

Office of the Governor | Mississippi Division of Medicaid

ORP Provider

Initial Enrollment Application

May 16, 2025



MISSISSIPPI DIVISION OF
MEDICAID

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

- **Taxonomies 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).
- **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.
- If the disclosing provider is a group/organization, the signatures should be by the person legally authorized to sign on behalf of the group/organization.
- 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.

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](#)

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MESA
MEDICAID ENTERPRISE SYSTEM ASSISTANCE

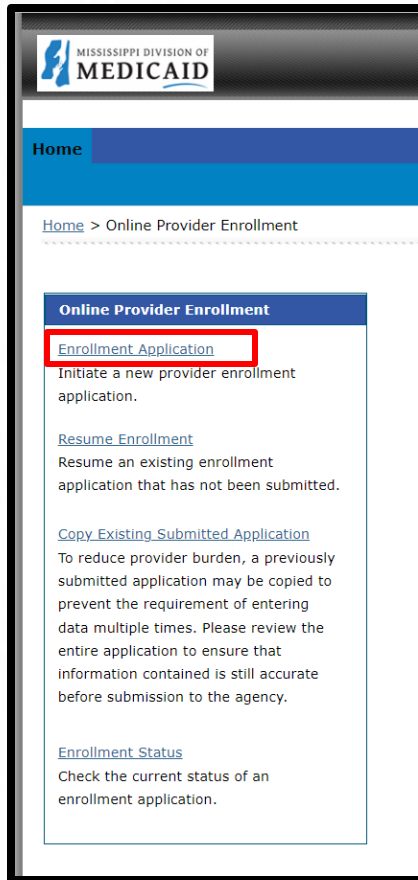
What you can do in the Medicaid Portal for Providers

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.**

Requested 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 \(Must View\)](#)

*Enrollment Type

*Taxonomy

*Requesting Enrollment Effective Date

Provider Information

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

*NPI

*NPI Zip + 4

*SSN

*Are you currently enrolled as a Provider? ☐ Yes ☒ No

*Were you previously enrolled as a Provider? ☐ Yes ☒ No

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

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

You can enter 2 or more characters of your taxonomy description or taxonomy number and a list of available taxonomies will display. Complete the remainder of the fields.

Complete the fields in the **Provider Information** section.

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

Select **“Continue”** 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 tax ID number 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](#)

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[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

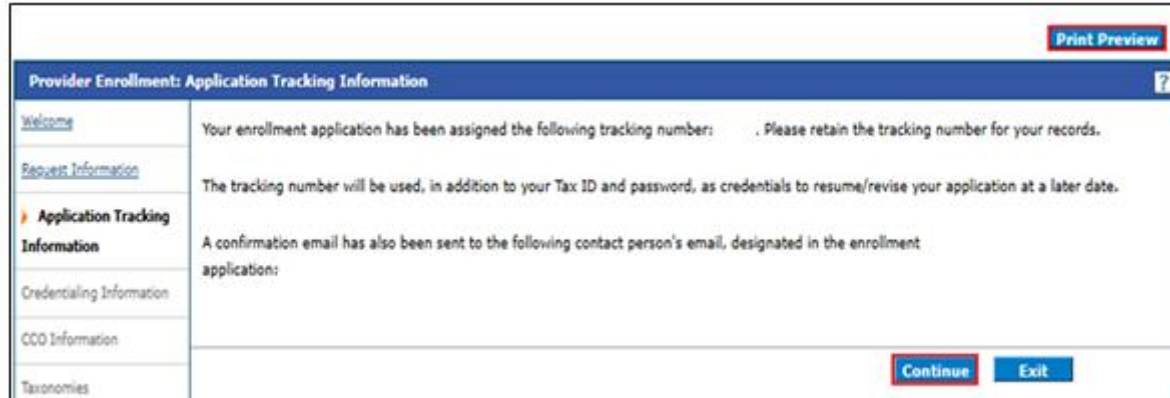
[Continue](#) [Cancel](#)

Application Tracking Information

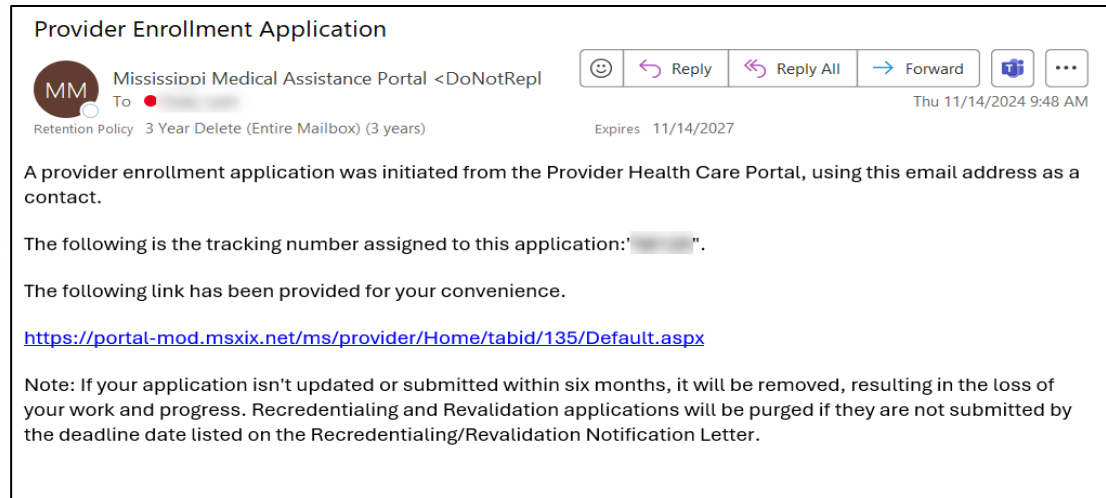
You will receive confirmation that will include **your application tracking number (ATN)**.

You will need this number and the **Tax ID** number 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), "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.



The screenshot shows an email titled "Provider Enrollment Application" from the "Mississippi Medical Assistance Portal <DoNotRepl>". The email header includes a "Retention Policy 3 Year Delete (Entire Mailbox) (3 years)" and an "Expires 11/14/2027" date. 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>. At the bottom, a note 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 "Print" icon.

Provider Identification

- ▶ Enter the **Legal Tax Name** and **DBA Name**.
- ▶ Select **Gender** and enter the **Birth Date** of the Provider.
- ▶ Enter the **License information** and select “**Add**” to save each license.
- ▶ If Applicable, enter the **DEA #** and **Effective Date**.
- ▶ Select “**Continue**” to the Address page.

* Indicates a required field.

Legal Tax Name

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

*Legal Tax Name

DBA Name

Individual Providers

*Gender *Birth Date

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"/> | | | | | | |

DEA #

DEA # Effective Date

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. | | | | | |
| <div> <div>*Address Type</div> <div> <div>Name Type</div> <div> <div>*Last Name</div> <div>*First Name</div> <div>Middle</div> <div>Title</div> </div> </div> </div> <div> <div>*Address</div> <div>*City</div> <div>*State</div> <div>*Contact Name</div> <div>*Primary Email</div> <div>*Phone</div> <div>Phone</div> </div> <div> <div>*County</div> <div>*Zip Code</div> <div>*Confirm Email</div> <div>Phone</div> <div>Phone</div> </div> | | | | | |

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 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.

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:
- *Phone: Ext:
- *Confirm Email:
- Phone:

A red callout box with the text "Must select Verify Address before the address can be added." points 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 Highland Colony Parkway

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

Use Original 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"/> |
| <hr/> | | | | | | | | |
| Service Provided Within State <input type="checkbox"/> | | | | | | | | |
| *Accepting New Patients | | | Yes <input type="checkbox"/> Accepting New Patients with Special Needs <input checked="" type="checkbox"/> | | | | | |
| Sedation | | | Permit/Licenses# <input type="text"/> | | | | | |
| Services for Intellectual Disability | | | Referral Needed? | | | Electronic Prescribing | | |
| Providing X Rays | | | Providing PET and MRI | | | Providing PET CT | | |
| Age Restrictions | | | Other Restrictions | | | <input type="text"/> | | |
| Verify Facility Name fields as it may have been auto populated by your browser. | | | | | | | | |
| Facility Administrator Last Name | | | First Name | | License # | | <input type="text"/> | |
| Medical Administrator Last Name | | | First Name | | License # | | <input type="text"/> | |
| Service Administrator Last Name | | | First Name | | <input type="text"/> | | | |
| TDD Capability | | | Phone | | <input type="text"/> | | Ext <input type="text"/> | |
| TTY Capability | | | Phone | | <input type="text"/> | | Ext <input type="text"/> | |
| *Telehealth Services | | | Telehealth and In-Person Services <input type="checkbox"/> | | | | | |
| *Website | | | Yes <input type="checkbox"/> | | URL | | MickeysAdultDaycare.com <input type="text"/> | |

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, 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**” to move to the Languages 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 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**

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 |
|--|--------|
| <input type="checkbox"/> 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.

Other Information

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 | <input type="text"/> | *Certificate # | <input type="text"/> | | |
| *Effective Date | <input type="text"/> | *End Date | <input type="text"/> | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | | |

Supervising Physician

The State of Mississippi requires a collaborative agreement for this enrollment. If your enrolling location is in Mississippi, you are required to list a Supervising Physician and Backup Supervising Physician in the fields displayed. If the enrolling provider is an Out-of-State provider and your state does not require a collaborative agreement, you are required to upload the regulation allowing independent practice. Please see [Administrative Code \(ms.gov\)](#) for additional information on these requirements.

*Supervising Physician Medicaid ID

Backup Supervising Physician Medicaid ID

ORP Other Information

*Have you already referred, ordered, or prescribed on behalf of a Mississippi Medicaid Member? ☒ Yes ☐ No

*Date of Initial Prescription

- Select “**Add**” after entering each certification.
- Using the drop down, select the applicable **Certification Type**, JCAHO, ASHA Certification or Certification of Disease Management. Enter the Certificate #, Effective Date and End Date.
- Enter the Supervising Physician Medicaid ID
- Answer “**Yes or No**” to the question under ORP Information. If yes, enter the date of the initial prescription.
- Select “**Continue**” to the Disclosure page.

Disclosure

- The Disclosure page will change depending on provider type. This example is for Ordering, Referring, and Prescribing Types.
- Read entirely and answer “Yes” or “No”. If yes, you must provide the Final Adverse Legal Action documentation and resolution in PDF format.
- Select “+” to add the copy of the Final Adverse Legal Action.
- Select, “Continue ”to the Supporting Documentation/Attachment and Fees page.

Provider Enrollment: Disclosure

ATN: 60594 ?

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Final Adverse Legal Action History

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.

Convictions

- Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,
- Has been convicted of a crime reference in Miss. Code Ann. § 43-13-121(7)(c)-(h), or
- 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

- 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,
- 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,
- Has had his/her/its license or certification revoked, or
- 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 |
|-----|---|------|--------|
| + | Click to add Final Adverse Legal Action | - | |

Continue

Exit

Supporting Documentation/Attachments and Fees

- 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 file, select **“All”** for the type. If not, select the appropriate type. **ORP providers must submit a copy of the current license.**
- Select **“Add”** to attach the document. It must be in PDF format to be added. If additional documents need to be attached, select **+ Click to add attachment”**.

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](#)

ORP Providers should attach:
The provider must submit a copy of the current license.

* 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 |
|--|---------------------|------|-----------------|--------|
| <div>Click to collapse.</div> <div> <div>*Transmission Method</div> <div>FT-File Transfer</div> </div> <div> <div>*Upload File</div> <div>Choose File No file chosen</div> </div> <div> <div>*Attachment Type</div> <div></div> </div> <div> <div>Add</div> <div>Cancel</div> </div> | | | | |

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


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

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

Select “I accept” box.

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

Select “Continue” .

| Terms of Agreement | |
|---|---|
|  | <div>Provider Name <input type="text"/></div> <div>Address <input type="text"/></div> <div>Tax ID <input type="text"/></div> <div>NPI <input type="text"/></div> <div>Contact Name <input type="text"/></div> <div>Contact Email <input type="text"/></div> <div>Programs selected for application:<ul style="list-style-type: none">None</div> |
| <p>SECTION 4: CERTIFICATION STATEMENT</p> <p>As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.</p> <p>The Certification Statement contains certain standards that must be met for initial and continuous registration in Mississippi Medical Assistance Program solely to order and refer items and services for Mississippi Medical Assistance Program clients.</p> <p>Review these requirements carefully.</p> <p>By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied or revoked from registering in Mississippi Medical Assistance Program if any requirements are not met.</p> <p>Certification Statement</p> <p>You MUST SIGN AND DATE the certification statement below in order to be registered in Mississippi Medical Assistance Program. In doing so, you are attesting to meeting and maintaining the Mississippi Medical Assistance Program requirements stated below.</p> <p>I, the undersigned, certify to the following:</p> <ol style="list-style-type: none">1. I understand that if I wish to be reimbursed by Mississippi Medical Assistance Program for services I have performed, I must first voluntarily withdraw my registration as an ordering, referring, or prescribing physician or non-physician practitioner, and enroll in Mississippi Medical Assistance Program as an individual practitioner.2. I have read the contents of this application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct and complete, I agree to notify the Medicaid fiscal agent immediately.3. I authorize the Mississippi Medical Assistance Program fiscal agent to verify the information contained herein. I agree to notify the Mississippi Medical Assistance Program fiscal agent of any changes to the information on this form within 90 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new application.4. I will not knowingly order and or refer an item and or service that allows a false or fraudulent claim to be presented for payment by Mississippi Medical Assistance Program.5. I further certify that I am the individual practitioner who is applying for the sole purpose of ordering, referring, and prescribing items or services to Mississippi Medical Assistance Program clients, and I have signed and dated this application. <p>You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.</p> <div><div><input checked="" type="checkbox"/> I accept</div><div>I understand that my electronic signature is equivalent to written signature.</div></div> <div><div>*Your Signature <input type="text"/></div><div>(Entering your name in the box to the right will constitute your electronic signature.)</div><div>Title <input type="text"/></div><div>Submission Date 10/18/2023</div></div> <div><div>Continue</div><div>Exit</div></div> | |

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

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 NPI Zip + 4

SSN

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

Provider Enrollment: Summary

Request Information

Initial Enrollment Information

Requesting Enrollment Effective Date 02/14/2025

Enrollment Type Facility

Instructions for Summary Page

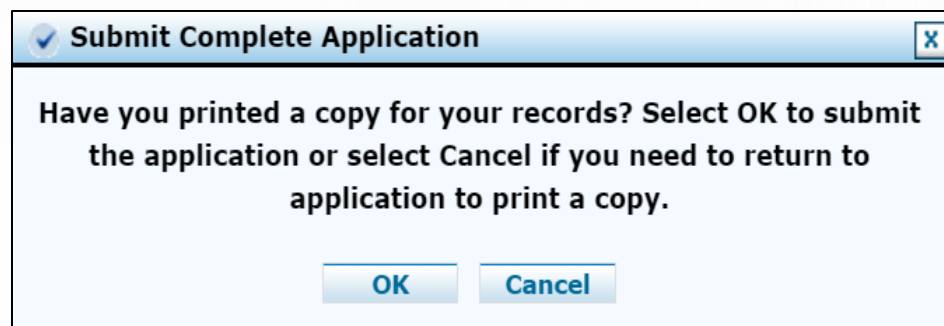
If changes are required after reviewing the Summary Page, click the appropriate link on the Table of Contents panel for the section and make the needed corrections. When completed, you will be given the opportunity to review the Summary Page again. Once you have reviewed the contents of the application, 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 **Tax ID** number 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

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

- 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.