Job Aid

Copy an Existing Provider Enrollment Application

This document outlines the steps to copy an existing provider enrollment application that was previously submitted and lists the prepopulated fields of a copied application.

The copy function duplicates specific fields of a previously submitted application. Those fields will be prepopulated as illustrated throughout this document.

Utilizing the copy functionality:

- Only previously submitted enrollment applications using the same taxonomy can utilize copy.
- **Not all data is copied**. Only certain fields are prepopulated therefore, it's crucial to check each field and make appropriate updates.
- Copying the application can save time and avoid inputting data multiple times.
- Additional taxonomies from the same family, as well as multiple service locations can be added after copying the application.

*It is imperative to review the entire application before submitting it to confirm all the information is still accurate. *

Steps to copy an existing enrollment application

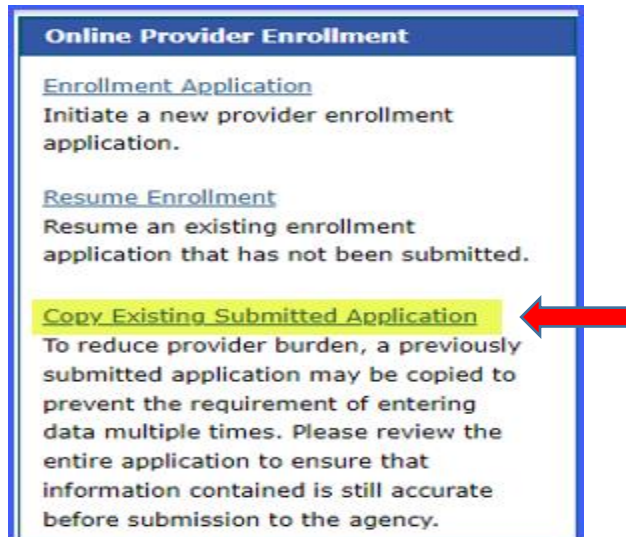1. Select the **Provider Enrollment Access hyperlink** found on the **Home** page of the MESA Provider Portal.

Figure 1: MESA Portal Home Page

2. Select the **Copy Existing Submitted Application hyperlink**:

Figure 2: Copy Hyperlink

3. Enter the **Tracking Number**- ATN Application Tracking Number, **Tax ID**, and **Password**, then select **Submit.**

   Tax ID is the SSN-social security number for indivudal providers.

   Password is the one that was created by the user while submitting the application which is being utilized to copy.

Figure 3: Copy Existing Submitted Application Sign In

🔍 **Verify the accuracy of all the information on each page to ensure it has not changed since the last time the application was submitted.**
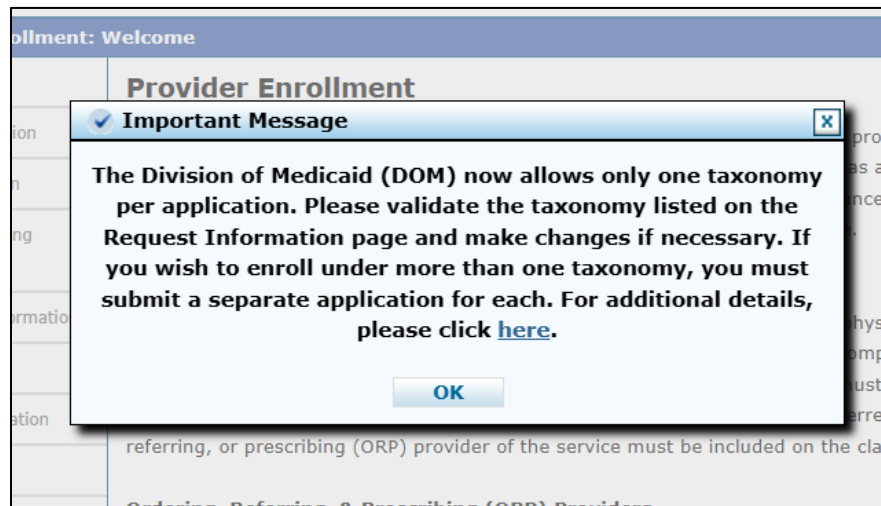
If the existing application includes multiple taxonomies, the message above will be displayed before continuing to the Welcome Page to the Enrollment Application.

Figure 4: Welcome Page of Enrollment Application

Select **Continue** to the **Request Information page.**

Follow the normal process to submit an application. The prepopulated fields are shown in the following examples.

Prepopulated fields on a copied application:

The **Request Information page** is <mark>prepopulated</mark>. Review all fields and make any necessary updates.

- The **effective date** must be updated to a current date.
- The link for **Additional Enrollment Requirements** must be selected in order to move forward in the application.

Figure 5: Request Information Page

The Password Creation Panel will display next. Enter the password you would like to use for this particular application.

Figure 6: Password Creation Panel

The Application Tracking information will display next. This information is sent to the contact person's email. Please make a note of the tracking number, the Tax ID, and the password created. It will be needed to access this application.

Figure 7: Application Tracking Information

==**MCO Providers Only**== (FFS providers skip this step) **– Credentialing Information page is ==prepopulated.==** Review each field, make any necessary updates then select Continue to the CCO Page.

Figure 9: Credentialing Information Page

==**MCO Providers Only**== (FFS providers skip this step) **– CCO Information page is ==prepopulated.==** Review each field, make any updates, select the Attestation statement, then select Continue to the Provider page.

Figure 10: CCO Information Page

Provider Identification page is <mark>prepopulated.</mark> Review each field, make any necessary updates then select Continue to the Address Page.

Figure 11: Provider Identification page

==Prepopulated== fields on the **Address page are ==Corporate Office, Mail To==**, and **==Pay To Addresses==.** The **Service Address** does ==**not**== ==prepopulate==. Review each field, using the **+** sign to expand and edit an address and to add the Service Address, make any necessary updates including required information such as contact information and hours, select Save after each update, then select Continue to the Affiliated Providers Page.

🔋👥 **Multiple service locations can be added to the copied application.**

Figure:12 Address page

Provider Addresses

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

	Contact Name	Address Type	Address	City	State	Action	
⊞	AKAN	Corporate Office	PO BOX		Mississippi	Copy	Remove
⊞	ANKS	Mail To	PO BOX		Mississippi	Copy	Remove
⊞	ANKS	Pay To	PO BOX		Mississippi	Copy	Remove
⊞	Click to add address.						

Continue   **Exit**

Affiliated Providers page is <mark>prepopulated</mark>. Review each field and make any necessary updates. To add another affiliated individual provider, select the **Add** Tab. Click the hyperlink in the top right corner to download Affiliations in a CSV file format. Select **Remove** to remove a provider from the list or **Reactivate** to keep the provider on the list. Once finished with updates, select **Continue** to the Languages page.

Figure 13: Affiliated Providers page

Language Page is <mark>prepopulated</mark>. Review each field, utilize the **+** sign to add any additional languages, use the remove hyperlink to remove any language, then Select **Continue** to the EFT Enrollment page.

Figure 14: Language page

The **EFT Information Page** is <mark>not prepopulated</mark>. Fill out each field then select Continue to the Other Information page.

Figure 15: EFT Information

Other Information Page is <mark>prepopulated</mark> when there is information from the application that is being copied. Review each field, make necessary updates, select Add to add any attachment(s) then Select Continue to the Disclosure page.

Figure 16: Other Information Page

Applicant History page is <mark>prepopulated</mark>. Review all answers then click on Continue at the bottom of the page.

Figure 17: Applicant History Page

Disclosures Page is <mark>prepopulated</mark> **except** for the **Signature** found at the bottom of **Section H.** Review all fields in Sections **B, C, D, E, F, G** and **H**, utilize the **+** sign to view, add or update any row or select remove to remove a row. In Section **H** make sure to **Accept**, enter the Name and Title. Select Continue to the Supporting Documentation/Attachments and Fees page.

Figure 18: Sections B of the Disclosure page

Instructions for Mississippi Medicaid Provider Disclosure Form

☐ Click to View Instructions

SECTION B
Direct/Indirect Ownership Interest and Managing Control Identification Information

NOTE: ONLY REPORT ORGANIZATIONS IN SECTION B-1. INDIVIDUALS WITH OWNERSHIP/MANAGING CONTROL MUST BE REPORTED IN SECTION B-2. The disclosing entity is responsible for reporting all ownership and managing control.

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

☐ Click to add Organization

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	PRICH...	MI...L	*****678...	- ---	Remove

☐ Click to add Individual

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

Figure 16: Section C, D, E and F of the Disclosures page

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		

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		

Figure 19: Section G, and signature portion in section H of the Disclosure page

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			

NOTE: If the disclosing provider is <u>an individual or a sole proprietor</u>, the application must be signed by the individual provider or sole proprietor. If the disclosing provider is a <u>group/organization</u>, 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 11/20/2024

[Continue] [Exit]

Supporting Documentation, Attachments and Fees page only <mark>prepopulates</mark> the <mark>Fee Payment Type</mark>.
Review all fields, click the Privacy Notice, make any updates, add all required data, utilize the **+** sign to add any attachments, select the Attestation statement then select Continue to the Agreement page.

Figure 20: Attachment and Fees page

Supporting Documentation

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

Instructions Privacy Notice (Must View)

Checklist of General Provider Information Needed
Important Check List Items can be found

* Indicates a required field.

Attachments	—

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

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
1	FT-File Transfer	12 FI IXO.pdf (229K)	All	Remove
⊞	Click to add attachment.			

Application Fee

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

      *Fee Payment Type | Made Payment to Medicare ⌄ |

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

Agreement Page is <mark>not</mark> prepopulated. Enter the signature, select I accept then select Submit to continue to the Summary Page.

Figure 21: Agreement Page

Instructions

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.

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.

The enrollment application terms must be accepted in order to submit the application for approval.

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.

Terms of Agreement

Provider Name	GROUP
Address	Jackson Mississippi,
Tax ID	
NPI	
Contact Name	AKAN
Contact Email	

Programs selected for application:

- Fee-For-Service (FFS)

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

Summary Page does <mark>not</mark> prepopulate. This is the time to review the entire application before submitting. The user can select **Print Preview** to print or save the application before submission. Select "I accept" then select **Continue** to submit the application.

Figure 22: End of Summary Page

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

*I accept ☑ I understand that my electronic signature is equivalent to written signature.

*Your Signature GROUP
(Entering your name in the box to the right will constitute your electronic signature.)

Title Owner

Submission Date 04/08/2025

[Continue] [Exit]

The Submit panel will give you the chance to preview the application and print a copy. If everything is correct, select **Submit**.

Figure 23: Submit Application

After clicking Submit, the system will ask if you need to print a copy of the application or if you are ready to submit. Click **OK** to complete submission of the application.

Figure 24: Print Application

The Application Tracking Information is displayed. Click **Exit** to leave the portal.

Figure 25: Application Tracking Information

Home > Online Provider Enrollment > Application Tracking Information   Tuesday 04/08/2025 01:53 PM CST

Print Preview

Provider Enrollment: Application Tracking Information

Your enrollment application has been submitted.

Your enrollment application has been assigned the following tracking number: 60980

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 reference your submitted application at a later date.

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

You are required to print, sign and submit the cover sheet via mail or FAX, along with all appropriate supporting documentation.

To save or print the coversheet for your records click here.

Exit

Change History

The following change history log contains a record of changes made to this document:

Version #	Published/ Revised	Author	Section/Nature of Change
1.0	11/15/2024	Gainwell	Initial publication
2.0	6/13/2025	Gainwell	Updated per CR2571
2.1	7/26/2025	Gainwell	Updated per CR2869