

Office of the Governor | Mississippi Division of Medicaid

Individual Provider

Initial Enrollment Application

May 16, 2025



Provider Enrollment

- Gainwell does not accept paper enrollment applications.
- Must have a taxonomy to enroll.
- Supporting documentation must be submitted via the web portal with the initial enrollment application submission.
- Required supporting documentation will vary depending on the taxonomy code and enrollment type.
- Incomplete enrollment applications will be returned to the provider or denied.
- If the enrollment application is returned to the provider for missing documentation, you have **60 days** to upload the documents to the web portal. If **not submitted**, the application will be **denied on the 61st day**.

Provider Enrollment

- **All providers must be screened in compliance with 42 CFR 455.410.**
- **Individuals considered High-Risk** will require owners that have a 5% or greater direct or indirect ownership interest to submit fingerprints for a Fingerprint Criminal Background Check (FCBC) and participate in a site visit (unless the provider is currently enrolled with Medicare and the application data for Medicare and Medicaid matches).
- **Individuals considered Moderate Risk** will require a site visit unless the provider is enrolled with Medicare and the application data for Medicare and Medicaid matches.

Application Tips

- 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 a required field.
- All application attachments must be in pdf, gif, jpg, jpeg, png, tif, tiff or txt format.
- At anytime during the application process, you can select “**EXIT**”, and it will prompt you to save your changes.
- If a new application is not completed within **6** months, it will be removed. Recredentialing and Revalidation is due by the date on the provider portal home page.
- Non-billing providers are only required to enroll once per NPI and taxonomy combination using their primary service location. After enrollment, non-billing providers must affiliate with a billing provider (such as a group practice) that will submit claims on their behalf. This affiliation must be established for each practice location where the non-billing provider renders services. Each additional servicing location provided will result in a separate Medicaid enrollment.

Accessing Provider Enrollment

- Go to the Mississippi Division of Medicaid's website to access the MESA Provider Portal. [Mississippi Division of Medicaid](#)
- Select Provider Portal, then Provider Login to access the home page of the Provider Portal. [MESA Provider Portal](#)
- Select the “[Provider Enrollment Access](#)” link.

Login ?

*User ID

Log In

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

Protect Your Privacy!

Always log off and close all of your browser windows

[Privacy Policy](#)

[Provider Enrollment Access](#)

[Enrollments Forms](#)

[340B Program Information](#)

[Trading Partner Enrollment](#)


[Late Breaking News](#)

[Provider Bulletins](#)

[UM/QIO](#)

[Provider Rates](#)


[EHR Incentive Program](#)



MESA
MEDICAID ENTERPRISE SYSTEM ASSISTANCE

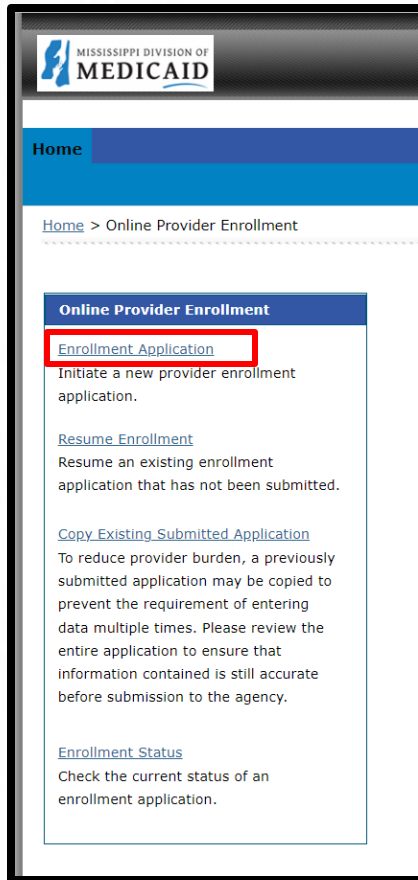
What you can do in the Medicaid Portal for Providers

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



Call Center Hours!
8:00 a.m. - 5:00 p.m.

Enrollment Application



- Select the “[Enrollment Application](#)” link.
- The Welcome page displays with explanations/definitions for each enrollment application type.

Welcome Page

This section of the Welcome Page provides an explanation of each provider type:

- Fee For Service (FFS)
- Ordering, Referring and Prescribing (ORP)
- Managed Care providers

The next page goes over the remainder of this section.

| 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. |
| Password Creation | |
| Application Tracking Information | |
| Taxonomies | Medicaid Fee-for-Service Providers |
| Provider Identification | 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 affiliated to the 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. |
| Addresses | Ordering, Referring, & Prescribing (ORP) Providers |
| Languages | 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. |
| EFT Enrollment | Managed Care Providers |
| Other Information | 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. |
| Disclosure | |
| Supporting Documentation / Attachments and Fees | Mississippi Coordinated Access Network (MississippiCAN) Providers |
| Agreement | 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. |
| Summary | 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. |

Welcome Page Cont'd

Explanation of:

- Credentialing/Recredentialing
- Revalidation
- 340B Program
- A link to required documents and enrollment requirements.
- Select Continue to move to the Request Information page.
- To view the requirements for an application, select the link under “Required Documents and Enrollment Requirements”.

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 MississippiCAN and/or CHIP. Upon completion of Division credentialing, providers may voluntarily contract with Coordinated Care Organizations (CCOs).

Recredentialing of providers actively enrolled in the Managed Care programs must be conducted at least every three (3) years, unless otherwise required by regulatory or accrediting bodies or a shorter term as determined by the Credentialing Committee. A recredentialing notice letter will initiate the process with each provider. The letter will provide instructions for completing the recredentialing process and will indicate the due date. Each provider must submit all required supporting documentation and is required to be successfully recredentialed for continued participation in a CCO network.

As part of the recredentialing process, providers 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. The recredentialing process incorporates re-verification and identification of changes in a providers (individual/organization) licensure, sanctions, certifications (including, but not limited to, malpractice experience, sanction history, hospital privilege related or other actions). This information is reviewed to assess whether providers continue to meet the standards set by national accrediting agencies and state and federal regulating bodies, including National Committee for Quality Assurance (NCQA).

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

Enrollment will be terminated for any provider who does not comply with recredentialing requirements. A new application will then be required for the provider to re-enroll in the Mississippi Medicaid program.

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 Service Act (PHSA). Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes, and qualified hospitals. These providers purchase, dispense and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of these drugs makes these drugs ineligible for the Medicaid drug rebate. State Medicaid programs are mandated to ensure that rebates are not claimed on these drugs thereby preventing duplicate discounts for these drugs.

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.

[Continue](#) [Cancel](#)



Request Information Page

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

- ▶ Individual Application Type – Individual practice. For a list of applicable Provider Types, [Click Here](#).
- ▶ Group Application Type – Entity that has associated providers. For a list of applicable Provider Types, [Click Here](#).
- ▶ Facility Application Type – Entity that does not have associated providers (example hospitals, long term care facilities, etc.). For a list of applicable Provider Types, [Click Here](#).
- ▶ Other Application Type – Entity that does not easily fit into any of the other Application Types (example DME, Pharmacy, IDD). For a list of applicable Provider Types, [Click Here](#).
- ▶ ORP Application Type – ORP providers are individual providers that may only order, refer or prescribe services within their legal scope of practice. ORP providers will not be reimbursed for any services provided, and are not eligible for contracting with Coordinated Care Organizations (CCOs). For a list of applicable Provider Types, [Click Here](#).

Key the taxonomy code or description which best describes the type of service that will be provided. A list will be displayed based on the information keyed. From the list, select the appropriate taxonomy code.

Complete the fields on each screen and click the Continue button to move forward to the next page.

Click the Finish Later button to save this application.

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

* Indicates a required field.

Initial Enrollment Information

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

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

*Enrollment Type

*Taxonomy

*Requesting Enrollment Effective Date

There are **five** application types:

➤ **Individual**

➤ **Group**

➤ **Facility**

➤ **Other**

➤ **(ORP) Ordering, Referring, and Prescribing**

➤ Select the **“Click Here”** link beside each enrollment type to view a list applicable taxonomy codes and descriptions.

➤ Select the **Additional Enrollment Requirements Checklist** link to view the checklist. **This must be done to move to the next steps.**

Request Information Page Cont'd

| |
|--|
| 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) |
| <div><div>* Enrollment Type</div><div>Individual</div></div> |
| <div><div>* Taxonomy</div><div></div></div> |
| <div><div>* Requesting Enrollment Effective Date</div><div>08/30/2023</div></div> |
| <div><div>* Are you enrolling only for the submission of the crossover claims? By selecting Yes, you agree that you will not be paid for any claim types other than crossover claims.</div><div><div>Yes</div><div>No</div></div></div> |
| <div><div>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.</div></div> |
| Provider Information |
| The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required. |
| <div><div>* NPI</div><div></div></div> <div><div>* NPI Zip + 4</div><div></div></div> |
| <div><div>* SSN</div><div></div></div> |
| <div><div>* Are you currently enrolled as a Provider?</div><div><div>Yes</div><div>No</div></div></div> |
| <div><div>* Were you previously enrolled as a Provider?</div><div><div>Yes</div><div>No</div></div></div> |
| Program Enrollment |
| Please choose a selection below (at least one is required). Note: When choosing MSCAN, Fee-For-Service (FFS) must also be chosen. Click Here , to view taxonomies excluded from MSCAN and/or MSCHIP enrollments. |
| <div><div>Fee-For-Service (FFS)</div><div>MSCAN</div><div>MSCHIP</div></div> |
| Application Contact Information |
| Enter the name of a contact person to answer any questions regarding the information provided in this enrollment application. |
| <div><div>* Last Name</div><div>LE</div></div> <div><div>* First Name</div><div>DS</div></div> <div><div>Title</div><div></div></div> <div><div>* Phone</div><div>5014551212</div><div>Ext</div><div></div></div> <div><div>Fax Number</div><div></div></div> <div><div>* Work Email</div><div>lezli.duke@gainwelltechnologies.com</div></div> <div><div>* Confirm Email</div><div>lezli.duke@gainwelltechnologies.com</div></div> <div><div>Preferred Method of Communication</div><div>Email</div></div> |
| <div><div>Continue</div><div>Exit</div></div> |

Select your **Enrollment Type** from the dropdown list. Once selected, additional instructions display.

Enter 2 or more characters of a taxonomy number and a list of available taxonomies will display.

Complete the fields in the **Provider Information** section. Individuals should provide their own NPI and SSN and not the Groups information they are affiliated with.

You must select at least one option to enroll in **Fee-For-Service (FFS)**, **MSCAN** and/or **MSCHIP**. Grayed-out options indicate they are not available for the specified taxonomy.

If **MSCAN** is chosen, **Fee For Service (FFS)** must also be chosen.

Complete the fields in the **Application Contact, Information** section.

Select **Continue** to move to the **Password Creation** page.

Password Creation

Create a password according to the Password Assistance panel.

To regain access to the Enrollment portal, you will need the new password along with the Social Security Number (SSN) submitted in the Requested Information page.

Remember to write it down! If you do not have this information, you will have to start the application process over.

Provider Enrollment: Password Creation

Welcome

[Request Information](#)

Password Creation

[Application Tracking Information](#)

[Credentialing Information](#)

[CCO Information](#)

[Taxonomies](#)

[Provider Identification](#)

[Addresses](#)

[Languages](#)

[EFT Enrollment](#)

[Other Information](#)

[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

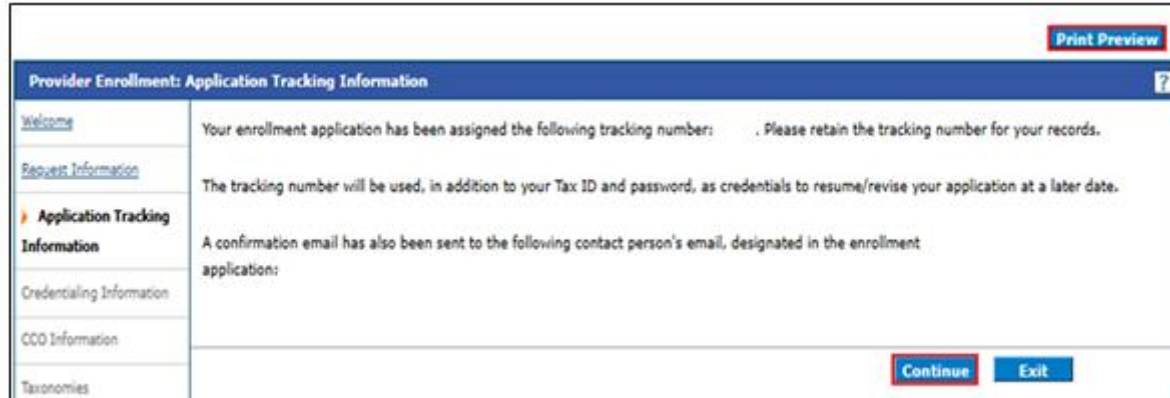
[Continue](#) [Cancel](#)

Application Tracking Information

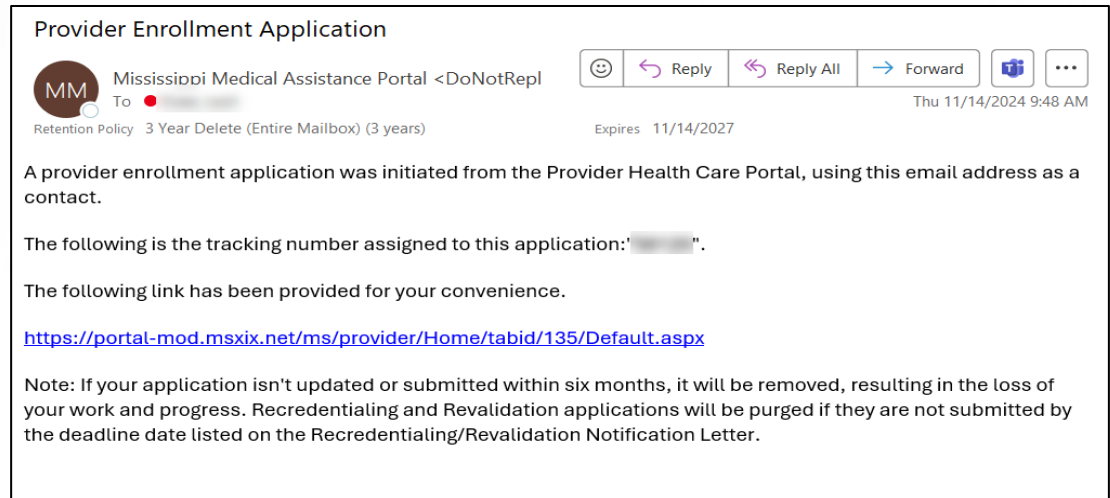
You will receive confirmation that will include **your application tracking number (ATN)**.

You will need this number and the **Social Security Number (SSN)** to view completed application status.

Also, an email confirmation will be sent to the email provided on the application under the **Contact Person**.



The screenshot shows a web interface titled "Provider Enrollment: Application Tracking Information". On the left is a sidebar menu with links: "Welcome", "Request Information", "Application Tracking Information" (highlighted with an orange arrow), "Credentialing Information", "COO Information", and "Taxonomies". The main content area contains the following text: "Your enrollment application has been assigned the following tracking number: . Please retain the tracking number for your records." followed by "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." and "A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:". At the bottom right of the main area are two buttons: "Continue" and "Exit". A "Print Preview" button is located in the top right corner of the page header.



The screenshot shows an email titled "Provider Enrollment Application" from "Mississippi Medical Assistance Portal <DoNotRepl>". The email header includes a "MM" logo, the sender name, and a "To" field with a redacted address. It also shows a "Retention Policy" of "3 Year Delete (Entire Mailbox) (3 years)" and an "Expires" date of "11/14/2027". The email body contains the following text: "A provider enrollment application was initiated from the Provider Health Care Portal, using this email address as a contact." followed by "The following is the tracking number assigned to this application: ' '." and "The following link has been provided for your convenience." Below this is a blue hyperlink: <https://portal-mod.msix.net/ms/provider/Home/tabid/135/Default.aspx>. A note at the bottom states: "Note: 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 they are not submitted by the deadline date listed on the Recredentialing/Revalidation Notification Letter." The email interface includes standard action buttons like "Reply", "Reply All", "Forward", and a "Thu 11/14/2024 9:48 AM" timestamp.

Credentialing Information

This is only applicable to providers that have selected MSCAN or MSCHIP.

The screenshot shows a web form titled "Provider Enrollment: Credentialing Information" with a user ID "ATN: 61443" in the top right. On the left is a sidebar menu with links: "Welcome", "Request Information", "Credentialing Information" (highlighted with an orange arrow), "Taxonomies", "Provider Identification", and "Addresses". The main content area is titled "Credentialing Information" and contains the instruction: "Either enter Credentialing Delegate Agency Name and Date or your CAQH ID." Below this, there are two input options. The first option consists of a dropdown menu for "Credentialing Delegate Agency Name" (currently showing "HUBHEALTH") and a date field for "Credentialing Date" (showing "01/01/2020"). The second option is a text field for "CAQH ID". Between these two options is the word "OR". At the bottom right of the form are two buttons: "Continue" and "Exit".

- Select the Credentialing Delegate Agency Name from the dropdown list or enter the CAQH ID.

- If the Credentialing Delegate Agency Name was selected, enter the most recent recredentialing date.
- Select Continue.

Coordinated Care Organization Selection (CCO)

This is only applicable to providers that have selected MSCAN or MSCHIP.

Select the CCOs the provider will be contracting with.

Select the **attestation statement** box.

Select **Continue** to the Taxonomies page.

You are only attesting to release your credentialing information to the selected CCOs; **you will have to contact each CCO directly to contract with them.**

| Provider Enrollment: CCO Information | | ATN: 60482 ? |
|---|---|--------------|
| Welcome | Coordinated Care Organization Selection | |
| Request Information | Note: You are only attesting to release your credentialing information to the selected CCOs. You will need to contact each CCO directly to set up a contract with them. | |
| Credentialing Information | Please select the CCOs the provider will be contracting with: | |
| CCO Information | <input type="checkbox"/> MAGNOLIA HEALTH | |
| Taxonomies | <input type="checkbox"/> MOLINA HEALTHCARE | |
| Provider Identification | <input type="checkbox"/> TRUECARE | |
| Addresses | <input type="checkbox"/> I attest to release the credentialing information upon approved MESA credentialing to the selected CCO's above. | |
| Languages | Continue Exit | |
| EFT Enrollment | | |



Provider Identification

- ▶ Select the appropriate **Organization Type** from the dropdown list. Fields will change based on selection.
- ▶ Select the appropriate box and enter Business Start or Incorporation Date if applicable.
- ▶ Select Public/Private Indicator from drop down.
- ▶ Select Gender and enter the Birth Date of the Provider.
- ▶ For Sole Proprietor: Enter the Legal Tax Name, DBA Name, Sole Proprietor Tax ID, Tax ID Type. The affiliated Group's Tax ID should not be provided.
- ▶ See next page for the remainder of this section.

This section is based on enrollment and organization type

| Organizational Structure | Organizational Structure |
|---|---|
| <ul style="list-style-type: none">If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.If you are affiliated with a Military Medical Treatment Facility (MTF), you must select the Military MTF option from the drop down.If you are affiliated with a Tribal Agency, you must select the Tribal Agency option from the drop down. | <ul style="list-style-type: none">If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.If you are affiliated with a Military Medical Treatment Facility (MTF), you must select the Military MTF option from the drop down.If you are affiliated with a Tribal Agency, you must select the Tribal Agency option from the drop down. |
| <p>*Organization Type Individual</p> | <p>*Organization Type Sole Proprietor</p> |
| <p>Registered with Secretary of State <input type="checkbox"/></p> | <p>Registered with Secretary of State <input type="checkbox"/></p> |
| <p>Incorporated <input type="checkbox"/></p> | <p>Incorporated <input type="checkbox"/></p> |
| <p>Chain Affiliated <input type="checkbox"/></p> | <p>Chain Affiliated <input type="checkbox"/></p> |
| <p>Operated by Management Company <input type="checkbox"/></p> | <p>Operated by Management Company <input type="checkbox"/></p> |
| <p>*Public/Private Indicator </p> | <p>*Public/Private Indicator Private</p> |
| <p>Business Start Date </p> | <p>Business Start Date </p> |
| <p>Incorporation Date </p> | <p>Incorporation Date </p> |
| <p>Legal Tax Name</p> | <p>Legal Tax Name</p> |
| <p>The provider legal name and information is provided once for each enrollment.</p> | <p>The provider legal name and information is provided once for each enrollment.</p> |
| <p>*Legal Tax Name </p> | <p>*Legal Tax Name </p> |
| <p>DBA Name </p> | <p>DBA Name </p> |
| <p>Sole Proprietor Tax Id </p> | <p>Sole Proprietor Tax Id </p> |
| <p>*Tax ID Type <input checked="" type="radio"/> EIN <input type="radio"/> SSN</p> | <p>*Tax ID Type <input checked="" type="radio"/> EIN <input type="radio"/> SSN</p> |
| <p>Individual Providers</p> | <p>Individual Providers</p> |
| <p>*Gender </p> | <p>*Gender </p> |
| <p>*Birth Date </p> | <p>*Birth Date </p> |

Provider Identification Cont'd

- Complete the **License** information and select “**Add**”.
- Enter the **Medicare Participation** fields data if applicable.
- Complete the **CLIA Certification** fields if applicable and select “**Add**”.
- Enter the **DEA #** and **Effective Date**, if applicable.
- Select “**Continue**” to move to the Address section.

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 | | *License # | | *License State | | |
| *Assigning Authority | | *Effective Date | | *End Date | | |
| <div>AddReset</div> | | | | | | |

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 # | *Effective Date | *End Date | |
| <div>AddReset</div> | | | |

DEA #

DEA #

Effective Date

ContinueExit

Provider Address

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 |
|--|--------------|---------|------|-------|--------|
| Click to collapse. | | | | | |
| <p>*Address Type <input type="text" value="Servicing"/></p> <p>Name Type <input type="text" value="Mail To"/></p> <p>*Last Name <input type="text" value="Pay To"/></p> <p>*First Name <input type="text" value="Corporate Office"/></p> <p>Middle <input type="text" value=""/></p> <p>Title <input type="text" value=""/></p> <p>*Address <input type="text" value=""/></p> <p>*City <input type="text" value=""/></p> <p>*State <input type="text" value=""/></p> <p>*Contact Name <input type="text" value=""/></p> <p>*Primary Email <input type="text" value=""/></p> <p>*Phone <input type="text" value=""/> Ext <input type="text" value=""/></p> <p>Phone <input type="text" value=""/> Ext <input type="text" value=""/></p> <p>*County <input type="text" value=""/></p> <p>*Zip Code <input type="text" value=""/></p> <p>*Confirm Email <input type="text" value=""/></p> <p>Phone <input type="text" value=""/> Ext <input type="text" value=""/></p> <p>Phone <input type="text" value=""/> Ext <input type="text" value=""/></p> <p><input type="button" value="Add"/> <input type="button" value="Reset"/></p> <p><input type="button" value="Continue"/> <input type="button" value="Exit"/></p> | | | | | |

Up to **four** addresses can be added: **Servicing, Pay To, Mail To and Corporate Office.**

At least one Servicing address (physical location) is required. If no other address is provided the servicing address will also default to the Pay To, Mail To and Corporate Office address.

Once "**Servicing**" is selected, the guidelines for "Servicing" address will populate for your review. Also, the service address information section will populate. See next page.

Provider Addresses

The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.


- The service location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The service location name must match the business name on the W-9.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBAs (405 IAC 1-19.1b) as an attachment to the packet.
- The service location address must be a physical location. A post office box is not a valid service location address.
- Providers that provide services at a "place of service site", such as at a hospital or nursing facility, should enter their home/business office as their service location address.
- The standard NPPE/License address must be entered as the Service address for any provider that is not a billing provider.

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

Verify Address

Once the Servicing address or Mail To address has been selected, the address must be verified to save the address.

After selecting **Verify Address** a message will populate either informing that the address can't be matched or for a suggested address to be used.



The screenshot shows a web form for verifying an address. The form includes the following fields:

- *First Name:
- Middle:
- Title:
- *Address:
- *City:
- *State:
- *Contact Name:
- *Primary Email:
- *Confirm Email:
- *Phone: Ext:
- Phone: Ext:

A red callout box with the text "Must select Verify Address before the address can be added." has a red arrow pointing to the "Verify Address" button, which is highlighted with a red border.

Verify Address Cont'd

To continue, select one of the options below.

Original Address

***Original address may be undeliverable.

Line 1

Line 2

City Ridgeland

State Mississippi Zip Code 39157-2079

County MADISON

When this message appears, click **Select**.

Suggested Address

Click on **SELECT** to load the address.

| Address | City, State | County | ZipCode | Action |
|----------------------|------------------------|---------|------------|---------------|
| HIGHLAND COLONY PKWY | RIDGELAND, Mississippi | MADISON | 39157-2073 | Select |

Unable to match address.

To continue, select one of the options below.

Original Address

***Original address may be undeliverable.

Line 1

Line 2

City Ridgeland

State Mississippi Zip Code 39157-2079

County MADISON

If you get this message and you know the address is correct, select **Use Original Address**

Use Original Address

- If you get a message that is suggesting an address, click **Select** to use that address. In the example shown, the suggested address changed Parkway to PKWY, so the address is still the same. Or the address may show the same as you entered but **Select** must still be clicked.
- If you get a message showing “Unable to match address” and you are certain the address is correct, select **Use Original Address**.
- Once the address has been verified, the Verify Address button will now be grayed out.

Verify Address

Servicing Address Information

Required fields include:

- Office Hours for each day of the week
- Accepting New Patients
- Telehealth Services
- Website
- ADA Compliant (next slide)

These must be answered before the **Servicing** address can be saved.

| Service Address Information | | | | | | | | |
|--|------|-----------------------------------|----|---|-------------|--|--------|--------------------------------|
| If 'Address Type' is changed from 'Servicing', the service information below will be lost upon 'Add' or 'Save' of address. | | | | | | | | |
| Office Hours | | | | | | | | |
| *Monday | From | 08:00 AM | To | 05:00 PM | Open 24 hrs | <input type="checkbox"/> | Closed | <input type="checkbox"/> |
| *Tuesday | From | 08:00 AM | To | 05:00 PM | Open 24 hrs | <input type="checkbox"/> | Closed | <input type="checkbox"/> |
| *Wednesday | From | 08:00 AM | To | 05:00 PM | Open 24 hrs | <input type="checkbox"/> | Closed | <input type="checkbox"/> |
| *Thursday | From | 08:00 AM | To | 05:00 PM | Open 24 hrs | <input type="checkbox"/> | Closed | <input type="checkbox"/> |
| *Friday | From | 08:00 AM | To | 05:00 PM | Open 24 hrs | <input type="checkbox"/> | Closed | <input type="checkbox"/> |
| *Saturday | From | 09:00 AM | To | 03:00 AM | Open 24 hrs | <input type="checkbox"/> | Closed | <input type="checkbox"/> |
| *Sunday | From | 10:00 AM | To | 02:00 AM | Open 24 hrs | <input type="checkbox"/> | Closed | <input type="checkbox"/> |
| Service Provided Within State <input type="checkbox"/> | | | | | | | | |
| *Accepting New Patients | | Yes | | Accepting New Patients with Special Needs <input checked="" type="checkbox"/> | | | | |
| Sedation | | <input type="checkbox"/> | | Permit/Licenses# <input type="text"/> | | | | |
| Services for Intellectual Disability | | <input type="checkbox"/> | | Referral Needed? | | <input type="checkbox"/> Electronic Prescribing <input type="checkbox"/> | | |
| Providing XRays | | <input type="checkbox"/> | | Providing PET and MRI | | <input type="checkbox"/> Providing PET CT <input type="checkbox"/> | | |
| Age Restrictions | | <input type="checkbox"/> | | Other Restrictions | | <input type="text"/> | | |
| Verify Facility Name fields as it may have been auto populated by your browser. | | | | | | | | |
| Facility Administrator Last Name | | <input type="text"/> | | First Name | | <input type="text"/> | | License # <input type="text"/> |
| Medical Administrator Last Name | | <input type="text"/> | | First Name | | <input type="text"/> | | License # <input type="text"/> |
| Service Administrator Last Name | | <input type="text"/> | | First Name | | <input type="text"/> | | |
| TDD Capability | | <input type="checkbox"/> | | Phone | | <input type="text"/> | | Ext <input type="text"/> |
| TTY Capability | | <input type="checkbox"/> | | Phone | | <input type="text"/> | | Ext <input type="text"/> |
| *Telehealth Services | | Telehealth and In-Person Services | | | | | | |
| *Website | | Yes | | URL | | MickeysAdultDaycare.com | | |

Servicing Address Information

- **ADA Compliant** is a required field.
- If the facility is **ADA Compliant**, continue by checking the Available Options as they apply.
- Click **Add** to add certain selections or **Add All** if all apply.

The screenshot shows a web form for selecting ADA compliant options. At the top, there is a label '*ADA Compliant?' followed by a dropdown menu set to 'Yes'. Below this, the form is divided into two main sections: 'Available Options' on the left and 'Selected Options' on the right. The 'Available Options' section contains a list of checkboxes for various facilities: EXAM TABLE, GURNEYS/STRETCHERS, PARKING (checked), PATIENT LIFTS, PUBLIC TRANSPORTATION, ACCESS, RADIOLOGIC EQUIPMENT, RESTROOM (checked), SIGNAGE, and WHEELCHAIR WEIGHT SCALE. Between the two sections are four buttons: 'Add >', 'Add All >>', 'Remove All <<', and 'Remove <'. The 'Selected Options' section on the right shows a list of the selected items: PARKING and RESTROOM.

Servicing Address Information

- Once you select “**Add**”, your address section will populate with the data you entered.
- Select “**+**” to add each additional applicable address (up to 21 additional addresses), including any additional servicing addresses. You must select “**Add**” after any data has been entered.
- Once all addresses have been added and saved, select “**Continue**”.

Provider Addresses

The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The service location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The service location name must match the business name on the W-9.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBAs (405 IAC 1-19.1b) as an attachment to the packet.
- The service location address must be a physical location. A post office box is not a valid service location address.
- Providers that provide services at a “place of service site”, such as at a hospital or nursing facility, should enter their home/business office as their service location address.
- The standard NPPES/License address must be entered as the Service address for any provider that is not a billing provider.

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"/> | LD | Servicing | | | Mississippi | Copy Remove |
| <input checked="" type="checkbox"/> | Click to add address. | | | | | |

Continue **Exit**

Affiliated Providers

- At the Affiliated Provider page, the applicant may add Affiliated Providers. If the applicant chooses not to affiliate with a Group, the system will allow the applicant to select Continue to the next page.
- This page defaults to the Summary tab. Select the Add tab to add affiliated providers.
- Enter the NPI of the provider and then tab to the magnifying glass. The information will auto populate.
- The applicant can change the date of the affiliation here.

Summary Add

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

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

No Affiliated Providers found.

Continue Exit

Summary Add

Enter information for the group being added.

Select the Summary tab to return to view the list of affiliated group providers and to continue to the next page.

Note: The date noted for the Requested Affiliation Effective Date is not guaranteed. This date is dependent on the approval date of the enrolling provider.

* Indicates a required field.

* Requested Affiliation Effective Date 12/11/2023

Affiliation End Date 12/31/9999

* Provider ID

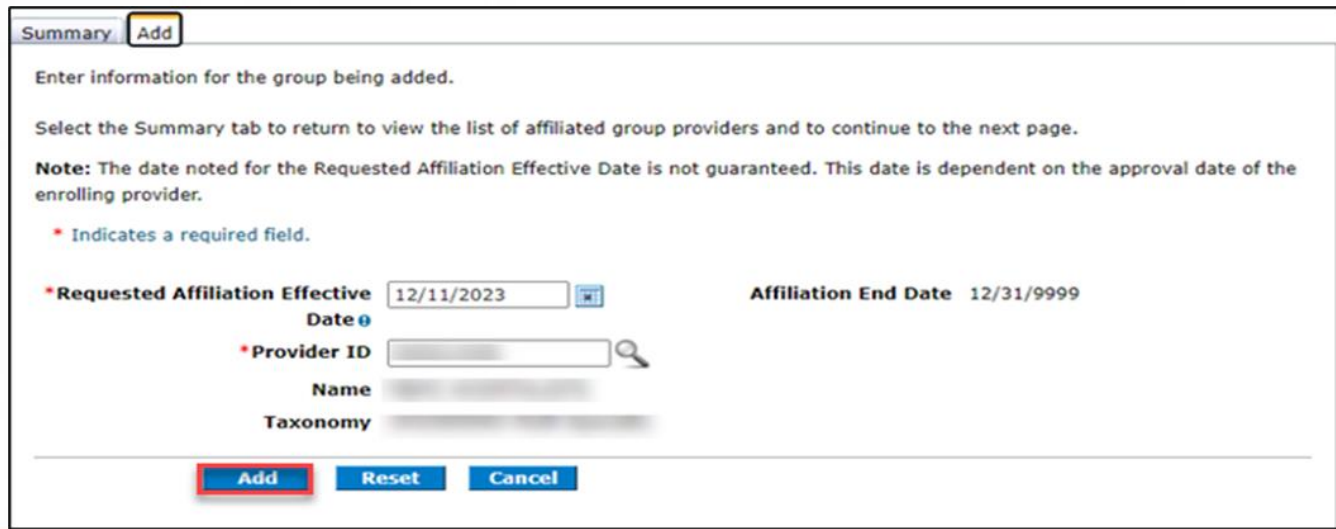
Name

Taxonomy

Add Reset Cancel

Affiliated Providers Cont'd

- Select Add to save the Affiliated Provider. Repeat the same steps to add additional Affiliated Providers.
- The date noted for the Requested Affiliation Effective Date is not guaranteed. The date is dependent on the approval date of the enrolling provider. The system will only permit past effective dates to be up to one year old or up to the provider's approved effective date, whichever is most recent. If a past date specified for affiliation effective date overlaps with past affiliations between the same entities, then the system will give an error message.
- The system will allow gaps between affiliations between the same entities. The system will allow affiliations between individual providers and organizational providers, such as groups; however, the system will not allow affiliations between two Individual providers.



The screenshot shows a web form titled 'Add' (highlighted with a red box) for adding an affiliated provider. The form includes a 'Summary' tab and an 'Add' button. The main content area contains instructions and a note about the effective date. Below the note, there are several input fields: 'Requested Affiliation Effective Date' (with a date picker set to 12/11/2023), 'Affiliation End Date' (set to 12/31/9999), 'Provider ID' (with a search icon), 'Name', and 'Taxonomy'. A red asterisk indicates required fields. At the bottom, there are three buttons: 'Add' (highlighted with a red box), 'Reset', and 'Cancel'.

Summary Add

Enter information for the group being added.

Select the Summary tab to return to view the list of affiliated group providers and to continue to the next page.

Note: The date noted for the Requested Affiliation Effective Date is not guaranteed. This date is dependent on the approval date of the enrolling provider.

* Indicates a required field.

* Requested Affiliation Effective Date 12/11/2023 Affiliation End Date 12/31/9999

* Provider ID [Search Icon]

Name [Text Field]

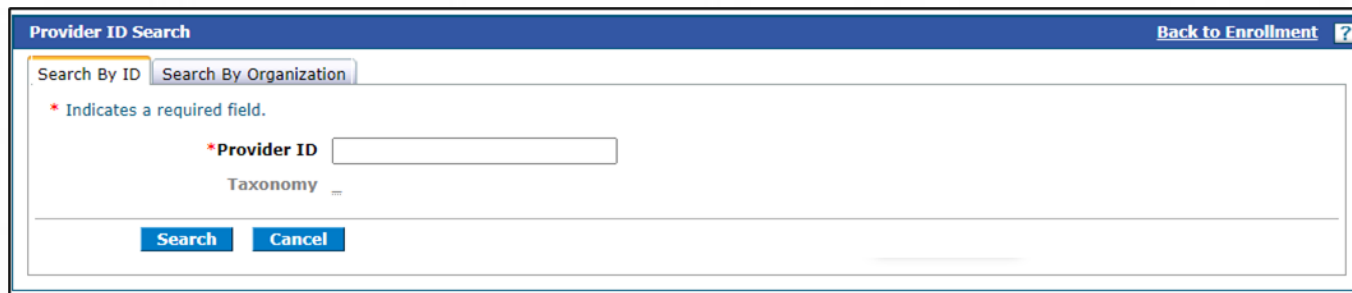
Taxonomy [Text Field]

Add Reset Cancel

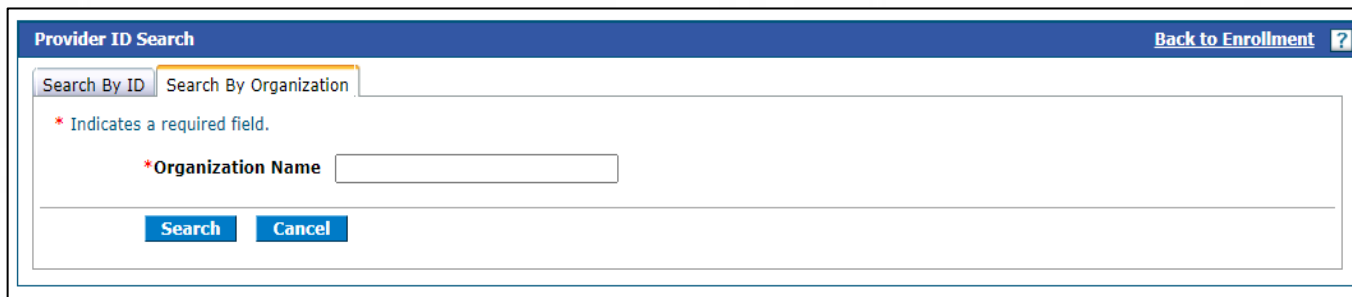


Affiliated Providers Cont'd

- If the applicant does a search by using the magnifying glass, the Search by ID and Search by Organization tabs will populate.
- The Search by ID tab allows the applicant to change the Provider ID Type to NPI, MCD or Medicaid ID. Select the Provider ID Type drop-down box to change the Provider ID Type.
- Select the Search by Organization tab to search by the Organization Name.



The screenshot shows the 'Provider ID Search' form. At the top right is a 'Back to Enrollment' link with a help icon. Below the title bar are two tabs: 'Search By ID' (selected) and 'Search By Organization'. A red asterisk indicates a required field. The form contains a label '*Provider ID' followed by a text input field. Below this is a 'Taxonomy' label with a dropdown arrow. At the bottom are 'Search' and 'Cancel' buttons.



The screenshot shows the 'Provider ID Search' form with the 'Search By Organization' tab selected. It features the same 'Back to Enrollment' link and help icon. The tabs 'Search By ID' and 'Search By Organization' are visible, with the latter being active. A red asterisk indicates a required field. The form contains a label '*Organization Name' followed by a text input field. At the bottom are 'Search' and 'Cancel' buttons.

Affiliated Providers Cont'd

- A list of the added Affiliated Providers displays on the Summary page. If finished, select Continue to the Languages page.
- If the applicant would like to remove an Affiliated Provider, select the Remove link found under the Summary tab to remove that Affiliated Provider.

The screenshot shows a web application interface for managing affiliated providers. At the top, there's a header bar with the title "Affiliated Providers" and a user ID "ATN: 63537". Below the header, there are two tabs: "Summary" (which is active) and "Add". The main content area contains instructions: "Select the Add tab to add one or more affiliated providers." and "Select the Expand button for a detailed view. Click the **Remove** link to remove the entire row." Below this is a table titled "Affiliated Providers". The table has a search bar labeled "Filter by NPI" and a "Total Records: 1" indicator. The table contains one row with the following data: Action (Remove), Name (THERAPY SERVICES UNLIMITED LLC), MCD (003504262), Affiliation Effective Date (07/02/2025), Affiliation End Date (empty), NPI (1023304110), and a status indicator (1!). At the bottom of the page, there are two buttons: "Continue" and "Exit".

| Action | Name | MCD | Affiliation Effective Date | Affiliation End Date | NPI | |
|------------------------|--------------------------------|-----------|----------------------------|----------------------|------------|----|
| Remove | THERAPY SERVICES UNLIMITED LLC | 003504262 | 07/02/2025 | | 1023304110 | 1! |

Languages page

Provider Enrollment: Languages ATN: 60594 ?

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

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 |
|--|--------|
| [-] Click to collapse. | |
| *Language <input type="text" value="ENGLISH"/> | |
| <input type="button" value="Add"/> | |

- ▶ Use the drop down to select the applicable Language, then select "**Add**". If more than one language is available, follow the same steps to add each language. At least **one** language must be selected.
- ▶ Once all languages are added, select "**Continue**" to the EFT Enrollment page.

EFT Information

- All providers agree to direct deposit or electronic funds transfer (EFT).
- EFT information is required and must be completed to continue.
- A pre-printed voided check (no starter checks) or letter from your financial institution must be uploaded as a PDF document.

| Provider Enrollment: EFT Information | | ATN: 60526 ? |
|---|--|--------------|
| Welcome | 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. | |
| Request Information | * Indicates a required field. | |
| Credentialing Information | | |
| CCO Information | | |
| Taxonomies | | |
| Provider Identification | | |
| Addresses | | |
| Languages | | |
| EFT Enrollment | | |
| Other Information | | |
| Applicant History | | |

*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

This page will change depending on the enrollment type. Some fields will not be visible to all provider types.

Certification required when no license information provided.
* Indicates a required field.

Insurance

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

Information regarding professional (malpractice) liability insurance coverage is required.
Please refer to the [CVO Professional Liability Insurance Policy](#) for coverage requirements.
Note: The Provider is required to upload proof of liability insurance.

| Name | Policy # | Effective Date | Expiration Date | Action |
|--|-----------------------------------|----------------|-----------------|--------|
| Click to collapse. | | | | |
| *Carrier or Self-Insured Name | *Policy Number | | | |
| *Address | | | | |
| *City | *County | | | |
| *State | *Zip Code | | | |
| *Effective Date | *Expiration Date | | | |
| *Do you have unlimited coverage with this insurance carrier? <input type="radio"/> Yes <input checked="" type="radio"/> No | | | | |
| *Amount of Coverage Per Occurrence | *Amount of Coverage Per Aggregate | | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | |

Complete the Insurance Coverage information section and select "Add" to save the data entered. **Information regarding professional (malpractice) liability insurance coverage is required.** Please refer to the CVO Professional Liability Insurance Policy hyperlink for coverage requirements. *This is not applicable to providers who selected the FFS program only.*

The Provider is required to upload proof of liability insurance as a PDF document on the Supporting Documentation page. *This is not applicable to providers who selected the FFS program only.*

Using the drop down, select the applicable certification type, JCAHO, ASHA Certification or Certification of Disease Management.

Select "Add" after entering each certification.
Select "Continue" to the Hospital Admittance 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 |
|-------------------------------------|----------------|-----------------|-----------|--------|
| Click to collapse. | | | | |
| *Certification Type | *Certificate # | *Effective Date | *End Date | |
| JCAHO - Joint Commission Approval | | | | |
| ASHA Certification | | | | |
| Certification of Disease Management | | | | |
| <input type="button" value="Add"/> | | | | |

Hospital Admittance

Make the applicable selection: **Admitting Privileges** or an **Admitting Plan**. If you do not have admitting privileges or an admitting plan, please select “Neither”.

If “**Neither**” is selected the fields will be grayed out but you **must** select “**Add**” then “**Continue**” to the Applicant History page.

Hospital Admittance

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

| Admitting Type | Hospital | Address | City | State | Action |
|--|----------|---------|------|-------|--------|
| <div> <div>Click to collapse.</div> <div> <div> <div> <div>*Do you have Admitting Privileges, an Admitting Plan or Neither?</div> <div> <input type="radio"/> Admitting Privileges <input type="radio"/> Admitting Plan / Alternate Arrangement <input type="radio"/> Neither </div> </div> </div> </div> </div> | | | | | |

Admitting Privileges

Primary Hospital

☐ Yes
☐ No

Hospital Name

Hospital Affiliation NPI

Address

City

State

County

Zip Code

Office Phone

Fax

Effective Date

End Date

Department Director Name

Full, Unrestricted Access?

☐ Yes
☐ No

Are Privileges Temporary?

☐ Yes
☐ No

Admitting Privileges Status

(e.g. None, Full Unrestricted, Provisional, Temporary)

Of Total Annual Admissions, What Percentage is to this Hospital?

%

Terminated Affiliation Information

Admitting Plan / Alternate Arrangement

Who will admit on your behalf?

Admitting Physician NPI

Please submit documentation of the agreement between you and the admitting physician.

Add

Reset

Hospital Admittance Cont'd

If you have **Admitting Privileges** the following section must be completed. Select **"Add"** to save the entered data.

If you have an **Admitting Plan** the following section must be completed. Also, you must attach the PDF agreement between you and the admitting physician. Select “**Add**” to save the entered data.

Select “**Continue**” to the Applicant History page.

| Admitting Privileges | |
|---|---|
| *Primary Hospital | <input type="radio"/> Yes <input type="radio"/> No |
| *Hospital Name | <input type="text"/> |
| *Hospital Affiliation NPI | <input type="text"/> |
| *Address | <input type="text"/> <input type="text"/> |
| *City | <input type="text"/> |
| *State | <input type="text"/> |
| *Office Phone | <input type="text"/> |
| *Effective Date | <input type="text"/> |
| *Department Director Name | <input type="text"/> |
| *Full, Unrestricted Access? | <input type="radio"/> Yes <input type="radio"/> No |
| *Are Privileges Temporary? | <input type="radio"/> Yes <input type="radio"/> No |
| *Admitting Privileges Status | <input type="text"/> (e.g. None, Full Unrestricted, Provisional, Temporary) |
| *Of Total Annual Admissions, What Percentage is to this Hospital? | <input type="text"/> % |
| *Terminated Affiliation Information | <input type="text"/> |

| Admitting Plan / Alternate Arrangement | |
|---|--------------------------------------|
| *Who will admit on your behalf? | <input type="text"/> |
| *Admitting Physician NPI | <input type="text"/> |
| Please submit documentation of the agreement between you and the admitting physician. | |
| <input type="button" value="Add"/> | <input type="button" value="Reset"/> |

Applicant History

This is only applicable to providers that have selected MSCAN or MSCHIP.

Read and answer “Yes or No” under Training. If “No,” is answered, please list explanation in the box provided.

Training

*Are you and your staff annually trained on Fraud, waste, and abuse?

☒ Yes ☐ No

If No, please explain:

Read and answer “Yes” or “No” to each question. If “Yes,” please enter your explanation in the box provided.

Hospital Privileges and Other Affiliations

*Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☒ No

*Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☒ No

*Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

☐ Yes ☒ No

If Yes, please explain:

Criminal / Civil History

*In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

☐ Yes ☒ No

*Have you ever been court-martialed for actions related to your duties as a medical professional?

☐ Yes ☒ No

If Yes, please explain:

Read and answer “Yes” or “No” to each question and provide applicable date. If “Yes”, please enter your explanation in the box provided. Select “Continue” to the Disclosure page.

Malpractice Claims History

*Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?

☐ Yes ☒ No

If Yes, provide information for each case using the Professional Liability Claims Information Form.

Professional/General Liability Insurance Information and Claims History

*Has your professional/general liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

☐ Yes ☒ No

*Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional/general liability insurance carrier, based on your individual liability history?

☐ Yes ☒ No

If Yes, please explain:

Corporate Integrity Agreements

*Are you currently or have you ever been subject to the terms of a Corporate Integrity Agreement (CIA)?

☐ Yes ☒ No

If yes, are you currently subject to the provisions of a Corporate Integrity Agreement?

☐ Yes ☒ No

What date did the facility enter into the Corporate Integrity Agreement?

If you are currently subject to the provisions of a CIA, provide the CIA and a Compliance letter.

Investigations

*Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs?

☐ Yes ☒ No

Continue

Exit



MISSISSIPPI DIVISION OF
MEDICAID

Disclosure

The Disclosure page for individual provider types is displayed below. Read entirely and answer “Yes” or “No”. If yes, you must provide the final adverse legal action documentation and resolution in PDF format.

Select, “Continue” to the Supporting Documentation/Attachment and Fees page.

Provider Enrollment: Disclosure ATN: 60526 ?

[Welcome](#) **Final Adverse Legal Action History**

[Request Information](#) This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspension for the enrolling provider. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

[Credentialing Information](#)

[CCO Information](#)

[Taxonomies](#)

[Provider Identification](#)

[Addresses](#)

[Affiliated Providers](#)

[Languages](#)

[EFT Enrollment](#)

[Other Information](#)

[Hospital Admittance](#)

[Applicant History](#)

Disclosure

[Supporting Documentation / Attachments and Fees](#)

[Agreement](#)

[Summary](#)

Convictions

1. Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,
2. Has been convicted of a crime reference in Miss. Code Ann. § 43-13-121(7)(c)-(h), or
3. Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c)-(h).

Exclusions, Revocations or Suspensions

1. Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,
2. Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,
3. Has had his/her/its license or certification revoked, or
4. Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.

Final Adverse Legal Action History

***Has the enrolling provider, under any current or former name or business identity, ever had a final adverse legal action imposed?**
☐ Yes ☒ No

If yes, report each final adverse legal action, when it occurred, the Federal or State Agency or the court/administrative body that imposed the action, and the resolution, if any.

Provide a copy of the final adverse legal action documentation and resolution.

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

| Row | Final Adverse Legal Action | Date | Action |
|--------------------------|---|------|--------|
| <input type="checkbox"/> | Click to add Final Adverse Legal Action | — | |

[Continue](#) [Exit](#)

Supporting Documentation

You must select the **“Instructions = Privacy Notice Link.”** A separate window will open to the Mississippi Division of Medicaid website. Once you have read the notice the window can be closed. If this is not selected, you cannot move to the next page.

Select **“Choose File”** to locate the appropriate file to be added. Select the **“Attachment Type”** drop-down that matches your file attachment. If your documents are saved in one document, select **“All”** for the type. If not, select the appropriate type.

Select **“Add”** to attach the document. It must be in gif, jpg, jpeg, png, tif, tiff, pdf or txt format to be added. If additional documents need to be attached, select **+ Click to add attachment”**.

Select the **box** for the **Attachment Attestation statement**. Select **“Continue”** to the Agreement page.

Supporting Documentation

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

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

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

* Indicates a required field.

Attachments

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

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

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

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

| # | Transmission Method | File | Attachment Type | Action | | | | | | | | | | |
|--|---------------------|-----------------|-----------------|------------------------|---|---------------------|------|-----------------|--------|---|------------------|-----------------|-----|------------------------|
| <input type="checkbox"/> Click to collapse. | | | | | | | | | | | | | | |
| <div> <div>*Transmission Method FT-File Transfer</div> <div>*Upload File Choose File No file chosen</div> <div>*Attachment Type </div> <div> <div>Add</div> <div>Cancel</div> </div> </div> | | | | | | | | | | | | | | |
| <h3>Attachment Attestation</h3> <div> <input type="checkbox"/> 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. </div> <div> <div>Continue</div> <div>Exit</div> </div> | | | | | | | | | | | | | | |
| <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>FT-File Transfer</td> <td>JATCM.pdf (91K)</td> <td>All</td> <td>Remove</td> </tr> </tbody> </table> <div> <input type="checkbox"/> Click to add attachment. </div> | | | | | # | Transmission Method | File | Attachment Type | Action | 1 | FT-File Transfer | JATCM.pdf (91K) | All | Remove |
| # | Transmission Method | File | Attachment Type | Action | | | | | | | | | | |
| 1 | FT-File Transfer | JATCM.pdf (91K) | All | Remove | | | | | | | | | | |

Terms of Agreement

The terms of enrollment are stated. You must accept these terms to submit the enrollment application.

Read all the instructions until you reach the bottom of the page.

Select “I accept” box.

Enter the **Signature** of the **Provider**.
Enter the **Title** (if applicable).

Select “Continue”.

Terms of Agreement

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

Programs selected for application:
• Fee-For-Service (FFS)

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

The Medicaid Provider Agrees

1. To provide medical services to eligible Medicaid beneficiaries without regard to race, color, religion, sex, national origin, handicap, or limited English proficiency.
2. To abide by federal and state laws and regulations affecting delivery of services.
3. Not to refuse to furnish services covered under the Medicaid program to an individual who is eligible for Medicaid because of potential third party liability for the services or to discriminate as to recipients served or services provided because of Medicaid eligibility or potential third party liability.

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** [REDACTED]
(Entering your name in the box to the right will constitute your electronic signature.)
Title [REDACTED]
Submission Date 10/18/2023

Continue **Exit**

This image only shows part of the terms for the Medicaid provider are listed.

Summary

- The **Summary** page shows your entire enrollment application. If any changes need to be made, select the appropriate link on the **Table of Contents** panel (left side) and make needed corrections.
- Select **Print Preview**, top right or bottom left, to either save or print the application. Once selected, another window will populate, select **“Print”**. Final window will populate providing a printer to physically print or change the drop down to “Microsoft Print to PDF” that will allow you to save an electronic copy of the application. Select **“Print”** for the final time.
- Once you have reviewed/saved/printed the application select **“Submit”**. This will submit the application.

Provider Enrollment: Summary

Welcome

Request Information

Credentialing Information

CCO Information

Taxonomies

Provider Identification

Addresses

Affiliated Providers

Languages

EFT Enrollment

Other Information

Hospital Admittance

Applicant History

Request Information

Initial Enrollment Information

Requesting Enrollment Effective Date 10/25/2023

Enrollment Type Individual

Taxonomy

Are you enrolling only for the submission of the crossover claims? By selecting Yes, you agree that you will not be paid for any claim types other than crossover claims.

NOTE: In accordance with the Mississippi Division of Medicaid Administrative Code found at [Mississippi Division of Medicaid](#), providers enrolling with certain taxonomies will only be eligible for the payment of crossover claims.

NPI

SSN

NPI Zip + 4

Are you currently enrolled as a Provider? No

Were you previously enrolled as a Provider? No

Print Preview

Wednesday 03/19/2025 10:23 AM CST

Print

ATN: 60526

Provider Enrollment: Summary

Request Information

Initial Enrollment Information

Requesting Enrollment Effective Date 02/14/2025

Enrollment Type Facility

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.

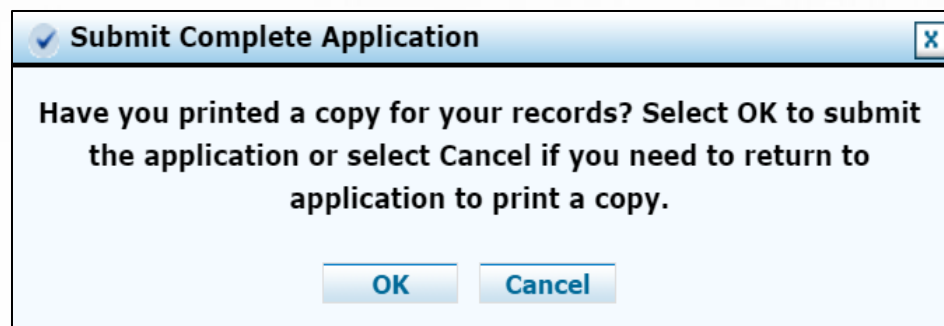
Print Preview

Submit

Exit

Print a Copy


- After selecting **Submit** on the summary page, a box will populate asking if you have printed a copy for your records. If you have **not**, please select “**Cancel**” and print/save a copy.
- Select “**OK**” once you have printed a copy



Application Submission and Tracking Number (ATN)




- You will receive confirmation that the application was submitted. Click the **EXIT** button to leave the application portal.
- Also, an email confirmation will be sent to the email provided on the application under the **Contact Person**.

Provider Enrollment Application



Mississippi Medical Assistance Portal <DoNotReply@gainwelltechnologies.com>
To ● Willems, Christine

Retention Policy 3 Year Delete (Entire Mailbox) (3 years)

 Reply

Expires 3/18/2028

A provider enrollment application was initiated from the Provider Health Care Portal, using this email address as a contact.

The following is the tracking number assigned to this application:"60526".

The following link has been provided for your convenience.

<https://portal-mod.msxix.net/ms/provider/Home/tabid/135/Default.aspx>

View Application Status

Online Provider Enrollment

[Enrollment Application](#)

Initiate a new provider enrollment application.

[Resume Enrollment](#)

Resume an existing enrollment application that has not been submitted.

[Copy Existing Submitted Application](#)

To reduce provider burden, a previously submitted application may be copied to prevent the requirement of entering data multiple times. Please review the entire application to ensure that information contained is still accurate before submission to the agency.

[Enrollment Status](#)

Check the current status of an enrollment application.

Provider Enrollment - Status

[Back to Home](#) ?

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For further questions, please contact Provider Services at 1-800-884-3222.

* Indicates a required field.

*Tracking Number

*Tax ID Number

Search

Cancel

- Select **Provider Enrollment Access** on the Provider Home Page
- Select the **Enrollment Status** link under Online Provider Enrollment
- Provide the **tracking number** and **SSN** submitted on the application.

View Application Status

Home > Online Provider Enrollment > Enrollment Status Wednesday 03/19/2025 10:43 AM CST

Provider Enrollment - Status [Back to Home](#) ?

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For further questions, please contact Provider Services at 1-800-884-3222.

* Indicates a required field.

*Tracking Number *Tax ID Number

[Search](#) [Cancel](#)

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For further questions, please contact Provider Services at 1-800-884-3222.

| | |
|----------------------------------|-------------------------------|
| Tracking Number 60526 | Status SUBMITTED |
| Date Submitted 03/19/2025 | Status Date 03/19/2025 |

For a new copy of your enrollment application cover sheet for your records [click here](#).

Provider Letters

Enter your Password in order to view the provider letters.

* Indicates a required field.

*Password

[Submit](#)

- The **Provider Enrollment Summary** lists the application status and the date for the status and submission date.
- To view any **Provider Letters**, enter the password for the application submitted.