Office of the Governor | Mississippi Division of Medicaid

Group Provider

Initial Enrollment Application

May 14, 2025

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MISSISSIPPI DIVISION OF MEDICAID

Provider Enrollment

- Gainwell does not accept paper enrollment applications.
- Must have a taxonomy to enroll.
- Supporting documentation must be submitted via the web portal with the initial enrollment application submission.
- Required supporting documentation will vary depending on the taxonomy code and enrollment type.
- Incomplete enrollment applications will be returned to the provider or denied.
- If the enrollment application is returned to the provider for missing documentation, you have **60 days** to upload the documents to the web portal. If **not submitted**, the application will be **denied on the 61st day**.

Provider Enrollment

- **All providers must be screened in compliance with 42 CFR 455.410.**
- **Taxonomies considered High-Risk** will require owners that have a 5% or greater direct or indirect ownership interest to submit fingerprints for a Fingerprint Criminal Background Check (FCBC) and participate in a site visit (unless the provider is currently enrolled with Medicare and the application data for Medicare and Medicaid matches).
- **Taxonomies considered Moderate Risk** will require a site visit unless the provider is enrolled with Medicare and the application data for Medicare and Medicaid matches.

Application Tips

- By selecting the "**+**" sign, you can view or update that specified row.
- To remove a row, select the "Remove" link located in that specific row.
- The red asterisk signifies a required field.
- If the disclosing provider is a group/organization, the signatures should be by the person legally authorized to sign on behalf of the group/organization. Note: This is the individual indicated as the Authorized Official within the application.
- All application attachments must be in pdf, gif, jpg, jpeg, png, tif, tiff or txt format.
- At anytime during the application process, you can select "**EXIT**", and it will prompt you to save your changes.
- If a new application is not completed within **6** months, it will be removed. Recredentialing and Revalidation is due by the date on the provider portal home page.

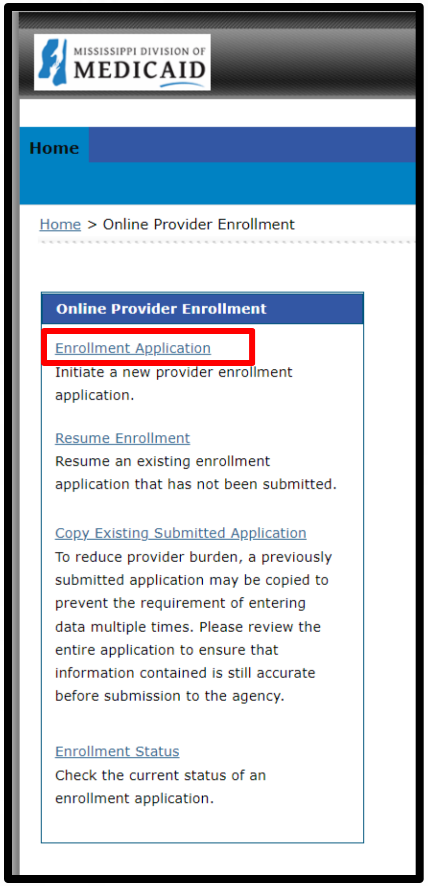
Accessing Provider Enrollment

- Go to the Mississippi Division of Medicaid's website to access the MESA Provider Portal. [Mississippi Division of Medicaid]

- Select Provider Portal, then Provider Login to access the home page of the Provider Portal. [MESA Provider Portal]

- Select the "[Provider Enrollment Access]" link.

Enrollment Application



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

Welcome Page

This section of the Welcome Page provides an explanation of each provider type:

- Fee For Service (FFS)
- Ordering, Referring and Prescribing (ORP)
- Managed Care providers

The next page goes over the remainder of this section.

Provider Enrollment

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.

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 affiliated to the group. If a FFS provider submits a claim for a referred service for a Medicaid member, the NPI of the ordering, referring, or prescribing (ORP) provider of the service must be included on the claim.

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.

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.

- **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.

Welcome Page Cont’d

Explanation of:

- Credentialing/Recredentialing
- Revalidation
- 340B Program
- A link to required documents and enrollment requirements.
- Select Continue to move to the Request Information page.
- To view the requirements for an application, select the link under “Required Documents and Enrollment Requirements”.

Credentialing/Recredentialing

The State of Mississippi is responsible for Credentialing/Recredentialing its providers that participate in the Managed Care programs (Mississippi Coordinated Access Network (MSCAN) and/or Mississippi Children’s Health Insurance Program (MSCHIP)). Credentialing/Recredentialing standards are set by national accrediting agencies and state and federal regulating bodies.

State regulation Mississippi Code 43-13-117 requires that the Division develop a single, consolidated credentialing process for providers, and requires managed care entities to accept the Division credentialing for managed care enrollment. Credentialing will be conducted when the provider selects MississippiCAN and/or CHIP. Upon completion of Division credentialing, providers may voluntarily contract with Coordinated Care Organizations (CCOs).

Recredentialing of providers actively enrolled in the Managed Care programs must be conducted at least every three (3) years, unless otherwise required by regulatory or accrediting bodies or a shorter term as determined by the Credentialing Committee. A recredentialing notice letter will initiate the process with each provider. The letter will provide instructions for completing the recredentialing process and will indicate the due date. Each provider must submit all required supporting documentation and is required to be successfully recredentialed for continued participation in a CCO network.

As part of the recredentialing process, providers will be required to review, update application information, and electronically sign the Mississippi Medicaid Provider Agreement and Acknowledgement of Terms of Participation. All required documents must be uploaded. Providers are subject to additional screening activities based on their risk level. The recredentialing process incorporates re-verification and identification of changes in a providers (individual/organization) licensure, sanctions, certifications (including, but not limited to, malpractice experience, sanction history, hospital privilege related or other actions). This information is reviewed to assess whether providers continue to meet the standards set by national accrediting agencies and state and federal regulating bodies, including National Committee for Quality Assurance (NCQA).

The recredentialing service location will also be revalidated with the submission of their recredentialing application. Service location(s) for which a recredentialing application is not submitted will be required to revalidate every three (3) years.

Enrollment will be terminated for any provider who does not comply with recredentialing requirements. A new application will then be required for the provider to re-enroll in the Mississippi Medicaid program.

Revalidation Information

Federal Regulation at 42 CFR 455.414 requires the State Medicaid Agency to revalidate the enrollment of all providers regardless of provider type at least every 5 years. As part of this required revalidation process, providers that are due for revalidation will be required to review, update application information, and electronically sign the Mississippi Medicaid Provider Agreement and Acknowledgement of Terms of Participation. All required documents must be uploaded. Providers are subject to additional screening activities based on their risk level. A revalidation notice letter will initiate the process with each provider. The letter will provide instructions for completing the revalidation and will indicate the due date.

Enrollment will be terminated for any provider who does not comply with revalidation requirements. A new application will then be required for the provider to re-enroll in the Mississippi Medicaid program. Providers are required to establish a Provider Portal account to compete the revalidation process.

340B Program

The 340B program is a Drug Pricing Program established by the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act (PHSA). Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes, and qualified hospitals. These providers purchase, dispense and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of these drugs makes these drugs ineligible for the Medicaid drug rebate. State Medicaid programs are mandated to ensure that rebates are not claimed on these drugs thereby preventing duplicate discounts for these drugs.

Health Resources and Services Administration (HRSA) is specifically responsible for the enforcement of covered entity compliance with the duplicate discount prohibition. More information regarding eligibility and program logistics can be found on HRSA’s website at www.hrsa.gov/opa.

Required Documents and Enrollment Requirements

To view required documents and enrollment requirements, please visit the Mississippi Division of Medicaid’s website.
Click here to go directly to the website.

Click the "**Continue**" button to start the enrollment application.

Continue | Cancel

Request Information Page

Click the down arrow next to Enrollment Type to select the appropriate application type – Individual, Group, Facility, Other or ORP (Ordering, Referring, Prescribing).

- Individual Application Type – Individual practice. For a list of applicable Provider Types, Click Here.
- Group Application Type – Entity that has associated providers. For a list of applicable Provider Types, Click Here.
- Facility Application Type – Entity that does not have associated providers (example hospitals, long term care facilities, etc.). For a list of applicable Provider Types, Click Here.
- Other Application Type – Entity that does not easily fit into any of the other Application Types (example DME, Pharmacy, IDD). For a list of applicable Provider Types, Click Here.
- ORP Application Type – ORP providers are individual providers that may only order, refer or prescribe services within their legal scope of practice. ORP providers will not be reimbursed for any services provided, and are not eligible for contracting with Coordinated Care Organizations (CCOs). For a list of applicable Provider Types, Click Here.

Key the taxonomy code or description which best describes the type of service that will be provided. A list will be displayed based on the information keyed. From the list, select the appropriate taxonomy code.

Complete the fields on each screen and click the Continue button to move forward to the next page.

Click the Finish Later button to save this application.

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

* Indicates a required field.

Initial Enrollment Information

Click the Additional Enrollment Requirements Checklist link to select a taxonomy.

Additional Enrollment Requirements Checklist (Must View)

*Enrollment Type

*Taxonomy

*Requesting Enrollment Effective Date 08/30/2023

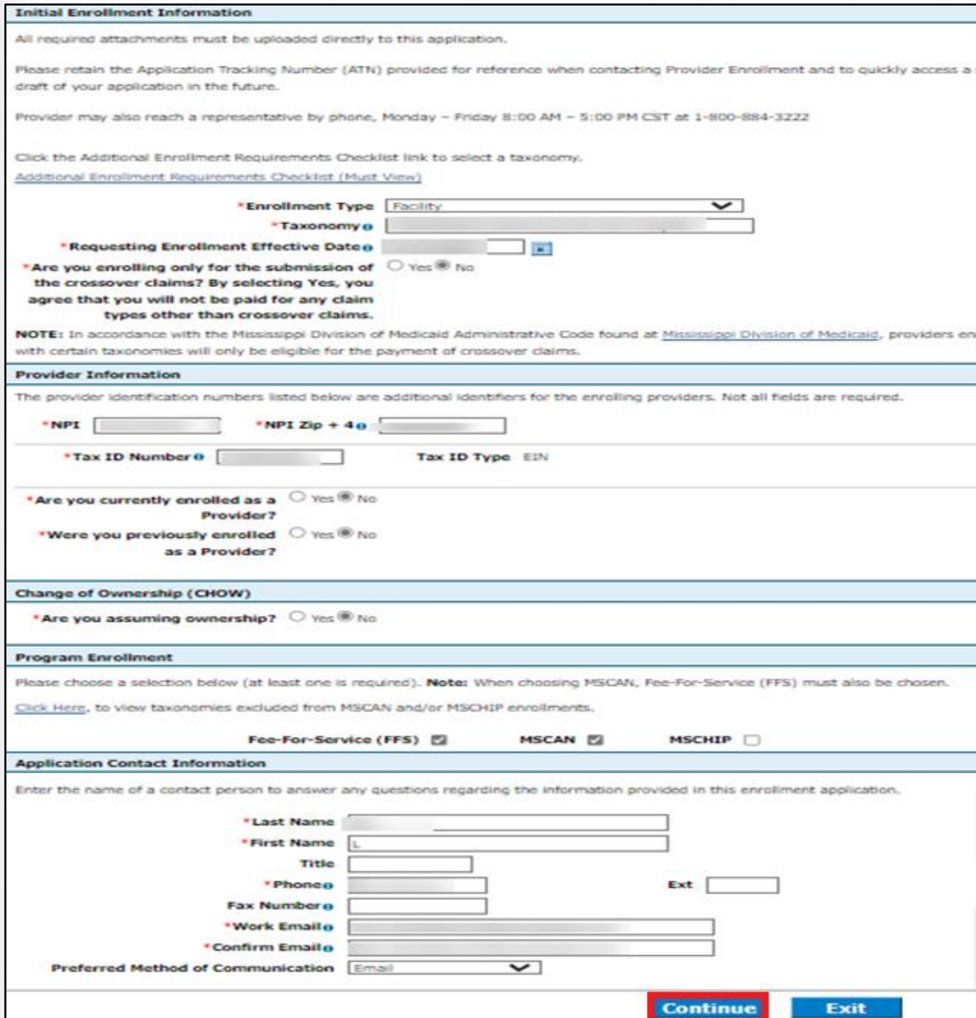
There are **five** application types:

- **Individual**
- **Group**
- **Facility**
- **Other**
- **(ORP) Ordering, Referring, and Prescribing**

- Select the "**Click Here**" link beside each enrollment type to view a list applicable taxonomy codes and descriptions.

- Select the **Additional Enrollment Requirements Checklist** link to view the checklist. **This must be done to move to the next steps.**

Request Information Page Cont'd



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

Enter 2 or more characters of a taxonomy number and a list of available taxonomies will display.

You must select at least one option to enroll in **Fee-For-Service** (FFS), **MSCAN** and/or **MSCHIP.** Grayed-out options indicate they are not available for the specified taxonomy.

If **MSCAN** is chosen, **Fee For Service (FFS)** must also be chosen.

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

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

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

CHOW
(Change of Ownership)

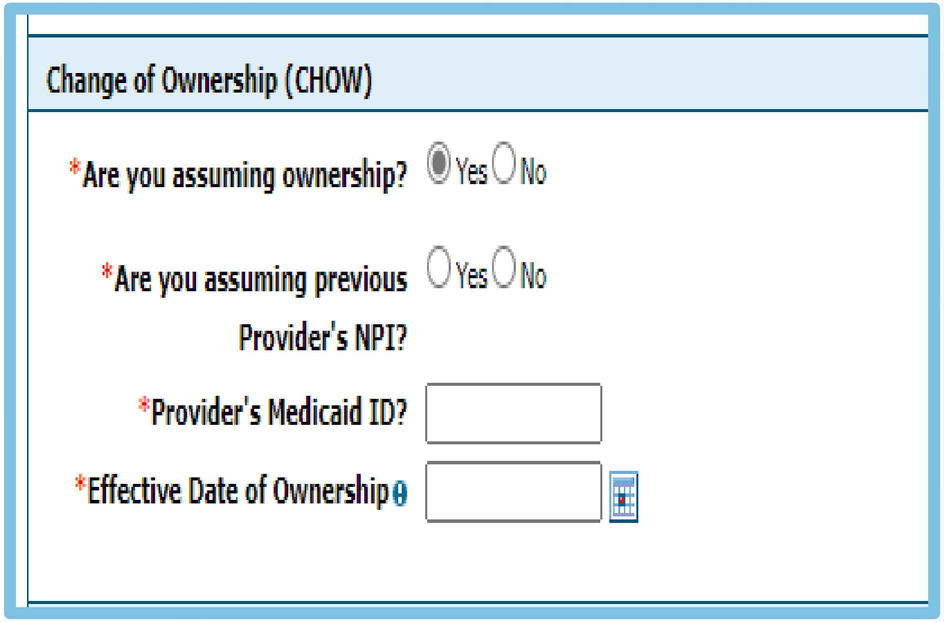
The **CHOW** panel will only appear for Group, Facility, and Other enrollment type.

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

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

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

Enter the **Effective Date of Ownership**.

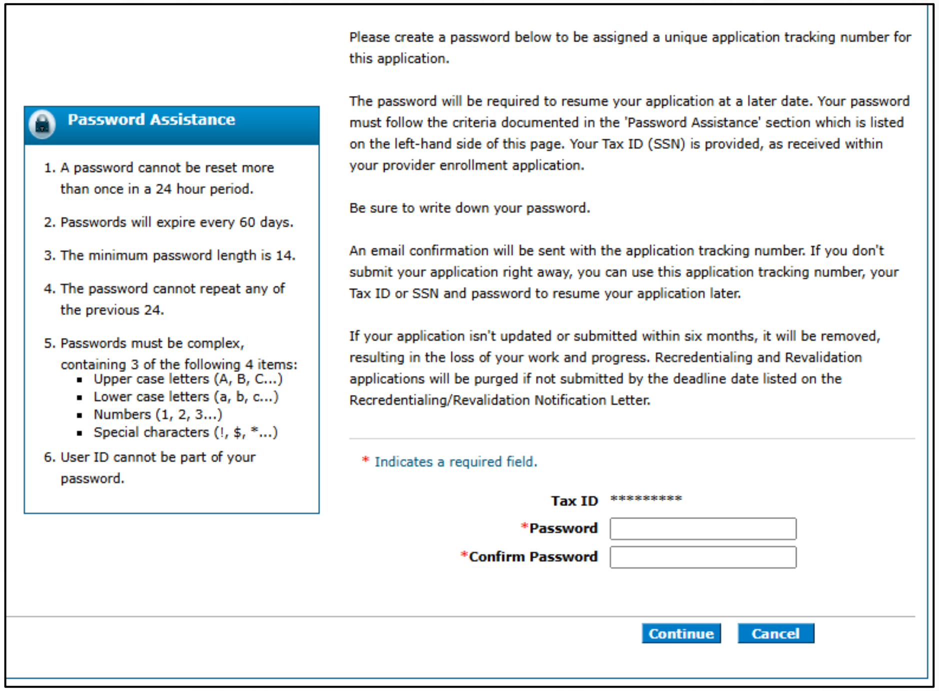


Password Creation

Create a password according to the Password Assistance panel.

To regain access to the Enrollment portal, you will need the new password along with the tax ID number submitted in the Requested Information page.

Remember to write it down! If you do not have this information, you will have to start the application process over.



Password Assistance

1. A password cannot be reset more than once in a 24 hour period.
2. Passwords will expire every 60 days.
3. The minimum password length is 14.
4. The password cannot repeat any of the previous 24.
5. Passwords must be complex, containing 3 of the following 4 items:
   - Upper case letters (A, B, C...)
   - Lower case letters (a, b, c...)
   - Numbers (1, 2, 3...)
   - Special characters (!, $, *...)
6. User ID cannot be part of your password.

Please create a password below to be assigned a unique application tracking number for this application.

The password will be required to resume your application at a later date. Your password must follow the criteria documented in the 'Password Assistance' section which is listed on the left-hand side of this page. Your Tax ID (SSN) is provided, as received within your provider enrollment application.

Be sure to write down your password.

An email confirmation will be sent with the application tracking number. If you don't submit your application right away, you can use this application tracking number, your Tax ID or SSN and password to resume your application later.

If your application isn't updated or submitted within six months, it will be removed, resulting in the loss of your work and progress. Recredentialing and Revalidation applications will be purged if not submitted by the deadline date listed on the Recredentialing/Revalidation Notification Letter.

* Indicates a required field.

Tax ID *********

***Password**

***Confirm Password**

Continue Cancel

Application Tracking Information

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

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

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


Print Preview

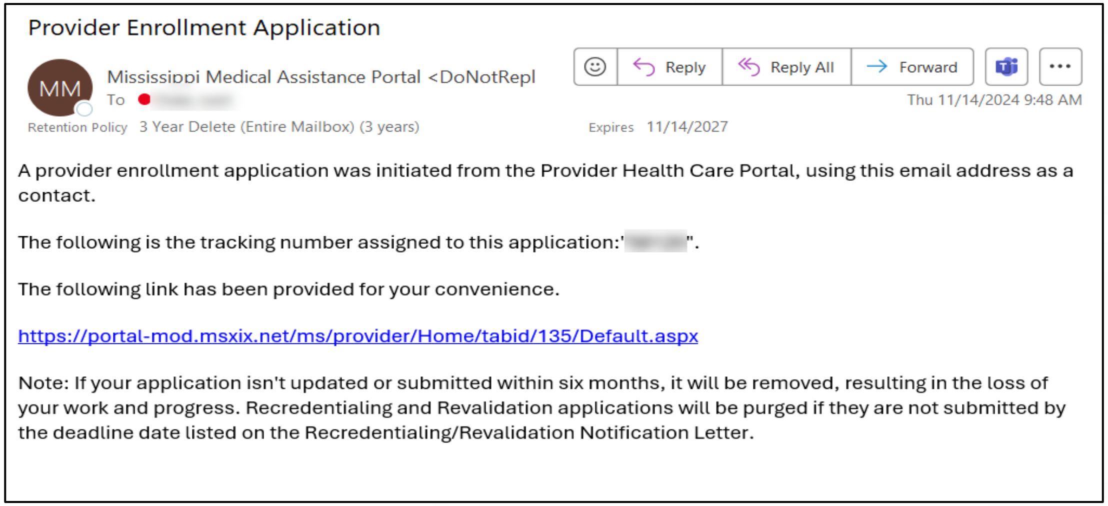
Application Tracking Information

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

Continue Exit


Provider Enrollment Application

MM Mississippi Medical Assistance Portal <DoNotRepl

To

Reply | Reply All | Forward

Thu 11/14/2024 9:48 AM

Retention Policy 3 Year Delete (Entire Mailbox) (3 years) Expires 11/14/2027

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

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

The following link has been provided for your convenience.

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

Note: If your application isn't updated or submitted within six months, it will be removed, resulting in the loss of your work and progress. Recredentialing and Revalidation applications will be purged if they are not submitted by the deadline date listed on the Recredentialing/Revalidation Notification Letter.

Coordinated Care Organization Selection (CCO)

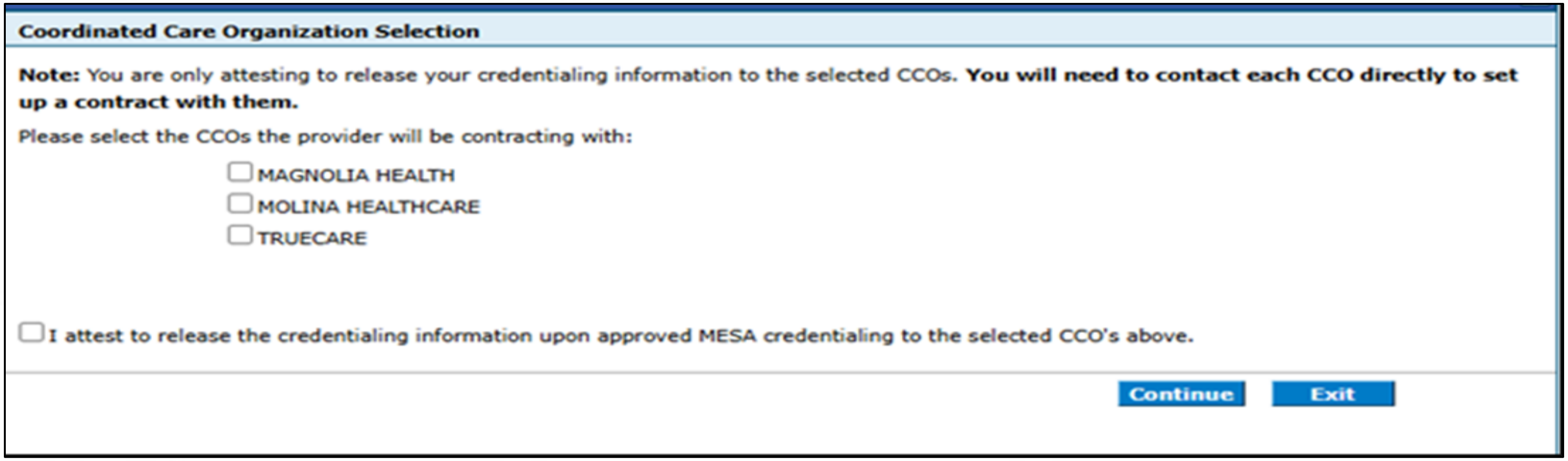
This is only applicable to providers that have selected MSCAN or MSCHIP.

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

Select the **attestation statement** box.

Select **Continue** to the Taxonomies page.

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


Coordinated Care Organization Selection

Note: You are only attesting to release your credentialing information to the selected CCOs. **You will need to contact each CCO directly to set up a contract with them.**

Please select the CCOs the provider will be contracting with:

- ☐ MAGNOLIA HEALTH
- ☐ MOLINA HEALTHCARE
- ☐ TRUECARE

☐ I attest to release the credentialing information upon approved MESA credentialing to the selected CCO's above.

Continue | Exit

Provider Identification

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

This section is based on enrollment and organization type

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**

Registered with Secretary of State ☐

Incorporated ☐

Chain Affiliated ☐

Operated by Management Company ☐

Business Start Date

Incorporation Date

***Public/Private Indicator**

Legal Tax Name

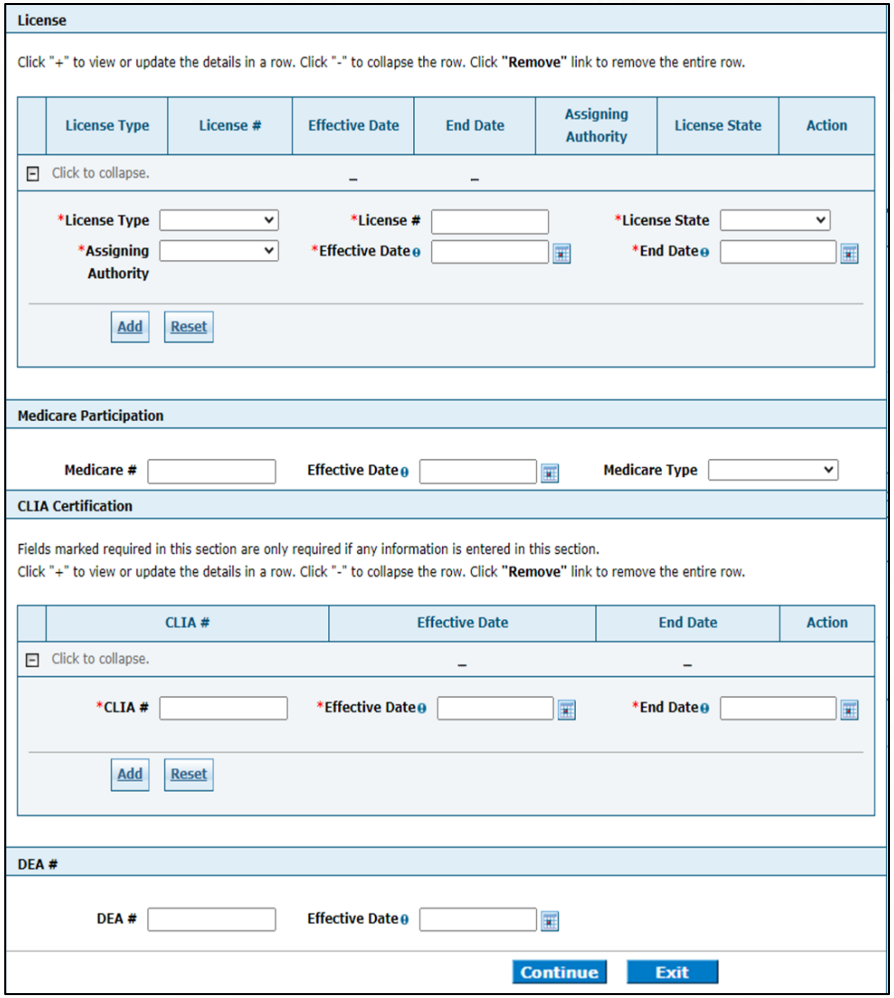
The provider legal name and information is provided once for each enrollment.

***Legal Tax Name**

***DBA Name**

Provider Identification Cont'd

- Complete the **License** information and select "**Add**".
- Enter the **Medicare Participation** fields data if applicable.
- Complete the **CLIA Certification** fields if applicable and select "**Add**".
- Enter the **DEA #** and **Effective Date**, if applicable.
- Select "**Continue**" to move to the Address section.



License

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

	License Type	License #	Effective Date	End Date	Assigning Authority	License State	Action
⊟ Click to collapse.			–	–			

*License Type   *License #   *License State
*Assigning Authority   *Effective Date   *End Date

Add   Reset

Medicare Participation

Medicare #   Effective Date   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
⊟ Click to collapse.		–	–	

*CLIA #   *Effective Date   *End Date

Add   Reset

DEA #

DEA #   Effective Date

Continue   Exit

Provider Address

Provider Addresses

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

	Contact Name	Address Type	Address	City	State	Action
⊟	Click to collapse.					

*Address Type
Name Type
*Last Name
*First Name
Middle
Title
*Address
*City
*County
*State
*Zip Code
*Contact Name
*Primary Email
*Confirm Email
*Phone Ext
Phone Ext
Phone Ext
Phone Ext

Mail To
Pay To
Servicing
Corporate Office

Add Reset

Continue Exit

Provider Addresses

The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The service location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The service location name must match the business name on the W-9.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBAs (405 IAC 1-19.1b) as an attachment to the packet.
- The service location address must be a physical location. A post office box is not a valid service location address.
- Providers that provide services at a "place of service site", such as at a hospital or nursing facility, should enter their home/business office as their service location address.
- The standard NPPES/License address must be entered as the Service address for any provider that is not a billing provider.

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

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

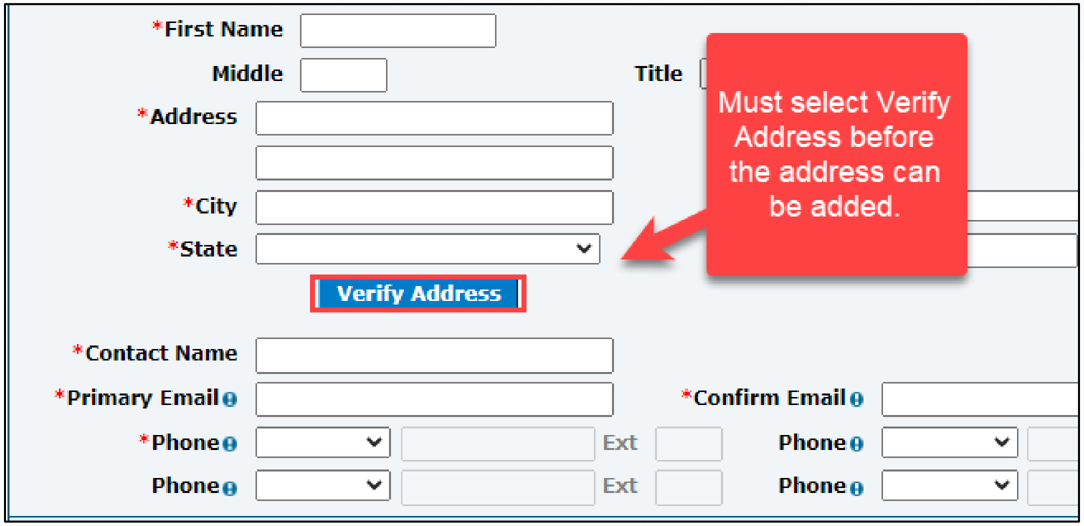
At least one Servicing address (physical location) is required. If no other address is provided the servicing address will also default to the Pay To, Mail To and Corporate Office address.

Once "**Servicing**" is selected, the guidelines for "Servicing" address will populate for your review. Also, the service address information section will populate. See next page.

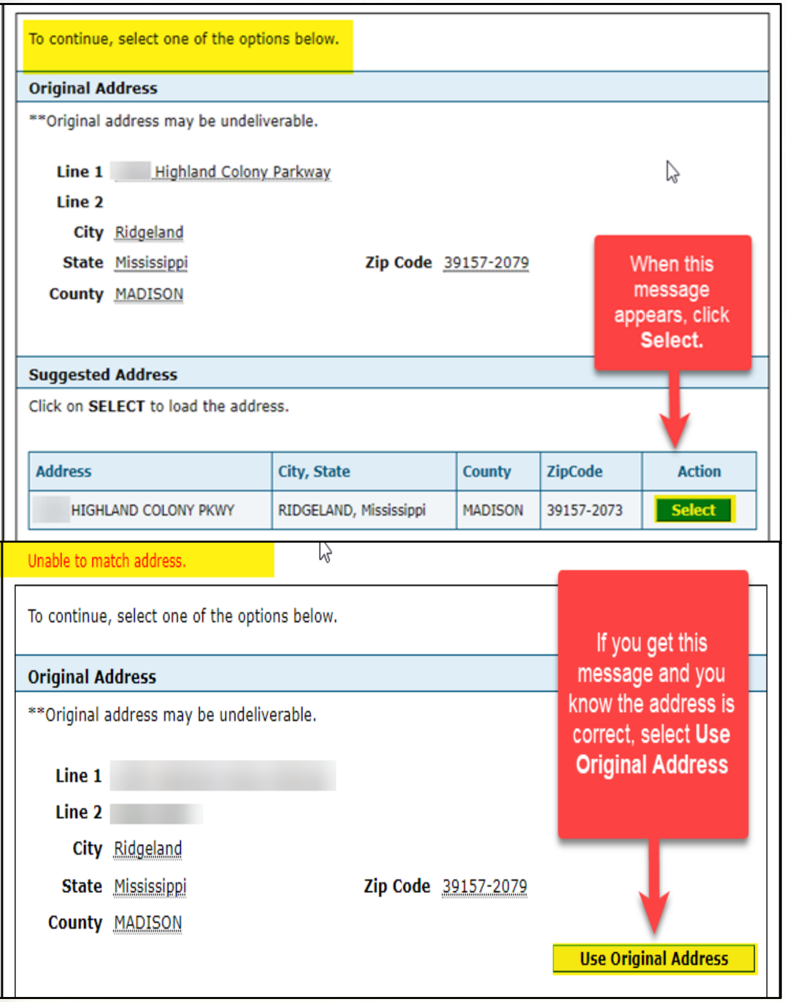
Verify Address

Once the Servicing address or Mail To address has been selected, the address must be verified to save the address.

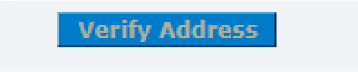
After selecting **Verify Address** a message will populate either informing that the address can't be matched or for a suggested address to be used.



Verify Address Cont'd



- If you get a message that is suggesting an address, click **Select** to use that address. In the example shown, the suggested address changed Parkway to PKWY, so the address is still the same. Or the address may show the same as you entered but **Select** must still be clicked.
- If you get a message showing "Unable to match address" and you are certain the address is correct, select **Use Original Address**.
- Once the address has been verified, the Verify Address button will now be grayed out.

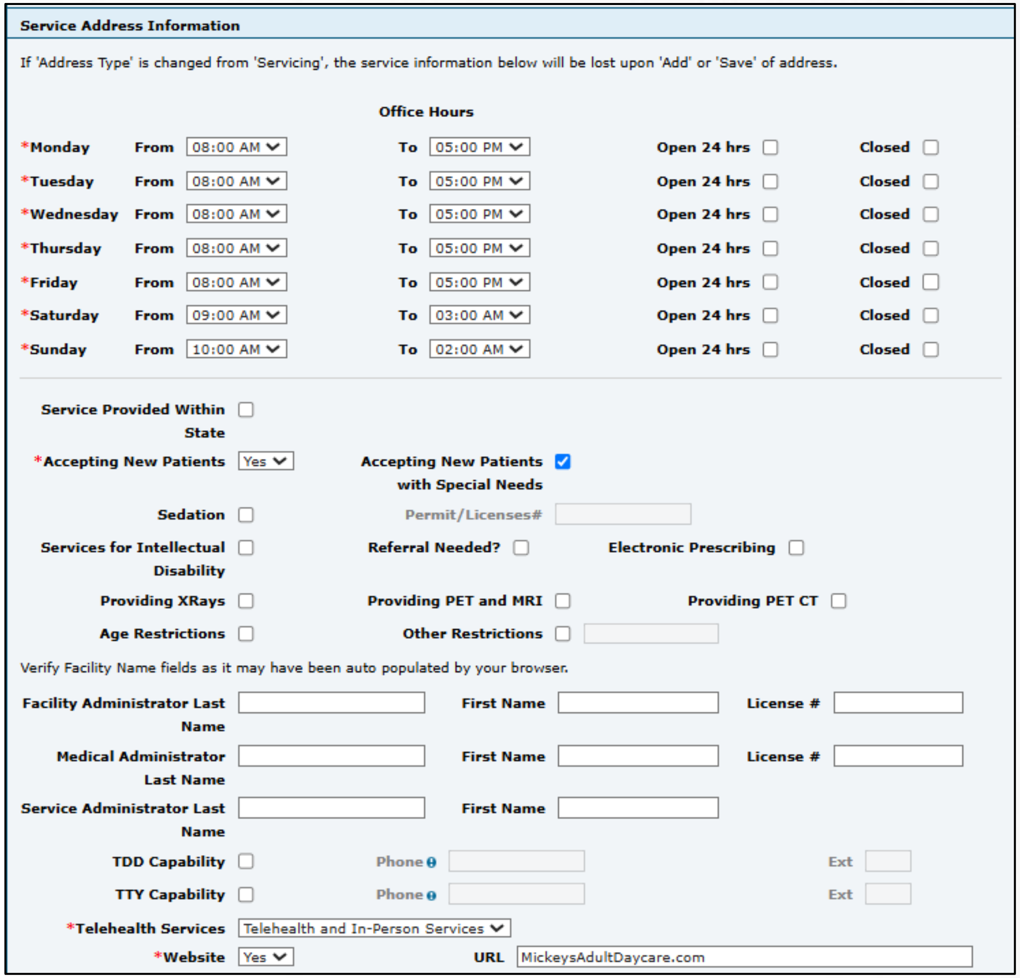


Servicing Address Information

Required fields include:

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

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


Service Address Information

If 'Address Type' is changed from 'Servicing', the service information below will be lost upon 'Add' or 'Save' of address.

Office Hours

*Monday	From	08:00 AM	To	05:00 PM	Open 24 hrs	Closed	
*Tuesday	From	08:00 AM	To	05:00 PM	Open 24 hrs	Closed	
*Wednesday	From	08:00 AM	To	05:00 PM	Open 24 hrs	Closed	
*Thursday	From	08:00 AM	To	05:00 PM	Open 24 hrs	Closed	
*Friday	From	08:00 AM	To	05:00 PM	Open 24 hrs	Closed	
*Saturday	From	09:00 AM	To	03:00 AM	Open 24 hrs	Closed	
*Sunday	From	10:00 AM	To	02:00 AM	Open 24 hrs	Closed	

Service Provided Within State

*Accepting New Patients: Yes | Accepting New Patients with Special Needs

Sedation | Permit/Licenses#

Services for Intellectual Disability | Referral Needed? | Electronic Prescribing

Providing XRays | Providing PET and MRI | Providing PET CT

Age Restrictions | Other Restrictions

Verify Facility Name fields as it may have been auto populated by your browser.

Facility Administrator Last Name | First Name | License #

Medical Administrator Last Name | First Name | License #

Service Administrator Last Name | First Name

TDD Capability | Phone | Ext

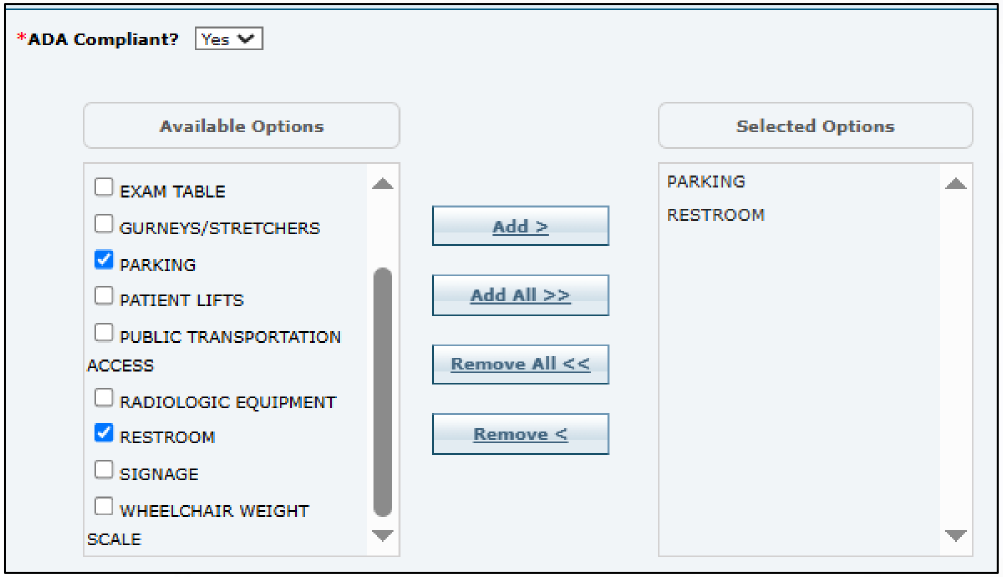
TTY Capability | Phone | Ext

*Telehealth Services: Telehealth and In-Person Services

*Website: Yes | URL: MickeysAdultDaycare.com

Servicing Address Information

- **ADA Compliant** is a required field.
- If the facility is **ADA Compliant**, continue by checking the Available Options as they apply.
- Click **Add** to add certain selections or **Add All** if all apply.



Servicing Address Information

- Once you select "**Add**", your address section will populate with the data you entered.
- Select "**+**" to add each additional applicable address, including any additional servicing addresses (up to 21 addresses). You must select "**Add**" after any data has been entered.
- Once all addresses have been added and saved, select "**Continue**" to move to the Affiliated Providers page.

Provider Addresses

The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

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- The standard NPPES/License address must be entered as the Service address for any provider that is not a billing provider.

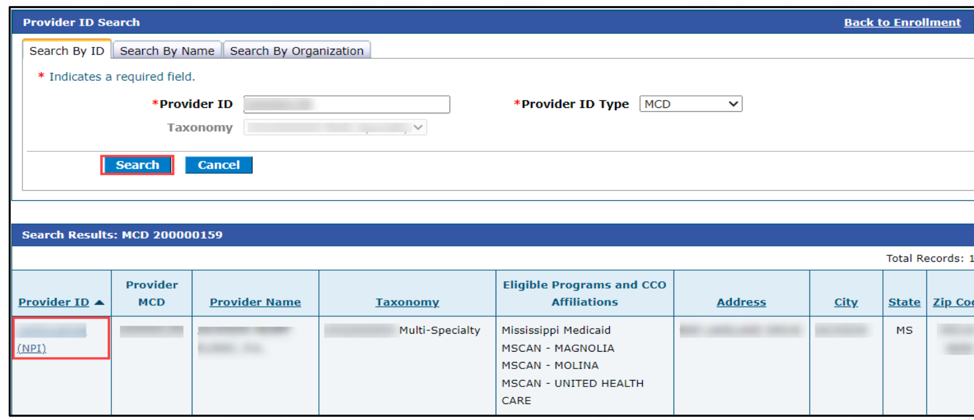
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **"Remove"** link to remove the entire row.

	Contact Name	Address Type	Address	City	State	Action
+	LD	Servicing	[illegible]	[illegible]	Mississippi	Copy Remove
+	Click to add address.					

Continue Exit

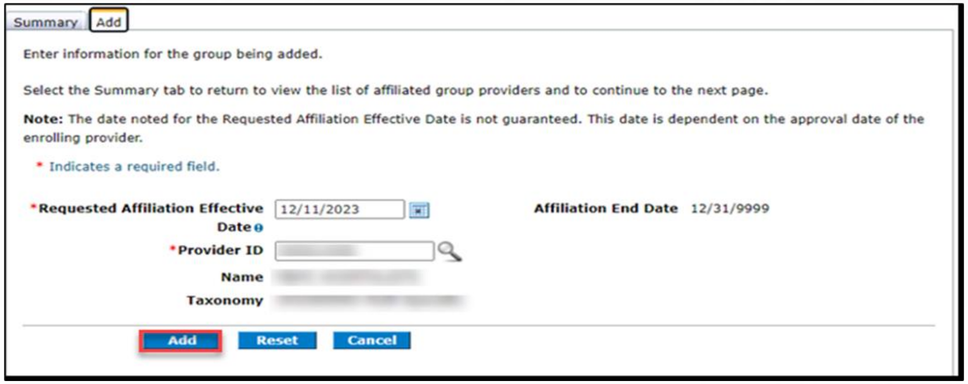
Affiliated Providers

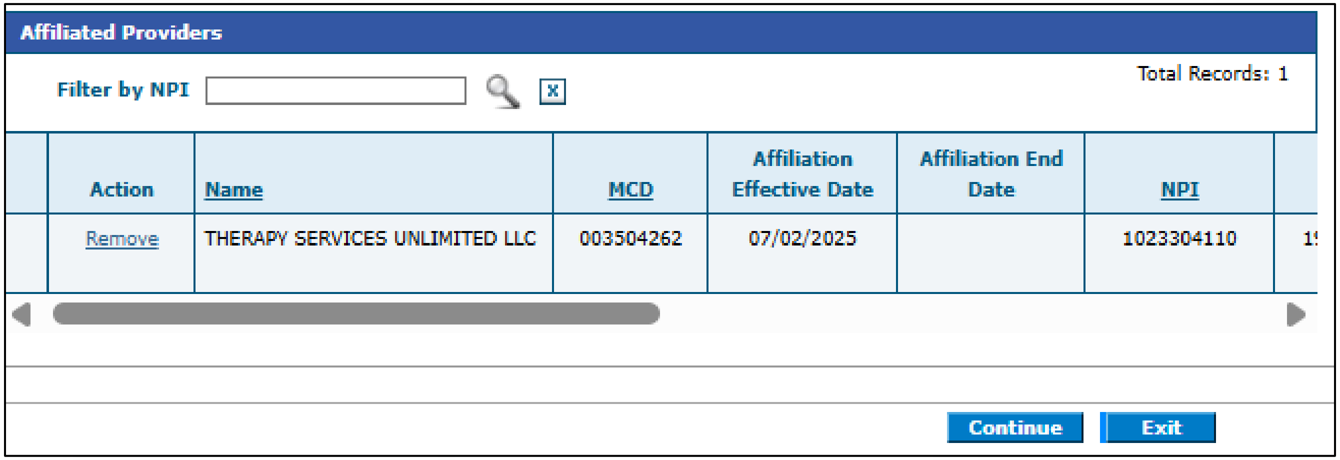
- This page defaults to the Summary tab. Select the **Add** tab to add affiliated providers. At least one provider must be added.
- Enter the provider information that you are adding and select or tab to the **magnify glass**.
- Select the "**hyperlink**" populated from your search.



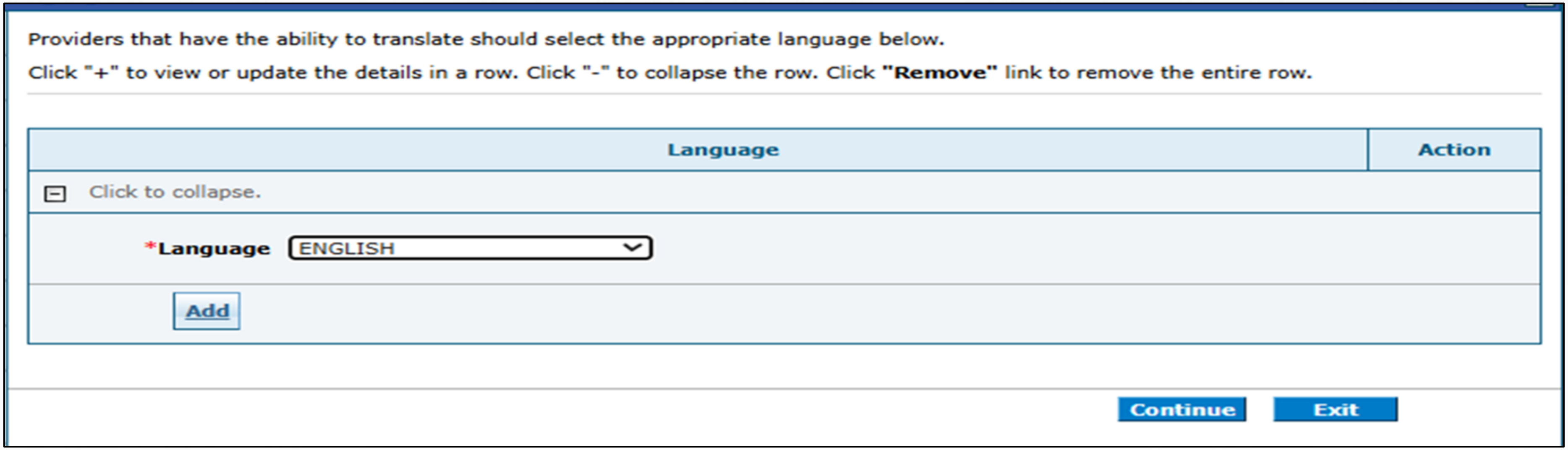
Affiliated Providers Cont'd

- Select "**Add**" after the data populates.
- The Affiliated Provider is added to the Summary Tab.





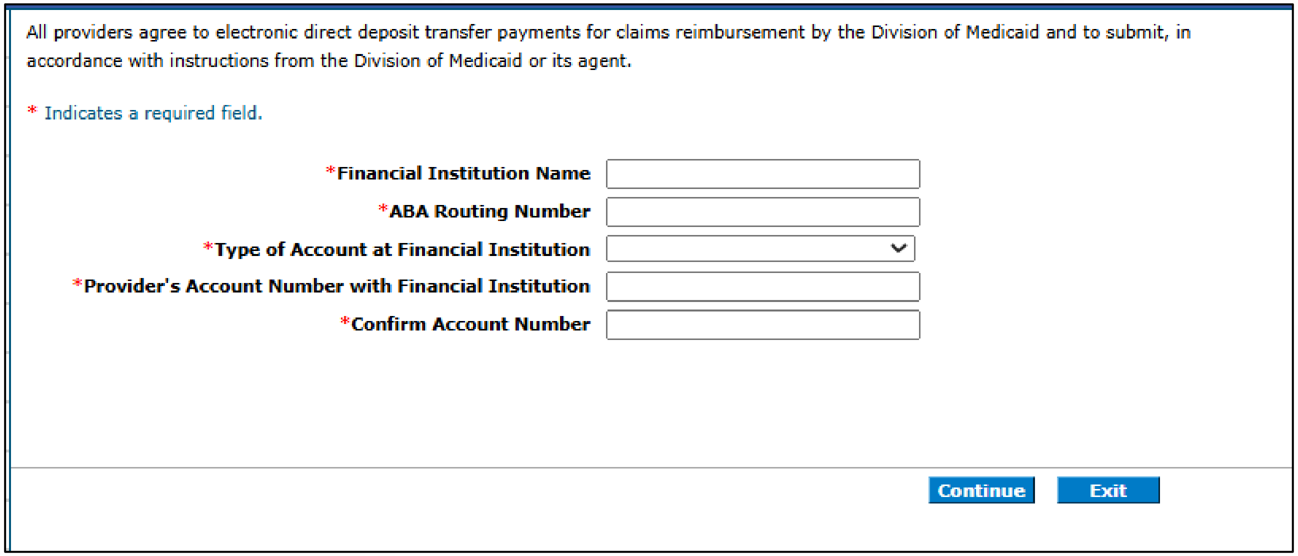
Languages page



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

EFT Information

- All providers agree to direct deposit through electronic funds transfer (EFT).
- EFT information is required and must be completed to continue.
- A pre-printed voided check (no starter checks) or letter from your financial institution must be uploaded as a PDF document.


All providers agree to electronic direct deposit transfer payments for claims reimbursement by the Division of Medicaid and to submit, in accordance with instructions from the Division of Medicaid or its agent.

* Indicates a required field.

*Financial Institution Name
*ABA Routing Number
*Type of Account at Financial Institution
*Provider's Account Number with Financial Institution
*Confirm Account Number

Continue Exit

Other Information

Certification required when no license information provided.

* Indicates a required field.

Board Certification

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

If board certified, please provide the board certification type, number, effective date, and expiration date of certification.

	Certification Type	Certificate #	Effective Date	End Date	Action
⊟	Click to collapse.				

*Certification Type *Certificate #

*Effective Date *End Date

Add Reset

Consolidated Cost Reports

*Does this organization file a consolidated cost report under another's Medicaid provider number? ○ Yes ○ No

Medicaid Provider Number

Continue Exit

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

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

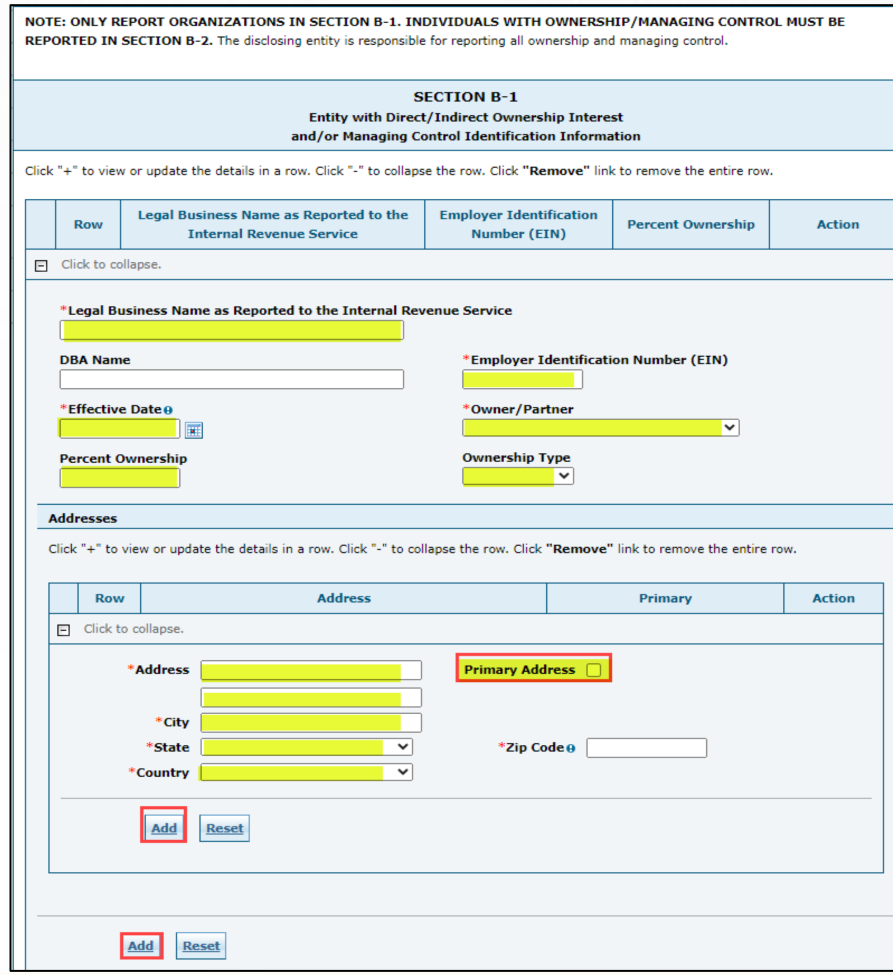
Select "**Add**" after entering each certification.

Select "Yes or No" to the question under Consolidated Cost Reports. If yes, provide the Medicaid Provider Number.

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

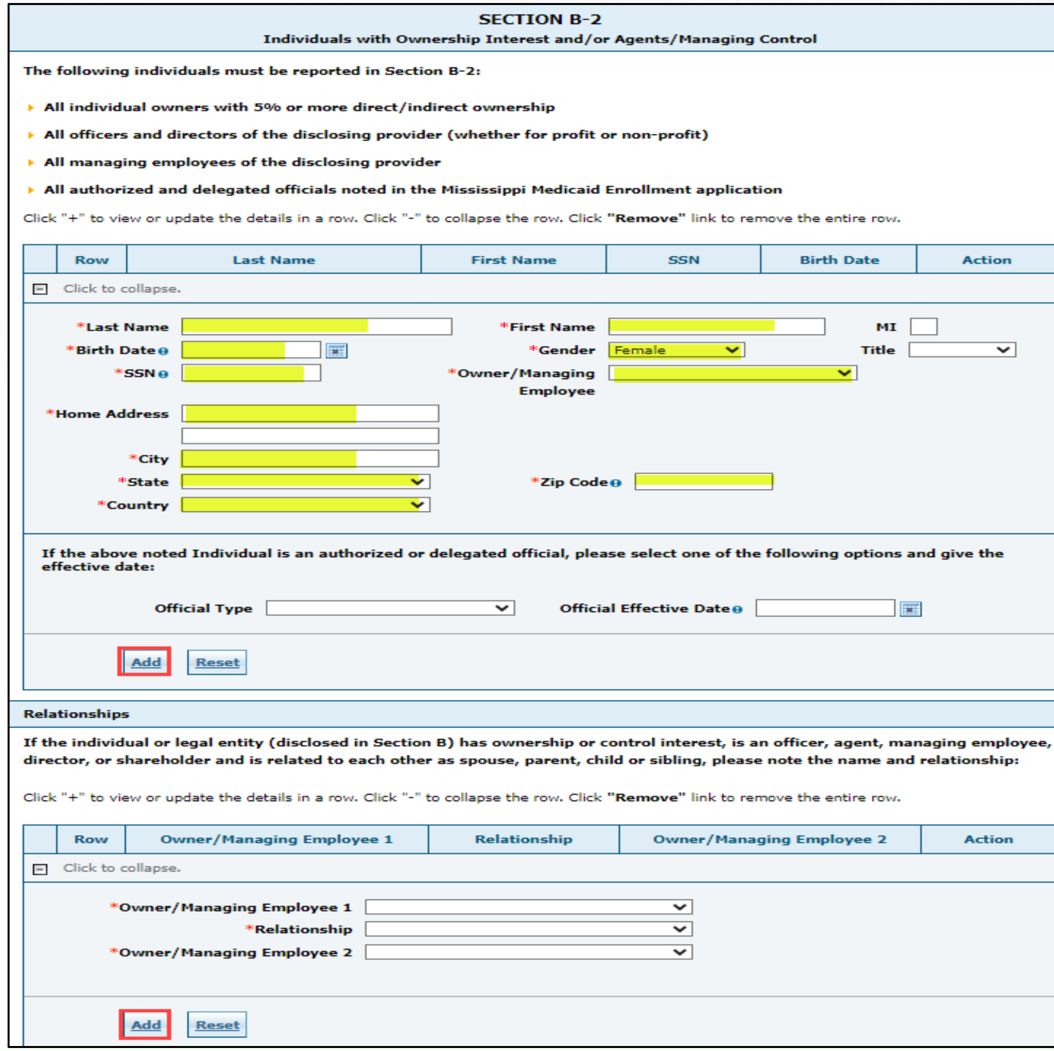
Disclosure Section B-1

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



Disclosure Section B-2

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


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

Click to collapse.

*Last Name *First Name MI
*Birth Date *Gender Female Title
*SSN *Owner/Managing Employee
*Home Address
*City
*State *Zip Code
*Country

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

Add Reset

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 collapse.

*Owner/Managing Employee 1
*Relationship
*Owner/Managing Employee 2

Add Reset

Disclosure Section C and D

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

SECTION C
Criminal Convictions and Other Sanctions

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

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

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

	Row	Name	Criminal/Sanction Info	Date	Action

Click to collapse.

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

Add Reset

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

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

i. has a direct or indirect ownership interest (or any combination thereof) of five percent (5%) or more in the group/organization;

ii. is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the group/organization or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets of the group/organization;

iii. is an officer or director of the group/organization, if the group/organization is organized as a corporation;

iv. is a partner in the group/organization, if the group/organization is organized as a partnership;

v. is an agent of the group/organization;

vi. is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the group/organization or part thereof, or directly or indirectly conducts the day-to-day operations of the group/organization or part thereof; or

vii. was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer or ownership or control interest to an immediately family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

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

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

	Row	Name	Relationship	Action

Click to collapse.

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

Add Reset

Disclosure Section E and F

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

SECTION E
Disclosure of Other Ownership and Control

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

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

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

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

*Other Legal Entity Name

*Other Legal Entity Address

*EIN of the Other

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

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

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

Add Reset

SECTION F
Disclosure of Subcontractor Information

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

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

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

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

*Name of the Subcontractor

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

*Address

*City

County

*State

*Zip Code

*SSN/EIN of the subcontractor

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

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

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

Add Reset

Disclosure Section G and H

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

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

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

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

	Row	Name of the Subcontractor	Name of Owner	Action

⊟ Click to collapse.

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

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

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

*

Add　Reset

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

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 <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 <u>a 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 10/18/2023

Continue　Exit

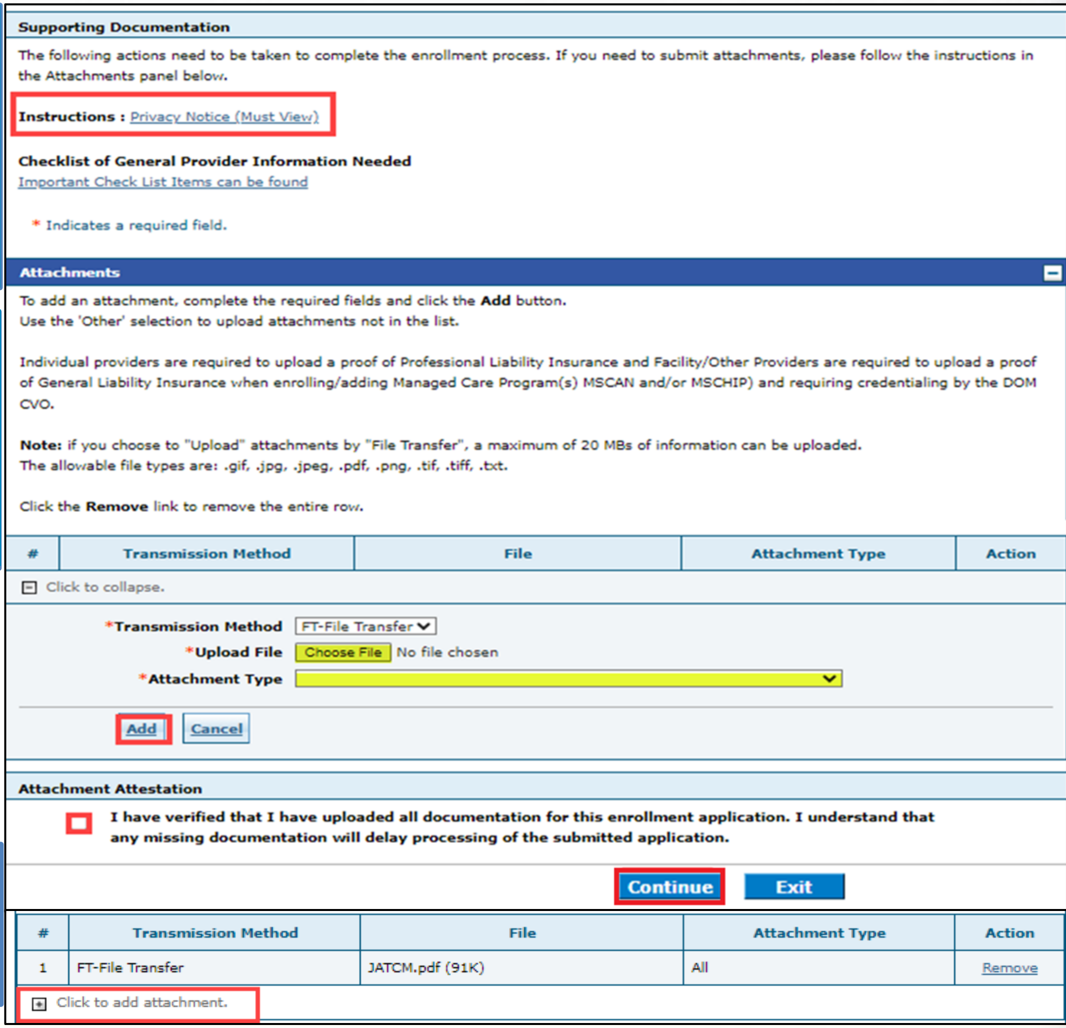
Supporting Documentation

You must select the "**Instructions = Privacy Notice Link**." A separate window will open to the Mississippi Division of Medicaid website. Once you have read the notice the window can be closed. If this is not selected, you cannot move to the next page.

Select "**Choose File**" to locate the appropiate file to be added. Select the "**Attachment Type**" drop-down that matches your file attachment. If your documents are saved in one document, select "**All**" for the type. If not, select the appropiate type.

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

Select the **box** for the **Attachment Attestation statement**. Select "Continue" to the Agreement page.



Terms of Agreement

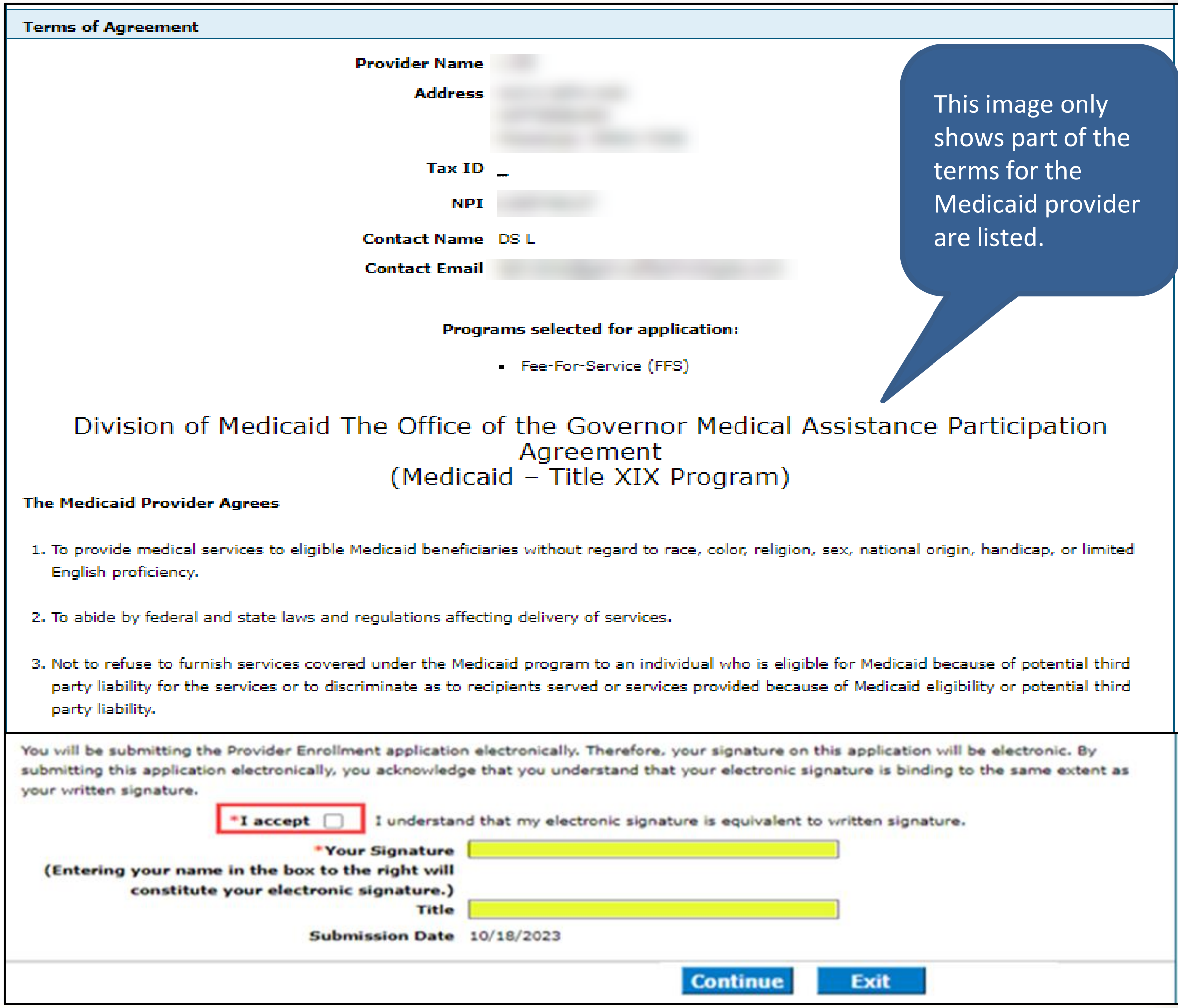
The terms of enrollment are stated. You must accept these terms to submit the enrollment application.

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

Select "**I accept**" box.

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

Select "**Continue**".

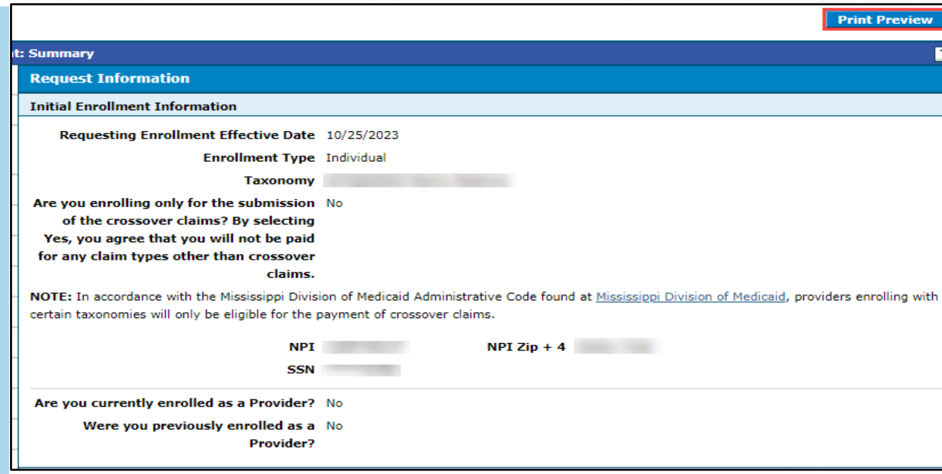


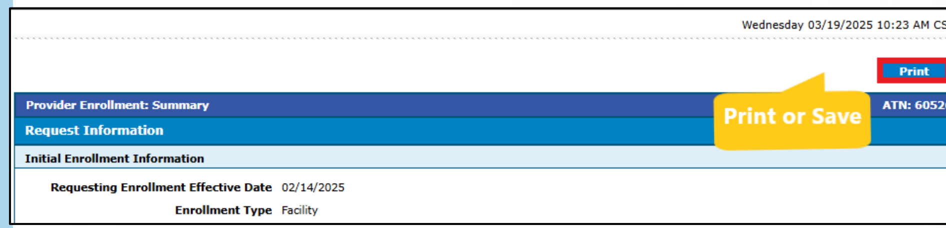
Summary

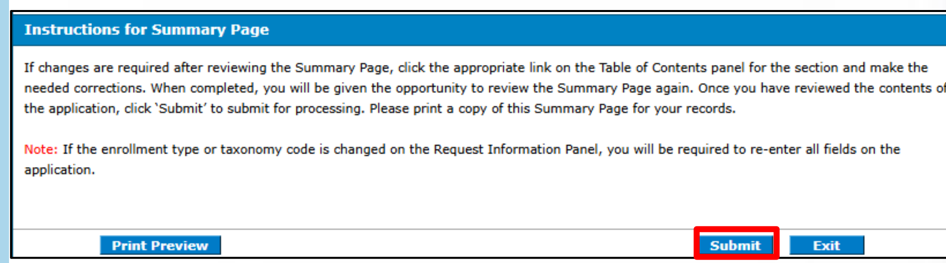
- The **Summary** page shows your entire enrollment application. If any changes need to be made, select the appropriate link on the **Table of Contents** panel (left side) and make needed corrections.

- Select **Print Preview**, **top right** or **bottom left**, to either save or print the application. Once selected, another window will populate, select "**Print**". Final window will populate providing a printer to physically print or change the drop down to "Microsoft Print to PDF" that will allow you to save an electronic copy of the application. Select "**Print**" for the final time.

- Once you have reviewed/saved/printed the application select "**Submit**". This will submit the application.



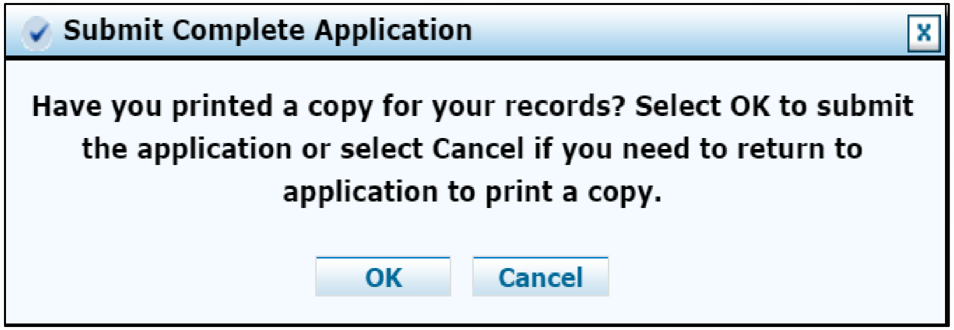




Print a Copy

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

- Select "**OK**" once you have printed a copy.



Application Submission and Tracking Number (ATN)

- You will receive confirmation that the application was submitted. Click the **EXIT** button to leave the application portal.

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

Provider Enrollment Application

MM Mississippi Medical Assistance Portal <DoNotReply@gainwelltechnologies.com>
To Willems, Christine

Reply

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

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

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

The following link has been provided for your convenience.

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

View Application Status

Online Provider Enrollment

Enrollment Application
Initiate a new provider enrollment application.

Resume Enrollment
Resume an existing enrollment application that has not been submitted.

Copy Existing Submitted Application
To reduce provider burden, a previously submitted application may be copied to prevent the requirement of entering data multiple times. Please review the entire application to ensure that information contained is still accurate before submission to the agency.

Enrollment Status
Check the current status of an enrollment application.

Provider Enrollment - Status Back to Home ?

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For further questions, please contact Provider Services at 1-800-884-3222.

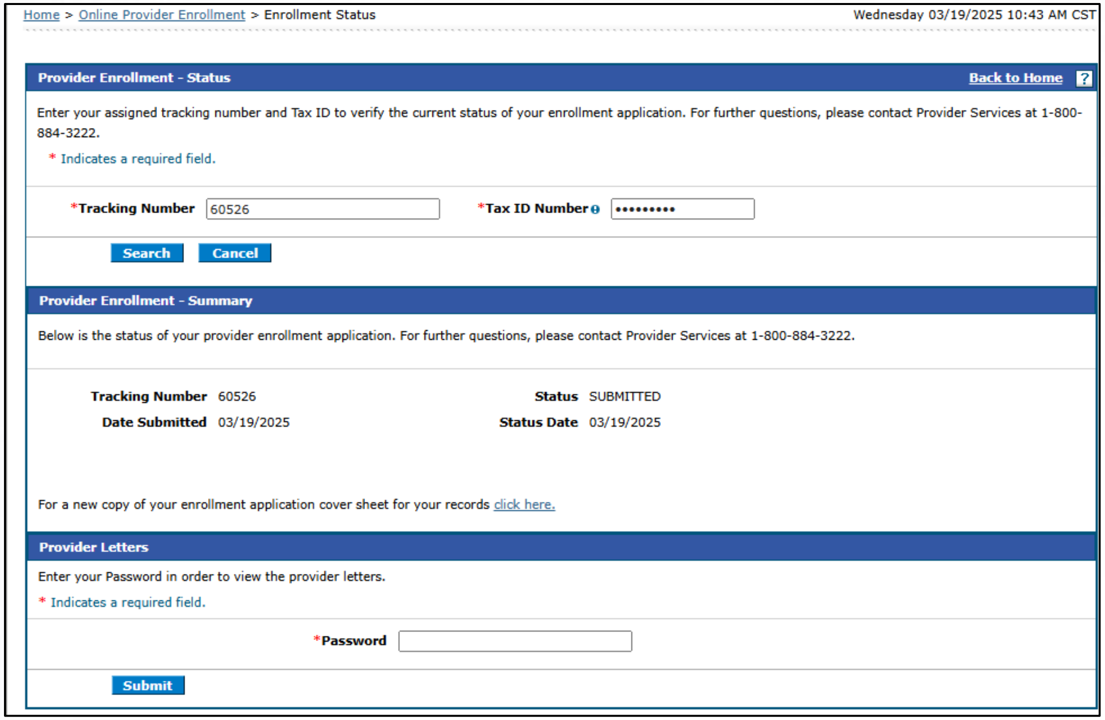
* Indicates a required field.

*Tracking Number *Tax ID Number

Search Cancel

- Select **Provider Enrollment Access** on the Provider Home Page.
- Select the **Enrollment Status** link under Online Provider Enrollment.
- Provide the **tracking number** and **Tax ID** number submitted on the application.

View Application Status


Home > Online Provider Enrollment > Enrollment Status   Wednesday 03/19/2025 10:43 AM CST

Provider Enrollment - Status   Back to Home ?

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For further questions, please contact Provider Services at 1-800-884-3222.

* Indicates a required field.

*Tracking Number 60526   *Tax ID Number •••••••••

Search   Cancel

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For further questions, please contact Provider Services at 1-800-884-3222.

Tracking Number	60526	**Status**	SUBMITTED
Date Submitted	03/19/2025	**Status Date**	03/19/2025

For a new copy of your enrollment application cover sheet for your records click here.

Provider Letters

Enter your Password in order to view the provider letters.

* Indicates a required field.

*Password

Submit

- The **Provider Enrollment Summary** lists the application status and the date for the status and submission date.

- To view any **Provider Letters**, enter the password for the application submitted.