Other Provider

Initial Enrollment MSCAN/MSCHIP Application

May 19, 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.

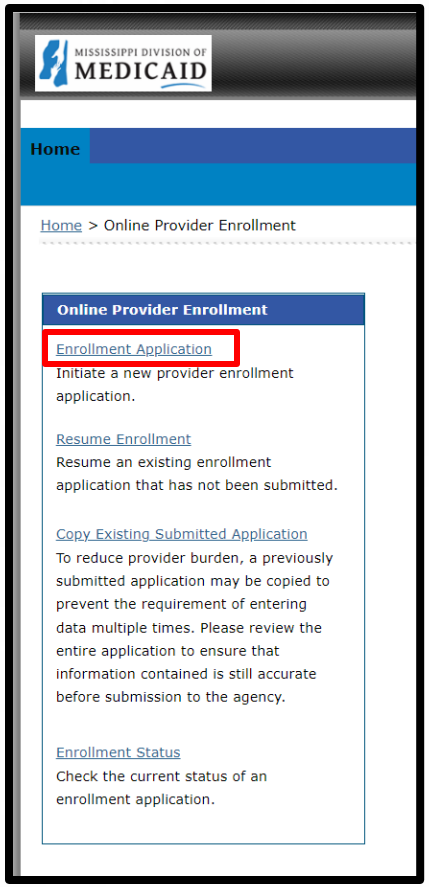
Application Tips

- 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.

Enrollment Application



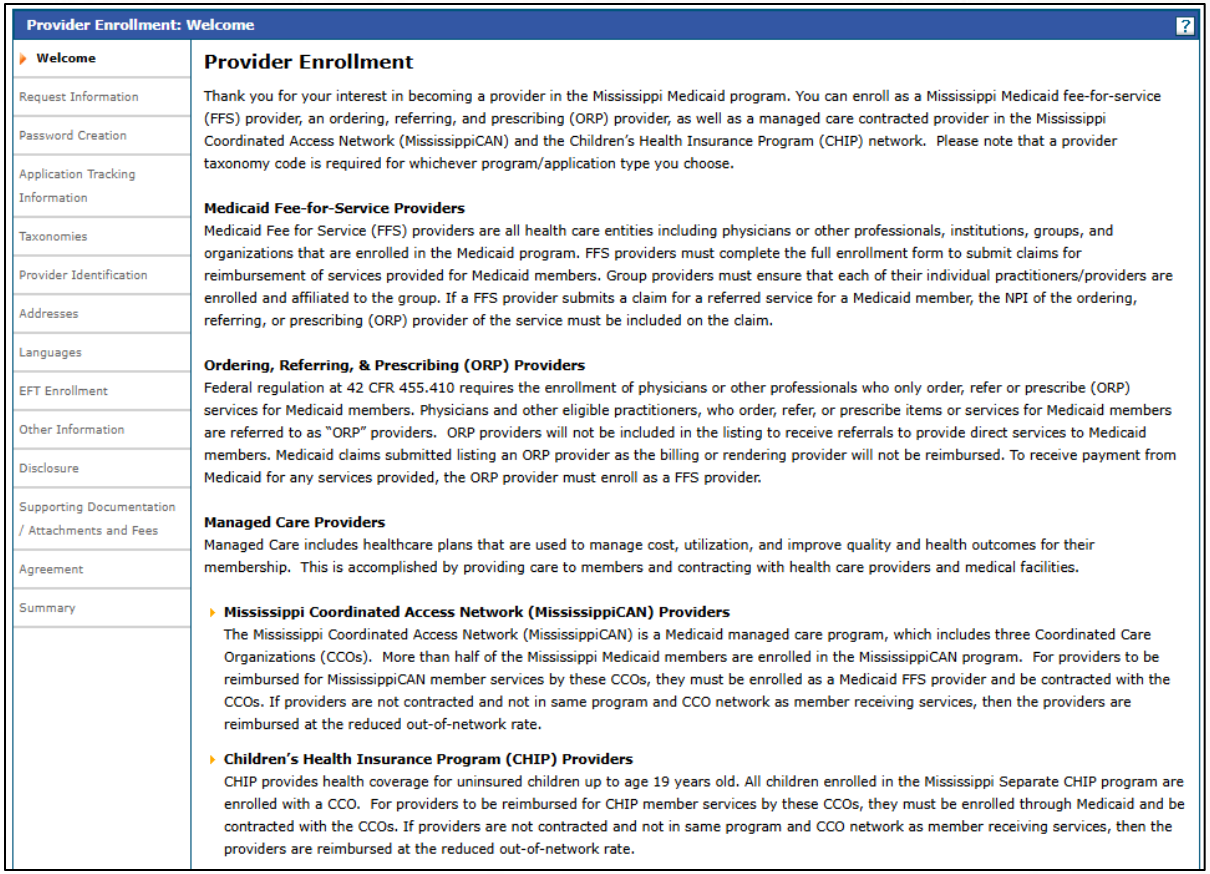
- Select the "Enrollment Application" link.
- The Welcome page displays with explanations/definitions for each enrollment application type.

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.

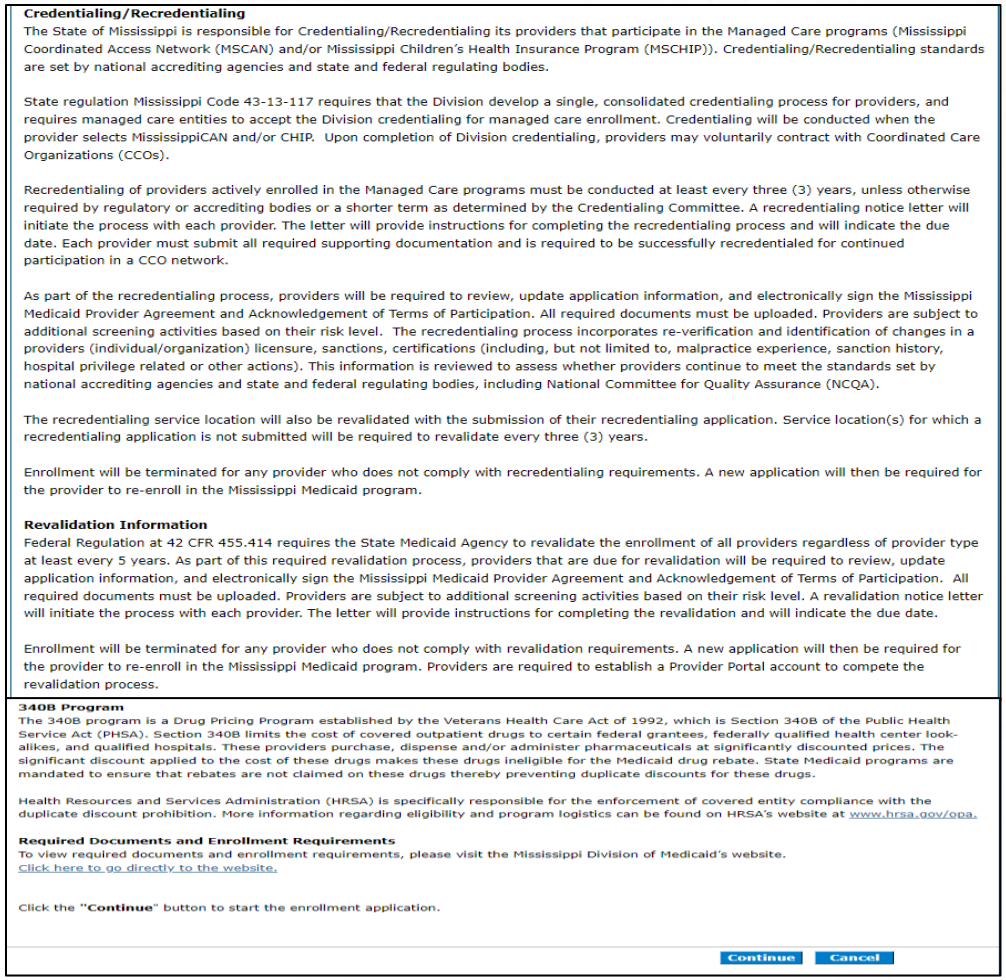
The next page goes over the remainder of this section.



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.

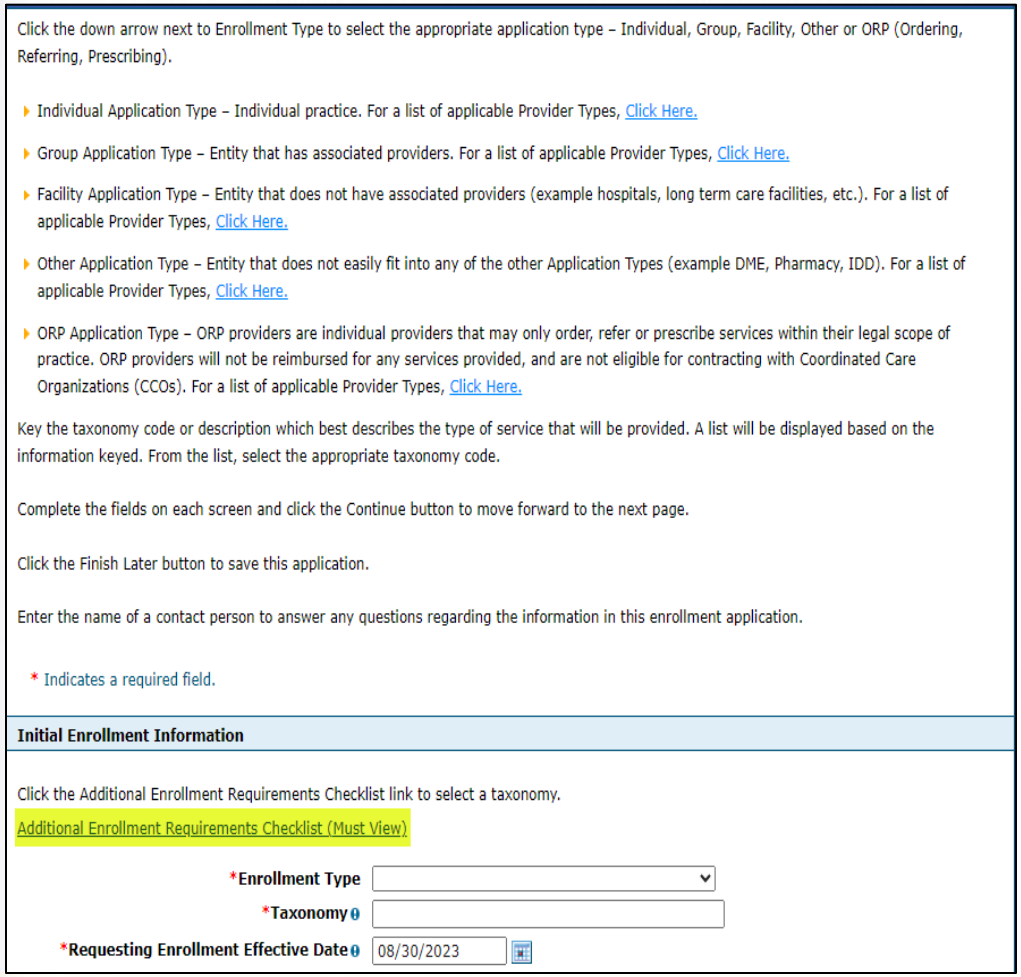
Required Documents and Enrollment Requirements

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 08/30/2023

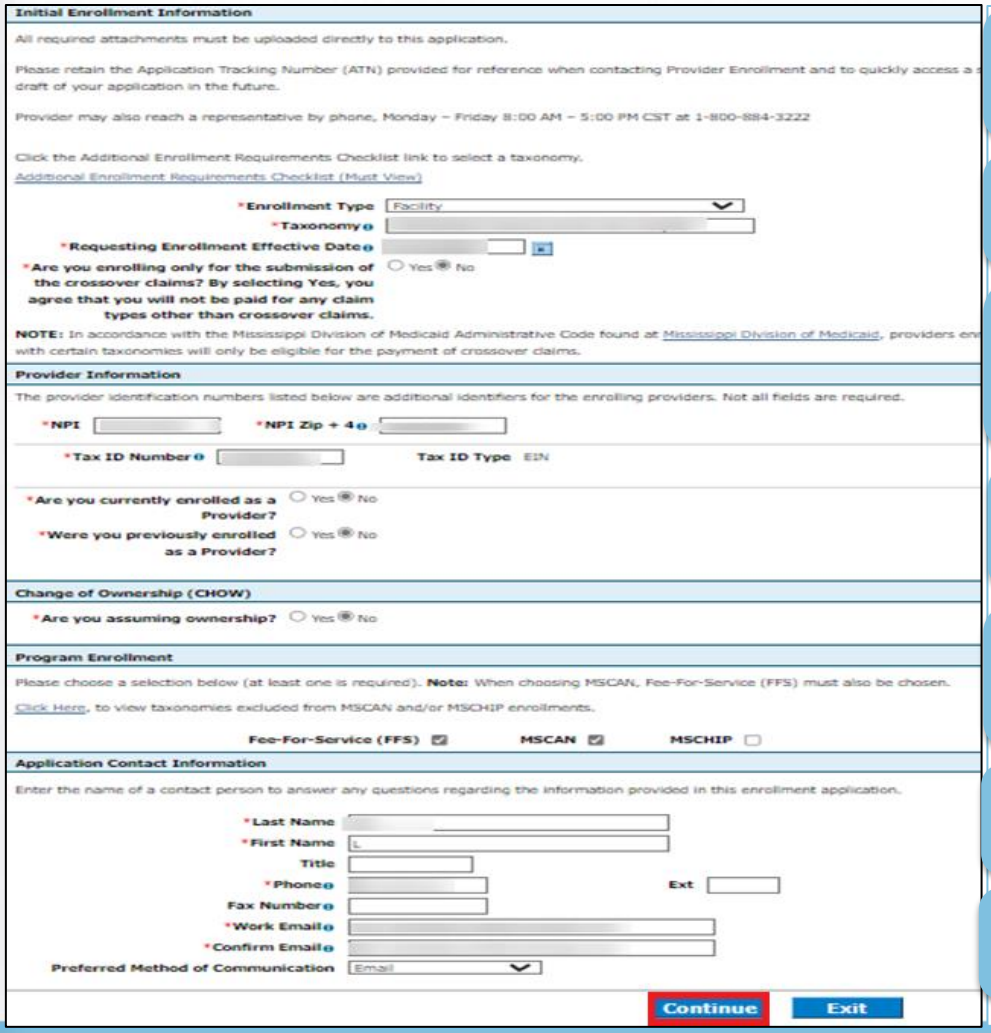
There are **five** application types**:**

- **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



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.

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.

If completing the **CHOW** portion, see the next page for required information.

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

CHOW
(Change of Ownership)

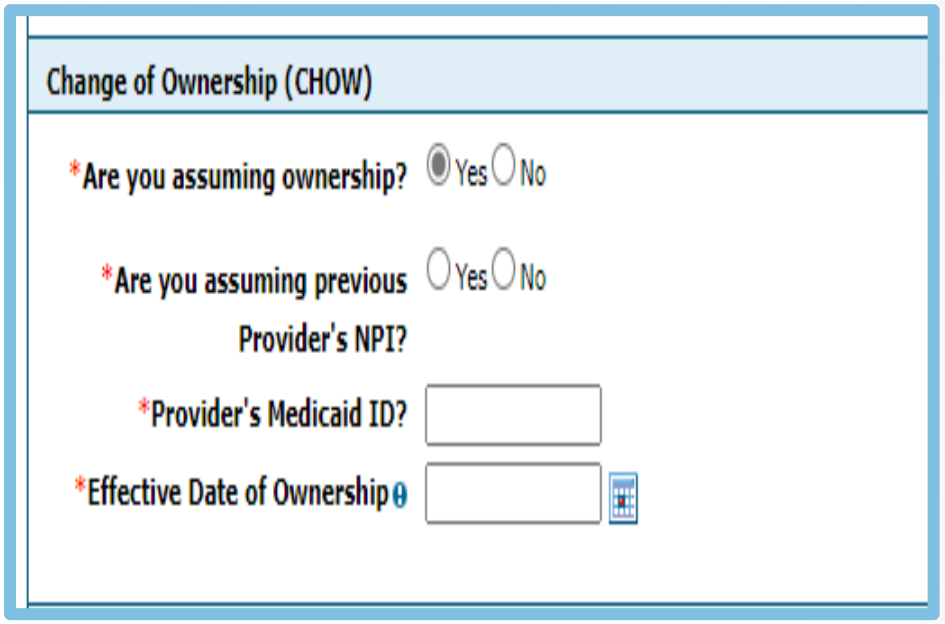
The **CHOW** panel will only appear for Group, Facility, and Other enrollment type.

*If you are completing a **CHOW** application for Change of Ownership, then you must select "**Yes**" for "**Are you assuming ownership**?"

Select "**Yes**" if you are assuming ownership of the **previous providers NPI**.

Enter **the previous provider's Medicaid ID**.

Enter the **Effective Date of Ownership**.

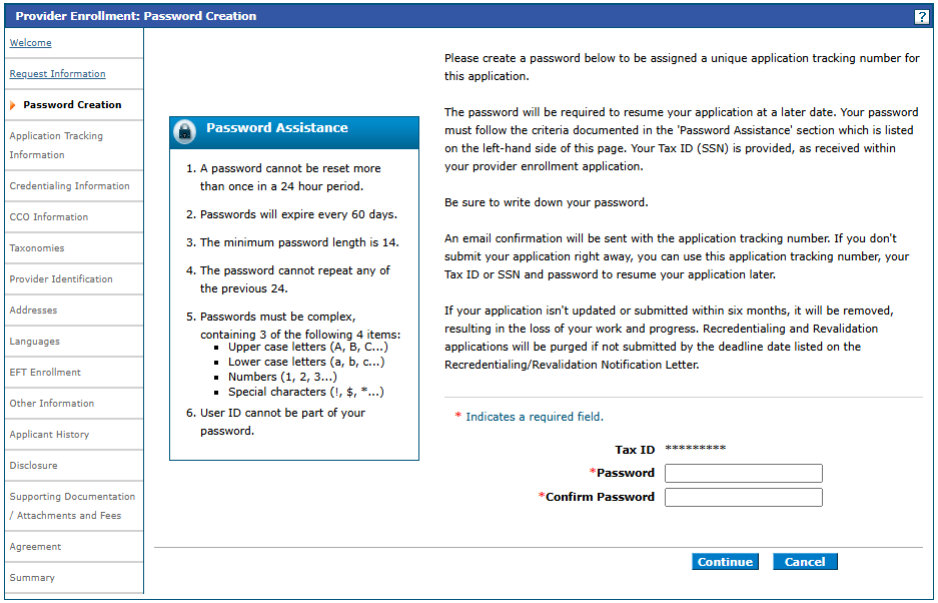


Password Creation

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.

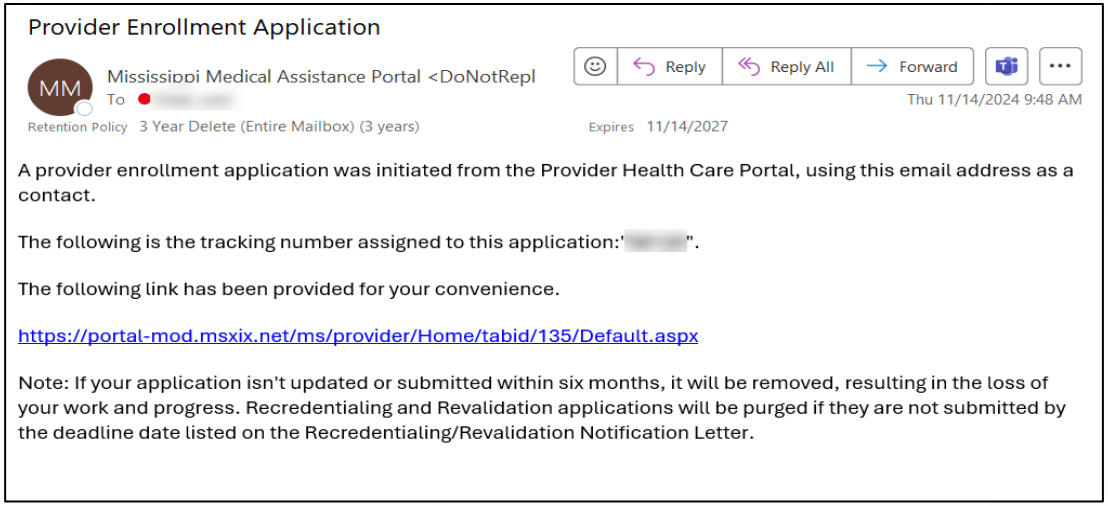


Application Tracking Information

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

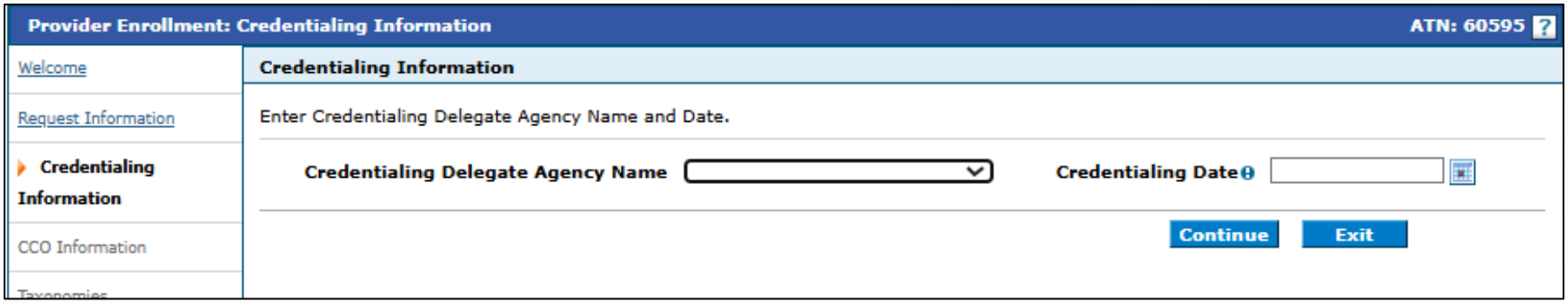
You will need this number and the **Tax ID** number to view completed application status.

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



Credentialing Information

This is only applicable to providers who chose to credential with CCO plan.



- Select the Credentialing Delegate Agency Name from the dropdown list.

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

Coordinated Care Organization Selection (CCO)

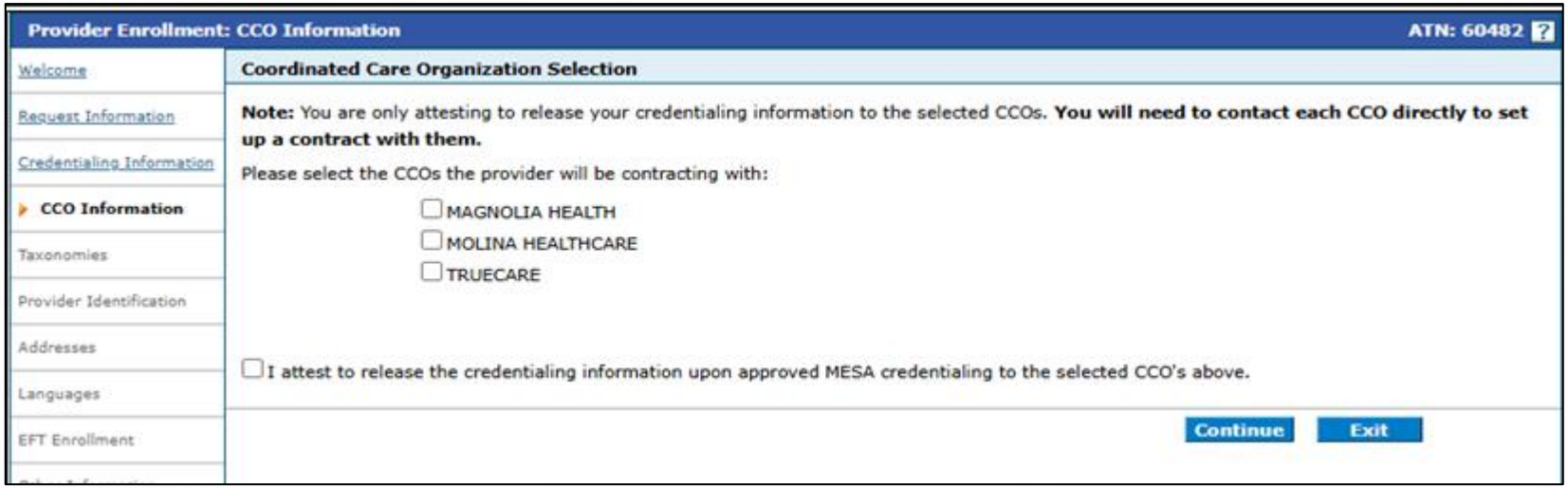
This is only applicable to providers who chose to credential with CCO plan.

Select the **CCOs** the provider will be contracting with.

Select the **attestation statement** box.

Select **Continue** to the next page.

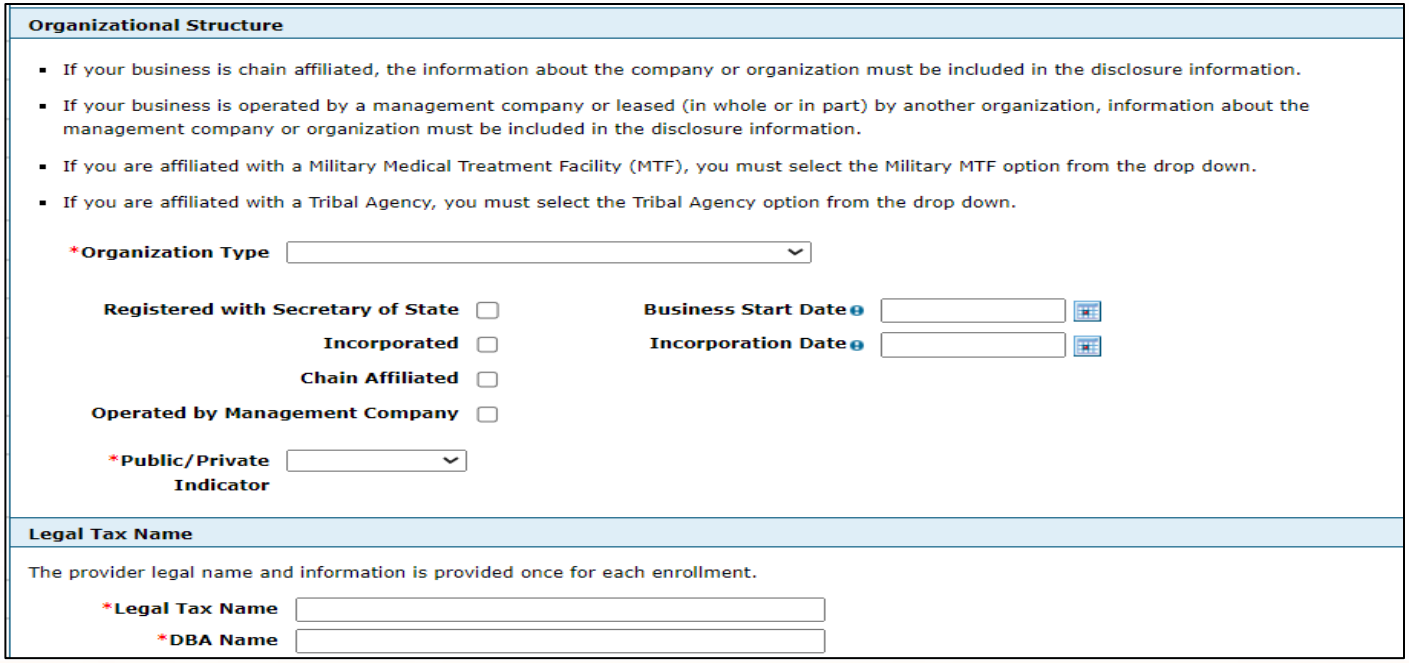
You are only attesting to release your credentialing information to the selected CCOs; **you will have to contact each CCO directly to contract with them.**



Provider Identification

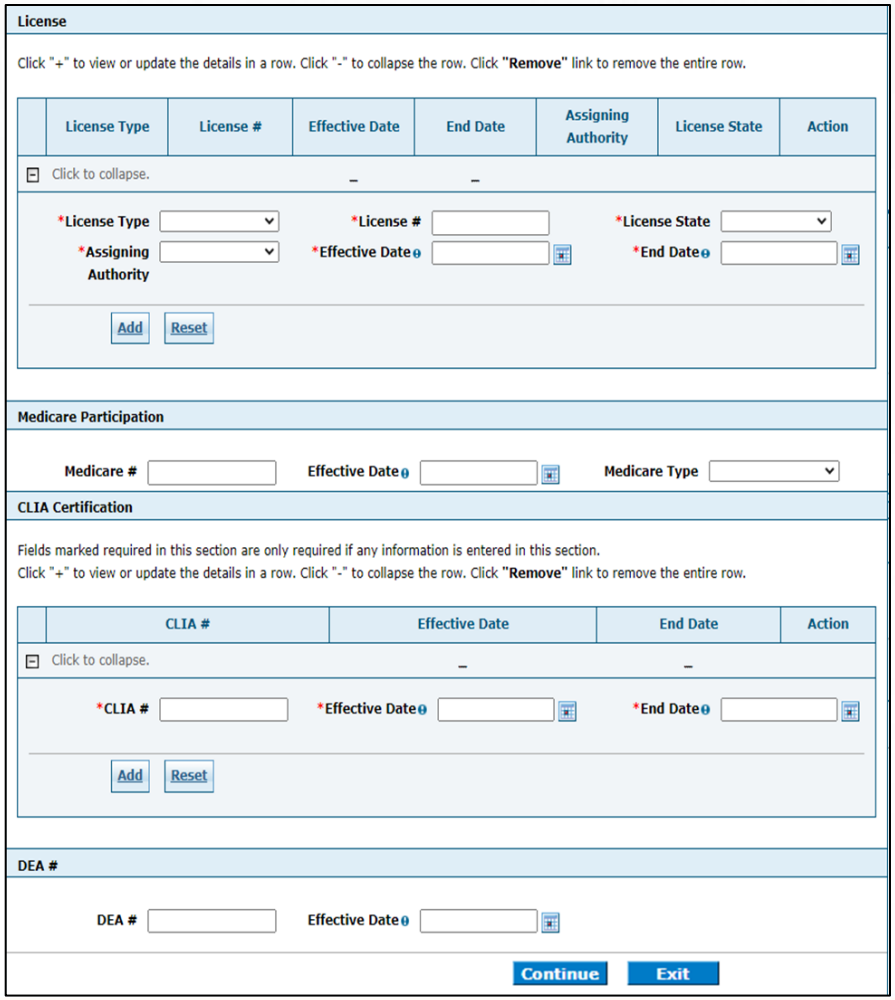
- Select the appropriate **Organization Type** from the dropdown list. Fields will change based on selection.
- Select the appropiate box and enter Business Start or Incorporation Date if applicable.
- Select **Public/Private** Indicator from drop down.
- Enter the **Legal Tax Name** and **DBA Name**.
- See next page for the remainder of this section.

This section is based on enrollment and organization type

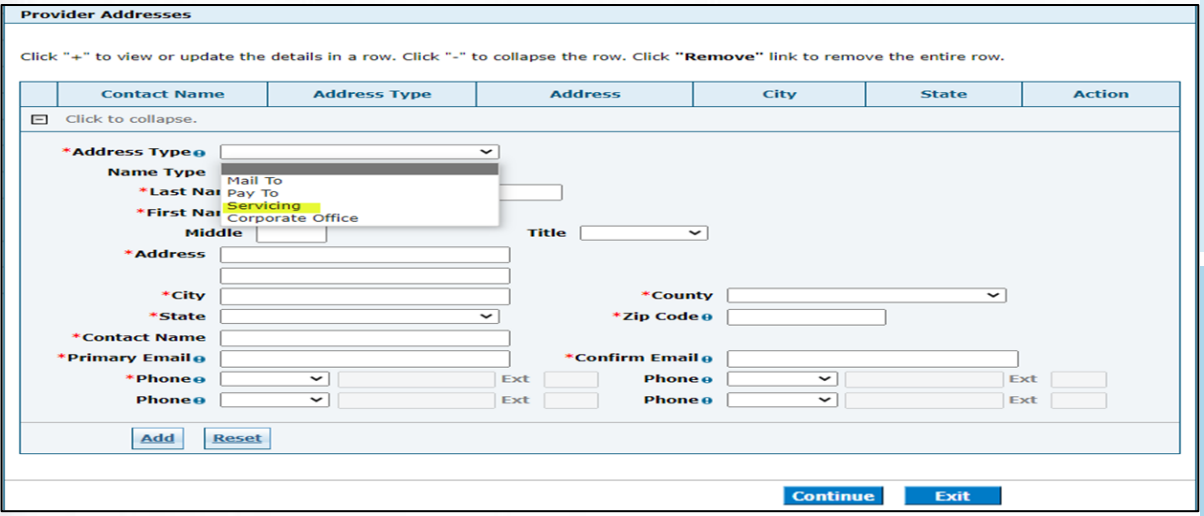


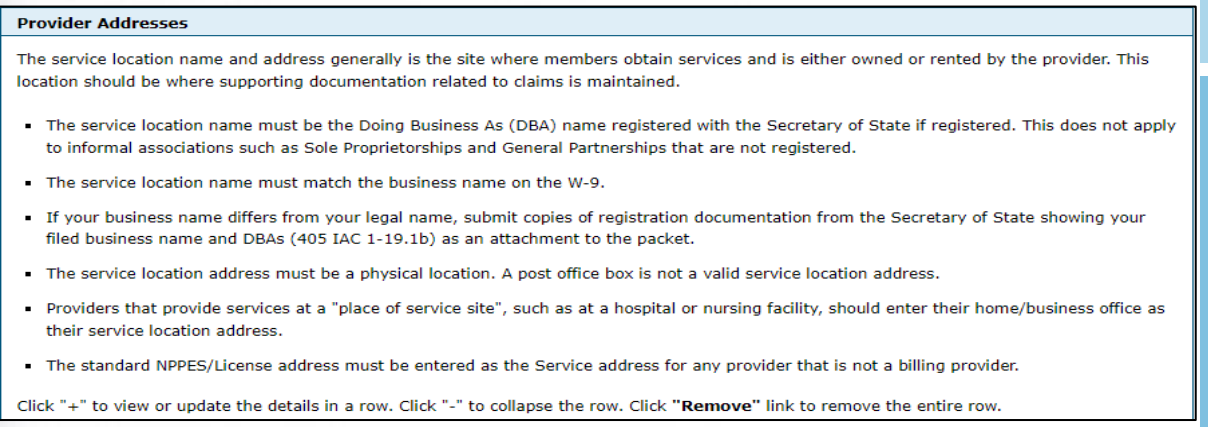
Provider Identification Cont'd

- 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.



Provider Address





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

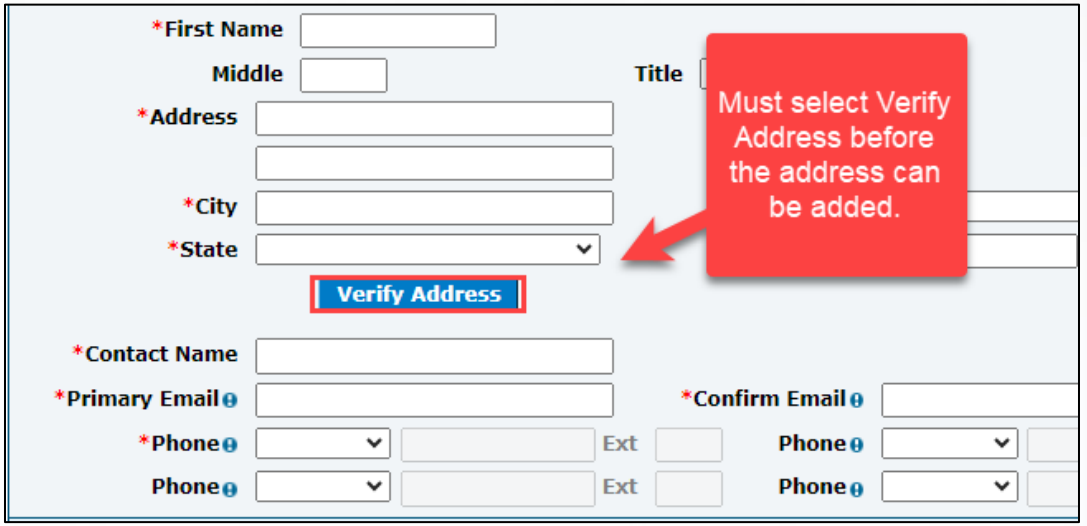
At least one Servicing address (physical location) is required. If no other address is provided the servicing address will also default to the Pay To, Mail To and Corporate Office address.

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.

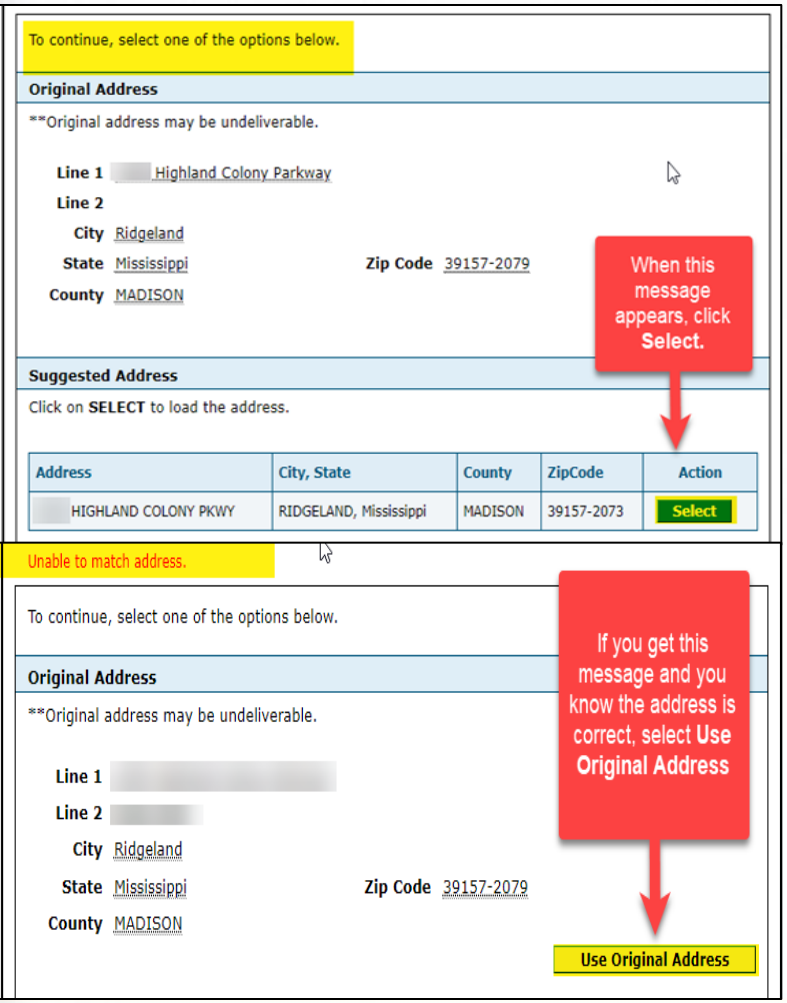
Verify Address

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.



Verify Address Cont'd



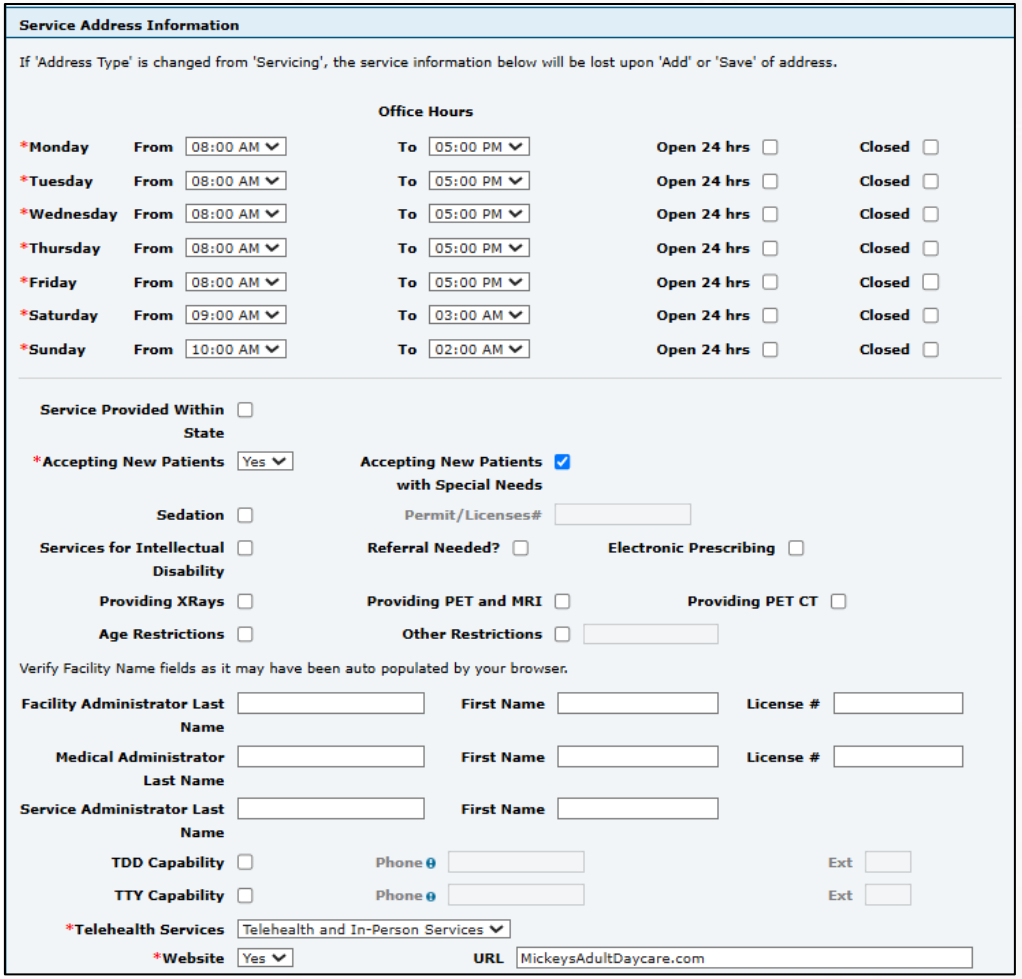
- If you get a message that is suggesting an address, click **Select** to use that address. In the example shown, the suggested address changed Parkway to PKWY, so the address is still the same. Or the address may show the same as you entered but **Select** must still be clicked.
- If you get a message 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.

Servicing Address Information

Required fields include:

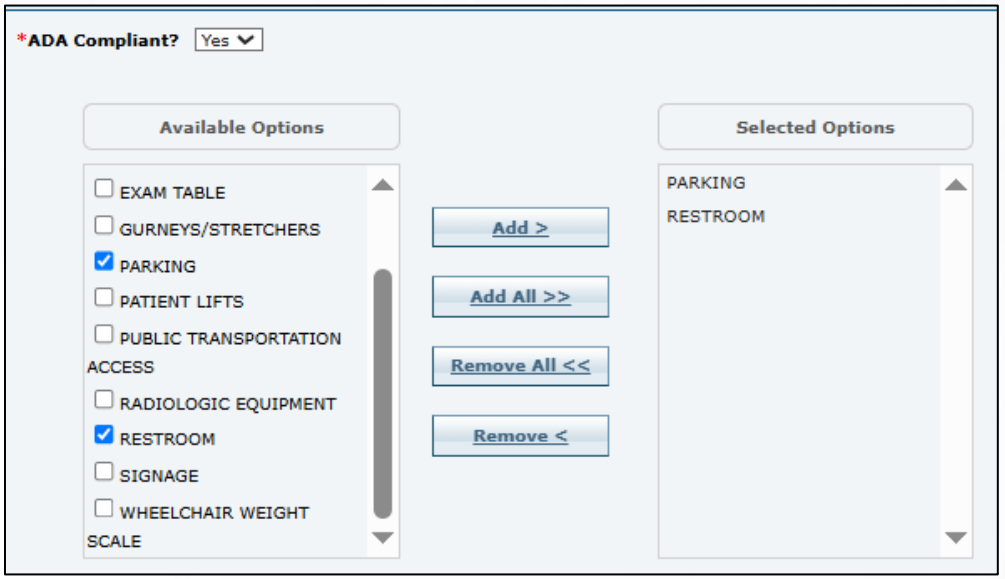
- Office Hours for each day of the week
- Accepting New Patients
- Telehealth Services
- Website
- ADA Compliant (next slide)

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



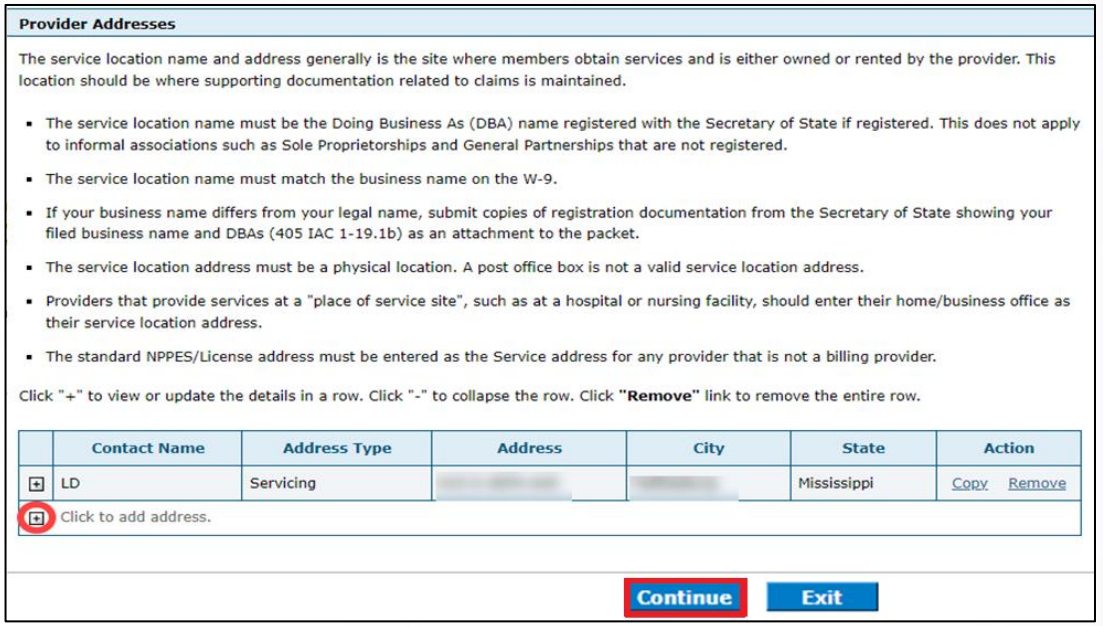
Servicing Address Information

- **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.

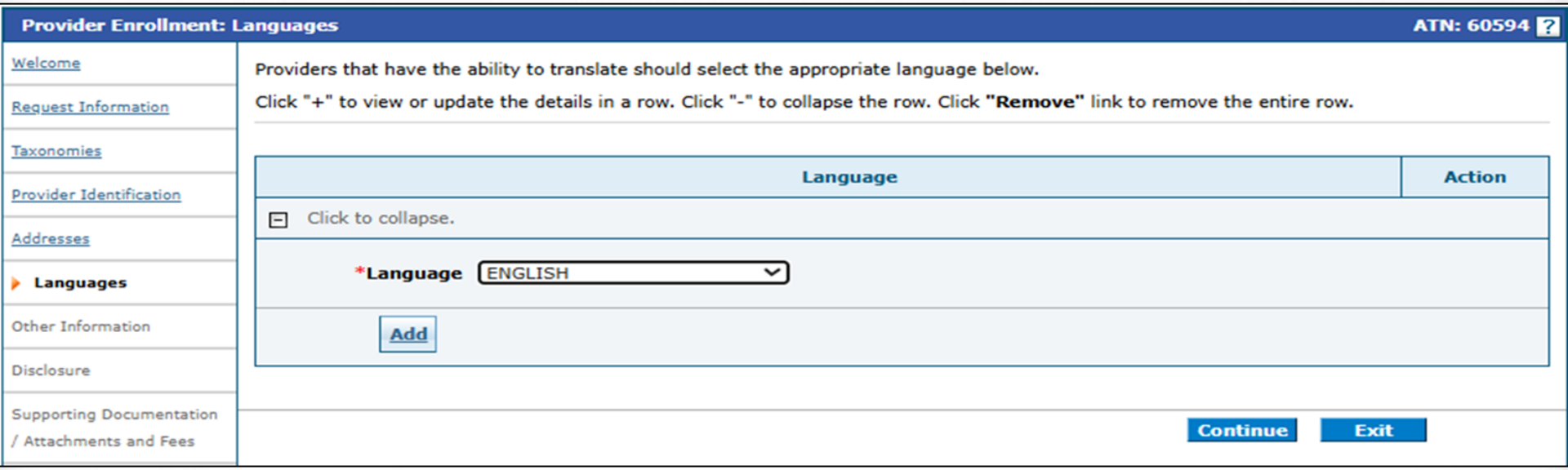


Servicing Address Information

- 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.



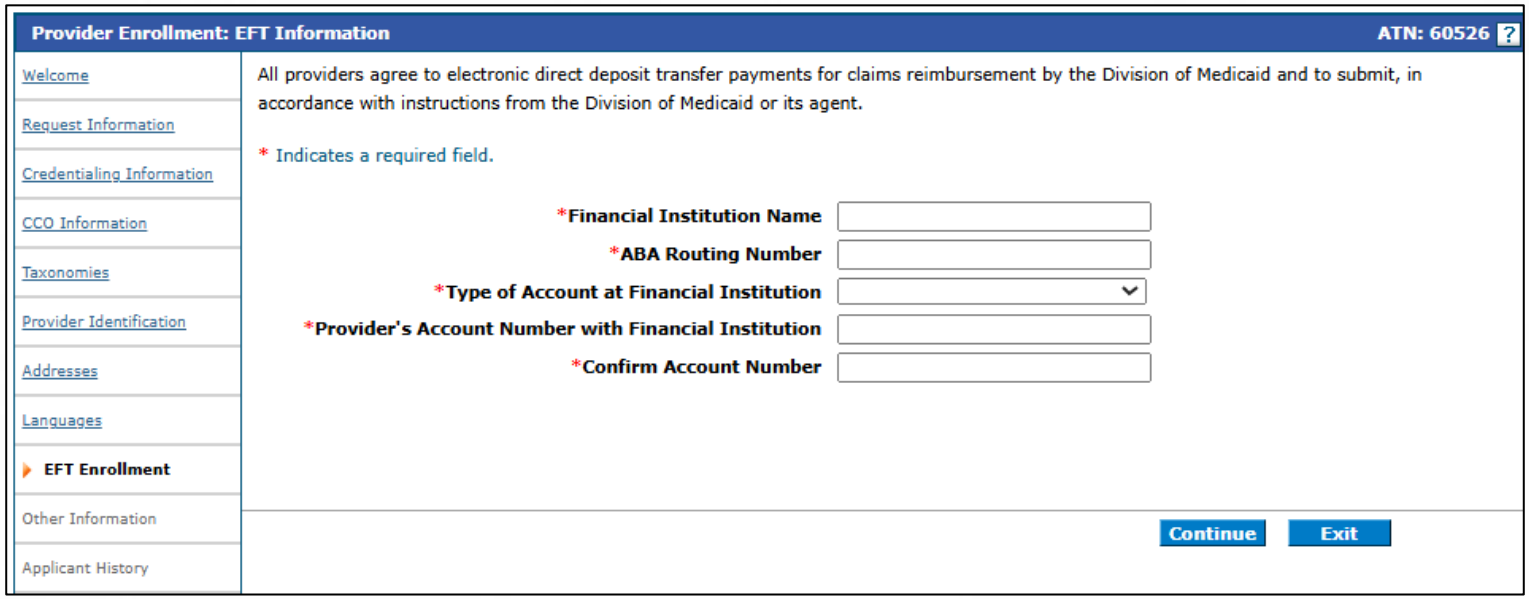
Languages page



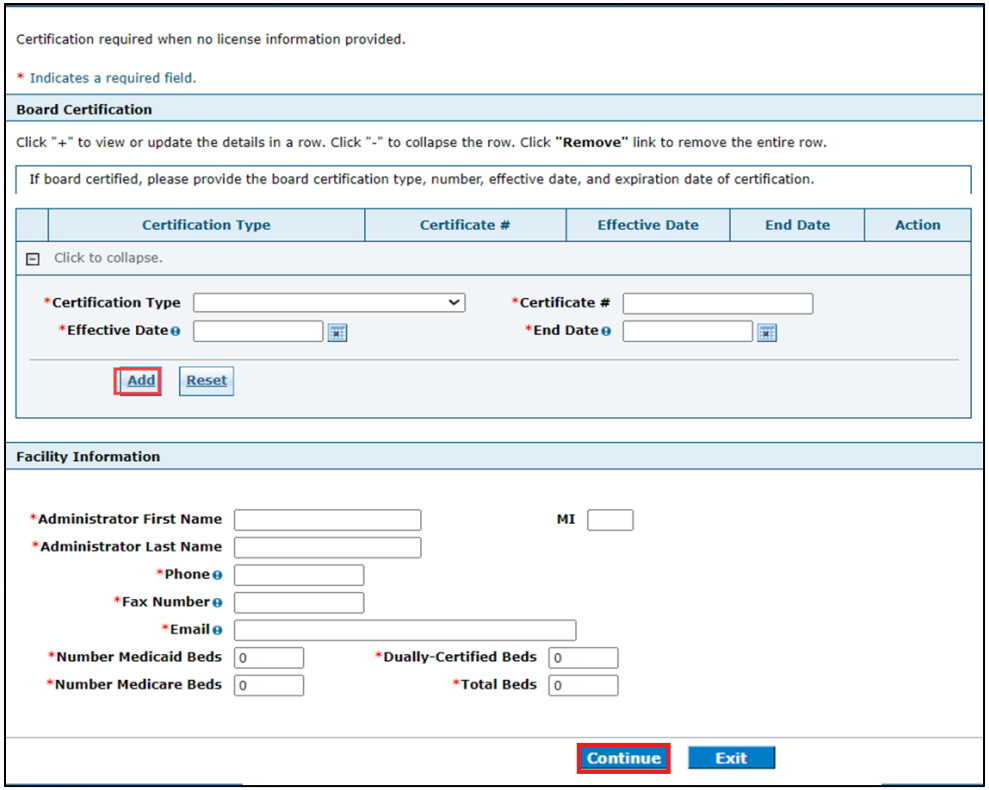
- Use the drop down to select the applicable Language, then select "**Add**". If more than one language is available, follow the same steps to add each language. At least **one** language must be selected.
- Once all languages are added, select "**Continue**" to the EFT Enrollment page.

EFT Information

- All providers agree to electronic direct deposit.
- EFT information is required and must be completed to continue.
- A voided check or letter from your financial institution must be uploaded as a PDF document.



Other Information



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

Using the drop down, select the applicable **Certification Type**, JCAHO, ASHA Certification or Certification of Disease Management. Along with the Certificate #, Effective date and End Date.

Select "**Add**" after entering each certification.

Complete the fields under **Facility Information**. These fields must be filled in to continue.

Select "**Continue**" to the Applicant History page.

Applicant history

This is only applicable to providers who chose to credential with CCO plan.

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.

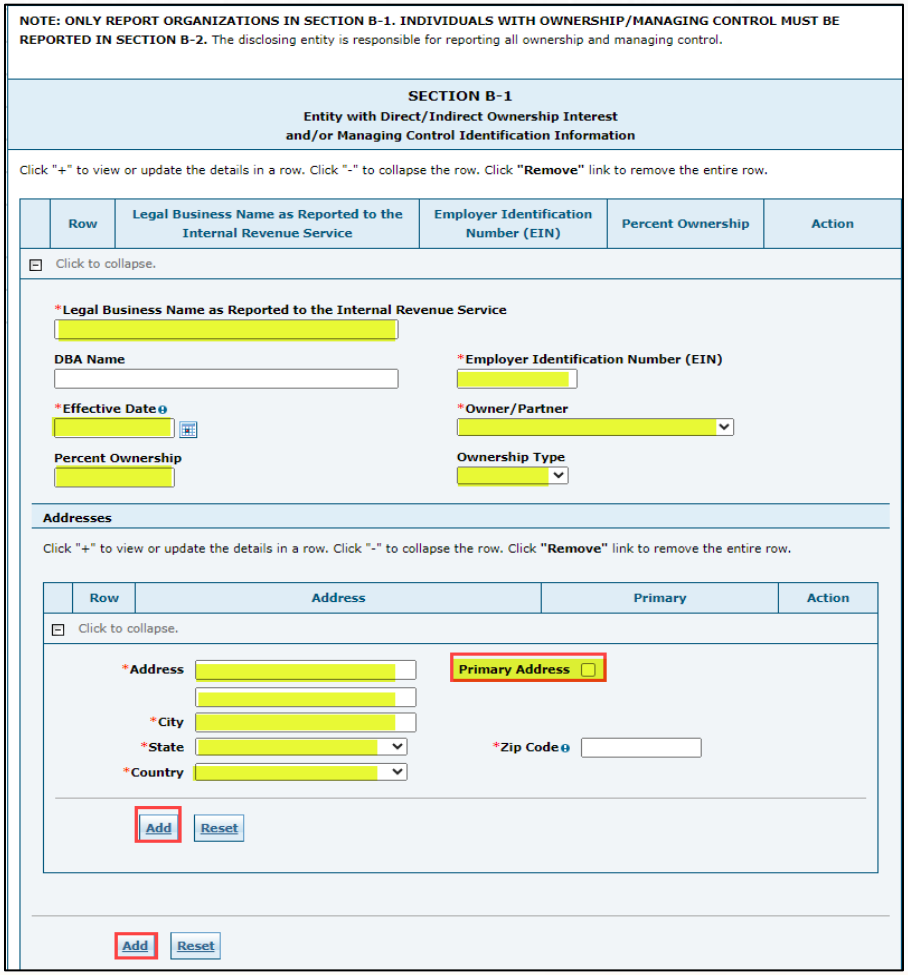
Investigations

*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

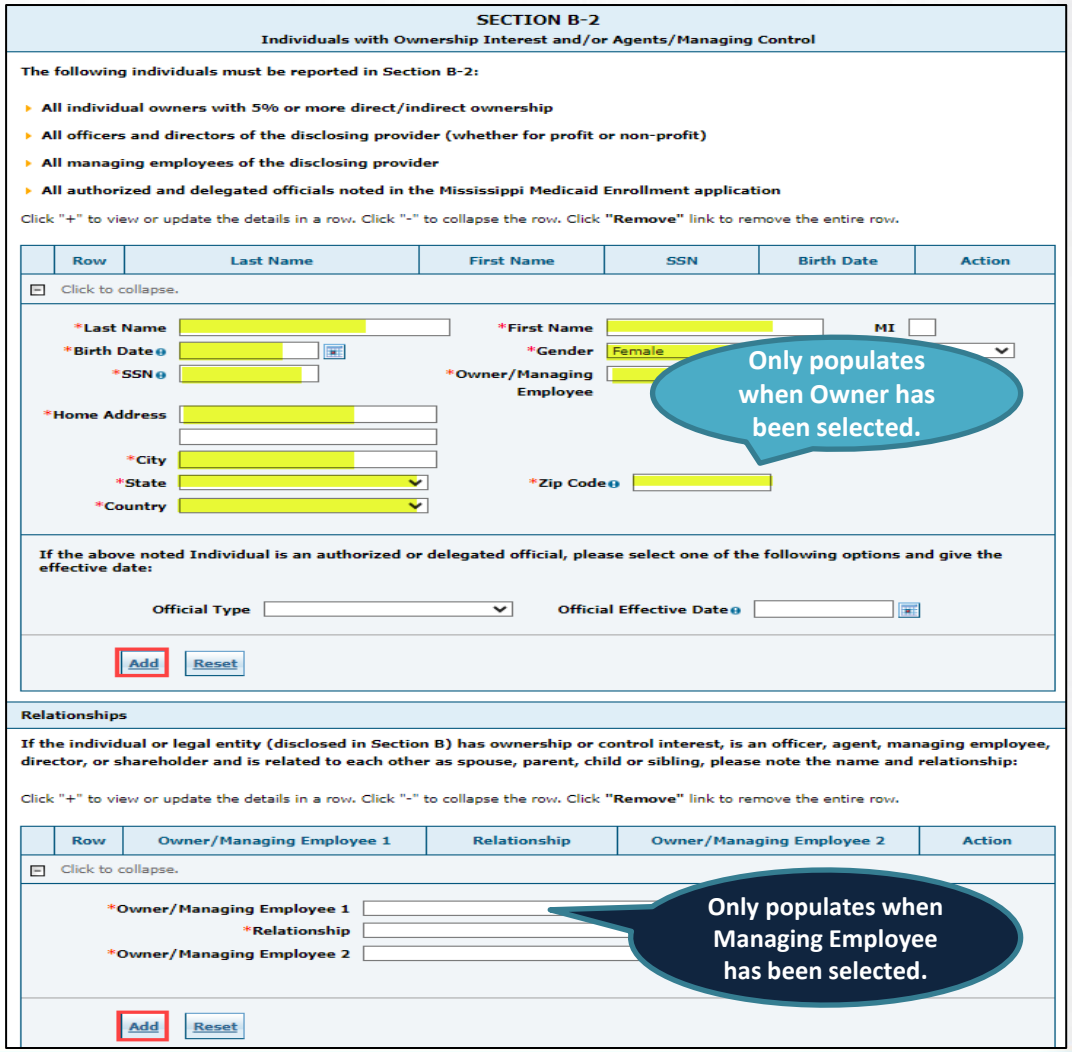
Disclosure Section B-1

- The **Disclosure** page will change depending on provider type. This example is for Group Provider Types.
- In Section **B-1** report any organization that has ownership of your business. Select the "**+**" to add the details of the organization and then again to add their address. Select the **Primary Address** box. If more than one address, make sure to select "**Add**" after each address. There must be a primary address listed.
- If data is entered, you must enter the **Percent Ownership** and the **Ownership Type**.
- Select "**Add**" after entering the data.



Disclosure Section B-2

- In Section **B-2,** report any Individuals with Ownership Interest and/or Agents/Managing Control. Select the "**+**" to add the details.
- Select "**Add**" after entering the data.
- Select the **Official Type** and effective date.
- At least **one managing employee** and **one authorized official** must be noted in section **B-2**.
- When adding an **Owner**, you must include the **percentage** of ownership and must select the **ownership type**.
- When adding a **Managing Employee**, you must select each one that applies and provide the effective date.
- If applicable, enter the data under Relationships and select "**Add.**"



Disclosure Section C and D

ENTER ANY APPLICABLE DATA AND SELECT 'ADD' AFTER ANY INFORMATION IS ENTERED.

SECTION C

Criminal Convictions and Other Sanctions

Provide the requested information in this section for any person who:
(1) Has an ownership or control interest in the disclosing provider OR is an agent or managing employee of the disclosing provider
AND
(2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,
OR
(3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c-h),
(4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h),
(5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,
(6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,
(7) Has had his/her/its license or certification revoked, or
(8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.

Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation.

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

	Row	Name	Criminal/Sanction Info	Date	Action
⊟	Click to collapse.				

*Name
*Criminal/Sanction Info
*Date
*Agency/Court/Administrative Body
*Resolution

Add Reset

SECTION D

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

Identify and provide the requested information in this section regarding any person who:
(1) has been convicted of a criminal offense as described in Sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;
(2) has had civil money penalties or assessments imposed under Section 1128A of the Social Security Act
OR
(3) has been excluded from participation in Medicare or any of the state health programs AND
(4) also has one or more of the following relationships to the disclosing provider:

i. has a direct or indirect ownership interest (or any combination thereof) of five percent (5%) or more in the group/organization;
ii. is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the group/organization or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets of the group/organization;
iii. is an officer or director of the group/organization, if the group/organization is organized as a corporation;
iv. is a partner in the group/organization, if the group/organization is organized as a partnership;
v. is an agent of the group/organization;
vi. is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the group/organization or part thereof, or directly or indirectly conducts the day-to-day operations of the group/organization or part thereof; or
vii. was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer or ownership or control interest to an immediately family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

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

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

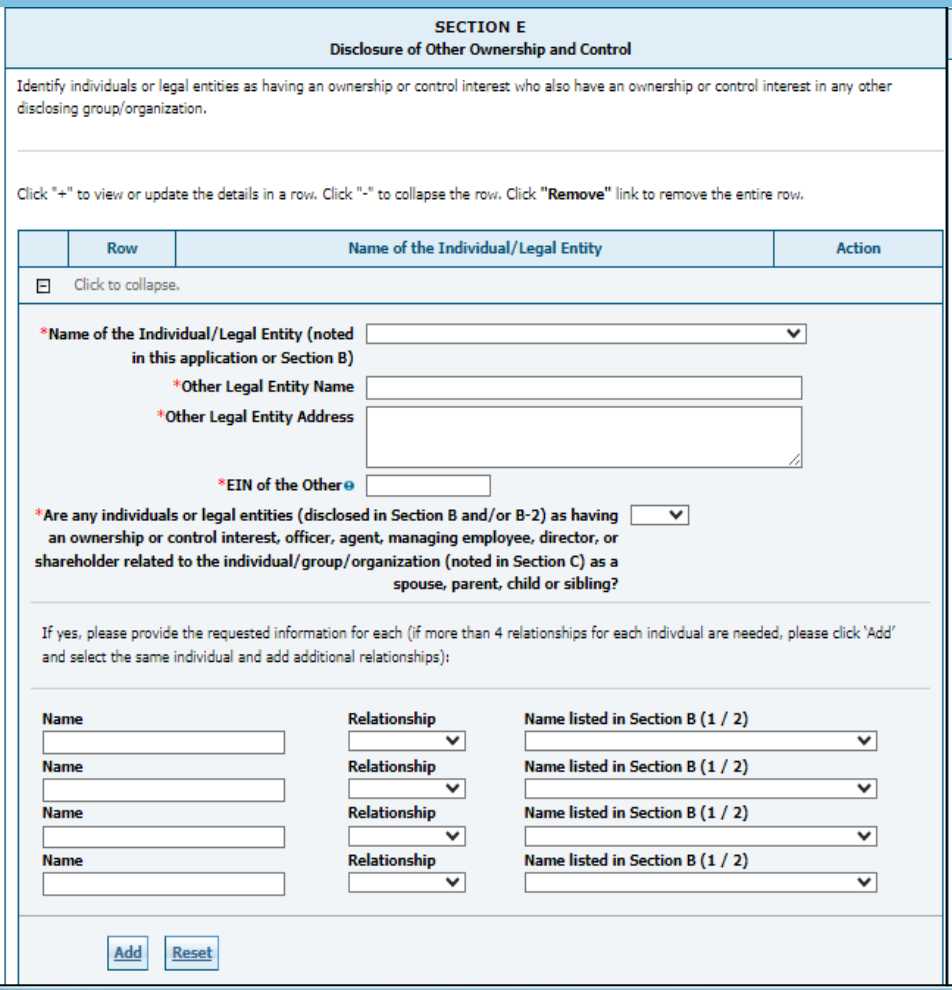
	Row	Name	Relationship	Action
⊟	Click to collapse.			

*Name
*Relationship
*Relationship Status
*Conviction Information (Crime)
*Date of Conviction
*Reason for Penalty or Assessment Information
*Date Imposed
*Reason for Medicare Exclusion Information
*Date Imposed
*State Health Care Program Exclusion
*State Agency and Reason
*Date of Exclusion

Add Reset

Disclosure Section E and F

ENTER ANY APPLICABLE DATA AND SELECT 'ADD' AFTER ANY INFORMATION IS ENTERED.



SECTION E
Disclosure of Other Ownership and Control

Identify individuals or legal entities as having an ownership or control interest who also have an ownership or control interest in any other disclosing group/organization.

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

	Row	Name of the Individual/Legal Entity	Action
⊟	Click to collapse.		

*Name of the Individual/Legal Entity (noted in this application or Section B)

*Other Legal Entity Name

*Other Legal Entity Address

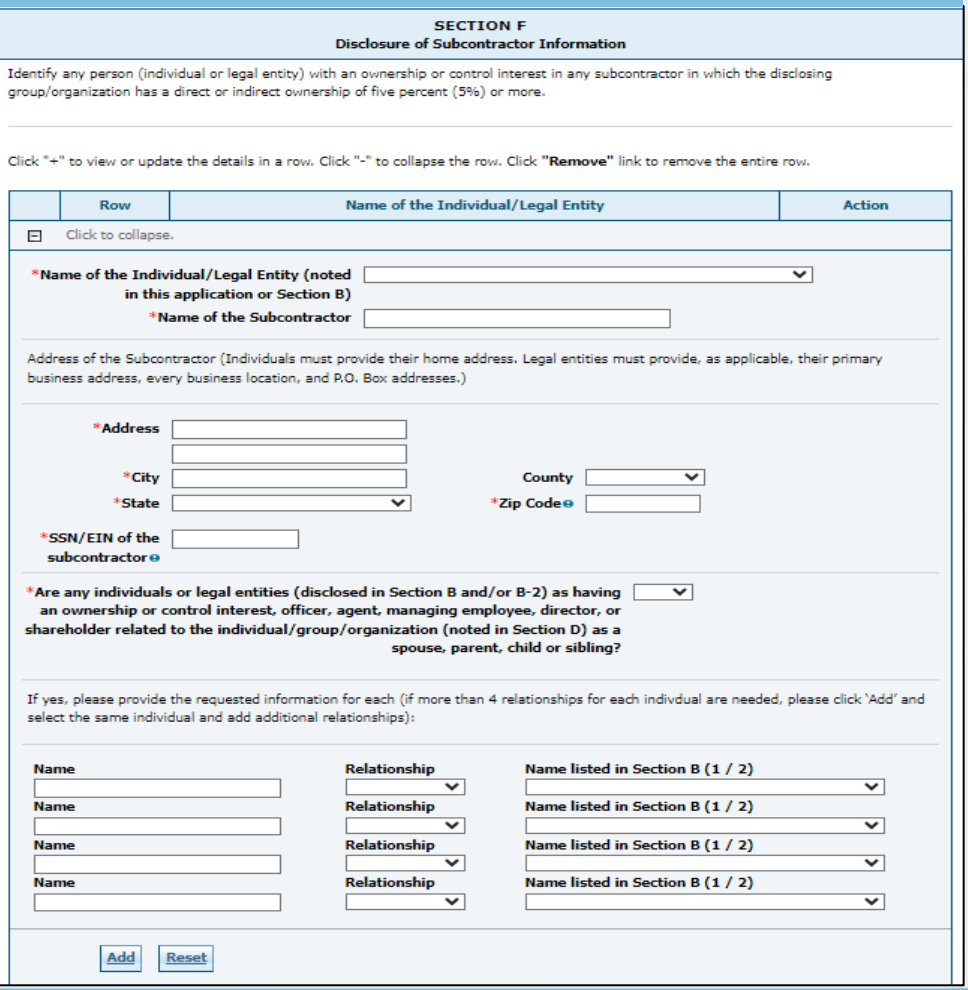
*EIN of the Other

*Are any individuals or legal entities (disclosed in Section B and/or B-2) as having an ownership or control interest, officer, agent, managing employee, director, or shareholder related to the individual/group/organization (noted in Section C) as a spouse, parent, child or sibling?

If yes, please provide the requested information for each (if more than 4 relationships for each indivdual are needed, please click 'Add' and select the same individual and add additional relationships):

Name	Relationship	Name listed in Section B (1 / 2)
Name	Relationship	Name listed in Section B (1 / 2)
Name	Relationship	Name listed in Section B (1 / 2)
Name	Relationship	Name listed in Section B (1 / 2)

Add Reset



SECTION F
Disclosure of Subcontractor Information

Identify any person (individual or legal entity) with an ownership or control interest in any subcontractor in which the disclosing group/organization has a direct or indirect ownership of five percent (5%) or more.

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

	Row	Name of the Individual/Legal Entity	Action
⊟	Click to collapse.		

*Name of the Individual/Legal Entity (noted in this application or Section B)

*Name of the Subcontractor

Address of the Subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and P.O. Box addresses.)

*Address

*City

County

*State

*Zip Code

*SSN/EIN of the subcontractor

*Are any individuals or legal entities (disclosed in Section B and/or B-2) as having an ownership or control interest, officer, agent, managing employee, director, or shareholder related to the individual/group/organization (noted in Section D) as a spouse, parent, child or sibling?

If yes, please provide the requested information for each (if more than 4 relationships for each indivdual are needed, please click 'Add' and select the same individual and add additional relationships):

Name	Relationship	Name listed in Section B (1 / 2)
Name	Relationship	Name listed in Section B (1 / 2)
Name	Relationship	Name listed in Section B (1 / 2)
Name	Relationship	Name listed in Section B (1 / 2)

Add Reset

Disclosure Section G and H

ENTER ANY APPLICABLE DATA AND SELECT 'ADD' AFTER ANY INFORMATION IS ENTERED.

READ SECTION H THEN SELECT THE "I ACCEPT BOX" AND ENTER THE REQUIRED SIGNATURE AND TITLE.

SECTION G
Business Transactions (This section should only be completed at the direction of Division of Medicaid (DOM))

Identify the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period before the date of this request. If there are multiple owners or shareholders, list only those with direct or indirect ownership of five percent (5%) or more.

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

Row	Name of the Subcontractor	Name of Owner	Action

Click to collapse.

*Name of the Subcontractor
*SSN or EIN
*Address
*City
County
*State
*Zip Code

*Name of Owner
*Address
*City
County
*State
*Zip Code

Identify any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period before the date of this request below. If there are no significant business transactions to report, please respond "None".

*

Add Reset

SECTION H
Attestation and Signature of the Disclosing Provider

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

In addition, I understand that:

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

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

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

*Your Signature
Title
Date 10/18/2023

Continue Exit

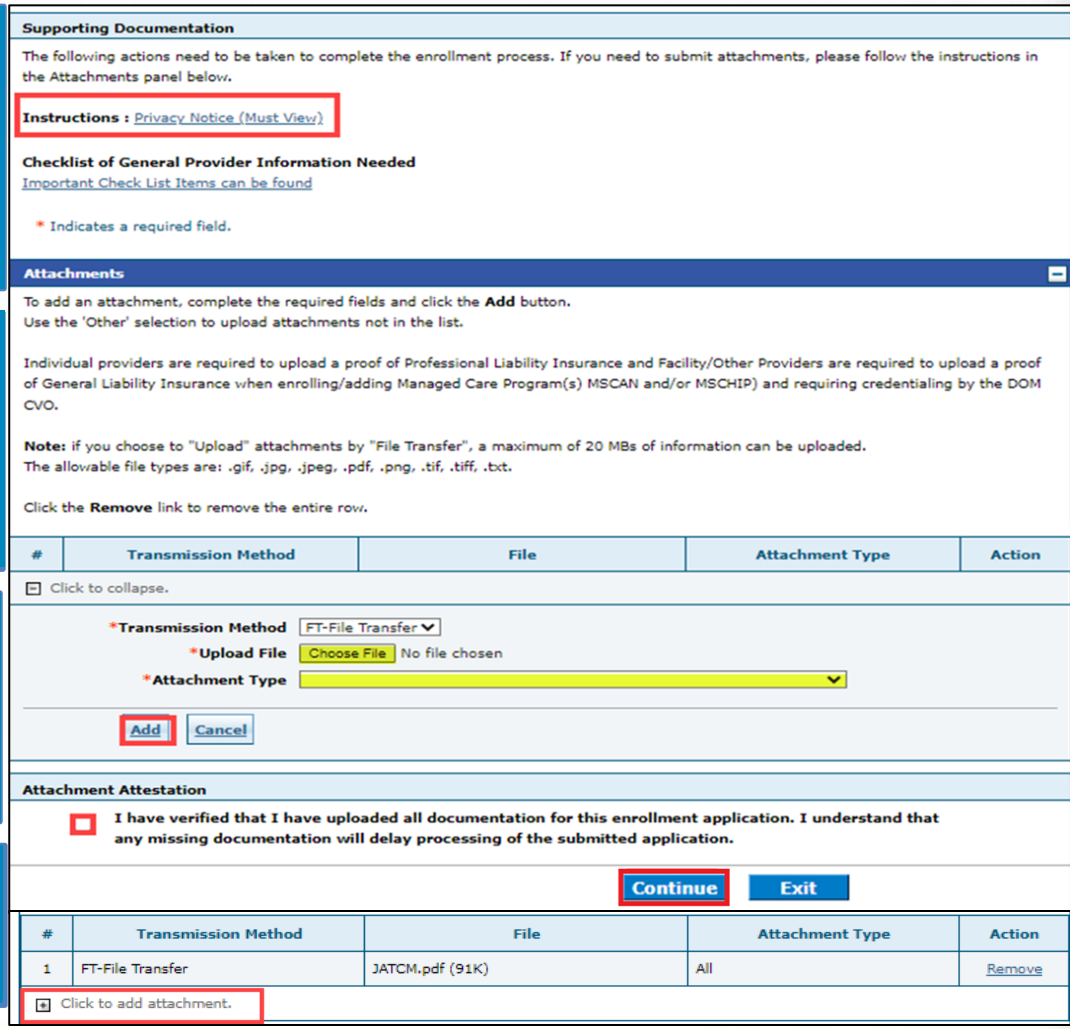
Supporting Documentation

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 appropiate 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 appropiate type.

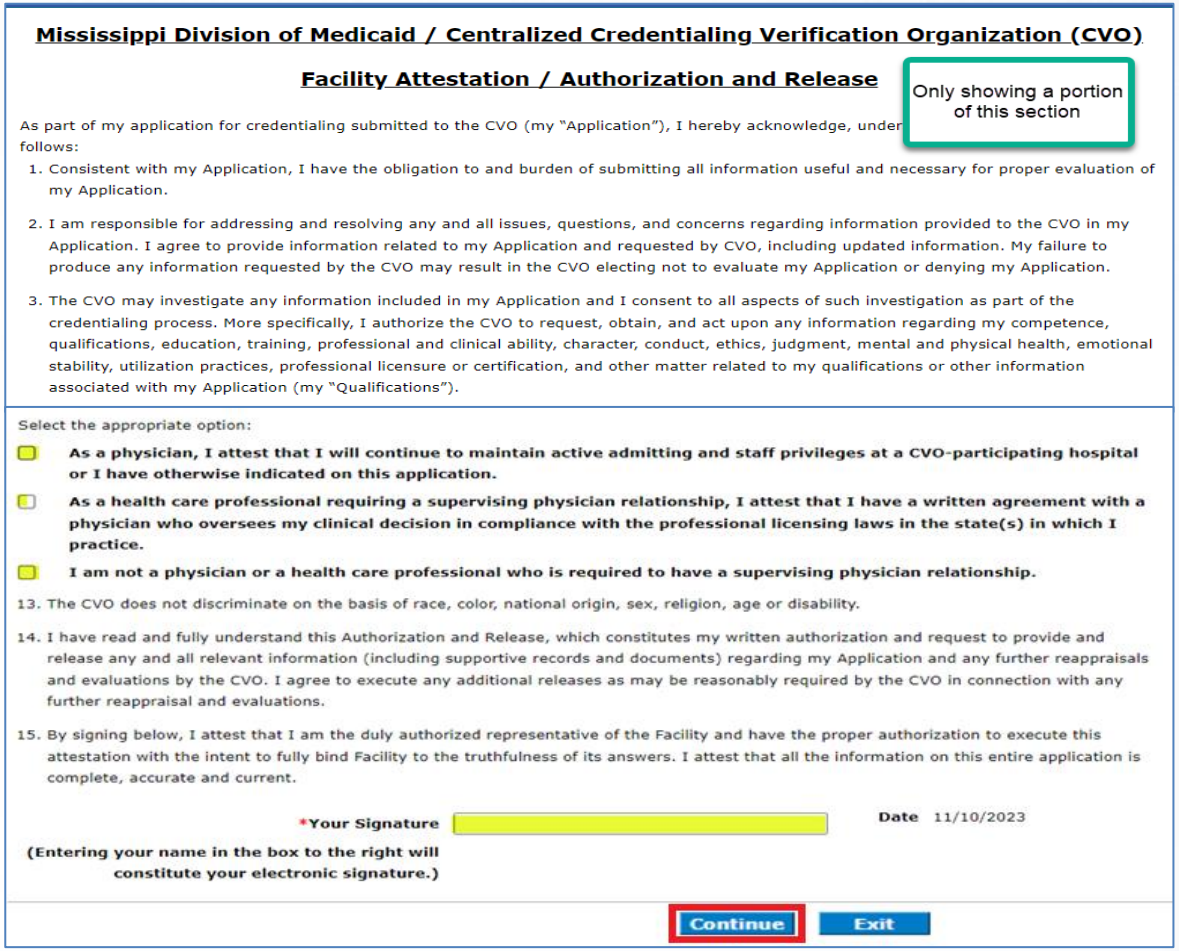
Select "**Add**" to attach the document. It must be in gif, jpg, jpeg, png, tif, tiff, pdf or txt format to be added. If additional documents need to be attached, select "**+ Click to add attachment**".

Select the **box** for the **Attachment Attestation statement**. Select "Continue" to the Facility Attestation and Release page.



Facility Attestation/Authorization and Release

- Read the following portion 1-15 and Select the appropriate option.
- Enter the Signature of the Provider or Authorized Representative.
- Select “Continue” to the Agreement page.



Mississippi Division of Medicaid / Centralized Credentialing Verification Organization (CVO)

Facility Attestation / Authorization and Release

Only showing a portion of this section

As part of my application for credentialing submitted to the CVO (my “Application”), I hereby acknowledge, under follows:

1. Consistent with my Application, I have the obligation to and burden of submitting all information useful and necessary for proper evaluation of my Application.
2. I am responsible for addressing and resolving any and all issues, questions, and concerns regarding information provided to the CVO in my Application. I agree to provide information related to my Application and requested by CVO, including updated information. My failure to produce any information requested by the CVO may result in the CVO electing not to evaluate my Application or denying my Application.
3. The CVO may investigate any information included in my Application and I consent to all aspects of such investigation as part of the credentialing process. More specifically, I authorize the CVO to request, obtain, and act upon any information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health, emotional stability, utilization practices, professional licensure or certification, and other matter related to my qualifications or other information associated with my Application (my “Qualifications”).

Select the appropriate option:

- **As a physician, I attest that I will continue to maintain active admitting and staff privileges at a CVO-participating hospital or I have otherwise indicated on this application.**
- **As a health care professional requiring a supervising physician relationship, I attest that I have a written agreement with a physician who oversees my clinical decision in compliance with the professional licensing laws in the state(s) in which I practice.**
- **I am not a physician or a health care professional who is required to have a supervising physician relationship.**

13. The CVO does not discriminate on the basis of race, color, national origin, sex, religion, age or disability.
14. I have read and fully understand this Authorization and Release, which constitutes my written authorization and request to provide and release any and all relevant information (including supportive records and documents) regarding my Application and any further reappraisals and evaluations by the CVO. I agree to execute any additional releases as may be reasonably required by the CVO in connection with any further reappraisal and evaluations.
15. By signing below, I attest that I am the duly authorized representative of the Facility and have the proper authorization to execute this attestation with the intent to fully bind Facility to the truthfulness of its answers. I attest that all the information on this entire application is complete, accurate and current.

***Your Signature** **Date** 11/10/2023

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

Continue Exit

Terms of Agreement

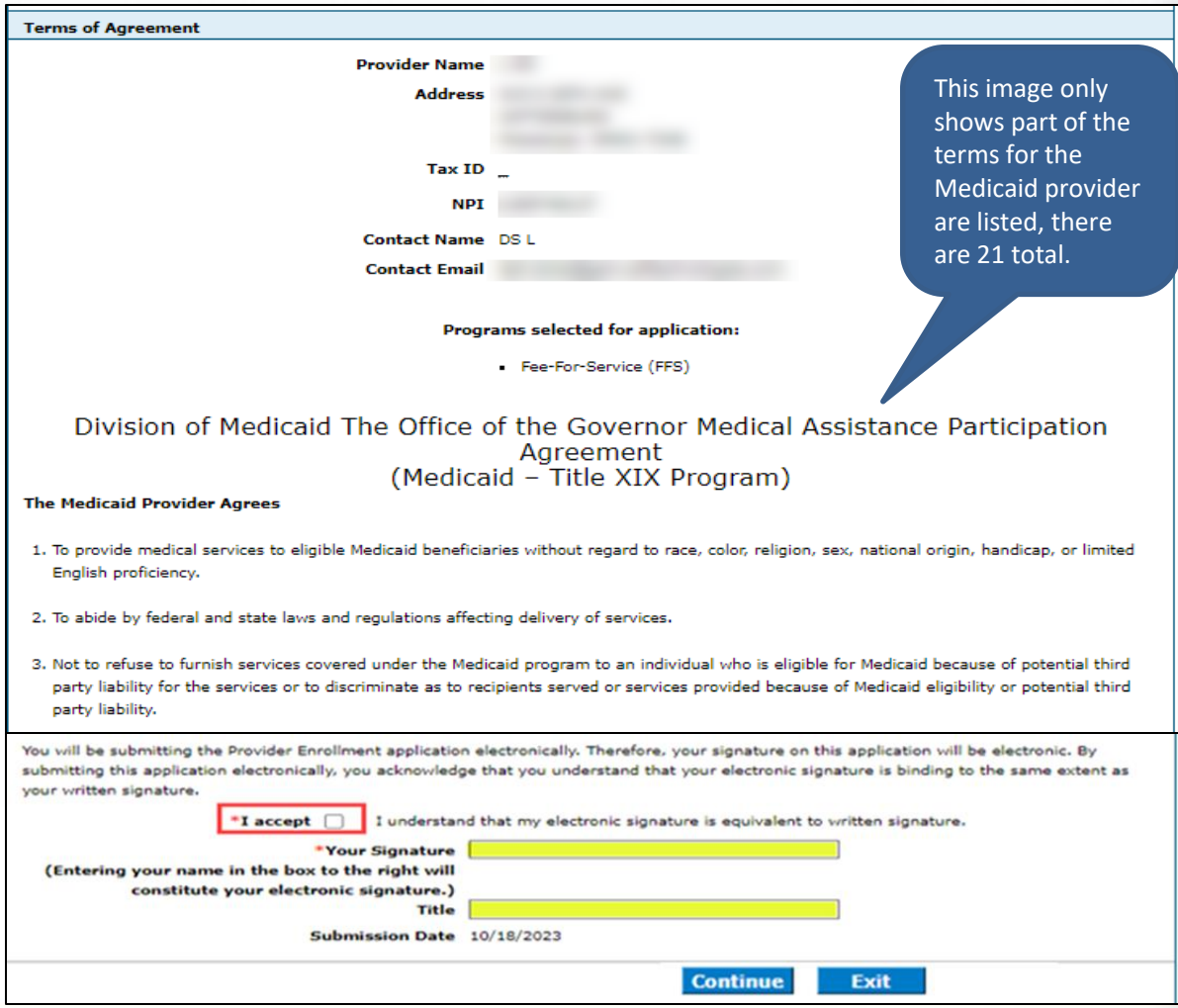
The terms of enrollment are stated. You must accept these terms to submit the enrollment application.

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

Select "**I accept**" box.

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

Select "**Continue**" .

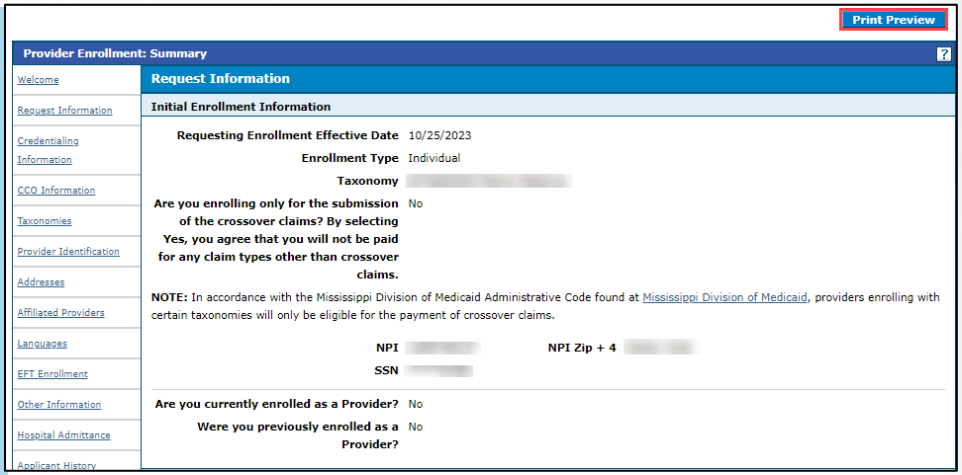


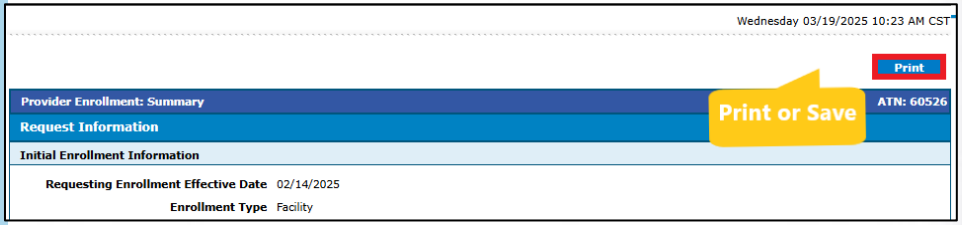
Summary

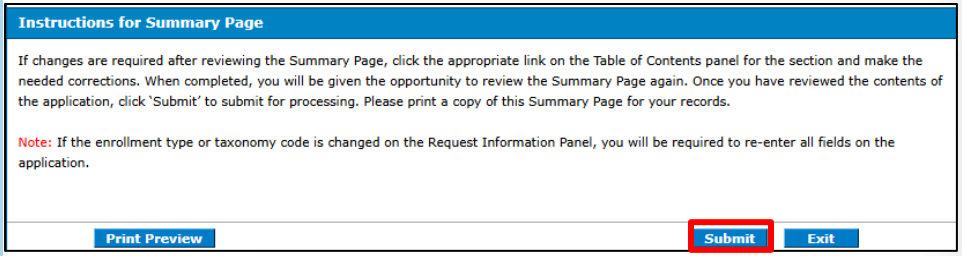
- The **Summary** page shows your entire enrollment application. If any changes need to be made, select the appropriate link on the **Table of Contents** panel (left side) and make needed corrections.

- 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.

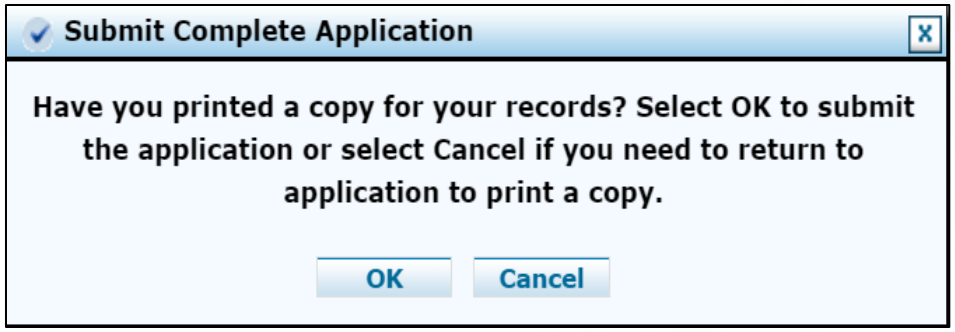






Print a Copy

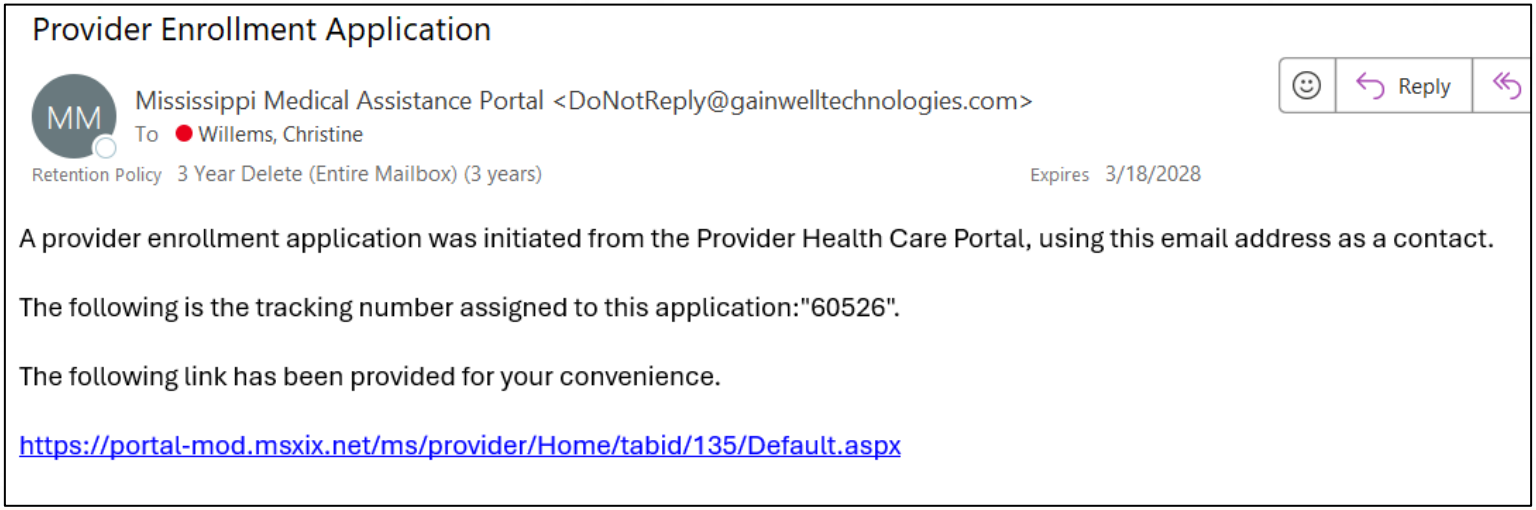
- After selecting **Submit** on the summary page, a box will populate asking if you have printed a copy for your records. If you have **not**, please select "**Cancel**" and print/save a copy.
- Select "**OK**" once you have printed a copy



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

MM

Mississippi Medical Assistance Portal <DoNotReply@gainwelltechnologies.com>

To Willems, Christine

Reply

Retention Policy 3 Year Delete (Entire Mailbox) (3 years) Expires 3/18/2028

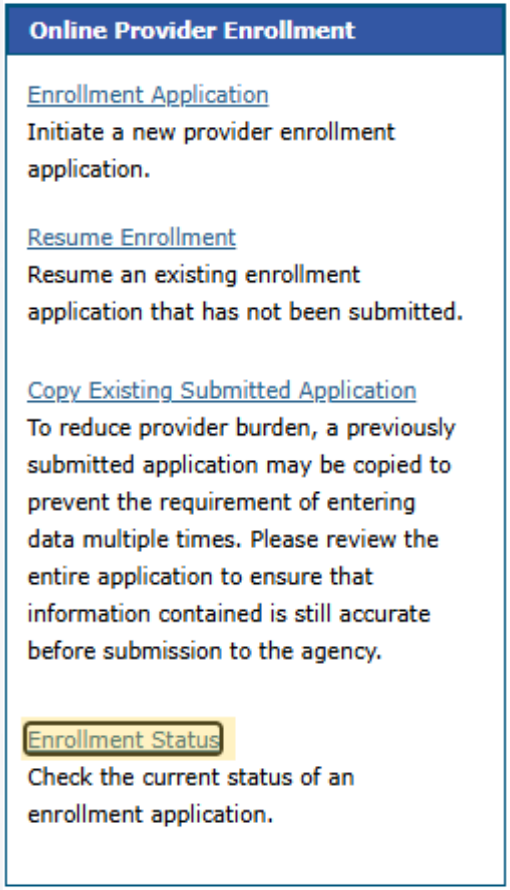
A provider enrollment application was initiated from the Provider Health Care Portal, using this email address as a contact.

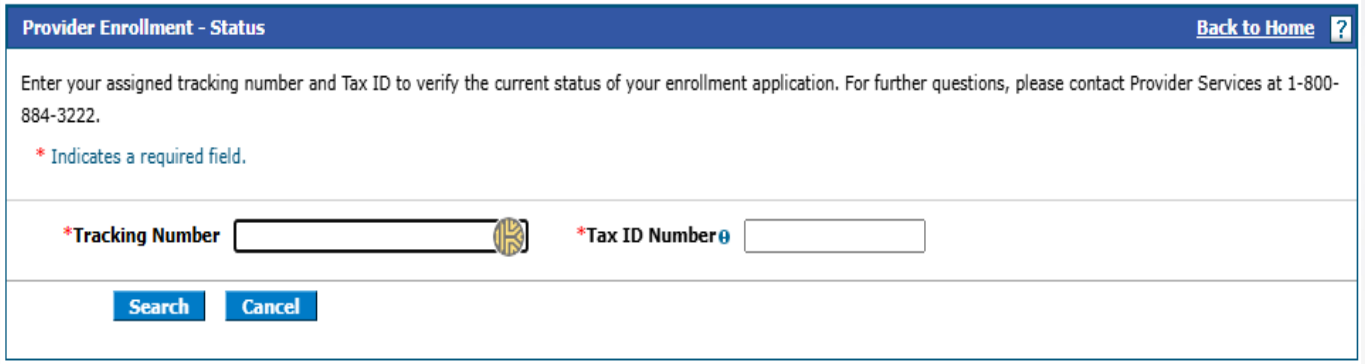
The following is the tracking number assigned to this application:"60526".

The following link has been provided for your convenience.

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

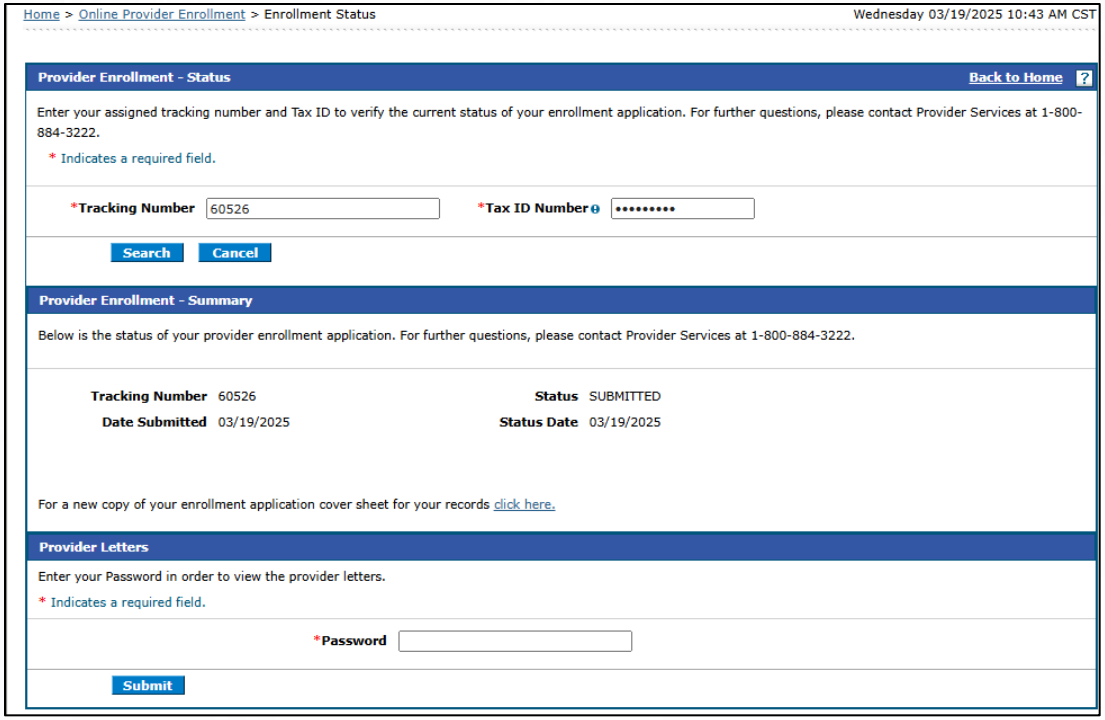
View Application Status





- 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



- 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.