

Job Aid

Copy an Existing Provider Enrollment Application

This document outlines the steps to copy an existing provider enrollment application that was previously submitted and lists the prepopulated fields of a copied application.

The copy function duplicates specific fields of a previously submitted application. Those fields will be prepopulated as illustrated throughout this document.

Utilizing the copy functionality:

- Only previously submitted enrollment applications using the same taxonomy can utilize copy.
- **Not all data is copied.** Only certain fields are prepopulated therefore, it's crucial to check each field and make appropriate updates.
- Copying the application can save time and avoid inputting data multiple times.
- Additional taxonomies from the same family, as well as multiple service locations can be added after copying the application.

***It is imperative to review the entire application before submitting it to confirm all the information is still accurate. ***

Steps to copy an existing enrollment application

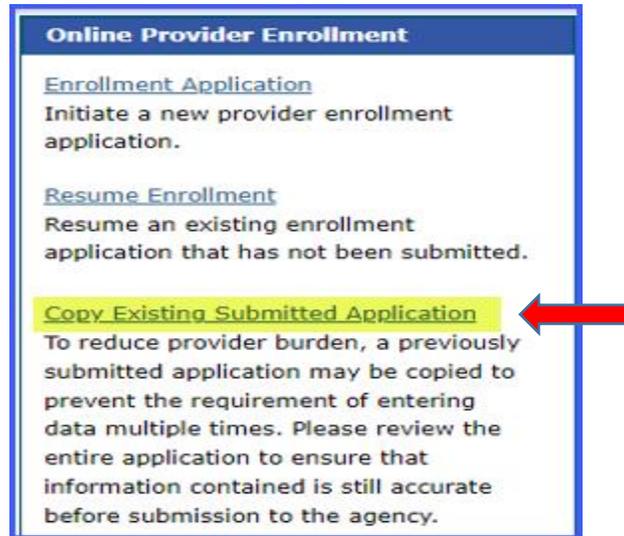
1. Select the **Provider Enrollment Access hyperlink** found on the **Home** page of the MESA Provider Portal.

Figure 1: MESA Portal Home Page



2. Select the **Copy Existing Submitted Application** hyperlink:

Figure 2: Copy Hyperlink



3. Enter the **Tracking Number**- ATN Application Tracking Number, **Tax ID**, and **Password**, then select **Submit**.

Tax ID is the SSN-social security number for individual providers.

Password is the one that was created by the user while submitting the application which is being utilized to copy.

Figure 3: Copy Existing Submitted Application Sign In

The screenshot shows a sign-in form titled "Provider Enrollment: Copy Existing Submitted Application". It includes instructions: "Enter your assigned Tracking Number, Tax ID and Password in order to copy an existing provider enrollment application. For further questions, please contact Provider Services at 1-800-884-3222." Below the instructions is a note: "* Indicates a required field." There are three input fields: "Tracking Number" (containing "28128"), "Tax ID" (containing "*****"), and "Password" (containing "*****"). At the bottom right, there are two buttons: "Submit" and "Cancel". A red arrow points to the "Submit" button.

 Verify the accuracy of all the information on each page to ensure it has not changed since the last time the application was submitted.

Figure 4: Welcome Page of Enrollment Application

Home > Online Provider Enrollment > Enrollment Application Wednesday 06/07/2023 12:06 PM CST

Provider Enrollment: Welcome ?

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.
Taxonomies	
Provider Identification	
Addresses	Medicaid Fee-for-Service Providers Medicaid Fee for Service (FFS) providers are all health care entities including physicians or other professionals, institutions, groups, and organizations that are enrolled in the Medicaid program. FFS providers must complete the full enrollment form to submit claims for reimbursement of services provided for Medicaid 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 service for a Medicaid member, the NPI of the ordering, referring, or prescribing (ORP) provider of the service must be included on the claim.
Affiliated Providers	
Languages	
EFT Enrollment	
Other Information	Ordering, Referring, & Prescribing (ORP) Providers Federal regulation at 42 CFR 455.410 requires the enrollment of physicians or other professionals who only order, refer or prescribe (ORP) services for Medicaid members. Physicians and other eligible practitioners, who order, refer, or prescribe items or services for Medicaid members 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.
Disclosure	
Supporting Documentation / Attachments and Fees	
Agreement	Managed Care Providers 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.
Summary	

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.

Continue
Cancel

Select **Continue** to the **Request Information** page.

Follow the normal process to submit an application. The prepopulated fields are shown in the following examples.

Prepopulated fields on a copied application:

The **Request Information** page is **prepopulated**. Review all fields and make any necessary updates.

- The **effective date** must be updated to a current date.
- The link for **Additional Enrollment Requirements** must be selected in order to move forward in the application.

FFS Providers the next page is Taxonomies.

Providers enrolled in Managed Care Organizations the next page will be CCO Information page.

Figure 5: Request Information Page

Provider Enrollment: Request Information ?

Welcome Click the down arrow next to Enrollment Type to select the appropriate application type – Individual, Group, Facility, Other or ORP (Ordering, Referring, Prescribing).

▶ **Request Information**

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

Click the Additional Enrollment Requirements Checklist link to select a taxonomy.

[Additional Enrollment Requirements Checklist \(Must View\)](#) ←

Must click this link or you cannot move forward in the application

Enrollment Type Group

Taxonomy 261QR1300X-Clinic/Center - Rural Health

***Requesting Enrollment Effective Date** 📅

***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.** Yes 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** ***NPI Zip + 4**

***Tax ID Number** ***Tax ID Type** EIN SSN

***Are you currently enrolled as a Provider?** Yes No ***Current Provider Identifier**

***Were you previously enrolled as a Provider?** Yes 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**

***First Name**

Title

***Phone** **Ext**

Fax Number

***Work Email**

***Confirm Email**

Preferred Method of Communication

Continue
Exit

The Password Creation Panel will display next. Enter the password you would like to use for this particular application.

Figure 6: Password Creation Panel

Provider Enrollment: Password Creation

Welcome

Request Information

Password Creation

Application Tracking Information

Credentialing Information

Taxonomies

Provider Identification

Addresses

Affiliated Providers

Languages

EFT Enrollment

Other Information

Hospital Admittance

Applicant History

Disclosure

Supporting Documentation / Attachments and Fees

Agreement

Summary

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 password.

Please create a password below to be assigned a unique application tracking number for this application.

The password 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 (SSN) is provided, as received within your provider enrollment application.

Be sure to write down your password.

An email confirmation will be sent with the application tracking number. If you don't submit your application right away, you can use this application tracking number, your Tax ID or SSN and password to resume your application later.

If your application isn't updated or submitted within six months, it will be removed, resulting in the loss of your work and progress. Recredentialing and Revalidation applications will be purged if not submitted by the deadline date listed on the Recredentialing/Revalidation Notification Letter.

* Indicates a required field.

Tax ID *****

*Password

*Confirm Password

Continue **Cancel**

The Application Tracking information will display next. This information is sent to the contact person's email. Please make a note of the tracking number, the Tax ID, and the password created. It will be needed to access this application.

Figure 7: Application Tracking Information

Home > Online Provider Enrollment > Enrollment Request Information > Enrollment Credentials >

Tuesday 04/08/2025 01:34 PM CST

Application Tracking Information

Print Preview

Provider Enrollment: Application Tracking Information

Welcome

Request Information

Application Tracking Information

Credentialing Information

Taxonomies

Provider Identification

Your enrollment application has been assigned the following tracking number:60980. Please retain the tracking number for your records.

The tracking number will be used, in addition to your Tax ID and password, as credentials to resume/revise your application at a later date.

A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:

Continue **Exit**

FS Providers only – (MCO Providers skip to next step) **Taxonomies Page** is **not prepopulated**. Complete each field with required data, select **Add** to enter a taxonomy, then select Continue to the Provider Identification page.

Figure 8: Taxonomies Page

MCO Providers Only (FFS providers skip this step) – **Credentialing Information page** is **prepopulated**. Review each field, make any necessary updates then select Continue to the CCO Page.

Figure 9: Credentialing Information Page

MCO Providers Only (FFS providers skip this step) – **CCO Information page is prepopulated.** Review each field, make any updates, select the Attestation statement, then select Continue to the Provider page.

Figure 10: CCO Information Page

Provider Identification page is prepopulated. Review each field, make any necessary updates then select Continue to the Address Page.

Figure 11: Provider Identification page

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

Medicare Participation

Medicare # Effective Date Medicare Type

CLIA Certification

Fields marked required in this section are only required if any information is entered in this section.
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

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

DEA #

DEA # Effective Date

Prepopulated fields on the **Address page** are **Corporate Office, Mail To,** and **Pay To Addresses**. The **Service Address** does **not** prepopulate. Review each field, using the + sign to expand and edit an address and to add the Service Address, make any necessary updates including required information such as contact information and hours, select Save after each update, then select Continue to the Affiliated Providers Page.



Multiple service locations can be added to the copied application.

Figure:12 Address 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
<input type="checkbox"/> AKAN	Corporate Office	PO BOX		Mississippi	Copy Remove
<input type="checkbox"/> ANKS	Mail To	PO BOX		Mississippi	Copy Remove
<input type="checkbox"/> ANKS	Pay To	PO BOX		Mississippi	Copy Remove
<input type="checkbox"/> Click to add address.					

Affiliated Providers page is prepopulated. Review each field, make any necessary updates, to add another affiliated individual provider select the Add Tab, then select Continue to the Languages page.

Figure 13: Affiliated Providers page

Summary **Add**

Select the Add tab to add one or more affiliated individual providers to the group.

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Affiliated Providers					Total Records: 12
#	Name	MCD	Effective Date	End Date	Action
1	MARK		01/01/1900	12/31/2299	Remove
2	KENNETH		10/28/2019	12/31/2299	Remove
3	MELISSA		12/18/2017	12/31/2299	Remove
4	STEPHANIE		02/04/2016	12/31/2299	Remove
5	JESSICA		01/01/2022	12/31/2299	Remove
6	PATRICIA		01/15/2020	12/31/2299	Remove
7	PATRICIA		01/15/2020	12/31/2299	Remove
8	LESLIE		09/28/2020	12/31/2299	Remove
9	ROBIN		04/25/2019	12/31/2299	Remove
10	COURTNEY		07/23/2020	12/31/2299	Remove

1 2

Continue **Exit**

Language Page is prepopulated. Review each field, utilize the + sign to add any additional languages, use the remove hyperlink to remove any language, then Select **Continue** to the EFT Enrollment page.

Figure 14: Language page

Provider Enrollment: Languages ATN: 60980 ?

Welcome

Request Information

Credentialing Information

Taxonomies

Provider Identification

Addresses

Affiliated Providers

Languages

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
<div style="border: 1px solid black; padding: 2px; display: inline-block;">+</div> Click to add language.	

Continue **Exit**

The **EFT Information Page** is **not** prepopulated. Fill out each field then select Continue to the Other Information page.

Figure 15: EFT Information

Provider Enrollment: EFT Information
ATN: 60980 ?

[Welcome](#)

[Request Information](#)

[Credentialing Information](#)

[Taxonomies](#)

[Provider Identification](#)

[Addresses](#)

[Affiliated Providers](#)

[Languages](#)

EFT Enrollment

[Other Information](#)

[Hospital Admittance](#)

All providers agree to electronic direct deposit transfer payments for claims reimbursement by the Division of Medicaid and to submit, in accordance with instructions from the Division of Medicaid or its agent.

* Indicates a required field.

*Financial Institution Name

*ABA Routing Number

*Type of Account at Financial Institution

*Provider's Account Number with Financial Institution

*Confirm Account Number

Continue
Exit

Other Information Page is **prepopulated** when there is information from the application that is being copied. Review each field, make necessary updates, select Add to add any attachment(s) then Select Continue to the Disclosure page.

Figure 16: Other Information Page

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
<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 45%;"> <p>* Certification Type <input style="width: 100%;" type="text"/></p> <p>* Effective Date <input style="width: 100%;" type="text"/></p> </div> <div style="width: 45%;"> <p>* Certificate # <input style="width: 100%;" type="text"/></p> <p>* End Date <input style="width: 100%;" type="text"/></p> </div> </div> <div style="margin-top: 10px; display: flex; justify-content: center; gap: 10px;"> Add Reset </div>				

Consolidated Cost Reports

* Does this organization file a consolidated cost report under another's Medicaid provider number? Yes No

Medicaid Provider Number

Continue
Exit

Applicant History page is prepopulated. Review all answers then click on Continue at the bottom of the page.

Figure 17: Applicant History Page

Provider Enrollment: Applicant History		ATN: 60980
<ul style="list-style-type: none"> Welcome Request Information Credentialing Information CCO Information Taxonomies Provider Identification Addresses Languages EFT Enrollment Other Information Applicant History Disclosure Supporting Documentation / Attachments and Fees 	<p>For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:</p> <ul style="list-style-type: none"> • An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals. • A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider. • An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association. <p>Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.</p>	
	<p>Training</p> <p>*Are you and your staff annually trained on Fraud, waste, and abuse? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>If No, please explain: <input style="width: 100%; height: 30px;" type="text"/></p>	
	<p>Investigations</p> <p>*Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>	
	<p>Continue Exit</p>	

Disclosures Page is **prepopulated** except for the **Signature** found at the bottom of **Section H**. Review all fields in Sections **B, C, D, E, F, G** and **H**, utilize the **+** sign to view, add or update any row or select remove to remove a row. In Section **H** make sure to **Accept**, enter the Name and Title. Select Continue to the Supporting Documentation/Attachments and Fees page.

Figure 18: Sections B of the Disclosure page

Instructions for Mississippi Medicaid Provider Disclosure Form

Click to View Instructions

SECTION B

Direct/Indirect Ownership Interest and Managing Control Identification Information

NOTE: ONLY REPORT ORGANIZATIONS IN SECTION B-1. INDIVIDUALS WITH OWNERSHIP/MANAGING CONTROL MUST BE REPORTED IN SECTION B-2. The disclosing entity is responsible for reporting all ownership and managing control.

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
Click to add Organization				

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	PRICHARD	MICHAEL	*****678		Remove
Click to add Individual					

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				

Figure 16: Section C, D, E and F of the Disclosures page

SECTION C																
Criminal Convictions and Other Sanctions																
<p>Provide the requested information in this section for any person who:</p> <p>(1) Has an ownership or control interest in the disclosing provider OR is an agent or managing employee of the disclosing provider AND</p> <p>(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</p> <p>(3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c-h), (4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h), (5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program, (6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program, (7) Has had his/her/its license or certification revoked, or (8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.</p> <hr/> <p>Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 10%;">Row</th> <th style="width: 35%;">Name</th> <th style="width: 35%;">Criminal/Sanction Info</th> <th style="width: 10%;">Date</th> <th style="width: 5%;">Action</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">+</td> <td colspan="5">Click to add Conviction/Sanction</td> </tr> </tbody> </table>						Row	Name	Criminal/Sanction Info	Date	Action	+	Click to add Conviction/Sanction				
	Row	Name	Criminal/Sanction Info	Date	Action											
+	Click to add Conviction/Sanction															

SECTION D														
Relationships to Excluded, Penalized, or Convicted Persons in Accordance with 42 CFR § 1002.3														
<p>Identify and provide the requested information in this section regarding any person who:</p> <p>(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</p> <p>(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:</p> <ul style="list-style-type: none"> 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. <p>NOTE: Please refer to the Instructions for Provider Disclosure Form for applicable definitions.</p> <hr/> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 10%;">Row</th> <th style="width: 35%;">Name</th> <th style="width: 35%;">Relationship</th> <th style="width: 10%;">Action</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">+</td> <td colspan="4">Click to add Relationship</td> </tr> </tbody> </table>						Row	Name	Relationship	Action	+	Click to add Relationship			
	Row	Name	Relationship	Action										
+	Click to add Relationship													

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
+	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
+	Click to add Relationship		

Figure 19: Section G, and signature portion in section H of the Disclosure page

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
+	Click to add Transaction			

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**

Title

Date 11/20/2024

Continue
Exit

Supporting Documentation, Attachments and Fees page only **prepopulates the Fee Payment Type.** Review all fields, click the Privacy Notice, make any updates, add all required data, utilize the + sign to add any attachments, select the Attestation statement then select Continue to the Agreement page.

Figure 20: Attachment and Fees 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.

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

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

#	Transmission Method	File	Attachment Type	Action
1	FT-File Transfer	12 FI IXO.pdf (229K)	All	Remove

Click to add attachment.

Application Fee

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

* **Fee Payment Type** Made Payment to Medicare v

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

Attachment Attestation

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

Continue
Exit

Agreement Page is not prepopulated. Enter the signature, select I accept then select Submit to continue to the Summary Page.

Figure 21: Agreement 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

Provider Name GROUP

Address
Jackson
Mississippi, --

Tax ID -----

NPI -----

Contact Name AKAN-----

Contact Email -----

Programs selected for application:

- Fee-For-Service (FFS)

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

Summary Page does not prepopulate. This is the time to review the entire application before submitting. The user can select **Print Preview** to print or save the application before submission. Select “I accept” then select **Continue** to submit the application.

Figure 22: End of Summary Page

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 04/08/2025

The Submit panel will give you the chance to preview the application and print a copy. If everything is correct, select **Submit**.

Figure 23: Submit Application

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 Group
Title Owner
Agreement Date 04/08/2025

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 'Submit' 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 **Submit** **Exit**

After clicking Submit, the system will ask if you need to print a copy of the application or if you are ready to submit. Click **OK** to complete submission of the application.

Figure 24: Print Application

Submit Complete Application

Have you printed a copy for your records? Select OK to submit the application or select Cancel if you need to return to application to print a copy.

OK **Cancel**

Agreement Date 04/08/2025

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 'Submit' 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 **Submit** **Exit**

The Application Tracking Information is displayed. Click **Exit** to leave the portal.

Figure 25: Application Tracking Information

The screenshot shows a web page titled "Application Tracking Information" under the "Online Provider Enrollment" section. The breadcrumb trail is "Home > Online Provider Enrollment > Application Tracking Information". The date and time are "Tuesday 04/08/2025 01:53 PM CST". A "Print Preview" button is in the top right. The main content area has a blue header "Provider Enrollment: Application Tracking Information" with a help icon. The text reads: "Your enrollment application has been submitted." "Your enrollment application has been assigned the following tracking number:60980" "Please retain the tracking number for your records. The tracking number will be used, in addition to your Tax ID and password, as credentials to reference your submitted application at a later date." "A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:{" "You are required to print, sign and submit the cover sheet via mail or FAX, along with all appropriate supporting documentation." "To save or print the coversheet for your records [click here.](#)" An "Exit" button is in the bottom right.

Change History

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

Version #	Published/ Revised	Author	Section/Nature of Change
1.0	11/15/2024	Gainwell	Initial publication
2.0	6/13/2025	Gainwell	Updated per CR2571