

Office of the Governor | Mississippi Division of Medicaid

Provider Revalidation

June 27, 2025



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	
September 18, 2023		
		
Mississippi Medicaid Provider Revalidation Deadline: 03/17/2024		
Dear Provider:		
<p>Our records indicate that  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.</p> <p>You are encouraged to begin the revalidation as soon as possible. To allow processing time, the revalidation must be submitted by 11/18/2023.</p> <p>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.</p> <p>To submit the revalidation, providers should do the following:</p> <ul style="list-style-type: none">• 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 <i>Responsibly providing access to quality health coverage for vulnerable Mississippians</i>		

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**.

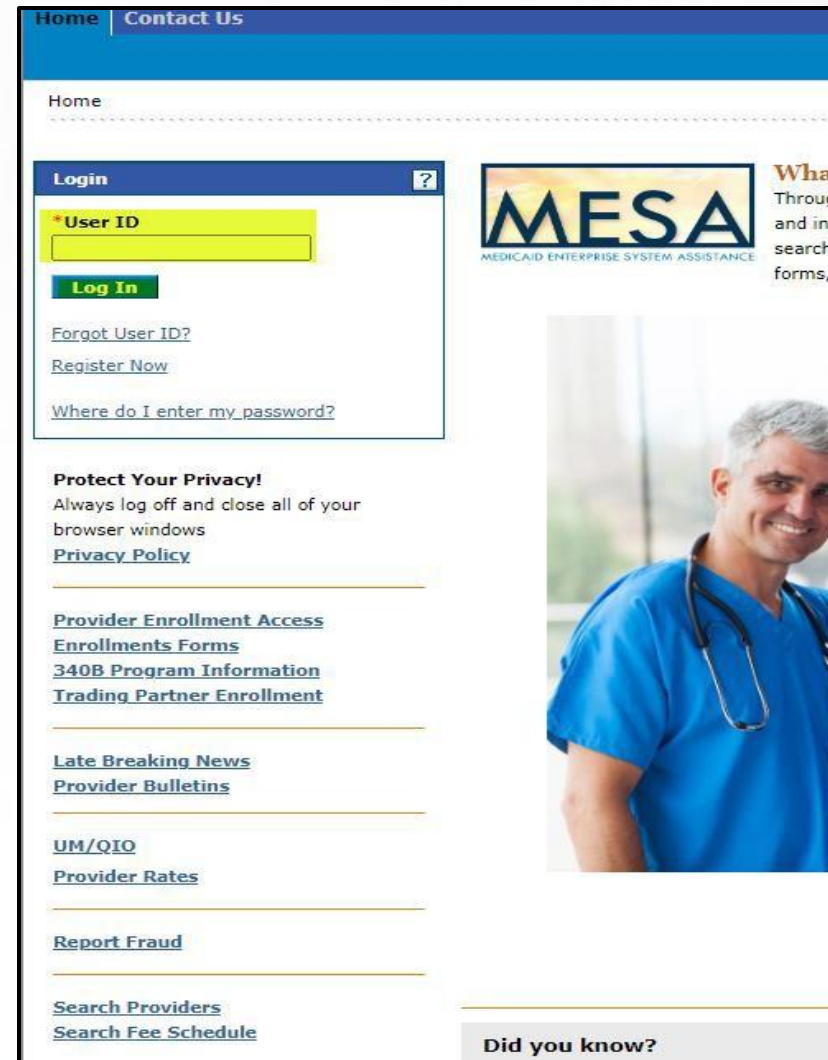
Submitting a Revalidation Application

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”.




The screenshot shows the MESA Provider Portal login page. At the top, there are links for 'Home' and 'Contact Us'. Below this, the 'Home' section contains a 'Login' box with a yellow background for the 'User ID' field and a green 'Log In' button. Links for 'Forgot User ID?', 'Register Now', and 'Where do I enter my password?' are provided. To the right of the login box is the MESA logo with the text 'MEDICAID ENTERPRISE SYSTEM ASSISTANCE' and a partial view of a doctor in blue scrubs. Below the login box, there are sections for 'Protect Your Privacy!' with a 'Privacy Policy' link, 'Provider Enrollment Access' with links for 'Enrollments Forms', '340B Program Information', and 'Trading Partner Enrollment', 'Late Breaking News' with a 'Provider Bulletins' link, 'UM/QIO' with a 'Provider Rates' link, and 'Report Fraud'. At the bottom, there are links for 'Search Providers' and 'Search Fee Schedule'. A 'Did you know?' section is visible at the very bottom right.

Submitting a Revalidation Application

Cont'd

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


**Confirm Site Key Token and Passphrase**

Confirm that your site key token and passphrase are correct.
If you recognize your site key token and passphrase, you can be more comfortable that you are at the valid HealthCare Portal site and therefore is safe to enter your password.

Make sure your site key token and passphrase are correct.

If the site key token and passphrase are correct, type your password and click **Sign In**.
If this is not your site key token or passphrase, do not type your password.
Call the customer help desk to report the incident using the appropriate number below:

Member Services – 1-800-884-3222.
Provider Services – 1-800-884-3222.

Site Key: 

Passphrase Password07242023!

***Password**

Sign In
[Forgot Password?](#)

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.

Provider Name [Redacted] Role IDs [Redacted]
Location [Redacted] Taxo [Redacted]

Eligible Programs and CCO Affiliations: Mississippi Medicaid

User Details
Welcome [Redacted]
[My Profile](#)
[Manage Accounts](#)

Provider
Name [Redacted]
Provider ID [Redacted]
Location ID [Redacted]
[Characteristics](#)

Upcoming Actions
Revalidation Start Date: 05/05/2023
Revalidation Due Date: 07/04/2023
Revalidate your Provider Enrollment

MESA
MEDICAID ENTERPRISE SYSTEM ASSISTANCE

Welcome Health Care Professional!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Broadcast Messages
The Pharmacy Drug Coverage Inquiry functionality is currently under construction and is not available at this time. Please check back later for updates.

Welcome Page

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

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.
Provider Identification	Medicaid Fee-for-Service Providers Medicaid Fee for Service (FFS) providers are all health care entities including physicians or other professionals, institutions, groups, and organizations that are enrolled in the Medicaid program. FFS providers must complete the full enrollment form to submit claims for reimbursement of services provided for Medicaid members. Group providers must ensure that each of their individual practitioners/providers are enrolled, and the individual providers have the same servicing address as the affiliated group. If a FFS provider submits a claim for a referred service for a Medicaid member, the NPI of the ordering, referring, or prescribing (ORP) provider of the service must be included on the claim.
Addresses	Ordering, Referring, & Prescribing (ORP) Providers Federal regulation at 42 CFR 455.410 requires the enrollment of physicians or other professionals who only order, refer or prescribe (ORP) services for Medicaid members. Physicians and other eligible practitioners, who order, refer, or prescribe items or services for Medicaid members are referred to as "ORP" providers. ORP providers will not be included in the listing to receive referrals to provide direct services to Medicaid members. Medicaid claims submitted listing an ORP provider as the billing or rendering provider will not be reimbursed. To receive payment from Medicaid for any services provided, the ORP provider must enroll as a FFS provider.
Languages	Managed Care Providers Managed Care includes healthcare plans that are used to manage cost, utilization, and improve quality and health outcomes for their membership. This is accomplished by providing care to members and contracting with health care providers and medical facilities.
Other Information	<ul style="list-style-type: none">➤ Mississippi Coordinated Access Network (MississippiCAN) Providers 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.➤ 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.
Applicant History	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.
Disclosure	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) in the...
Supporting Documentation / Attachments and Fees	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.
Agreement	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 complete the revalidation process.
Summary	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.
	<div>Continue Cancel</div>



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)	<input checked="" type="checkbox"/>
MSCAN	<input checked="" type="checkbox"/>
MSCHIP	<input checked="" type="checkbox"/>
Application Contact Information	
Enter the name of a contact person to answer any questions regarding the information provided in this enrollment application.	
*Last Name	<input type="text"/>
*First Name	<input type="text"/>
Title	<input type="text"/>
*Phone	<input type="text"/>
Ext	<input type="text"/>
Fax Number	<input type="text"/>
*Work Email	<input type="text"/>
*Confirm Email	<input type="text"/>
Preferred Method of Communication	Email <input type="text"/>
<input type="button" value="Continue"/> <input type="button" value="Exit"/>	

Create a Password

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](#)

- 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

Provider Enrollment: Application Tracking Information ? Print Preview

Welcome	Your enrollment application has been assigned the following tracking number:60595. Please retain the tracking number for your records.
Request Information	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.
Application Tracking Information	A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:
Credentialing Information	
CCO Information	
Taxonomies	

Continue Exit

- 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.

Provider Enrollment: Provider Identification ATN: 60594

[Welcome](#) [Request Information](#) [Credentialing Information](#) [Addresses](#) **Provider Identification** [Languages](#) [Other Information](#) [Hospital Admittance](#) [Applicant History](#) [Disclosure](#) [Supporting Documentation / Attachments and Fees](#) [Agreement](#) [Summary](#)

* Indicates a required field.

Provider Legal Name
The provider legal name and information is provided once for each enrollment.
Last Name JONES
First Name RUBEN
Middle B Title _

Individual Providers
*Gender Male *Birth Date 05/24/1957

Organizational Structure

- If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.
- If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.
- If you are affiliated with a Military Medical Treatment Facility (MTF), you must select the Military MTF option from the drop down.
- If you are affiliated with a Tribal Agency, you must select the Tribal Agency option from the drop down.

Organization Type Other
Registered with Secretary of State ☐ Business Start Date
Incorporated ☐ Incorporation Date
Chain Affiliated ☐
Operated by Management Company ☐
*Public/Private Private Indicator

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
+ Regular	12132	07/01/1989	06/30/2022	MS BOARD OF MEDICAL LICENSURE	Mississippi	Remove
+ Click to add license						

Medicare Participation
Medicare # 7564387023 Effective Date 08/12/1990 Medicare Type

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

CLIA #	Effective Date	End Date	Action
+ 25D0665723	01/01/1900	12/31/2299	Remove
+ Click to add CLIA			

DEA #
DEA # Effective Date
[Continue](#) [Exit](#)



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.

The screenshot shows a web form for updating address information. At the top, there is a dropdown for 'Address Type' set to 'Servicing'. Below it, a message states: 'You must Verify Address in order to enable the Save button.' The form contains several fields: '*Name' (SMITH FAC), '*Address' (empty), '*City' (NATCHEZ), '*State' (Mississippi), '*County' (ADAMS), and '*Zip Code' (391203327). A blue 'Verify Address' button is located below the state field. Further down, there are fields for '*Contact Name' (BOB), '*Primary Email' (empty), and '*Confirm Email' (empty). There are also phone number fields with dropdowns for 'Office' and 'Phone', and 'Ext' (extension) boxes. At the bottom of the form, there are two columns of checkboxes under 'Available Options' and 'Selected Options'. The 'Available Options' column includes: BUILDING EXTERIOR, BUILDING INTERIOR, EXAM ROOM, EXAM TABLE, GURNEYS/STRETCHERS, PARKING, PATIENT LIFTS, PUBLIC TRANSPORTATION, ACCESS, RADIOLOGIC EQUIPMENT, and RESTROOM. The 'Selected Options' column includes: PARKING and RESTROOM. Between the columns are buttons: 'Add >', 'Add All >>', 'Remove All <<', and 'Remove <'. At the very bottom of the form, there are three buttons: 'Save' (highlighted with a red box), 'Reset', and 'Cancel'.

Language Page

Provider Enrollment: Languages ATN: 60594 ?

[Welcome](#)
[Request Information](#)
[Credentialing Information](#)
[Addresses](#)
[Provider Identification](#)
▶ Languages
[Other Information](#)

Providers that have the ability to translate should select the appropriate language below.
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Language	Action
ENGLISH	Remove
+ Click to add language.	

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

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

Other Information Page

Provider Enrollment: Other Information

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

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
<input type="checkbox"/> 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"/>				

Facility Information

*Administrator First Name MI

*Administrator Last Name

*Phone

*Fax Number

*Email

*Number Medicaid Beds *Dually-Certified Beds

*Number Medicare Beds *Total Beds

- 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

SECTION B-1
Entity with Direct/Indirect Ownership Interest
and/or Managing Control Identification Information

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

Row	Legal Business Name as Reported to the Internal Revenue Service	Employer Identification Number (EIN)	Percent Ownership	Action
1			5	Remove

***Legal Business Name as Reported to the Internal Revenue Service**

DBA Name

***Effective Date**

***Employer Identification Number (EIN)**

***Owner/Partner**

Percent Ownership

Ownership Type

Addresses

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

Row	Address	Primary	Action
1		Yes	Remove

***Address**

***City**

***State**

***Country**

Primary Address ☒

***Zip Code**

[Save](#) [Reset](#) [Cancel](#)

Click to add address.

[Save](#) [Reset](#) [Cancel](#)

- 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.

SECTION B-2

Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported in Section B-2:

- ▶ All individual owners with 5% or more direct/indirect ownership
- ▶ All officers and directors of the disclosing provider (whether for profit or non-profit)
- ▶ All managing employees of the disclosing provider
- ▶ All authorized and delegated officials noted in the Mississippi Medicaid Enrollment application

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

Row	Last Name	First Name	SSN	Birth Date	Action
1					Remove

*Last Name

*First Name

MI

*Birth Date

*Gender

Male

Title

*SSN

*Owner/Managing Employee

Both (Owner and managing Employee)

*Home Address

*City

*State

Mississippi

*Zip Code

*Country

UNITED STATES

If the above noted individual is an owner, please select one of the following options and give the effective date:

*Owner/Partner

5 Percent (5%) or More Owner

Effective Date

12/30/2018

Percent Ownership

5

Ownership Type

Direct

If the above noted Individual is a managing employee, please select all that apply and give the effective date:

Director/Officer

Managing Employee(W-2)

Contracted Managing Employee

Agent

If the above noted Individual is an authorized or delegated official, please select one of the following options and give the effective date:

Official Type

Official Effective Date

Save

Reset

Cancel

Relationships

If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing employee, director, or shareholder and is related to each other as spouse, parent, child or sibling, please note the name and relationship:

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

Row	Owner/Managing Employee 1	Relationship	Owner/Managing Employee 2	Action
+	Click to add Relationship			

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:
- has a direct or indirect ownership interest (or any combination thereof) of five percent (5%) or more in the group/organization;
 - 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;
 - is an officer or director of the group/organization, if the group/organization is organized as a corporation;
 - is a partner in the group/organization, if the group/organization is organized as a partnership;
 - is an agent of the group/organization;
 - 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
 - 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	
<input type="button" value="+"/> 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	
<input type="button" value="+"/> 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
<input type="button" value="+"/> Click to add Transaction				

Disclosure Page

Section H

SECTION H Attestation and Signature of the Disclosing Provider	
<p>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.</p> <p>In addition, I understand that:</p> <ul style="list-style-type: none">▪ 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:<ol style="list-style-type: none">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. <p>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.</p> <p>*I accept <input checked="" type="checkbox"/> I have read and agree to the terms stated above</p> <p>*Your Signature <input type="text" value="d"/></p> <p>Title <input type="text" value="d"/></p> <p>Date 03/22/2023</p> <p>Continue Exit</p>	

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

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

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

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

* Indicates a required field.

Attachments

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

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

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

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

#	Transmission Method	File	Attachment Type	Action
<input type="checkbox"/> Click to collapse.				
<div> <div>*Transmission Method</div> <div>FT-File Transfer</div> </div> <div> <div>*Upload File</div> <div> <input type="button" value="Choose File"/> <div>No file chosen</div> </div> </div> <div> <div>*Attachment Type</div> <div></div> </div> <div> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </div>				

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

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

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

#	Transmission Method	File	Attachment Type	Action
<input type="checkbox"/> Click to collapse.				
<div> <div>*Transmission Method</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>				

Supporting Documentation

Application Fees and Attestation

Application Fee

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

* Fee Payment Type ▼

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

Attachment Attestation

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

Continue Exit

This is only visible to providers taxonomies that are required to pay the fee to Medicare or Medicaid.

- 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.

Instructions
<p>The terms of enrollment are stated below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.</p> <p>Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.</p> <p>The enrollment application terms must be accepted in order to submit the application for approval.</p> <p>Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.</p>
Terms of Agreement
<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> <p>*I accept <input type="checkbox"/> I understand that my electronic signature is equivalent to written signature.</p> <p>*Your Signature <input type="text"/></p> <p>(Entering your name in the box to the right will constitute your electronic signature.)</p> <p>Title <input type="text"/></p> <p>Submission Date 10/18/2023</p> <p>Continue Exit</p>

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.

Provider Enrollment: Summary [Print Preview](#)

Welcome [Request Information](#) [Credentiaing Information](#) [CCO Information](#) [Taxonomies](#) [Provider Identification](#) [Addresses](#) [Affiliated Providers](#) [Languages](#) [EFT Enrollment](#) [Other Information](#) [Hospital Admittance](#) [Applicant History](#)

Request Information

Initial Enrollment Information

Requesting Enrollment Effective Date 10/25/2023
Enrollment Type Individual
Taxonomy [REDACTED]
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.
NPI [REDACTED] NPI Zip + 4 [REDACTED]
SSN [REDACTED]
Are you currently enrolled as a Provider? No
Were you previously enrolled as a Provider? No

Wednesday 03/19/2025 10:23 AM CST

Provider Enrollment: Summary [Print](#) ATN: 60526

Request Information [Print or Save](#)

Initial Enrollment Information

Requesting Enrollment Effective Date 02/14/2025
Enrollment Type Facility

Instructions for Summary Page

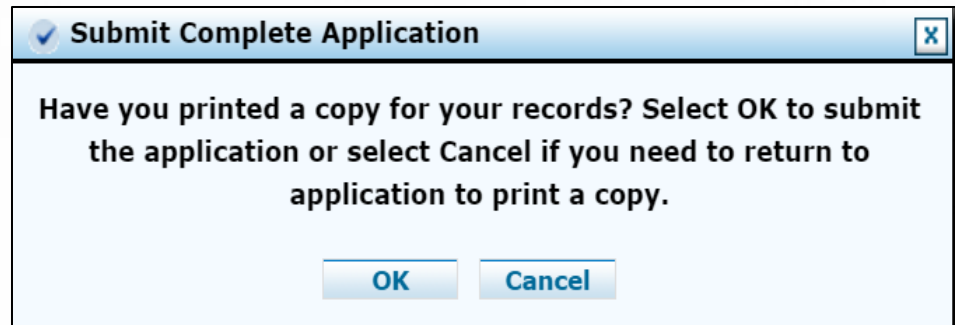
If changes are required after reviewing the Summary Page, click the appropriate link on the Table of Contents panel for the section and make the needed corrections. When completed, you will be given the opportunity to review the Summary Page again. Once you have reviewed the contents of the application,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



Tracking Information

Print Preview

Provider Enrollment: Tracking Information ?

Your enrollment application has been assigned the following tracking number:33786. Please retain the tracking number for your records.

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

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

Exit

- 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.

	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 [redacted] 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		