Office of the Governor | Mississippi Division of Medicaid

Provider Revalidation

June 27, 2025

MISSISSIPPI DIVISION OF MEDICAID

Revalidation Facts

Title 42 CFR 455.414 of the Federal Regulations requires all providers, regardless of provider type, to revalidate their enrollment with the Mississippi Division of Medicaid (DOM) at least every 5 years.

Revalidation is the process of validating the current enrollment information on your provider file is accurate and up to date and to collect updated disclosures.

* * *

- Providers will receive a revalidation notification letter **180** days prior to their next revalidation due date.
- Providers revalidation link will be available on their *MESA Provider Portal Home Page.*

Revalidation Facts
Cont'd

- Providers will receive a letter **180** days prior to their revalidation due date and their revalidation link will be available on the Home Page of the MESA Provider Portal.
- There is a list of providers that are due for revalidation on the Division Of Mississippi Medicaid website. See link under Providers>Provider Six-Month Revalidation Due List: **Home - Mississippi Division of Medicaid (ms.gov)**

You will have **60** days to submit your revalidation application from the due date.

- Once the provider's revalidation due date has passed, or the application has been completely submitted, the revalidation link is no longer available on the Provider Portal.

Providers that fail to revalidate or submit supporting documentation by the deadline will be terminated and must re-enroll.

Application Tips

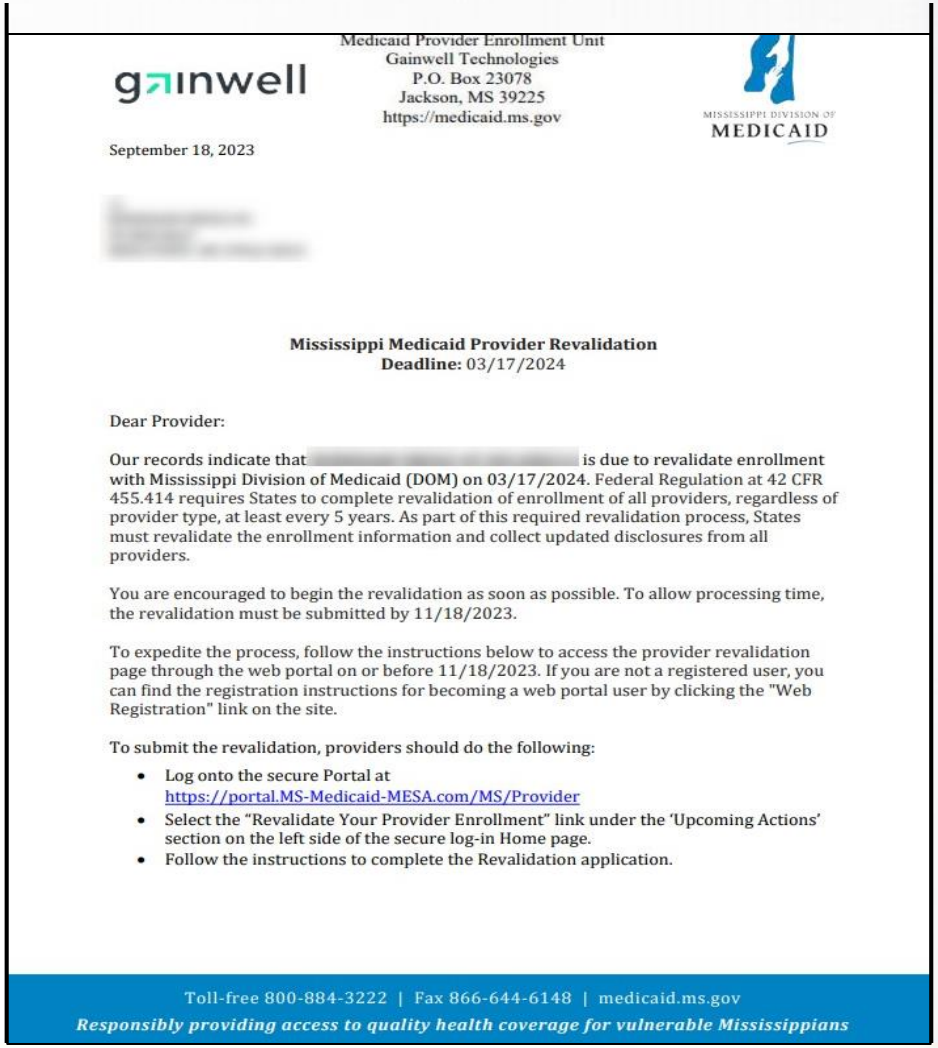
- **Grayed-out** fields cannot be updated.

  If any updates are needed for grayed-out fields, send a **Secure Correspondence** with proof of changes needed or contact:

  Customer Service at **1-800-884-3222**.
- By selecting the "**+**" sign, you can view or update that specified row.
- To remove a row, select the **Remove** link located in that specific row.
- If the disclosing provider is an **individual** or **sole proprietor**, the application must be signed by the individual or sole proprietor.
- If the disclosing provider is a **group/organization**, the signature should be by the person legally authorized to sign on behalf of the group/organization.
- All application attachments must be in **PDF** format.

Sample Revalidation Notice

- You will receive a letter **180** days prior to your revalidation due date.
- The submission date noted in the body of the letter is the **recommended submission date** to allow time for processing before the deadline date. You will see this date on the Provider Portal.
- The **final due date** is shown at the top of this letter.



Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 23078
Jackson, MS 39225
https://medicaid.ms.gov

MISSISSIPPI DIVISION OF MEDICAID

September 18, 2023

[redacted]

Mississippi Medicaid Provider Revalidation
Deadline: 03/17/2024

Dear Provider:

Our records indicate that [redacted] is due to revalidate enrollment with Mississippi Division of Medicaid (DOM) on 03/17/2024. Federal Regulation at 42 CFR 455.414 requires States to complete revalidation of enrollment of all providers, regardless of provider type, at least every 5 years. As part of this required revalidation process, States must revalidate the enrollment information and collect updated disclosures from all providers.

You are encouraged to begin the revalidation as soon as possible. To allow processing time, the revalidation must be submitted by 11/18/2023.

To expedite the process, follow the instructions below to access the provider revalidation page through the web portal on or before 11/18/2023. If you are not a registered user, you can find the registration instructions for becoming a web portal user by clicking the "Web Registration" link on the site.

To submit the revalidation, providers should do the following:

- Log onto the secure Portal at https://portal.MS-Medicaid-MESA.com/MS/Provider
- Select the "Revalidate Your Provider Enrollment" link under the 'Upcoming Actions' section on the left side of the secure log-in Home page.
- Follow the instructions to complete the Revalidation application.

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

Sample Revalidation Notice Cont'd

Current provider information allows the Medicaid Program to send appropriate communications, make accurate and timely payments on your Medicaid claims, as well as ensure that correct information is included in the provider directory. By complying with the revalidation process prior to your due date, there will not be a disruption in the processing of claims filed.

Failure to submit all the information required in the revalidation by the due date above may cause your enrollment to be terminated and your claims to be denied. A new application will be required to re-enroll in the Mississippi Medicaid program.

In accordance with Federal Regulation at 42 CFR 455.460 and 42 CFR 424.514, certain providers applying to participate in the Medicaid program are required to pay an application fee unless you meet one of the exemptions.

Additionally, if the revalidation is not completed in the allotted time and the provider is also enrolled with one or all MississippiCAN Coordinated Care Organizations (CCO), Magnolia Health, United Healthcare Community Plan, and Molina Healthcare, enrollment with the CCO(s) will be terminated.

Providers are able to track the status of their revalidation application after the materials are submitted by doing the following:

- Access Provider Portal at https://portal.MS-Medicaid-MESA.com/MS/Provider
- Select Provider Enrollment Access link from the left-hand side of the page.
- Select Enrollment Status link under the Online Provider Enrollment section on the left-hand side of the Provider Enrollment page.
- Enter Application Tracking Number (provided after submitting the revalidation application) to view the status of the application.

Thank you for your prompt response to this request. Please contact Provider Services staff at 1-800-884-3222 with any inquiries between the hours of 8:00 a.m. and 5:00 p.m. CST, Monday through Friday.

Sincerely,

Provider Services

- The letter contains important information about **revalidating**.
- Also, the letter includes a link to the secure Provider Portal.

Submitting a Revalidation Application

You have received your letter and are ready to log onto the MESA Provider Portal.

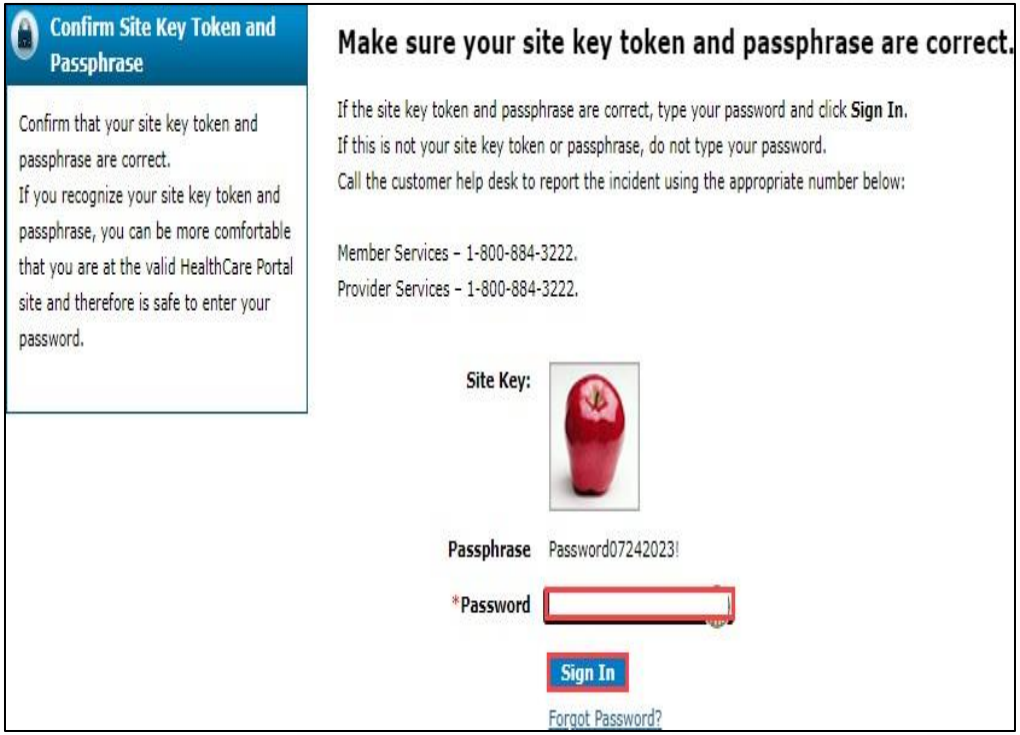
To access the MESA Provider Portal, use the link on DOM's website: *Home > Provider Portal > Provider Log in*.

MESA Portal for Providers
ms.gov

Enter your User ID and select , "**Log In**".

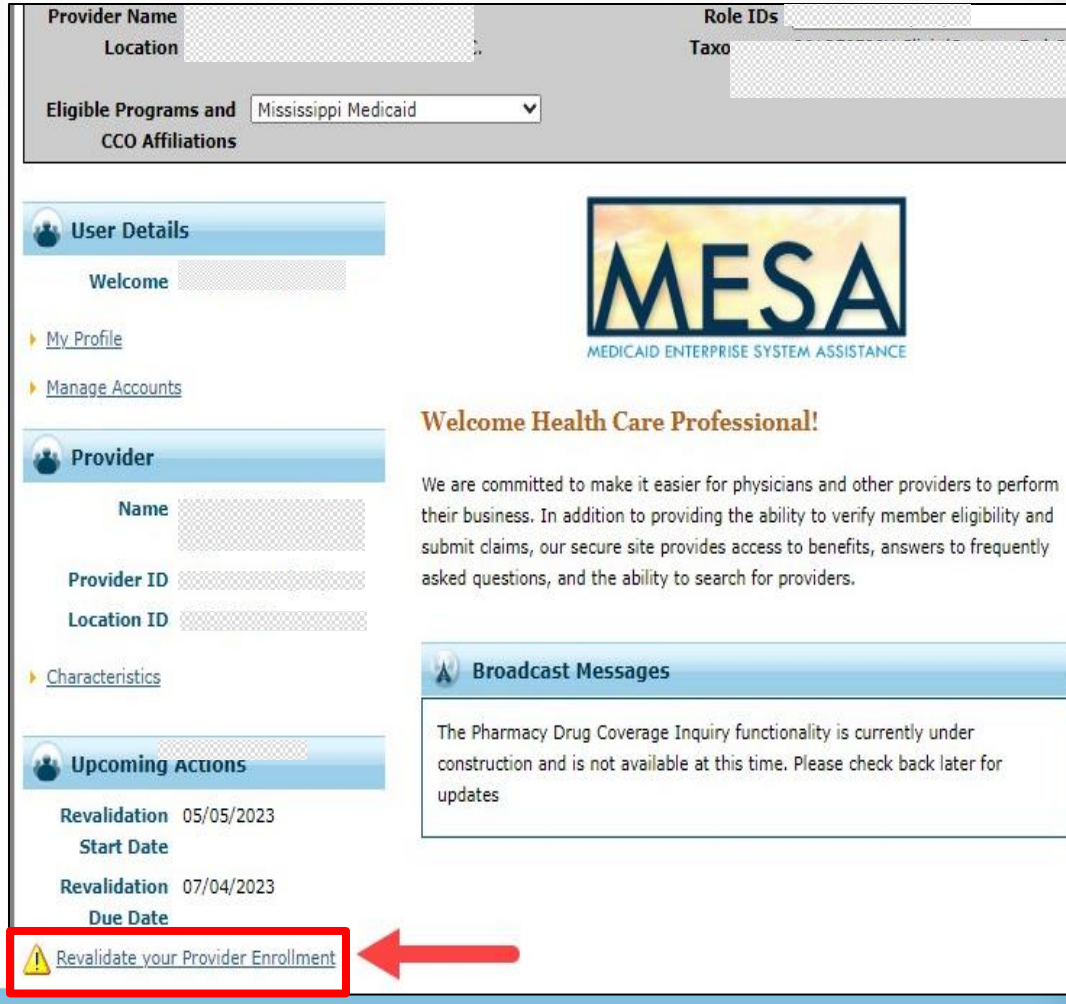
Submitting a Revalidation Application Cont'd

- Enter your password and select "Sign In".
- Make sure your site key picture and passphrase are correct.



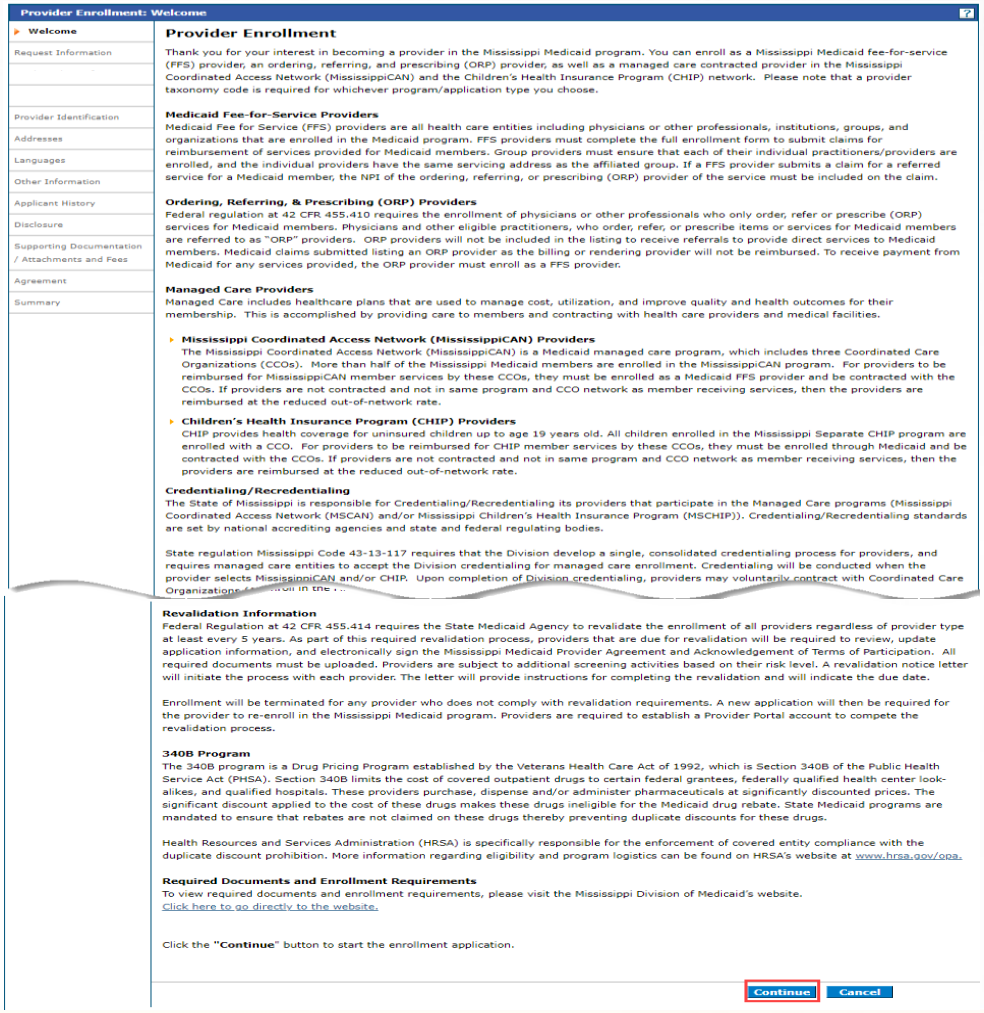
Submitting a Revalidation Application Cont'd

- After logging in, select the "**Revalidate your Provider Enrollment**" link on the Home page.
- Reminder, if you have already submitted your application or are past the due date, this link will no longer be available.



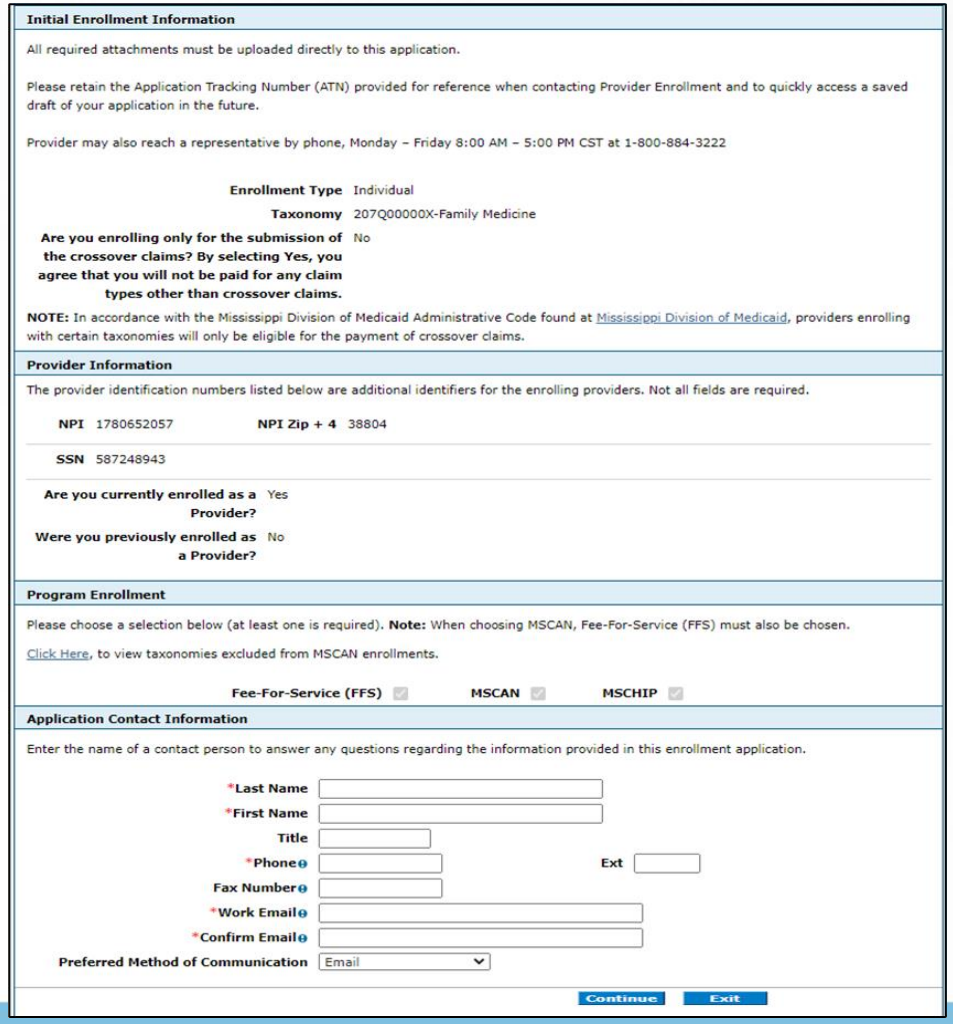
Welcome Page

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



Request Information Page

- Update the **Application Contact Information** and Select "**Continue**" to the Provider Identification Page**.**
- This is the only portion on this page that must be updated.
- Next, are the steps to create a password.



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

Enrollment Type Individual

Taxonomy 207Q00000X-Family Medicine

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. No

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

Provider Information

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

NPI 1780652057 **NPI Zip + 4** 38804

SSN 587248943

Are you currently enrolled as a Provider? Yes

Were you previously enrolled as a Provider? No

Program Enrollment

Please choose a selection below (at least one is required). **Note:** When choosing MSCAN, Fee-For-Service (FFS) must also be chosen.

Click Here, to view taxonomies excluded from MSCAN enrollments.

Fee-For-Service (FFS) **MSCAN** **MSCHIP**

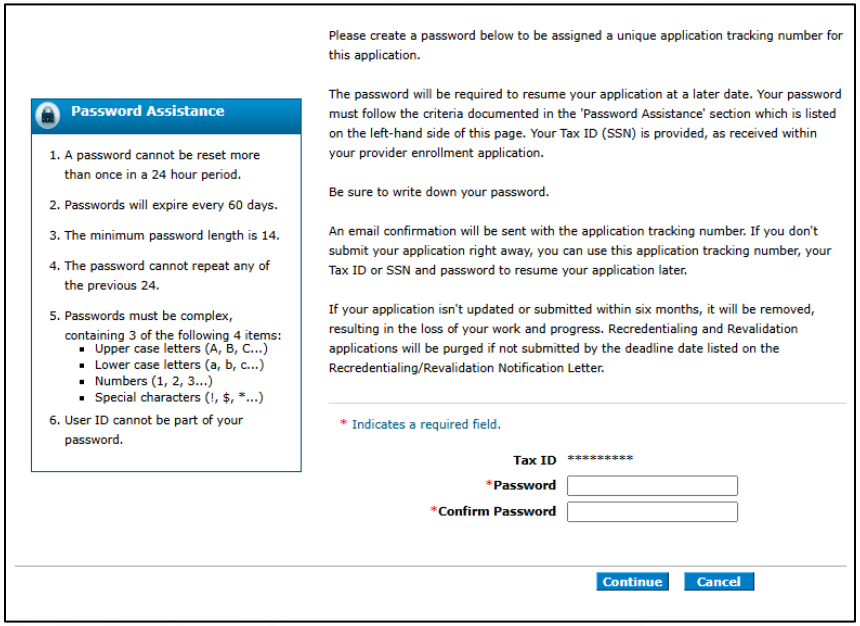
Application Contact Information

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

*Last Name
*First Name
Title
*Phone Ext
Fax Number
*Work Email
*Confirm Email
Preferred Method of Communication Email

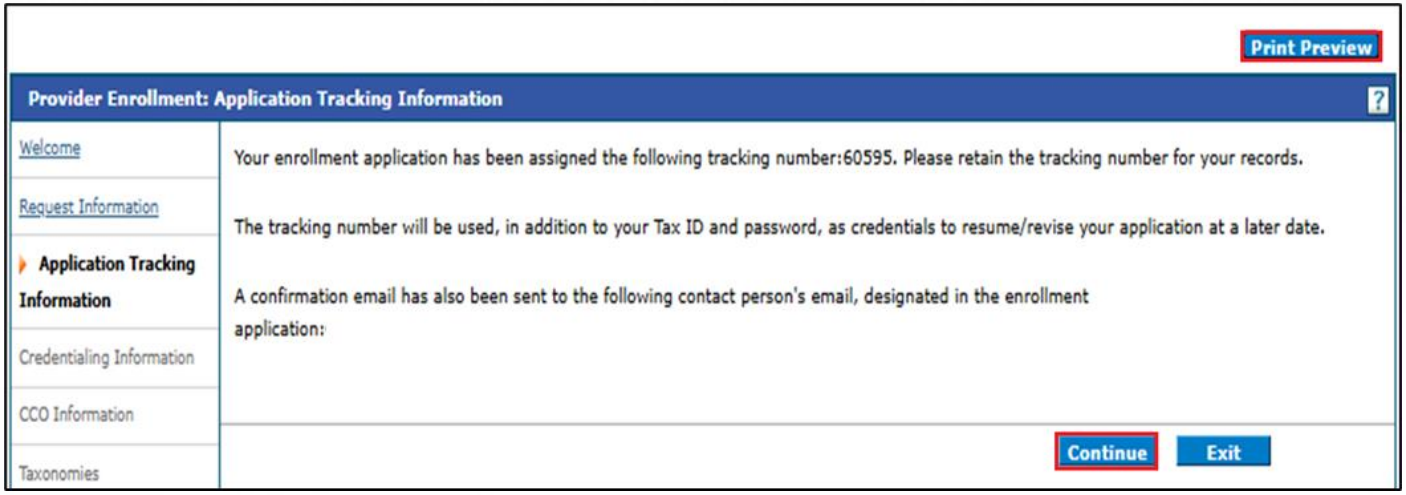
Continue Exit

Create a Password



- Create a password to be assigned a unique application tracking number for this application.
- This password will allow you to resume your application at a later date.
- Passwords must follow the criteria documented in the **Password Assistance** section on the left side of the page.

Application Tracking Number



- You will receive confirmation that will include your application tracking number. You will need this number and the Tax ID number to view completed application status or to Resume Recredentialing.

Provider Identification Page

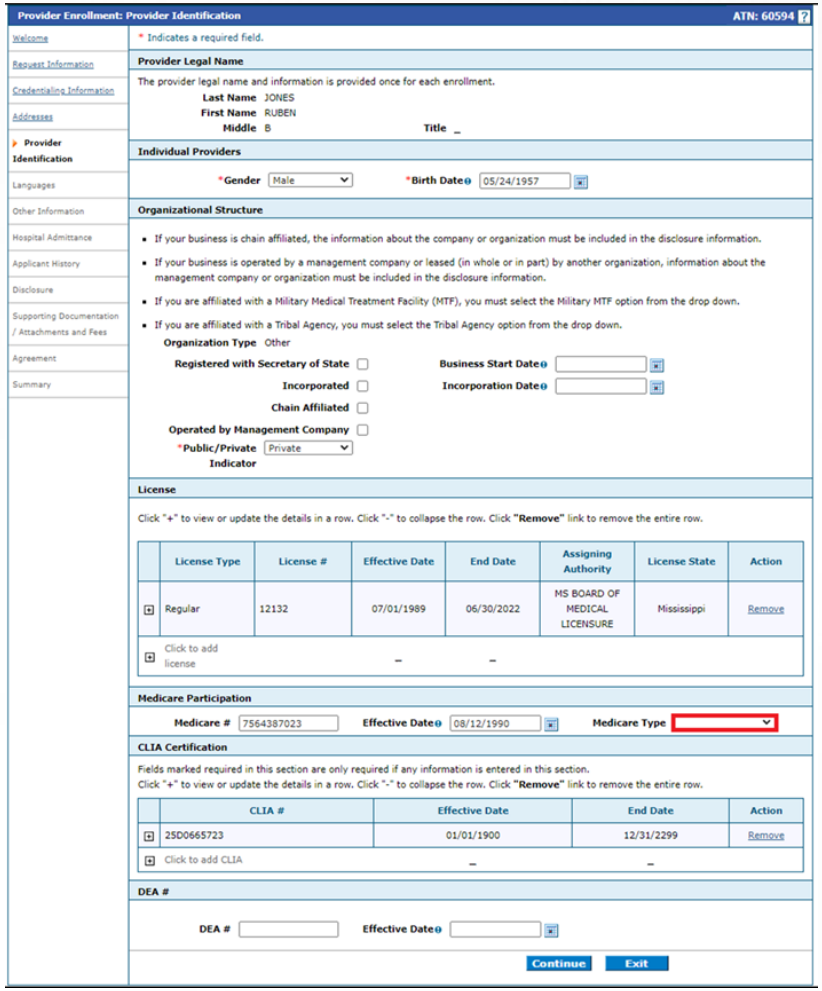
Make sure all the information is correct in each section and make any necessary updates.

If a license has been extended, please update the **End Date** for that License. Select "**+**" to expand that field and update the end date.

If you have a new license, make sure to add it in the license section. You must select "**Add**" after you have entered the required information.

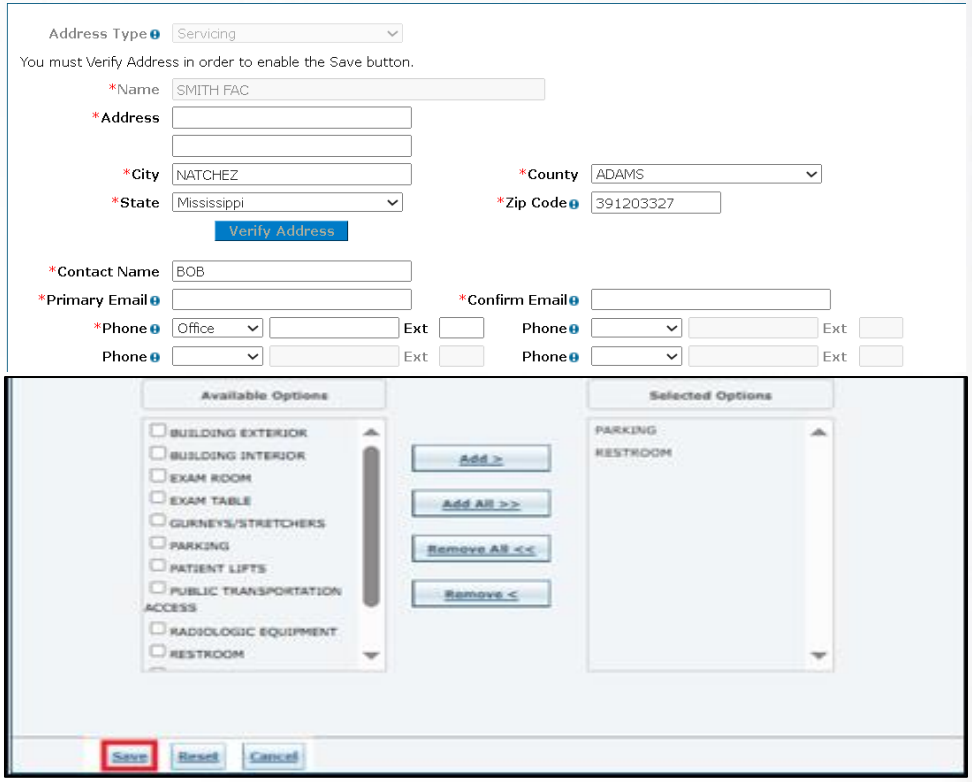
To remove a specific license, you will expand the section by clicking "**+**" and select the "**Remove**" link and that license will be removed.

Once all updated information has been entered, select **Continue** to the **Address** page.

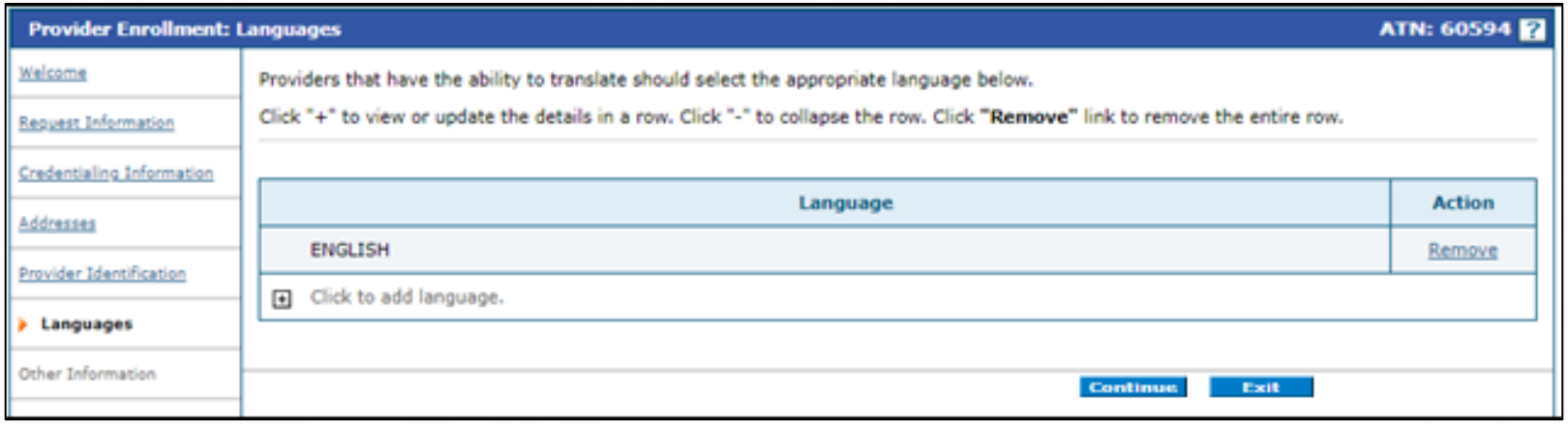


Address Page

- Make all updates to each section. The **Pay To** and **Servicing Address may** be updated on the application, but the **Name** cannot be changed.
- The **primary contact information** for the **Servicing Address** can be updated as well as the other addresses, if applicable.
- After all updates have been made, you **must** select **"Save"** otherwise the data will not be saved.
- Select **Continue** to the **Language page**.

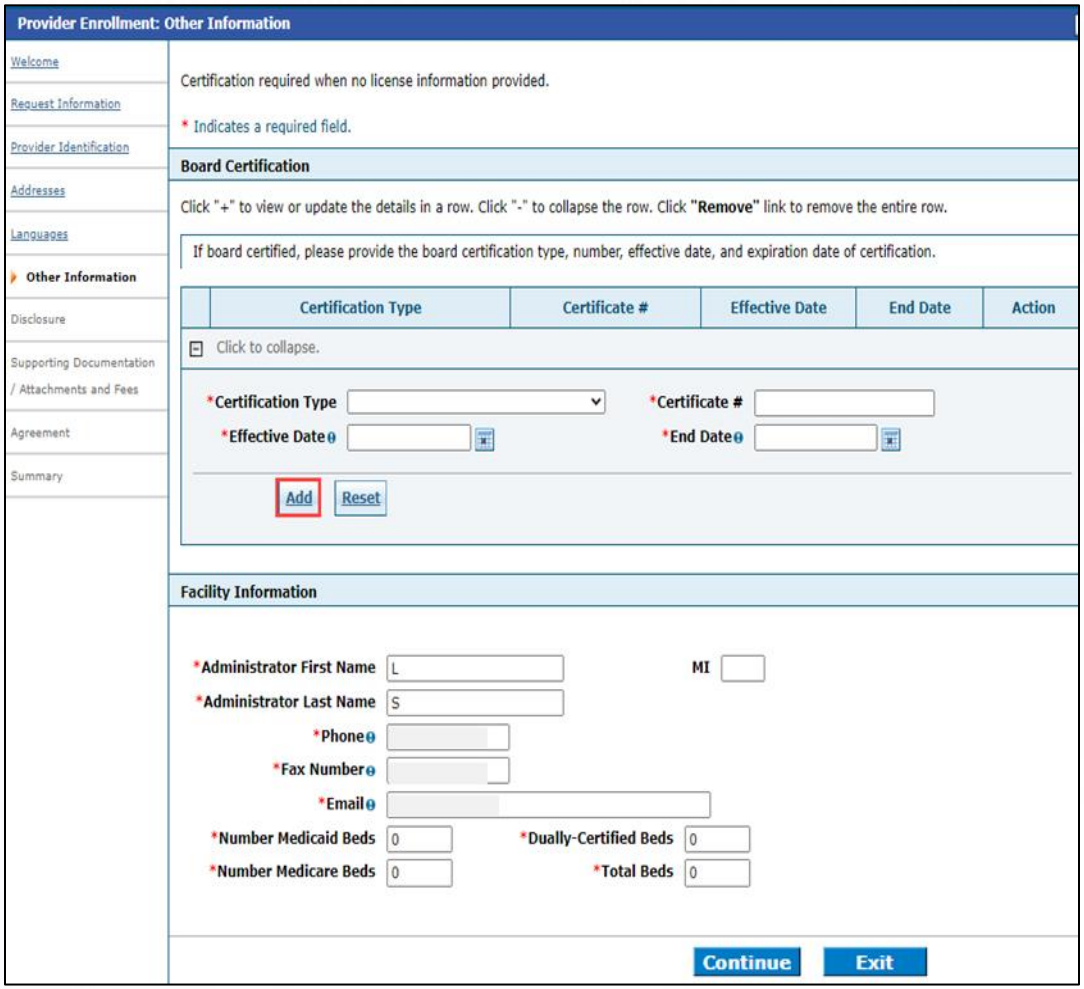


Language Page



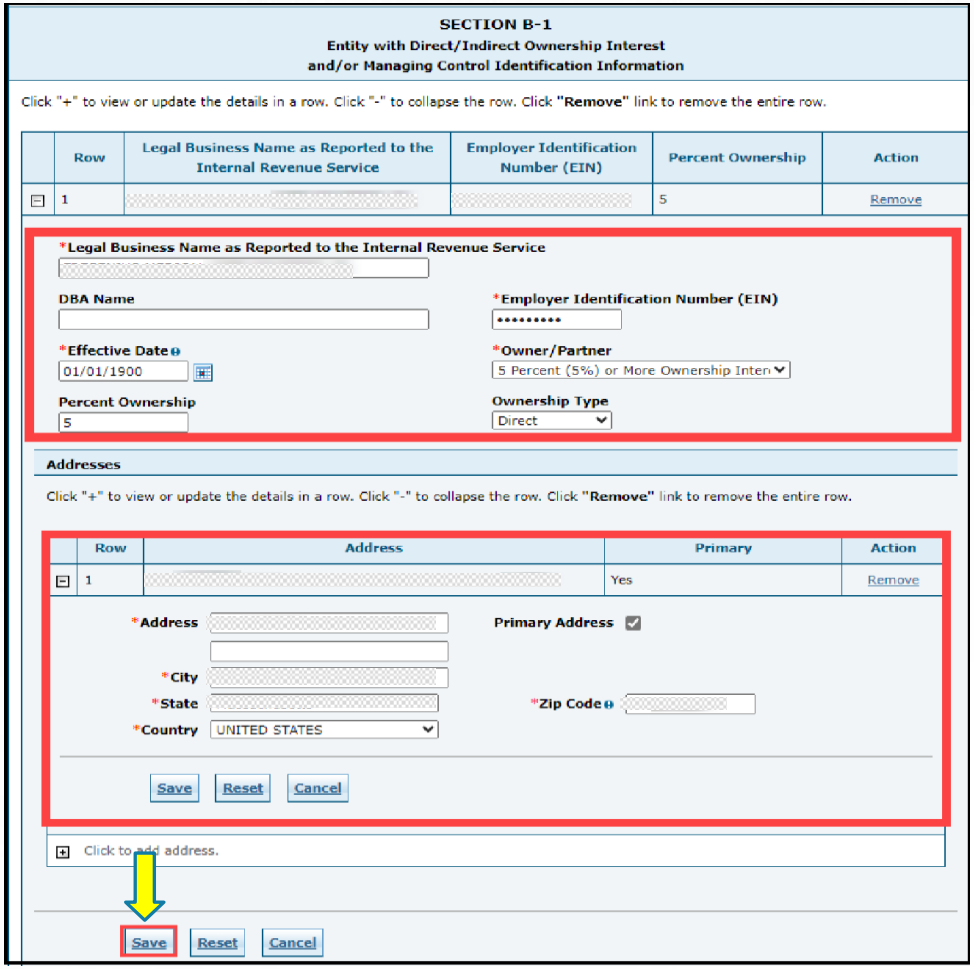
Make any necessary updates and select **Continue**, to the Other Information page.

Other Information Page



- Make any updates needed to each section.
- If you have a certification type noted in the dropdown list that needs to be added, complete the fields, then select **Add.**
- **Facility Information** will only populate if you are facility provider.
- Select **Continue** to the Disclosure page.

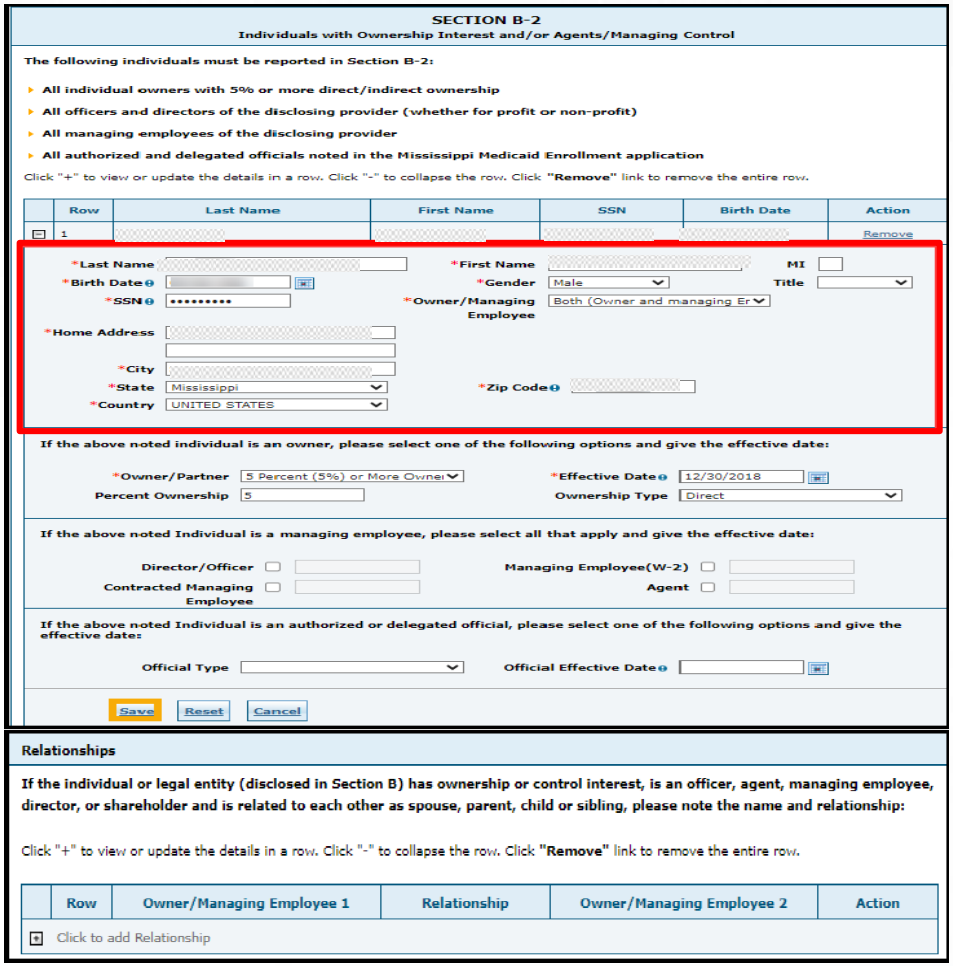
Disclosure Page
Section B-1



- Check each section and make any necessary updates.
- To view or update a row select the **+** sign.
- To remove a row, select the **Remove** link.
- **Save** must be selected after the updates have been made.

Disclosure Page
Section B-2

- Check each section and make any necessary updates.
- **Save** must be selected after the updates have been made.



Disclosure Page
Section C & D

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 add Conviction/Sanction				

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.

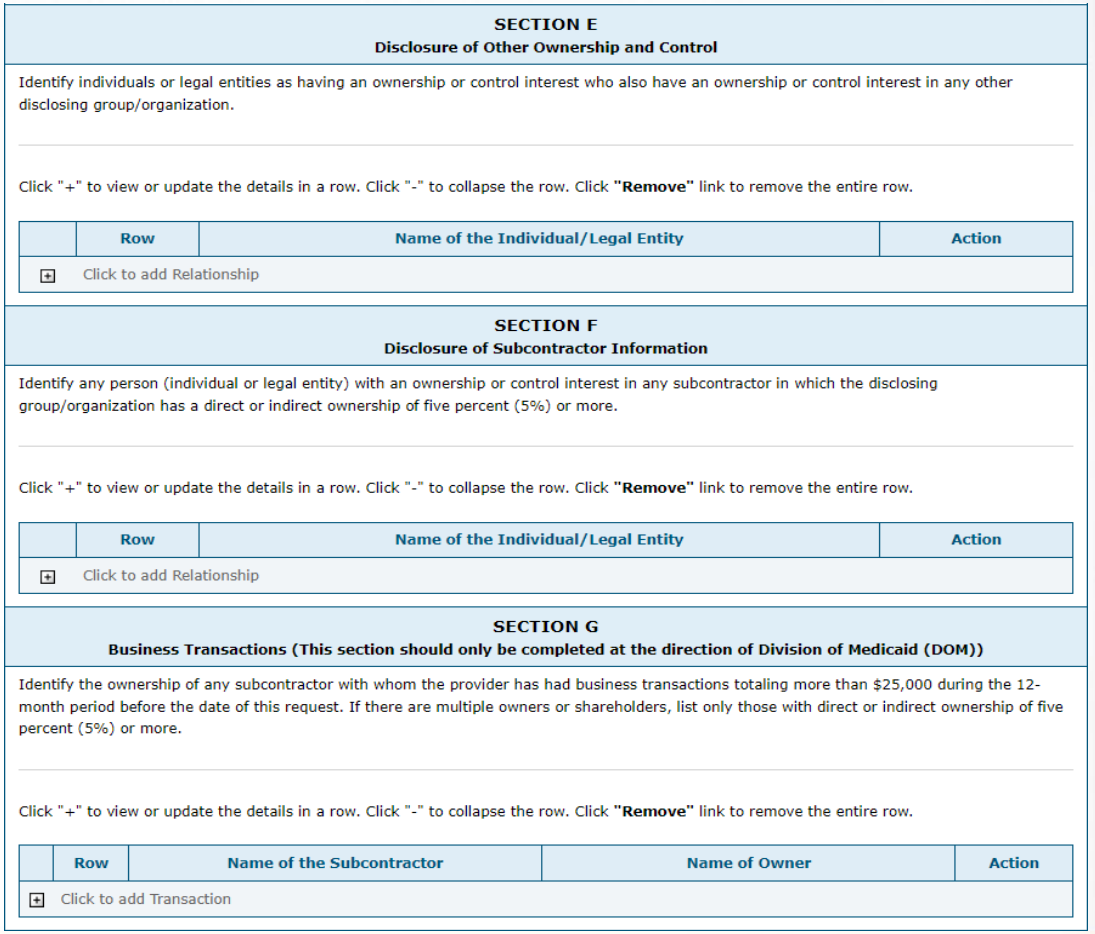
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "**Remove**" link to remove the entire row.

	Row	Name	Relationship	Action
⊞	Click to add Relationship			

- Check each section and make any necessary updates.
- **Save** must be selected after the updates have been made.

Disclosure Page
Section E, F, & G

- Check each section and make any necessary updates.
- **Save** must be selected after the updates have been made.



SECTION E
Disclosure of Other Ownership and Control

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

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

	Row	Name of the Individual/Legal Entity	Action
⊞	Click to add Relationship		

SECTION F
Disclosure of Subcontractor Information

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

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

	Row	Name of the Individual/Legal Entity	Action
⊞	Click to add Relationship		

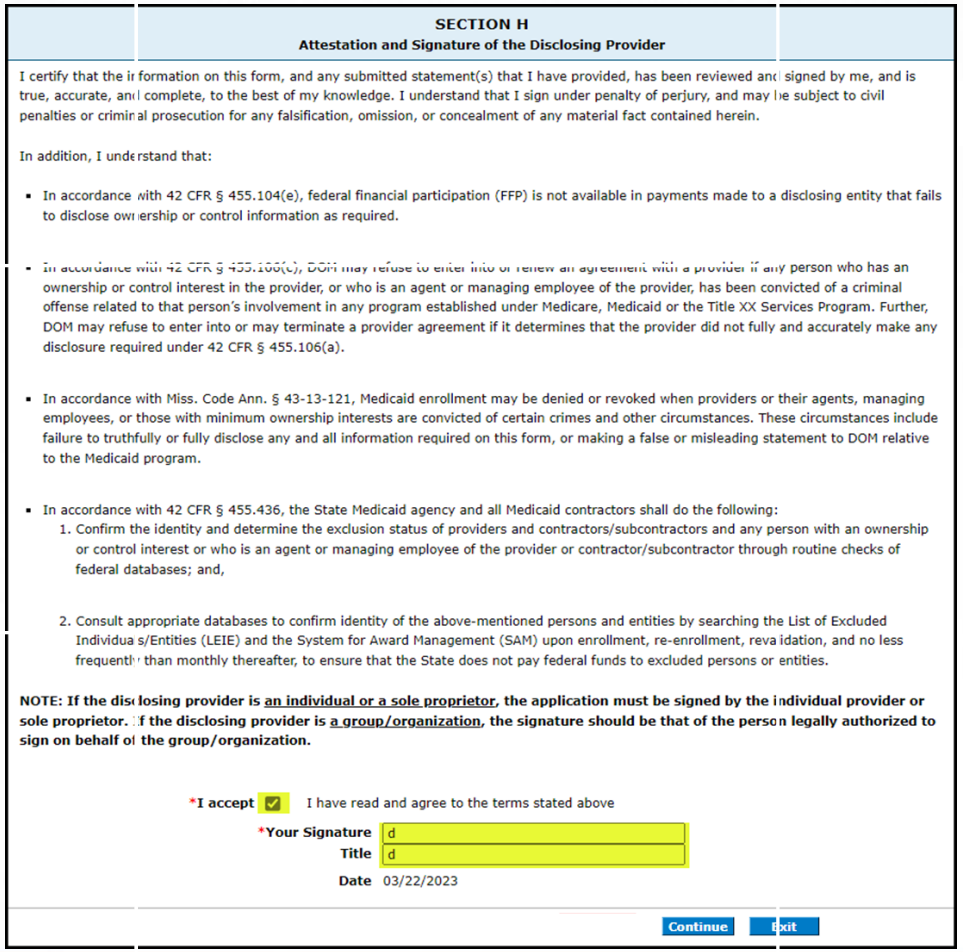
SECTION G
Business Transactions (This section should only be completed at the direction of Division of Medicaid (DOM))

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

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

	Row	Name of the Subcontractor	Name of Owner	Action
⊞	Click to add Transaction			

Disclosure Page
Section H



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 d

Title d

Date 03/22/2023

Continue Exit

Read

Once all updates are made in each section, **read** instructions and **select** " I accept".

Enter

Enter the required **signature** (the Authorized Official or the Enrolling Individual provider) and **title.**

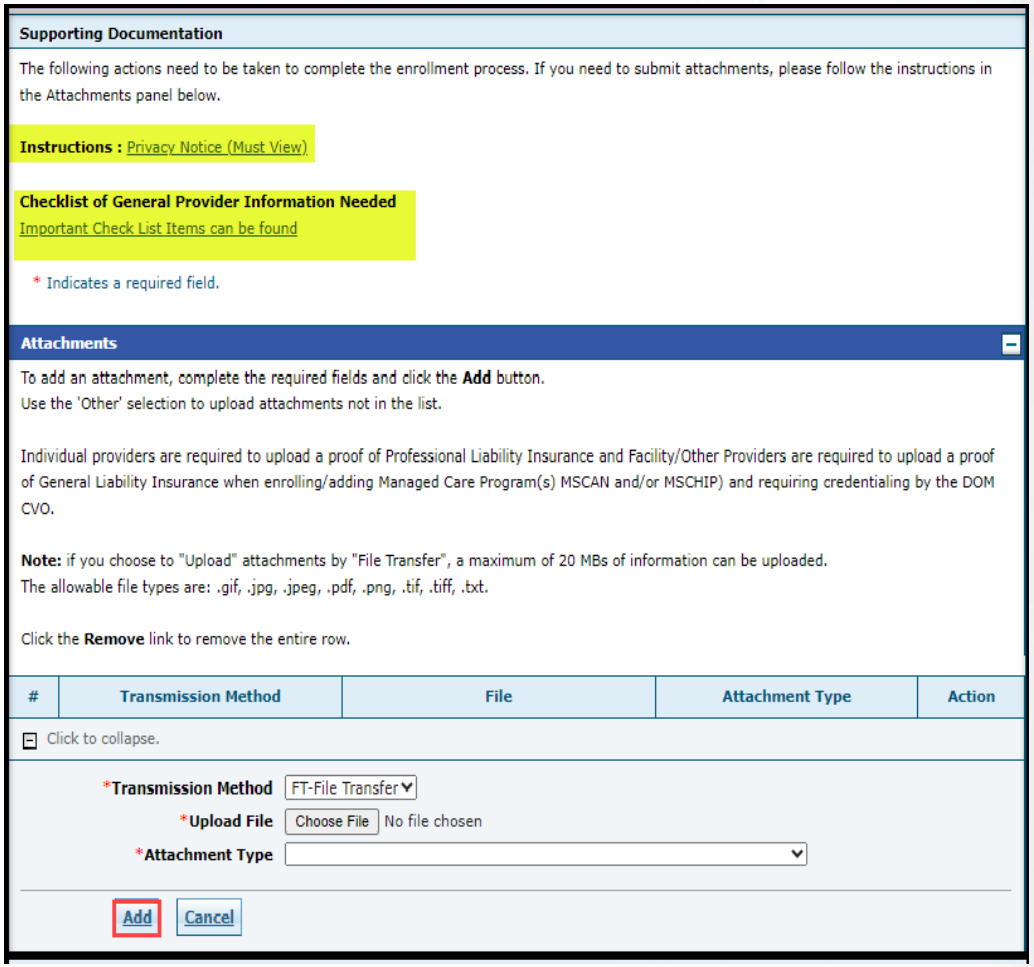
Select

Select **Continue.**

Supporting Documentation
Attachments

- The ***Privacy Notice*** link must be selected in order to continue to the next page.

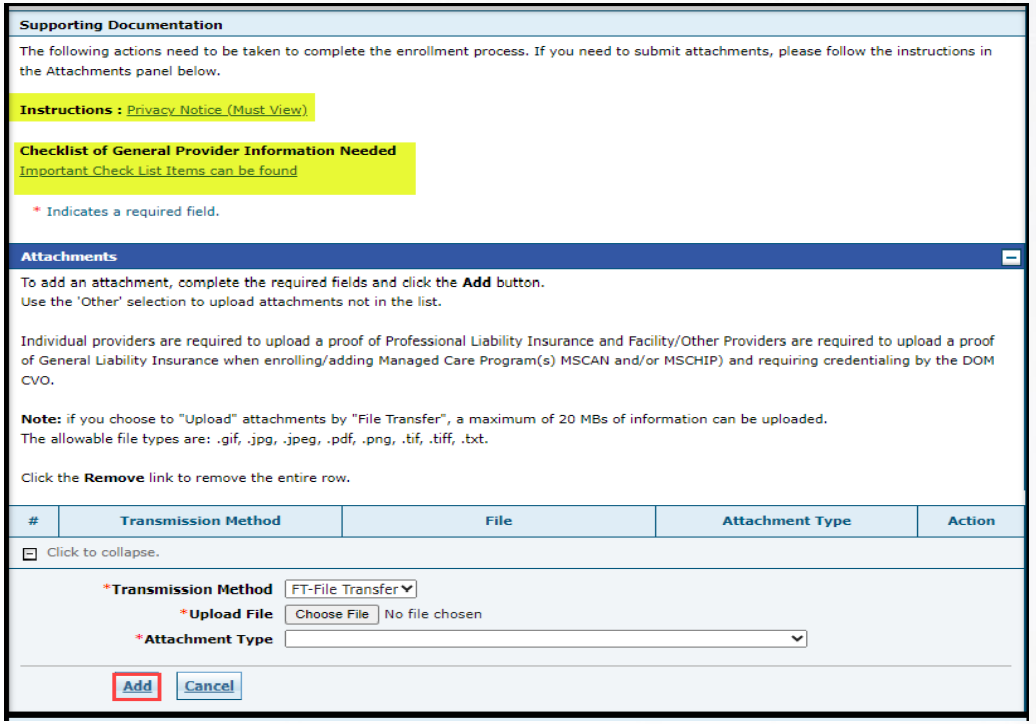
  The link directs you to the *Division of MS Medicaid* page.
- If all your documents are combined into one file, select Attachment Type "**All**" to add as one PDF document.
- When adding each document separately, choose the appropriate **Attachment Type** for each document.



Supporting Documentation

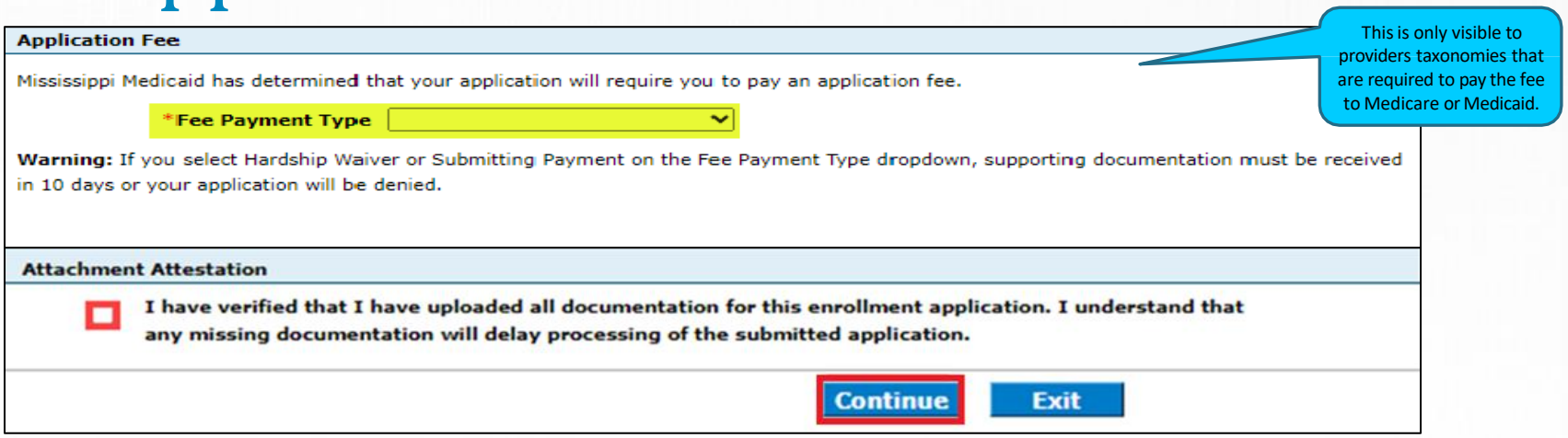
Attachments cont'd

- **Add** must be selected to **add** the attachment(s).
- **Individual** Providers must attach proof of **Professional** Liability Insurance.
- **Facility** and **Other** Providers must attach proof of **General** Liability Insurance.
- All forms can be located at: *Forms - Mississippi Division of Medicaid*



Supporting Documentation

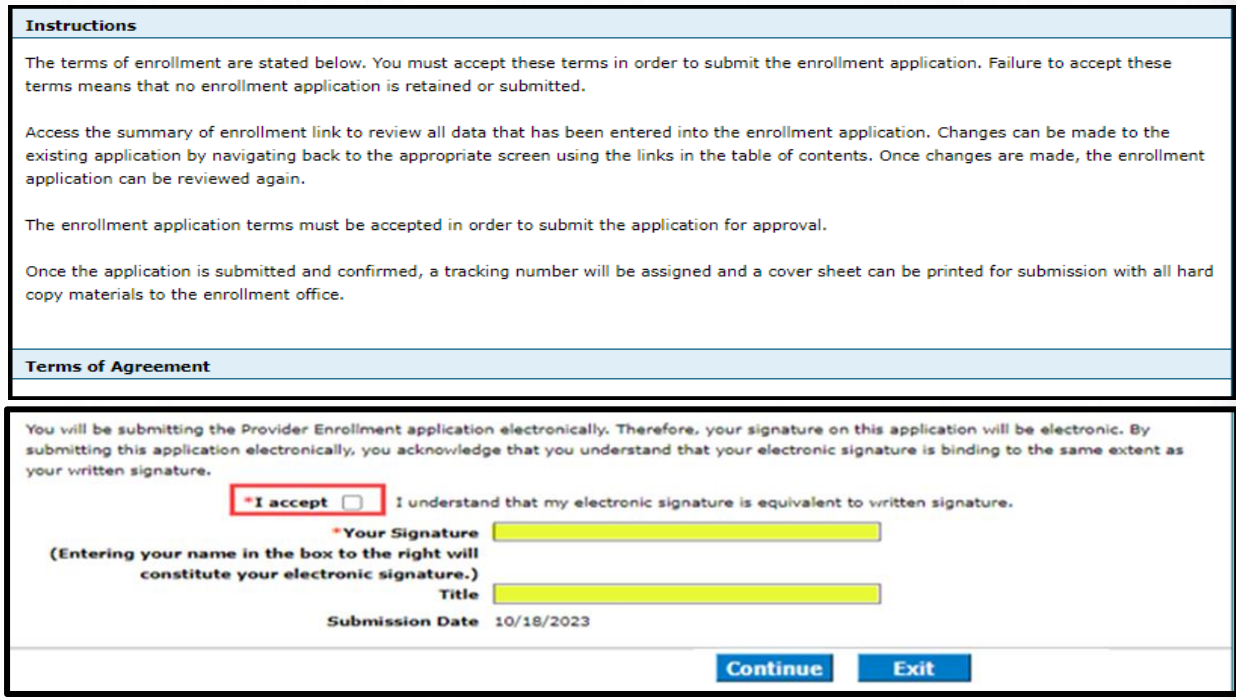
Application Fees and Attestation



- Select the appropriate **Fee Payment Type**.
  - *Application Fee section will only be visible to providers taxonomies that are required to pay the fee to Medicare or Medicaid.*
  - The ***Provider Enrollment Application Fee*** link can be utilized to verify if your taxonomy code is required to pay an application fee.
- Select the check box under *Attestation Statement*
- Select **Continue** to the Agreement page.

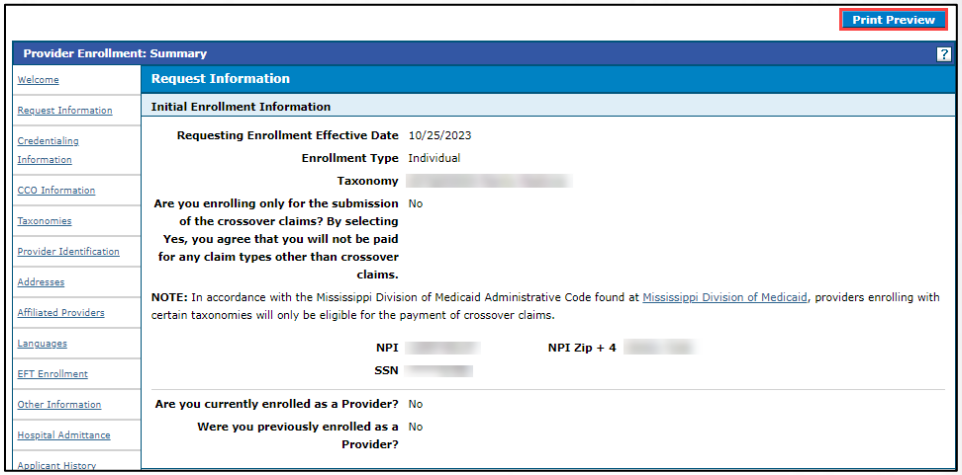
Agreement Page

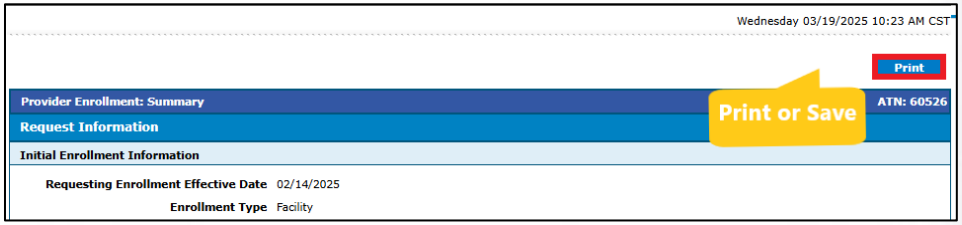
- Read all the instructions until you reach the bottom of the page.
- Select "**I Accept**".
- Enter the **Signature** of the **Provider or Authorized Representative.** Enter the **Title** (if applicable).
- Select **Continue** to advance to the **Summary** page.

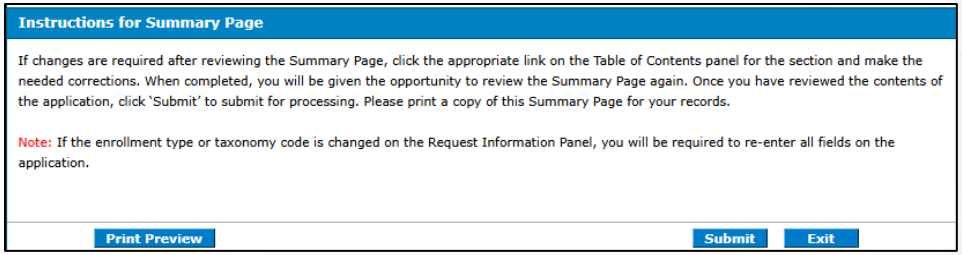


Summary Page

- 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.

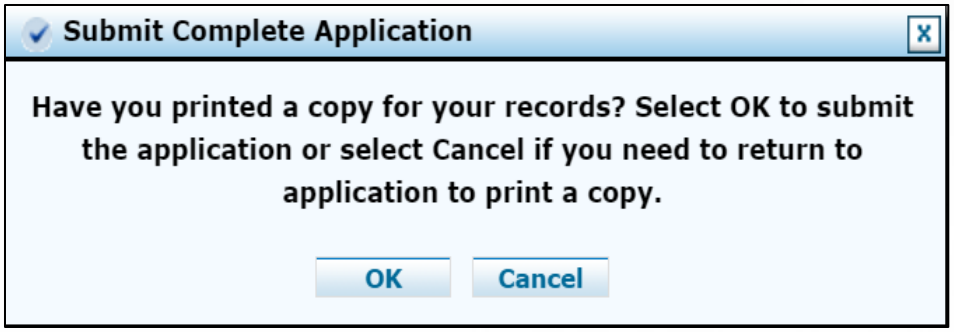




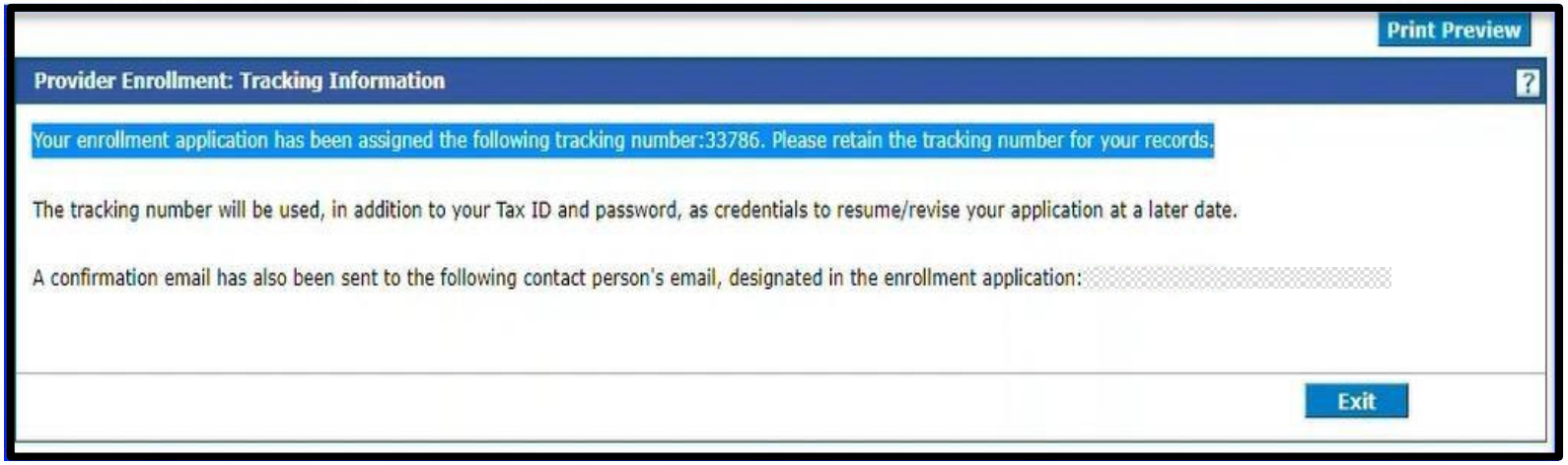


Print a Copy

- 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.



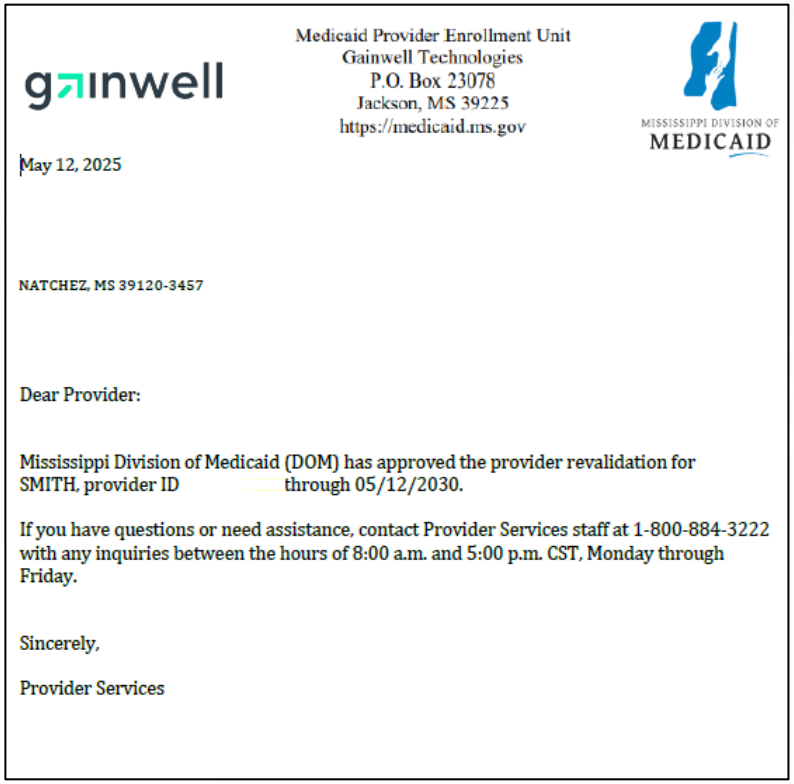
Tracking Information



- Your application has been submitted. An Application Tracking Number (**ATN**) is provided and will be emailed to you.
- Select **Print Preview** to save or print this information.
- Use your **ATN** to check the status of your application and make updates requested from Gainwell through the Provider Portal.
- Any documents faxed or mailed to Gainwell should reference your ATN.
- Select **Exit** to exit the portal.

Sample Revalidation Approval Letter

- Once your Revalidation Application has been approved, you will receive an approval letter with the date you are approved through.
- You can also log into your provider portal and select the **View Letters** link at the top of the portal.



gainwell

Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 23078
Jackson, MS 39225
https://medicaid.ms.gov

MISSISSIPPI DIVISION OF MEDICAID

May 12, 2025

NATCHEZ, MS 39120-3457

Dear Provider:

Mississippi Division of Medicaid (DOM) has approved the provider revalidation for SMITH, provider ID through 05/12/2030.

If you have questions or need assistance, contact Provider Services staff at 1-800-884-3222 with any inquiries between the hours of 8:00 a.m. and 5:00 p.m. CST, Monday through Friday.

Sincerely,

Provider Services