicate that 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.

Toll-free 800-884-3222 | Fax 866-644-6148 | medicaid.ms.gov Responsibly providing access to quality health coverage for vulnerable Mississippians 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**
- On the MESA Provider portal homepage, enter your User ID and select "Log In".

Contact Us Friday 08/04/2023 Home Friday 08/04/2023 Login ? What you can do in the Medicaid Portal for Providers Through this secure and easy to use internet portal, health care providers can su	01:49 PM CS Ibmit claims files, and locate claim
Home Friday 08/04/2023 Login Priday 08/04/2023 What you can do in the Medicaid Portal for Providers Through this secure and easy to use internet portal, health care providers can su	01:49 PM CS Ibmit claims files, and locate claim
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*User ID and inquire on the status of their claims, inquire on a patient's eligibility, upload search for other providers. In addition, health care providers can use this site to	Leader to the second
Log In	irces.
Forgot User ID? Register Now	
Where do I enter my password?	
Protect Your Privacy!	
Always log off and close all of your browser windows	11
Privacy Policy	
Provider Enrollment Access	
Enrollments Forms 340B Program Information	
Trading Partner Enrollment	6
Late Breaking News	
Provider Bulletins	
Provider Rates Call Center Hours!	
Report Fraud 8:00 a.m 5:00 p.m.	
1-800-884-3222	
Search Providers Search Fee Schedule	

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.



Passphrase Password07242023!



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.

lome Eligibility Claims Care M	anagement Patient Health History Files Exchange Resources Cont	act Us
Home		Thursday 08/31/2023 09:22 AM (
lonie		Thursday 00/01/2020 05/22 APr C
Provider Name Location	Role IDs Taxonomy	▼
Eligible Programs and Mississippi Me CCO Affiliations	dicaid 🗸	
User Details	AFCA	Sign Up to Receive News
Welcome My Profile		Secure Correspondence
Manage Accounts	Welcome Health Care Professional!	Latest News
Provider Name	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	Late Breaking News
Provider ID	submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.	<u>Provider Bulletins</u> <u>UM/QIO</u>
Location ID		Report Fraud
<u>Characteristics</u>	Broadcast Messages	
Upcoming Actions	The Pharmacy Drug Coverage Inquiry functionality is currently under construction and is not available at this time. Please check back later for undates	
Revalidation 05/05/2023 Start Date Revalidation 07/04/2023		
Due Date		
Revalidate your Provider Enrollment		

Welcome Page

Review the information while scrolling to the bottom and select Continue to the Request Information page.

riouder Emonment:	
Welcome	Provider Enrollment
Request Information	Thank you for your interest in becoming a provider in the Mississippi Medicaid program. You can enroll as a Mississippi Medicaid fee-for-service (FFS) provider, an ordering, referring, and prescribing (ORP) provider, as well as a managed care contracted provider in the Mississippi Coordinated Access Network (MississippiCAN) and the Children's Health Insurance Program (CHIP) network. Please note that a provider taxonomy code is required for whichever program/application type you choose.
Provider Identification	Medicaid Fee-for-Service Providers
Addresses	organizations that are enrolled in the Medicaid program. FFS providers must complete the full enrollment form to submit claims for
anguages	reimbursement of services provided for Medicaid members. Group providers must ensure that each of their individual practitioners/providers are enrolled, and the individual providers have the same servicing address as the affiliated group. If a FFS provider submits a claim for a referred
Other Information	service for a Medicaid member, the NPI of the ordering, referring, or prescribing (ORP) provider of the service must be included on the claim.
Applicant History	Ordering, Referring, & Prescribing (ORP) Providers Federal regulation at 42 CER 455 410 requires the enrollment of physicians or other professionals who only order, refer or prescribe (ORP)
Disclosure	services for Medicaid members. Physicians and other eligible practitioners, who other, refer, or prescribe items or services for Medicaid members
Supporting Documentation Attachments and Fees	are referred to as "ORP" providers. ORP providers will not be included in the listing to receive referrals to provide direct services to Medicaid members. Medicaid claims submitted listing an ORP provider as the billing or rendering provider will not be reimbursed. To receive payment from Medicaid for any services provided, the ORP provider must enroll as a FFS provider.
Agreement	Managed Care Providers
Summary	Managed Care includes healthcare plans that are used to manage cost, utilization, and improve quality and health outcomes for their membership. This is accomplished by providing care to members and contracting with health care providers and medical facilities.
	Mississippi Coordinated Access Network (MississippiCAN) Providers The Mississippi Coordinated Access Network (MississippiCAN) is a Medicaid managed care program, which includes three Coordinated Care Organizations (CCOs). More than half of the Mississippi Medicaid members are enrolled in the MississippiCAN program. For providers to be reimbursed for MississippiCAN member services by these CCOs, they must be enrolled as a Medicaid FFS provider and be contracted with the CCOs. If providers are not contracted and not in same program and CCO network as member receiving services, then the providers are reimbursed at the reduced out-of-network rate.
	Children's Health Insurance Program (CHIP) Providers CHIP provides health coverage for uninsured children up to age 19 years old. All children enrolled in the Mississippi Separate CHIP program are enrolled with a CCO. For providers to be reimbursed for CHIP member services by these CCOs, they must be enrolled through Medicaid and be contracted with the CCOs. If providers are not contracted and not in same program and CCO network as member receiving services, then the providers are reimbursed at the reduced out-of-network rate.
	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/or Mississippi Children's Health Insurance Program (MSCHIP)). Credentialing/Recredentialing standards are set by national accrediting agencies and state and federal regulating bodies.
	State regulation Mississippi Code 43-13-117 requires that the Division develop a single, consolidated credentialing process for providers, and requires managed care entities to accept the Division credentialing for managed care enrollment. Credentialing will be conducted when the provider selects MississinniCAN and/or CHIP. Upon completion of Division credentialing, providers may voluntarily contract with Coordinated Care Organizations of Completion of Division credentialing, providers may voluntarily contract with Coordinated Care
	Revalidation Information Federal Regulation at 42 CFR 455.414 requires the State Medicaid Agency to revalidate the 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 electronically sign the Mississippi Medicaid Provider Agreement and Acknowledgement of Terms of Participation. All required documents must be uploaded. Providers are subject to additional screening activities based on their risk level. A revalidation notice 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. Providers are required to establish a Provider Portal account to compete the revalidation process.
	340B Program 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

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 lookalikes, 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.

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.

Required Documents and Enrollment Requirements

To view required documents and enrollment requirements, please visit the Mississippi Division of Medicaid's website. Click here to go directly to the website.

Click the "Continue" button to start the enrollment application.

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 upload	ded directly to this application.
Please retain the Application Tracking Nu draft of your application in the future.	umber (ATN) provided for reference when contacting Provider Enrollment and to quickly access a saved
Provider may also reach a representative	e by phone, Monday – Friday 8:00 AM – 5:00 PM CST at 1-800-884-3222
Enrolln	ment Type Facility
T	Taxonomy
Are you enrolling only for the subr the crossover claims? By selecting agree that you will not be paid for types other than crossov	mission of No g Yes, you any claim rer claims.
NOTE: In accordance with the Mississipp with certain taxonomies will only be eligi	pi Division of Medicaid Administrative Code found at <u>Mississippi Division of Medicaid</u> , providers enrolling ible for the payment of crossover claims.
Provider Information	
The provider identification numbers liste	ed below are additional identifiers for the enrolling providers. Not all fields are required.
NPI NP	PI Zip + 4
Tax ID Number	Tax ID Type EIN
Are you currently enrolled as a Ye Provider? Were you previously enrolled as N	Ves Current Provider Identifier
Are you currently enrolled as a You Provider? Were you previously enrolled as Note Provider? Program Enrollment	Yes Current Provider Identifier
Are you currently enrolled as a Your Provider? Were you previously enrolled as Note a Provider? Program Enrollment Please choose a selection below (at least	res Current Provider Identifier
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- 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

		= Save
Continue	Cancel	
E rror A failure occurred during a Contact Name is required. Ownership Type Code is re Percent Ownership must be	database insert. quired. a greater than or equal to 5.00.	
Provider Enrollment: Cr	edentials	?
equest Information	Password Assistance	Your enrollment application will be suspended for ## days, pending completion. Upon expiration, you will need to reinitiate a new enrollment application.
edentialing Information	1. A password cannot be reset more	
ovider Identification	than once in a 24 hour period.	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
idresses	 Passwords will expire every 60 days. The minimum password length is 14. 	'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.
nguages	4. The password cannot repeat any of	Once this information is entered and the Submit button is selected, a tracking number
ther Information	the previous 24.	will be provided. The tracking number along with the following information, will be used
pplicant History	5. Passwords must be complex,	as your credentials to resume your suspended enrollment application.
is <mark>clo</mark> sure	Upper case letters (A, B, C) Lower case letters (a, b, c)	* Indicates a required field.
upporting Documentation	 Numbers (1, 2, 3) Special characters (1 \$ *) 	Tax ID *******
Attachments and Fees	6. User ID cannot be part of your	*Password
		*Confirm Dacsword

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 <u>does not mean</u> 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 Structu	re					
 If your business is characteristic 	ain affiliated, the infor	mation about the co	mpany or organizatio	on must be included	in the disclosure info	rmation.
 If your business is op- management compan 	erated by a managem y or organization mus	ent company or leas t be included in the	ed (in whole or in pa disclosure informatio	art) by another organ	ization, information a	about the
 If you are affiliated with the second second	ith a Military Medical T	Freatment Facility (M	ITF), you must select	the Military MTF opt	tion from the drop do	wn.
 If you are affiliated with the second second	ith a Tribal Agency, yo	u must select the Tr	ibal Agency option fr	om the drop down.		
*Organization Type	Other		~			
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	Incorporated		Incorporation Date	20		
	Chain Affiliated					
Operated by Man	agement Company					
*Public/Private Indicato	Private V]				
Legal Tax Name						
The provider legal name a	and information is pro	vided once for each	enrollment.			
*Legal Tax Nam	e					
*DBA Nam	e					
License						
Click "+" to view or updat	te the details in a row.	. Click "-" to collapse	e the row. Click "Rer	nove" link to remov	e the entire row.	
License Type	License #	Effective Date	End Date	Assigning Authority	License State	Action
Click to collapse.		-	—			
*License Type	~	*License	#	*Lice	nse State	~
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Authority						
Add	Reset					
License						
Click "+" to view or upda	te the details in a row.	. Click "-" to collapse	the row. Click "Rem	ove" link to remove	the entire row.	
License Type	License #	Effective Date	End Date	Assigning Authority	License State	Action
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Click to collapse.]	*Effective Date	••		d Date o	
bbA	Reset					
DEA #						
DEA #		Effective Date] 🛲		
			C	Finish	Later Cancel	

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: <u>medicaid.ms.gov/resources/forms</u>
- The **primary contact informatio**n 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**.

		-									
Click	"+" to view or u	update the	details in a	row. Click "-"	to collapse	the row.	Click "R	emove"	link to remo	ve the entire row.	
	Contact N	ame	Addr	ess Type		Address			City	State	Action
E	ANKS		Corporate	Office						Tennessee	NA
Œ	ANKS		Mail To							Arizona	NA
	JESSI CALINDA	-	Day To				200000			Topposoo	NA
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				Offic	e Hours			_			
* Moi * Ture	nday Fro	m [08:00		To 05:00		Open	24 hrs 24 hrs		Close		
*we	dnesday Fro	m 08:00		To 05:00	PM 💙	Open	24 hrs		Closed		
*Thu	ursday Fro	m 08:00	AM	To 05:00 P	PM 🗸	Open	24 hrs		Close	1 🗆	
*Fric	day Fro	m 08:00	MA V	To 05:00 P	PM 🗸	Open	24 hrs		Closed		
*Sat	urday Fro	m	~	То	~	Open	24 hrs		Close		
50						open	24 1113		ciose		
S	ervice Provide	d Within State	\checkmark								
~	ccepting New	Patients	~	Accept	ing New	Patients					
	:	Sedation		F	ith Specia Permit/Lie	censes#					
Se	ervices for Int	ellectual									
	Providir	isability		Provid	ding PET :	and MRI			Providin	g PET CT	
	Age Res	trictions		c	Other Res	trictions					
Verify	y Facility Name	fields as it	may have	been auto popu	ulated by y	our brows	er.				
Faci	lity Administra	ator Last Name			Fir	st Name				icense #	
	Medical Admi	nistrator			Fir	st Name				icense #	
Serv	ice Administra	ator Last			Fir	st Name					
	TDD C	Name apability		Phor	100					Ext	
	TTY C	apability		Phor	1C 0					Ext	
Acce	ssibility Optio	ns									
Click	"+" to view or	update the	details in a	a row. Click "-"	to collaps	e the row.	Click "I	Remove"	link to remo	ve the entire row	<i>.</i>
				Acces	ssibility T	уре					Action
E	Click to ad	d a Option									
	Save	Reset	Cancel								
								Continu	e Finic	h Later Ca	ncel
	on Dotaile										to Dessive Norm
U	ser Details						~			Sign Up 1	to Receive News
	Welcome Mod_0	09320839_A	nks								orrospondonco
My Pr	ofile					TERPRISE SYS	STEM ASSI	STANCE		<u>Secure C</u>	onespondence
Mana	g <u>e Accounts</u>									I Latest N	ews
Dr	ovider		W	/eicome Heal	th Care I	'rotessio	nal!			E cutest N	
									_		

Provider Addresse

Languages Page

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

Language		Action
ENGLISH		Remove
• Click to add language.		
	Continue Finish Later Cance	

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

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: C	Other Information				
Welcome	Certification required when no license informa	tion provided			
Request Information	Tediastee a service field	and provided.			
Provider Identification	• Indicates a required field.				
Addresses	Board Certification				
Languages	Click "+" to view or update the details in a row	I. Click "-" to collapse the row. Click "	Remove" link to remove	the entire row.	
Other Information	If board certified, please provide the board	ertification type, number, effective da	te, and expiration date of	certification.	
	Certification Type	Certificate #	Effective Date	End Date	Action
	 Click to collapse. 				
Supporting Documentation / Attachments and Fees	*Cartification Turce	10 10 10 10 10 10 10 10 10 10 10 10 10 1	iente #		
Agreement	*Effective Date 0	v +Certin IIII *End			
Summary					
	Add Reset				
	Facility Information				
	*Administrator First Name	N	11		
	*Administrator Last Name S				
	*Phone 🛛				
	*Fax Number e		_		
	*Email@	*Dually Castified parts in			
	*Number Medicare Beds	*Dually-Certified Beds 0			
]		

Finish Later

Continue

Cancel

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: <u>Forms -</u> <u>Mississippi Division of Medicaid</u>
- 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.

			S Entity with Direc and/or Managing C	SECTION B-1 t/Indirect Ownership control Identification I	Interest nformation		
Click	"+" to vi	ew or upd	ate the details in a row. Click "-" to collap.	se the row. Click "Remo	ve" link to remove th	e entire row.	
	Row	Lega	l Business Name as Reported to the Internal Revenue Service	Employer Identifica Number (EIN)	tion Percent Ov	vnership	Action
Ξ	1				5		Remove
	DBA Na *Effecti 01/01/1 Percent	me ve Date 900 Owners) I III hip	*Employer Iden ••••••• *Owner/Partne 5 Percent (5%) Ownership Type	tification Number (r pr More Ownership Ir	EIN)	
-	5			Direct 🗸]		
A	Addresse	s o view or w	update the details in a row. Click "-" to co Address	Direct V) move" link to remov Primar	e the entire ro	w. Action
	Addresse	s o view or w	update the details in a row. Click "-" to co Address	Direct V] move" link to remov Primar Yes	e the entire ro Y	ow. Action Remove
C	Addresse	s o view or w *Addr *(*St *Cour	update the details in a row. Click "-" to co Address ess City ate UNITED STATES V	Direct v ollapse the row. Click "Re Primary Addres	move" link to remov Primar Yes s	e the entire ro	w. Action Remove
	Addresse	s o view or *Addr *Gour Sa to add a	update the details in a row. Click "-" to co Address ess City UNITED STATES Ve Reset Cancel ddress.	Direct V	move" link to remov Primar Yes S	e the entire ro	ow. Action Remove

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.

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 Active Plant Date Plant
 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 ananaging 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 Active Remore * Last Name * First Name MI Remore * Last Name * First Name MI Remore * SSN * Title * "Country UNITED STATES If the above noted individual is an owner, please select one of the following options and give the effective date:
 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 Activ * a tast Name * First Name SSN Birth Date Activ * a tast Name * First Name SSN Birth Date Activ * Birth Date * # Gender Male * Title * # Gender Male * Title * # Gender Male * Title * # SSN * # Title * # Gender Male * * * * * * * * * * * * * * * * * * *
 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 Active Remore "link to remove the entire row. *Last Name *First Name SSN Birth Date Active Remore *Implement application Remore *SSN # 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 Active Remore *Implement application Remore *Implement application
• 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 Active *Last Name *First Name MI Remove *Last Name *First Name MI Remove *Last Name *Gender Male Title Title *SSN 0 **Owner/Managing Both Owner and managing Er Title Title Title *State Mississippi * *Zip Code 0 Title
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 Active *Last Name *First Name MI Remo *Last Name *First Name MI MI *Birth Date 0 Image: SSN 0 *Owner/Managing Both (Owner and managing Erv) Title *SSN 0 *Owner/Managing Both (Owner and managing Erv) Employee *City *State *Zip Code0 If the above noted individual is an owner, please select one of the following options and give the effective date:
Row Last Name First Name SSN Birth Date Active 1
*Last Name *Birth Date 0 *SSN 0 *SSN 0 *City *City *State Mississippi *Country UNITED STATES If the above noted individual is an owner, please select one of the following options and give the effective date:
*Last Name *First Name *Birth Date 9 *Gender *SSN 9 **Owner/Managing Both (Owner and managing Er V) *Home Address *City *State Mississippi *State Mississippi *Country UNITED STATES If the above noted individual is an owner, please select one of the following options and give the effective date:
*Birth Dateθ *Gender Male Title *SSN θ *Owner/Managing Both (Owner and managing Er ♥) *Home Address Employee *City *State Mississippi *Zip Codeθ *Country UNITED STATES If the above noted individual is an owner, please select one of the following options and give the effective date:
*SNU *Owner/Managing Both (Owner and managing Er V) *Home Address Employee *City *State Mississippi *State Mississippi *Zip Code 0 *Country UNITED STATES *Zip Code 0 If the above noted individual is an owner, please select one of the following options and give the effective date:
*Home Address
*City *State Mississippi *Country UNITED STATES If the above noted individual is an owner, please select one of the following options and give the effective date:
*City *State Mississippi *Country UNITED STATES If the above noted individual is an owner, please select one of the following options and give the effective date:
*State Mississippi ✓ *Zip Code ⊕ ✓ *Country UNITED STATES ✓ ✓ If the above noted individual is an owner, please select one of the following options and give the effective date: ✓
If the above noted individual is an owner, please select one of the following options and give the effective date:
If the above noted individual is an owner, please select one of the following options and give the effective date:
If the above noted Individual is a managing employee, please select all that apply and give the effective date:
Director/Officer
Contracted Managing Agent Employee
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 V Official Effective Date
Save Reset Cancel
Relationships
Relationships If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, acoust, managing employed
Relationships If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing empl director, or shareholder and is related to each other as shouse, parent, child or sibling, please note the pare and relationship
Relationships If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing empl director, or shareholder and is related to each other as spouse, parent, child or sibling, please note the name and relationship
Relationships If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing empl 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.
Relationships If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing empl 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

Disclosure Page, Sections C and D

Check each section and make any necessary updates.

Save must be selected after the updates have been made.

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,

SECTION C Criminal Convictions and Other Sanctions

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 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.

		dd conviction, Sancdon			
		Relationships to Excluded, Penalize	SECTION D ed, or Convicted Persons in Accordance with	42 CFR § 1002.3	
(dentif (1) ha (2) ha Of (3) ha (4) al	iy and pro as been o as had civ R as been e so has o	ovide the requested information in this section convicted of a criminal offense as described in vil money penalties or assessments imposed excluded from participation in Medicare or an me or more of the following relationships to t	on regarding any person who: n Sections 1128(a) and 1128(b) (1), (2), or (3) o under Section 1128A of the Social Security Act ny of the state health programs AND he disclosing provider:	f the Social Security	Act;
	i. has a ii. is the	direct or indirect ownership interest (or any owner of a whole or part interest in any more	combination thereof) of five percent (5%) or mo rtgage, deed of trust, note, or other obligation se	re in the group/orgar cured (in whole or in	nization; part) by
	the gr the to	roup/organization or any of the property asse stal property and assets of the group/organiz	ets thereof, in which whole or part interest is equa ation;	al to or exceeds five p	percent (5%
	iii. is an o iv. is a p	officer or director of the group/organization, artner in the group/organization, if the group	if the group/organization is organized as a corpo	ation;	
	v. is an	agent of the group/organization;			
	vi. is a m opera of the	nanaging employee, that is, an individual (inc tional or managerial control over the group/o group/organization or part thereof; or	cluding a general manager, business manager, ad organization or part thereof, or directly or indirect	ministrator, or directo ly conducts the day-	or) who exer to-day opera
`	vii. was fo owner antici	ormerly described in subparagraphs (i) throu rship or control interest to an immediately fa pation of or following a conviction, assessme	igh (vi), immediately above, but is no longer so d imily member or a member of the person's house int of a civil monetary penalty, or imposition of an	escribed because of a hold as defined in thi exclusion.	a transfer or is section, in
NOTE:	Please r	efer to the Instructions for Provider Disclosu	re Form for applicable definitions.		

	Row	Name	Relationship	Action
+	Click to ad	d 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 Indiv	idual/Legal Entity	Action
+	Click to add Rela	ationship		
		SECT Disclosure of Subco	ION F ntractor Information	
lentif oup/	y any person (indiv organization has a	vidual or legal entity) with an ownership or cont direct or indirect ownership of five percent (5%	rol interest in any subcontractor in which the d b) or more.	isclosing
ick "·	+" to view or upda	te the details in a row. Click "-" to collapse the r	row. Click " Remove" link to remove the entire	row.
	Row	Name of the Indiv	idual/Legal Entity	Action
ŧ	Row Click to add Rela	Name of the Indivi	idual/Legal Entity	Action
ŧ	Row Click to add Rela Business Tr	Name of the Indivi ationship SECT ransactions (This section should only be co	idual/Legal Entity ION G mpleted at the direction of Division of Med	Action
t dentif ionth ercen	Row Click to add Rela Business Tr y the ownership of period before the t (5%) or more.	Name of the Indivi ationship SECT ransactions (This section should only be con any subcontractor with whom the provider has date of this request. If there are multiple owner	idual/Legal Entity ION G mpleted at the direction of Division of Med had business transactions totaling more than \$ s or shareholders, list only those with direct or	Action licaid (DOM)) \$25,000 during the 12- indirect ownership of fi
tentifi ionth ercen	Row Click to add Rela Business Tr y the ownership of period before the t (5%) or more. +" to view or upda	Name of the Indivi ationship SECT ransactions (This section should only be con any subcontractor with whom the provider has date of this request. If there are multiple owner te the details in a row. Click "-" to collapse the n	idual/Legal Entity ION G mpleted at the direction of Division of Med had business transactions totaling more than \$ s or shareholders, list only those with direct or row. Click "Remove" link to remove the entire	Action

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:

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

*I accept 🔽 🛛 I have read

I have read and agree to the terms stated above

Title d Date 03/22/2023			Continue	Finish Later	Cancel
Title d	Date	03/22/2023			
	Title	d			
*Your Signature	*Your Signature	d			

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, <u>Provider Enrollment Application Fee</u> 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
#	Tansmission Pietriou	riie	Attachment Type	ACTION
ΞC	lick to collapse.			
	*Transmission Method FT-File	Transfer 💙		
	*Upload File Choose	File No file chosen		
	*Attachment Type		~	
	Add Cancel			
Appli	cation Fee			
Missis	sippi Medicaid has determined that your a	application will require you to pay an applicatio	I his is only visib	le to
			providers taxono	omies
	*Fee Payment Type		that are required	to pay
Warn	ing: If you select Hardship Waiver or Sub	mitting Payment on the Fee Payment Type dro	p ^{down, s} the fee to Medica	are or
in 10	days or your application will be denied.		Modicaid	
			Wieulcalu.	
L				
Attac	hment Attestation			
	I have verified that I have uple any missing documentation wi	baded all documentation for this enrollme Il delay processing of the submitted appli	nt application. I understand that cation.	



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 understan	nd that my electronic sign	ature is equivalent t	o written signature	e.	
•	*Your Signature					
(Entering your name in the box	to the right will			_		
constitute your electr	onic signature.)					
	Title					
s	ubmission 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	
Address	
Tax ID	
NPI	
Contact Name	
Contact Email	
Division of Medicaid The Office o	f the Governor Medical Assistance Participation Agreement
(Medicai	d – 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 understan	d that my electronic signa	ature is equivalent	to written signatu	re.
		*Your S	Signature	LD			
Entering your name	in the box	to the	right will				
constitute	your electr	onic si	gnature.)			_	
			Title				
	5	Submis	sion Date	08/14/2023			
					Submit	Finish Later	Cancel

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 righthand side, change the Printer dropdown 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 <u>Confirm</u> 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 <u>not</u> 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.

Print Preview	Confirm	Finish Later	Cancel
Provider Enrollment: Summary Request 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 Even pages only e.g. 1-5, 8, 11-13 Color Black and white Print Cancel		

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.

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.

our enrollment application has b	en assigned the following tracking numl	er:33786. Please retain the t	racking number for your record	ds.
he tracking number will be used,	in addition to your Tax ID and password	, as credentials to resume/rev	vise your application at a later	date.
confirmation email has also bee	n sent to the following contact person's o	ma <mark>il, designa</mark> ted in t <mark>h</mark> e enroll	ment application:LS@GMAIL.C	COM.

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:

provider ID

Mississippi Division of Medicaid (DOM) has approved the provider revalidation for

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

Toll-free 800-884-3222 | Fax 866-644-6148 | medicaid.ms.gov Responsibly providing access to quality health coverage for vulnerable Mississippians