Office of the Governor | Mississippi Division of Medicaid

Individual Provider

Initial Enrollment Application

May 16, 2025

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.**
- **Individuals 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).
- **Individuals 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

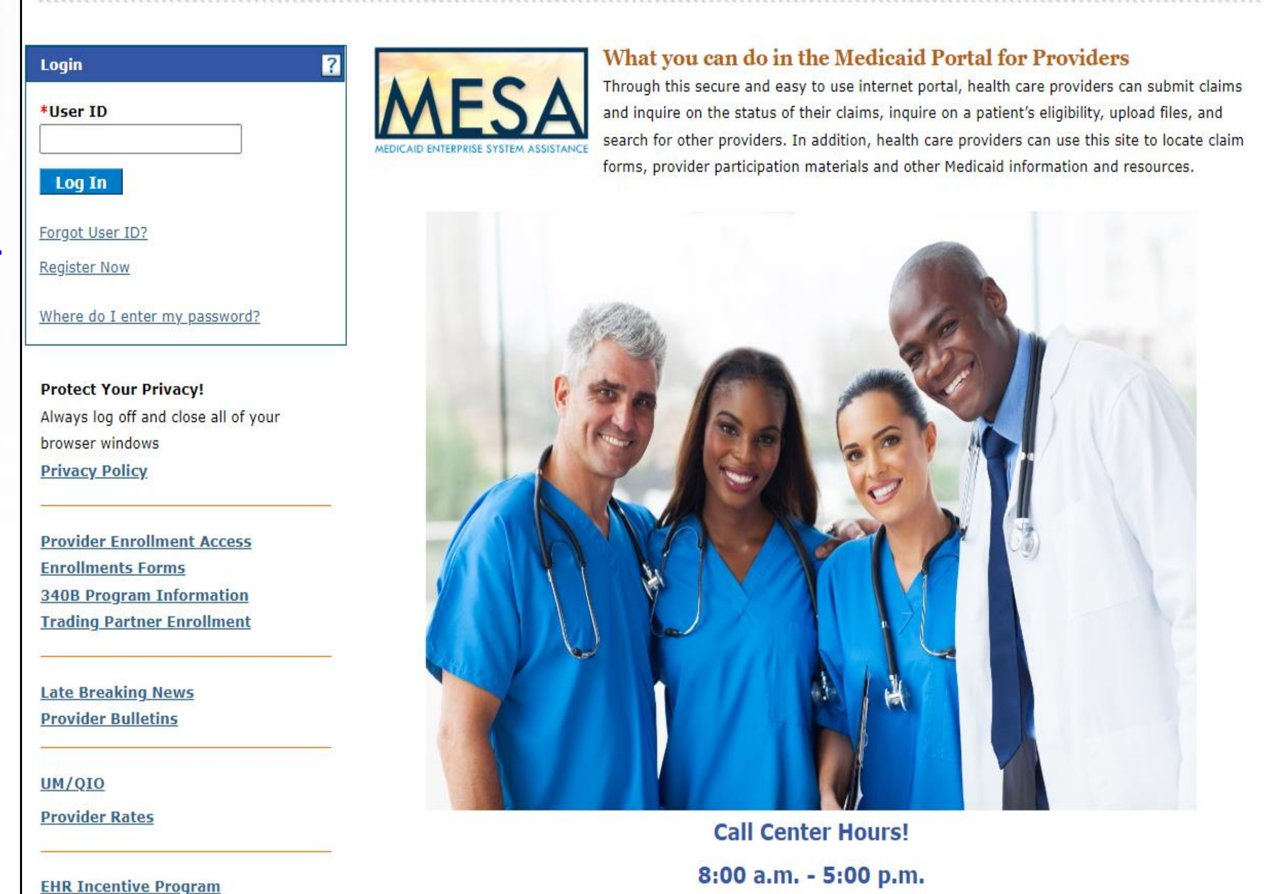
- By selecting the "**+**" sign, you can view or update that specified row.
- To remove a row, select the "Remove" link located in that specific row.
- The red asterisk signifies a required field.
- All application attachments must be in pdf, gif, jpg, jpeg, png, tif, tiff or txt format.
- At anytime 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.
- Non-billing providers are only required to enroll once per NPI and taxonomy combination using their primary service location. After enrollment, non-billing providers must affiliate with a billing provider (such as a group practice) that will submit claims on their behalf. This affiliation must be established for each practice location where the non-billing provider renders services. Each additional servicing location provided will result in a separate Medicaid enrollment.

Accessing Provider Enrollment

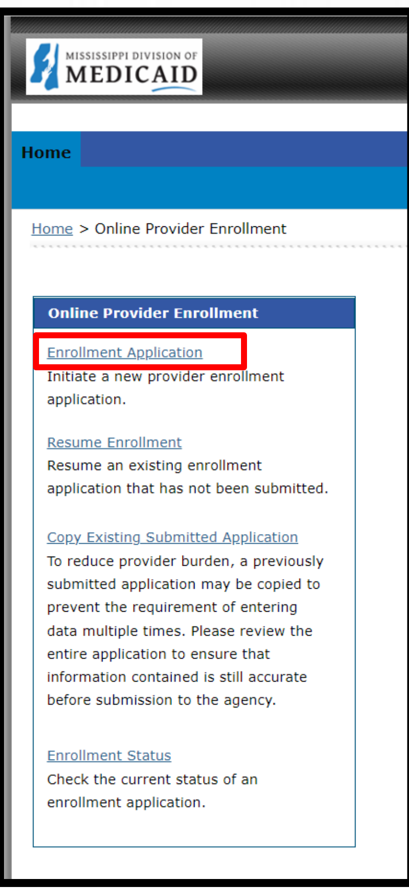
- Go to the Mississippi Division of Medicaid's website to access the MESA Provider Portal. Mississippi Division of Medicaid

- 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.

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

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

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

Additional Enrollment Requirements Checklist (Must View)

*Enrollment Type: Individual

*Taxonomy:

*Requesting Enrollment Effective Date: 08/30/2023

*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. Yes / 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 | *NPI Zip + 4

*SSN

*Are you currently enrolled as a Provider? Yes / No

*Were you previously enrolled as a Provider? Yes / 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 and/or MSCHIP enrollments.

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

Application Contact Information

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

*Last Name: LE

*First Name: DS

Title:

*Phone: 5014551212 | Ext

Fax Number:

*Work Email: lezli.duke@gainwelltechnologies.com

*Confirm Email: lezli.duke@gainwelltechnologies.com

Preferred Method of Communication: Email

Continue | Exit

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.

Complete the fields in the **Provider Information** section. Individuals should provide their own NPI and SSN and not the Groups information they are affiliated with.

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.

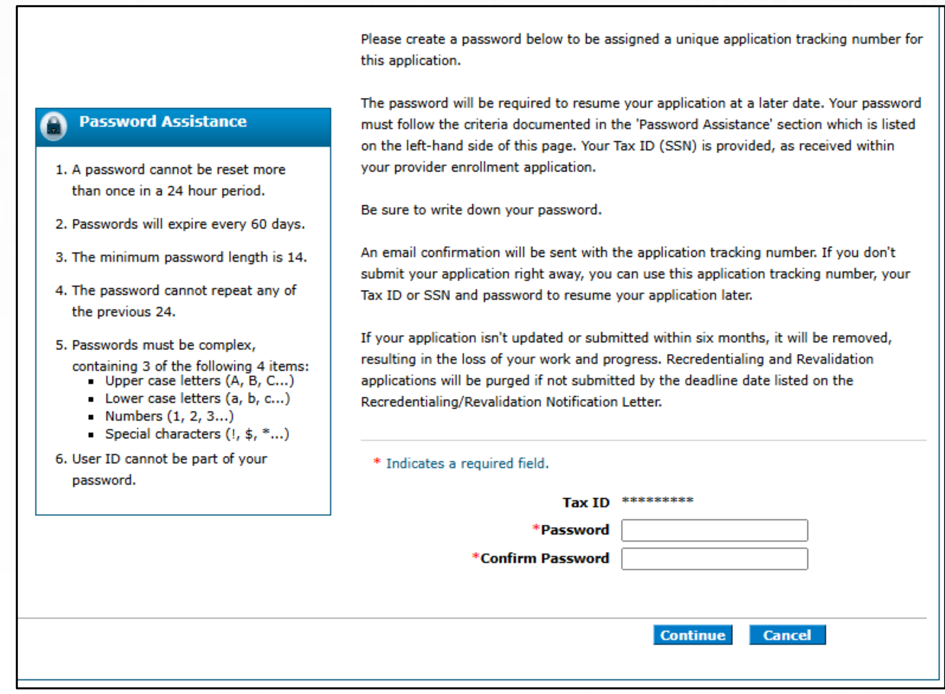
Select **Continue** to move to the **Password Creation** page.

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 Social Security Number (SSN) 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

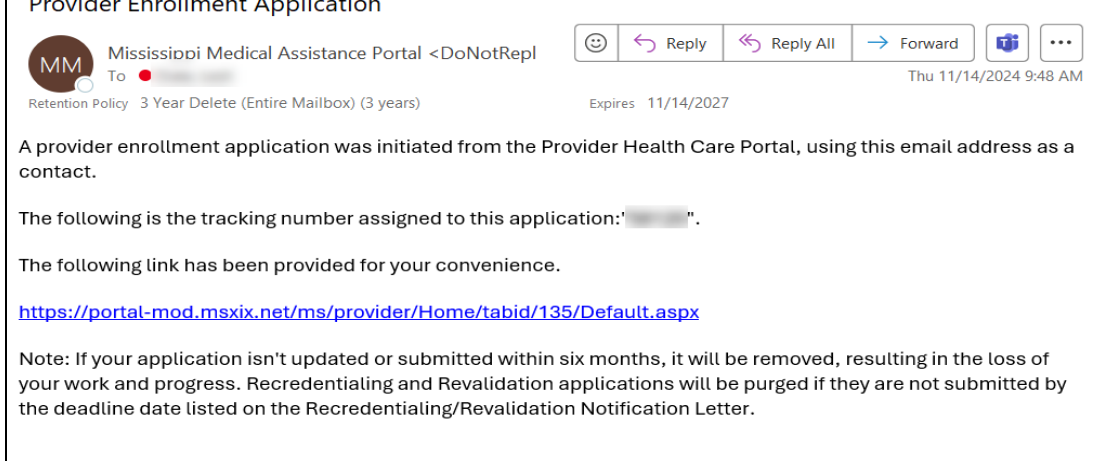
Continue Cancel

Application Tracking Information

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

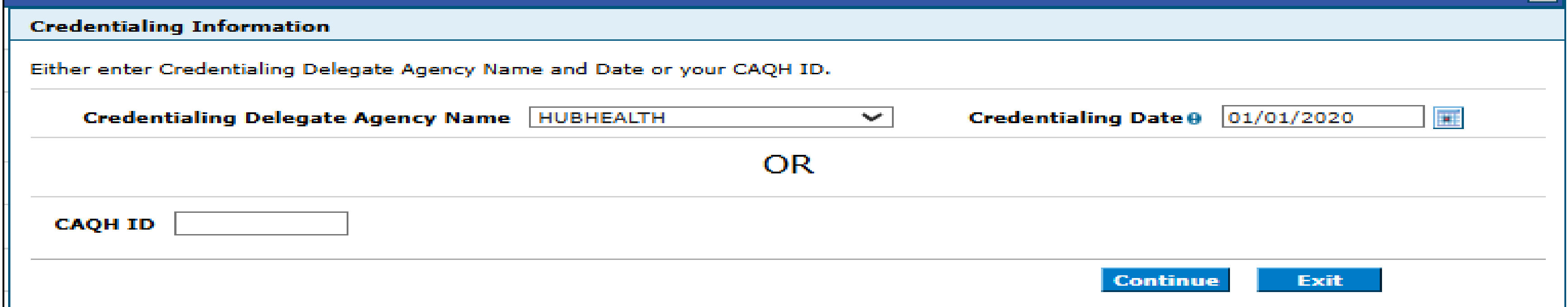
You will need this number and the **Social Security Number (SSN)** to view completed application status.

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



Credentialing Information

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



- Select the Credentialing Delegate Agency Name from the dropdown list or enter the CAQH ID.

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

Coordinated Care Organization Selection (CCO)

This is only applicable to providers 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 appropriate box and enter Business Start or Incorporation Date if applicable.
- Select Public/Private Indicator from drop down.
- Select Gender and enter the Birth Date of the Provider.
- For Sole Proprietor: Enter the Legal Tax Name, DBA Name, Sole Proprietor Tax ID, Tax ID Type. The affiliated Group's Tax ID should not be provided.
- 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 dr

Individual

*Organization Type: Individual

Registered with Secretary of State ☐ Business Start Date
Incorporated ☐ Incorporation Date
Chain Affiliated ☐
Operated by Management Company ☐

*Public/Private Indicator

Individual Providers

*Gender *Birth Date

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 th

Sole Proprietor

*Organization Type: Sole Proprietor

Registered with Secretary of State ☐ Business Start Date
Incorporated ☐ Incorporation Date
Chain Affiliated ☐
Operated by Management Company ☐

*Public/Private Indicator: Private

Legal Tax Name

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

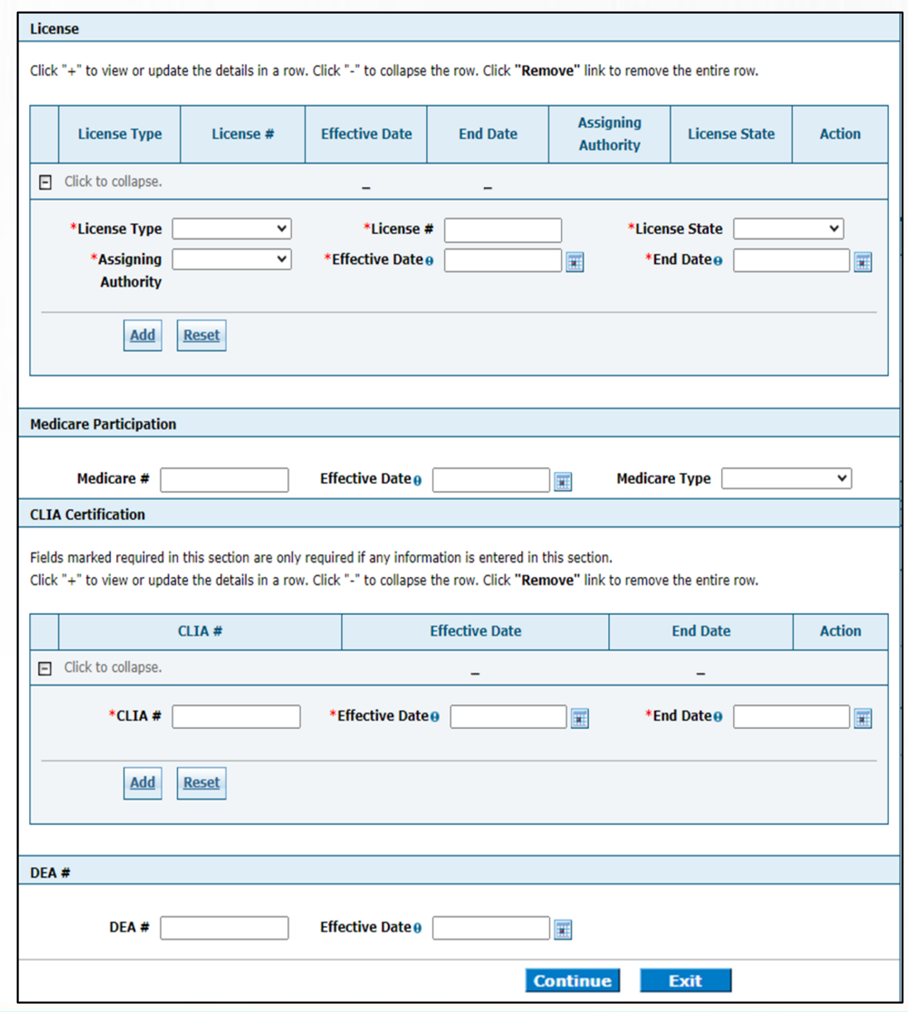
*Legal Tax Name
DBA Name
Sole Proprietor Tax Id *Tax ID Type ◉ EIN ○ SSN

Individual Providers

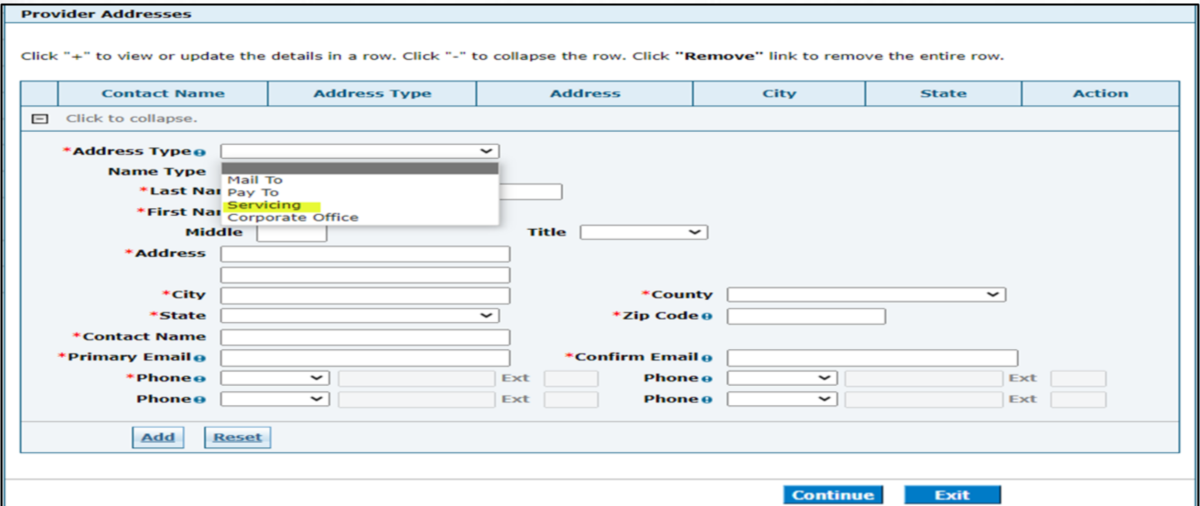
*Gender *Birth Date

Provider Identification Cont'd

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



Provider Address



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
Mail To
Pay To
Servicing
Corporate Office
*Last Na
*First Na
Middle
Title
*Address
*City
*County
*State
*Zip Code
*Contact Name
*Primary Email
*Confirm Email
*Phone Ext
Phone Ext
Phone Ext
Phone Ext
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**.

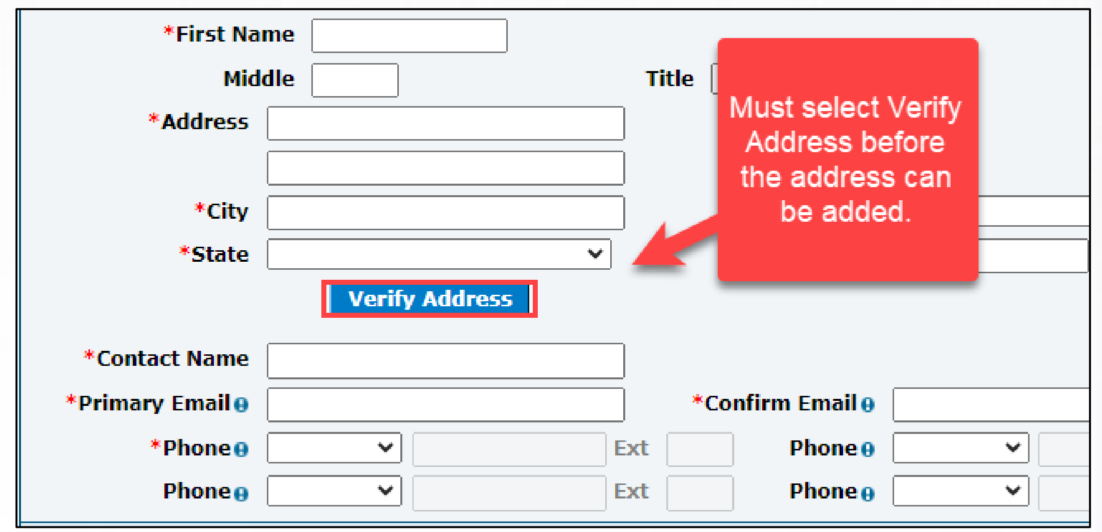
At least one Servicing address (physical location) is required. If no other address is provided the servicing address will also default to the Pay To, Mail To and Corporate Office address.

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.

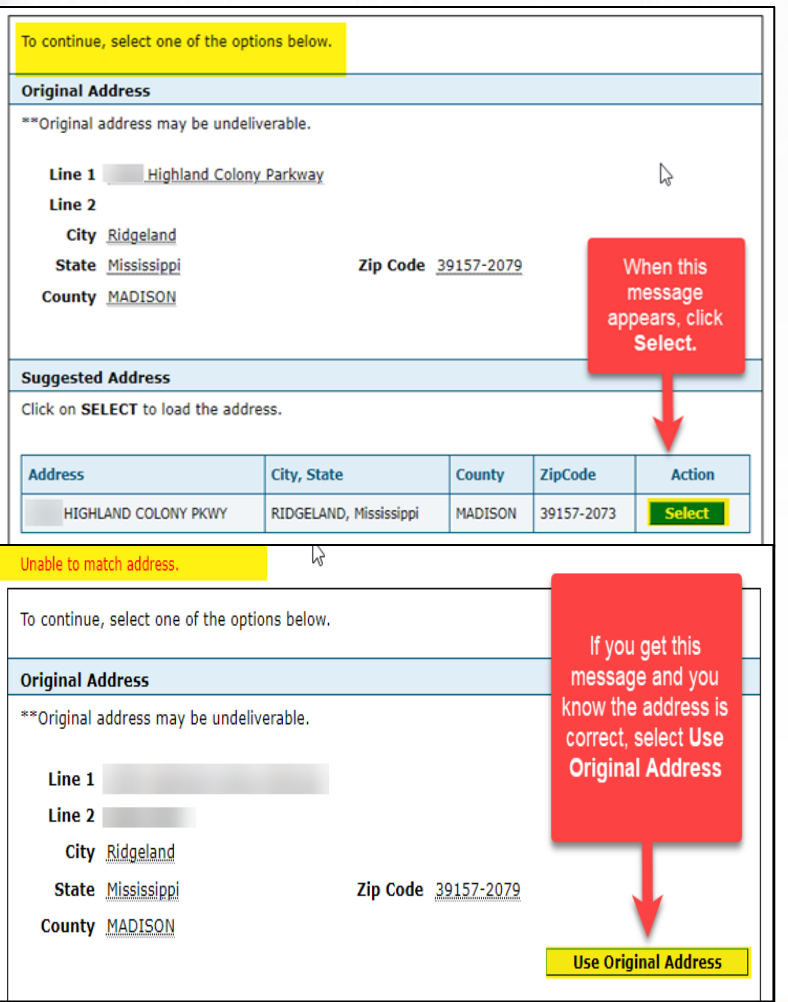
Verify Address

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.

Verify Address

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

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

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

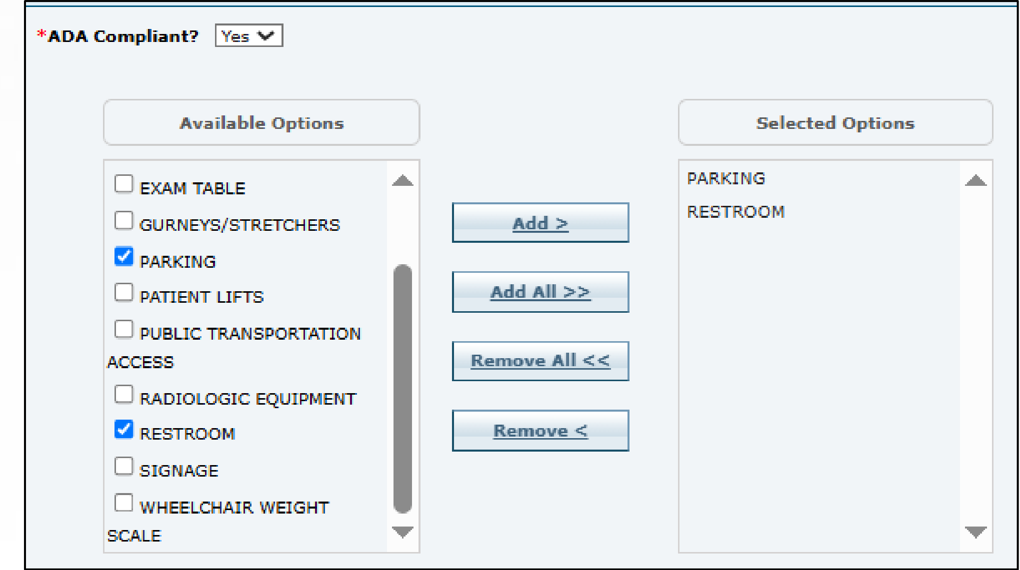
TTY Capability ☐ — Phone — Ext

*Telehealth Services: Telehealth and In-Person Services

*Website: Yes — URL: MickeysAdultDaycare.com

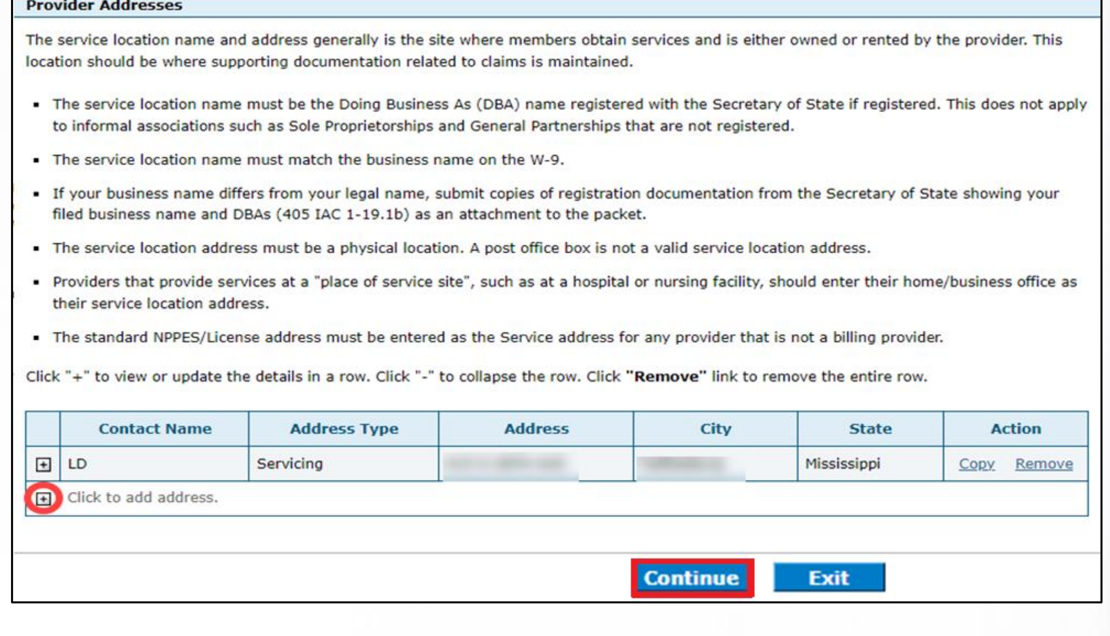
Servicing Address Information

- **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.



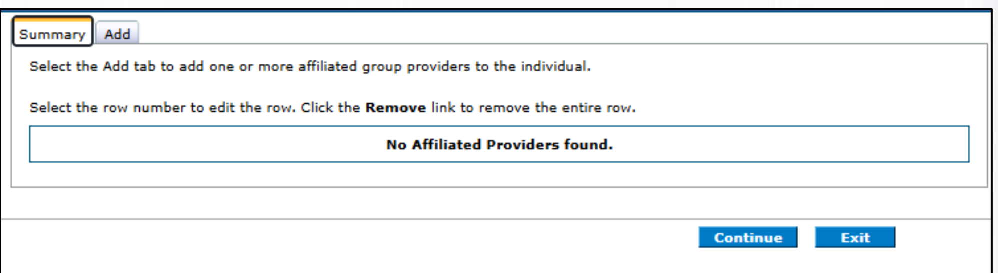
Servicing Address Information

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



Affiliated Providers

- At the Affiliated Provider page, the applicant may add Affiliated Providers. If the applicant chooses not to affiliate with a Group, the system will allow the applicant to select Continue to the next page.
- This page defaults to the Summary tab. Select the Add tab to add affiliated providers.
- Enter the NPI of the provider and then tab to the magnifying glass. The information will auto populate.
- The applicant can change the date of the affiliation here.



Summary | Add

Enter information for the group being added.

Select the Summary tab to return to view the list of affiliated group providers and to continue to the next page.

Note: The date noted for the Requested Affiliation Effective Date is not guaranteed. This date is dependent on the approval date of the enrolling provider.

* Indicates a required field.

***Requested Affiliation Effective Date** 12/11/2023 **Affiliation End Date** 12/31/9999

***Provider ID**

Name

Taxonomy

Add | Reset | Cancel

Affiliated Providers Cont’d

- Select Add to save the Affiliated Provider. Repeat the same steps to add additional Affiliated Providers.
- The date noted for the Requested Affiliation Effective Date is not guaranteed. The date is dependent on the approval date of the enrolling provider. The system will only permit past effective dates to be up to one year old or up to the provider’s approved effective date, whichever is most recent. If a past date specified for affiliation effective date overlaps with past affiliations between the same entities, then the system will give and error message.
- The system will allow gaps between affiliations between the same entities. The system will allow affiliations between individual providers and organizational providers, such as groups; however, the system will not allow affiliations between two Individual providers.

Summary | Add

Enter information for the group being added.

Select the Summary tab to return to view the list of affiliated group providers and to continue to the next page.

Note: The date noted for the Requested Affiliation Effective Date is not guaranteed. This date is dependent on the approval date of the enrolling provider.

* Indicates a required field.

*Requested Affiliation Effective Date: 12/11/2023

Affiliation End Date: 12/31/9999

*Provider ID

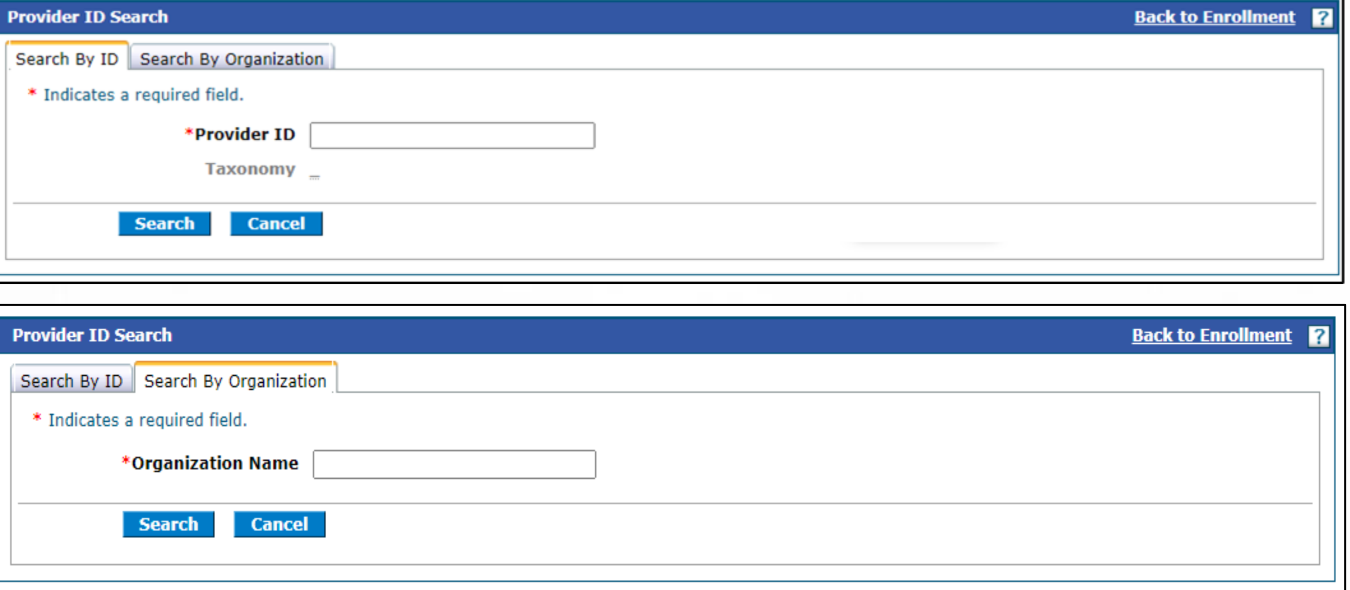
Name

Taxonomy

Add | Reset | Cancel

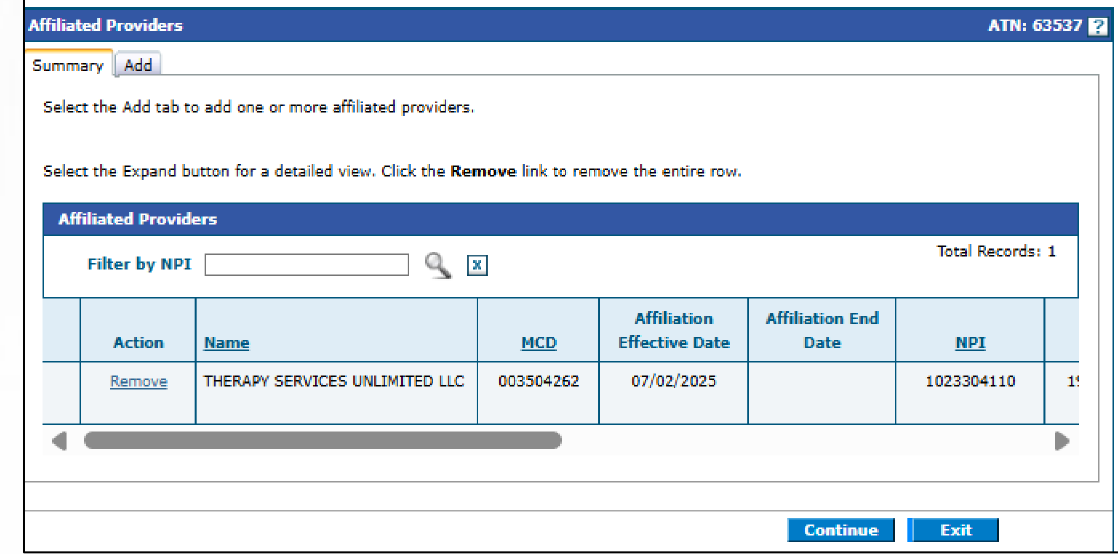
Affiliated Providers Cont'd

- If the applicant does a search by using the magnifying glass, the Search by ID and Search by Organization tabs will populate.
- The Search by ID tab allows the applicant to change the Provider ID Type to NPI, MCD or Medicaid ID. Select the Provider ID Type drop-down box to change the Provider ID Type.
- Select the Search by Organization tab to search by the Organization Name.

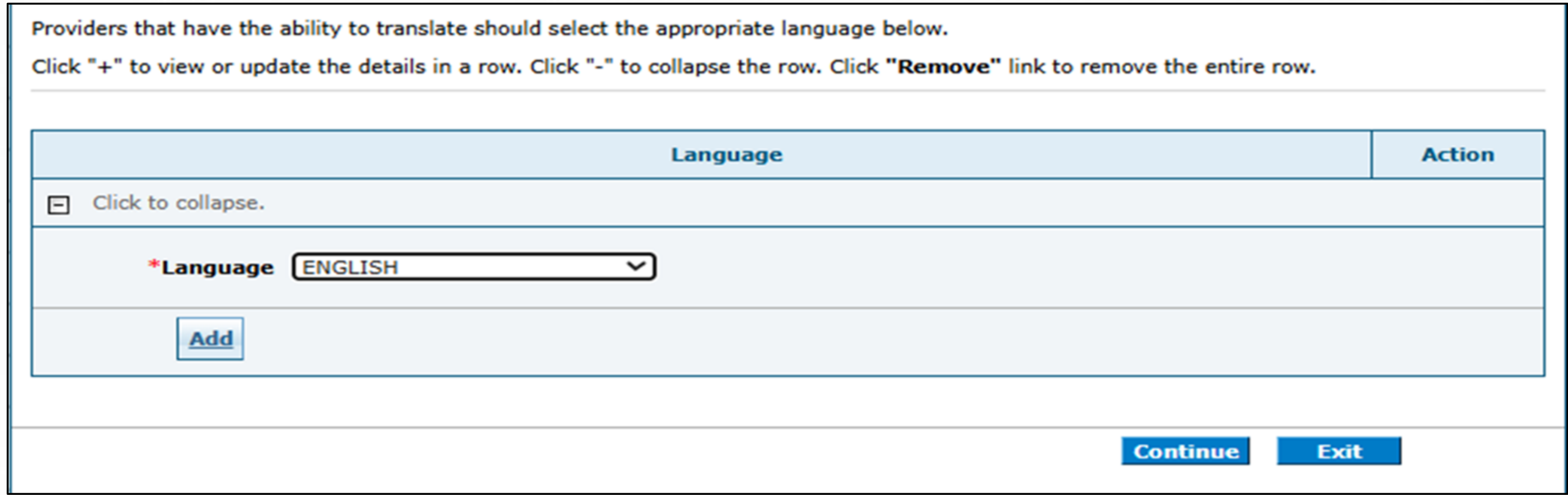


Affiliated Providers Cont'd

- A list of the added Affiliated Providers displays on the Summary page. If finished, select Continue to the Languages page.
- If the applicant would like to remove an Affiliated Provider, select the Remove link found under the Summary tab to remove that Affiliated Provider.



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 or 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

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

Certification required when no license information provided.

* Indicates a required field.

Insurance

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

Information regarding professional (malpractice) liability insurance coverage is required.

Please refer to the CVO Professional Liability Insurance Policy for coverage requirements.

Note: The Provider is required to upload proof of liability insurance.

Name	Policy #	Effective Date	Expiration Date	Action

Click to collapse.

*Carrier or Self-Insured Name | *Policy Number
*Address
*City | *County
*State | *Zip Code
*Effective Date | *Expiration Date
*Do you have unlimited coverage with this insurance carrier? Yes No
*Amount of Coverage Per Occurrence | *Amount of Coverage Per Aggregate

Add | Reset

Complete the Insurance Coverage information section and select "Add" to save the data entered. **Information regarding professional (malpractice) liability insurance cowage is required.** Please refer to the CVO Professional Liability Insurance Policy hyperlink for coverage requirements. *This is not applicable to providers who selected the FFS program only.*

The Provider is required to upload proof of liability insurance as a PDF document on the Supporting Documentation page. *This is not applicable to providers who selected the FFS program only.*

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

JCAHO - Joint Commission Approval
ASHA Certification
Certification of Disease Management

Add

Continue | Exit

Using the drop down, select the applicable certification type, JCAHO, ASHA Certification or Certification of Disease Management.

Select "Add" after entering each certification.

Select "Continue" to the Hospital Admittance page.

Hospital Admittance

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

Make the applicable selection:, **Admitting Privileges** or an **Admitting Plan**. If you do not have admitting privileges or an admitting plan, please select "Neither".

Hospital Admittance

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

	Admitting Type	Hospital	Address	City	State	Action
⊟ Click to collapse.						

***Do you have Admitting Privileges, an Admitting Plan or Neither?** ○ Admitting Privileges ○ Admitting Plan / Alternate Arrangement ○ Neither

Admitting Privileges

Primary Hospital ○ Yes ○ No
Hospital Name
Hospital Affiliation NPI
Address
City
County
State
Zip Code
Office Phone
Fax
Effective Date
End Date
Department Director Name
Full, Unrestricted Access? ○ Yes ○ No
Are Privileges Temporary? ○ Yes ○ No
Admitting Privileges Status (e.g. None, Full Unrestricted, Provisional, Temporary)
Of Total Annual Admissions, What Percentage is to this Hospital? %
Terminated Affiliation Information

Admitting Plan / Alternate Arrangement

Who will admit on your behalf?
Admitting Physician NPI
Please submit documentation of the agreement between you and the admitting physician.

Add Reset

If "**Neither**" is selected the fields will be grayed out but you **must** select "**Add**" then "Continue" to the Applicant History page.

Hospital Admittance Cont'd

If you have **Admitting Privileges** the following section must be completed. Select "**Add**" to save the entered data.

Admitting Privileges

*Primary Hospital ◯ Yes ◯ No
*Hospital Name
*Hospital Affiliation NPI
*Address
*City
*County
*State
*Zip Code
*Office Phone
Fax
*Effective Date
*End Date
*Department Director Name
*Full, Unrestricted Access? ◯ Yes ◯ No
*Are Privileges Temporary? ◯ Yes ◯ No
*Admitting Privileges Status (e.g. None, Full Unrestricted, Provisional, Temporary)
*Of Total Annual Admissions, What Percentage is to this Hospital? %
*Terminated Affiliation Information

Add | Reset

If you have an **Admitting Plan** the following section must be completed. Also, you must attach the PDF agreement between you and the admitting physician. Select "**Add**" to save the entered data.

Admitting Plan / Alternate Arrangement

*Who will admit on your behalf?
*Admitting Physician NPI

Please submit documentation of the agreement between you and the admitting physician.

Add | Reset

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

Applicant History

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

Read and answer "Yes or No" under Training. If "**No**," is answered, please list explanation in the box provided.

Training

*Are you and your staff annually trained on Fraud, waste, and abuse? ◉ Yes ○ No

If No, please explain:

Read and answer "**Yes**" or "**No**" to each question. If "Yes," please enter your explanation in the box provided.

Hospital Privileges and Other Affiliations

*Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? ○ Yes ◉ No

*Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? ○ Yes ◉ No

*Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ○ Yes ◉ No

If Yes, please explain:

Criminal / Civil History

*In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ○ Yes ◉ No

*Have you ever been court-martialed for actions related to your duties as a medical professional? ○ Yes ◉ No

If Yes, please explain:

Read and answer "Yes" or "No" to each question and provide applicable date. If "Yes", please enter your explanation in the box provided. Select "Continue" to the Disclosure page.

Malpractice Claims History

*Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? ○ Yes ◉ No

If Yes, provide information for each case using the Professional Liability Claims Information Form.

Professional/General Liability Insurance Information and Claims History

*Has your professional/general liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? ○ Yes ◉ No

*Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional/general liability insurance carrier, based on your individual liability history? ○ Yes ◉ No

If Yes, please explain:

Corporate Integrity Agreements

*Are you currently or have you ever been subject to the terms of a Corporate Integrity Agreement (CIA)? ○ Yes ◉ No

If yes, are you currently subject to the provisions of a Corporate Integrity Agreement? ○ Yes ◉ No

What date did the facility enter into the Corporate Integrity Agreement?

If you are currently subject to the provisions of a CIA, provide the CIA and a Compliance letter.

Investigations

*Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs? ○ Yes ◉ No

Continue | Exit

Disclosure

The Disclosure page for individual provider types is displayed below. Read entirely and answer "**Yes**" or "**No**". If yes, you must provide the final adverse legal action documentation and resolution in PDF format.

Select, "**Continue** "to the Supporting Documentation/Attachment and Fees page.

Final Adverse Legal Action History

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspension for the enrolling provider. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,
2. Has been convicted of a crime reference in Miss. Code Ann. § 43-13-121(7)(c)-(h), or
3. 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).

Exclusions, Revocations or Suspensions

1. 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,
2. 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,
3. Has had his/her/its license or certification revoked, or
4. Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.

Final Adverse Legal Action History

***Has the enrolling provider, under any current or former name or business identity, ever had a final adverse legal action imposed?**
Yes No

If yes, report each final adverse legal action, 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 the final adverse legal action documentation and resolution.

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

	Row	Final Adverse Legal Action	Date	Action
+	Click to add Final Adverse Legal Action		–	

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.

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

Click to collapse.

*Transmission Method FT-File Transfer
*Upload File Choose File No file chosen
*Attachment Type

Add Cancel

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

#	Transmission Method	File	Attachment Type	Action
1	FT-File Transfer	JATCM.pdf (91K)	All	Remove

Click to add attachment.

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.** Enter the **Title** (if applicable).

Select "**Continue**" .

Terms of Agreement

Provider Name
Address
Tax ID
NPI
Contact Name DS L
Contact Email

This image only shows part of the terms for the Medicaid provider are listed.

Programs selected for application:

- Fee-For-Service (FFS)

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

The Medicaid Provider Agrees

1. To provide medical services to eligible Medicaid beneficiaries without regard to race, color, religion, sex, national origin, handicap, or limited English proficiency.
2. To abide by federal and state laws and regulations affecting delivery of services.
3. Not to refuse to furnish services covered under the Medicaid program to an individual who is eligible for Medicaid because of potential third party liability for the services or to discriminate as to recipients served or services provided because of Medicaid eligibility or potential third party liability.

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.

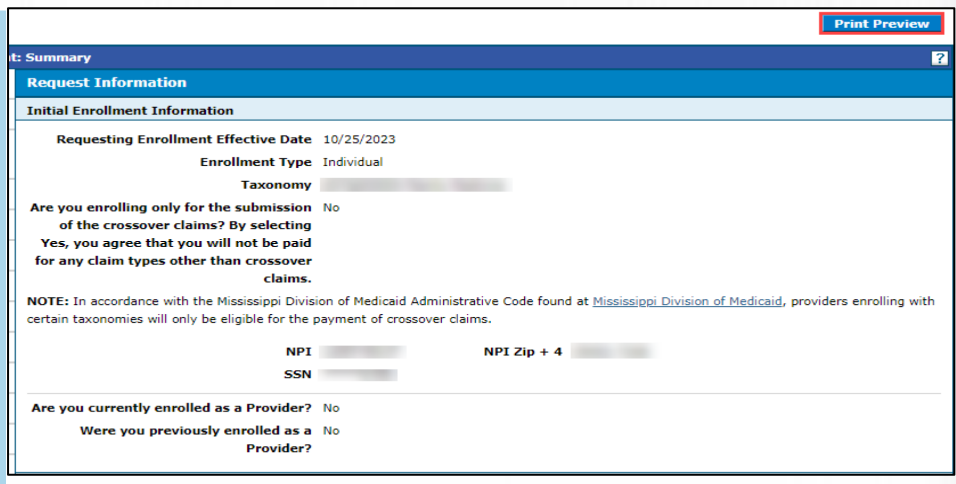
***I accept** ☐ I understand that my electronic signature is equivalent to written signature.

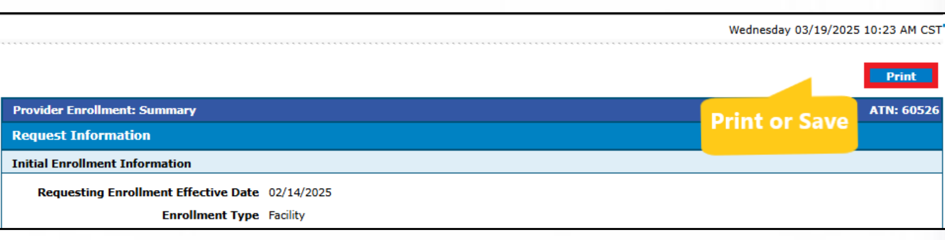
***Your Signature**
(Entering your name in the box to the right will constitute your electronic signature.)
Title
Submission Date 10/18/2023

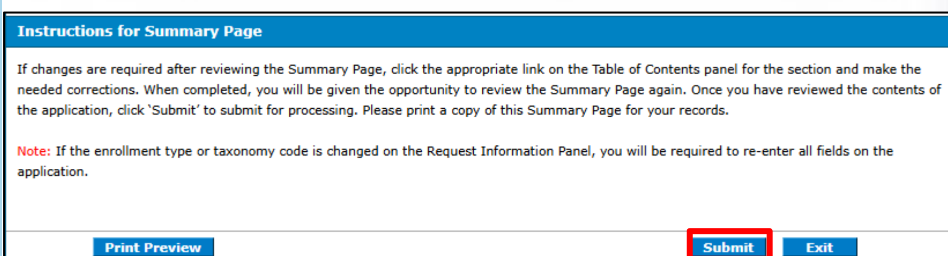
Continue | Exit

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.



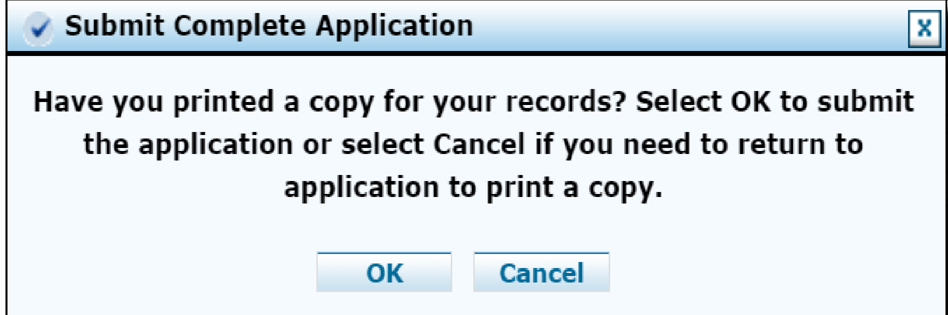




Print a Copy

- 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.

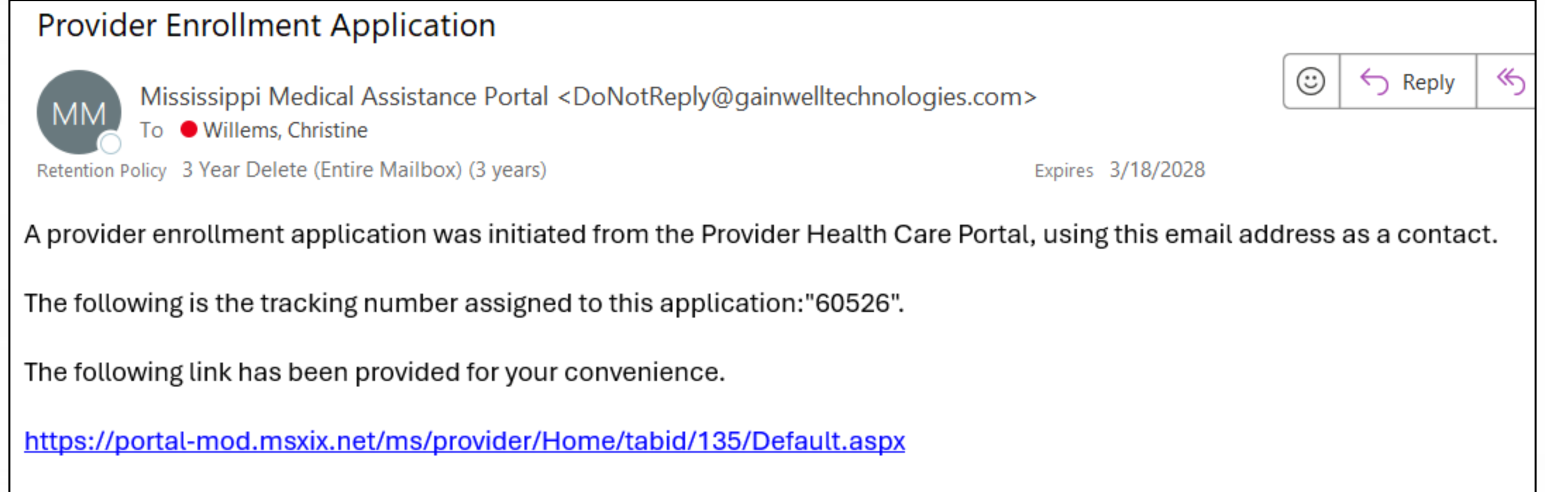
- Select “**OK**” once you have printed a copy



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**.



View Application Status

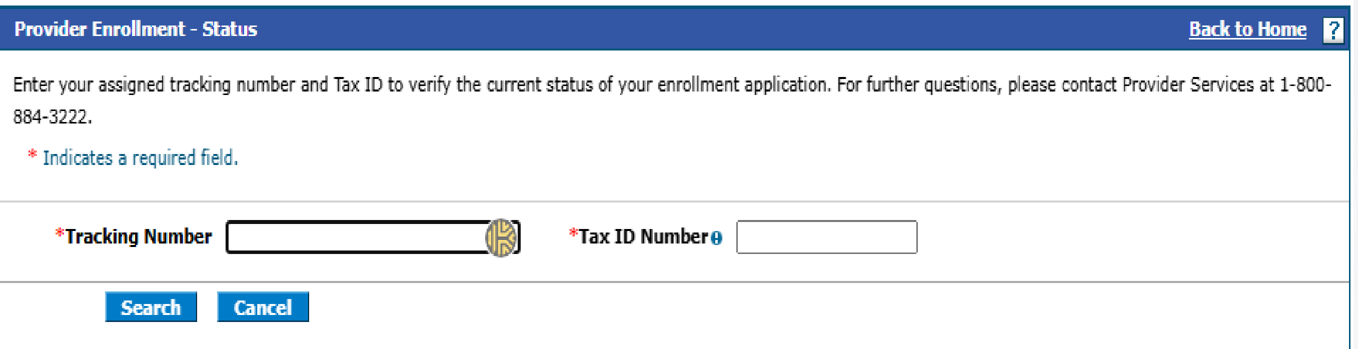
Online Provider Enrollment

Enrollment Application
Initiate a new provider enrollment application.

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

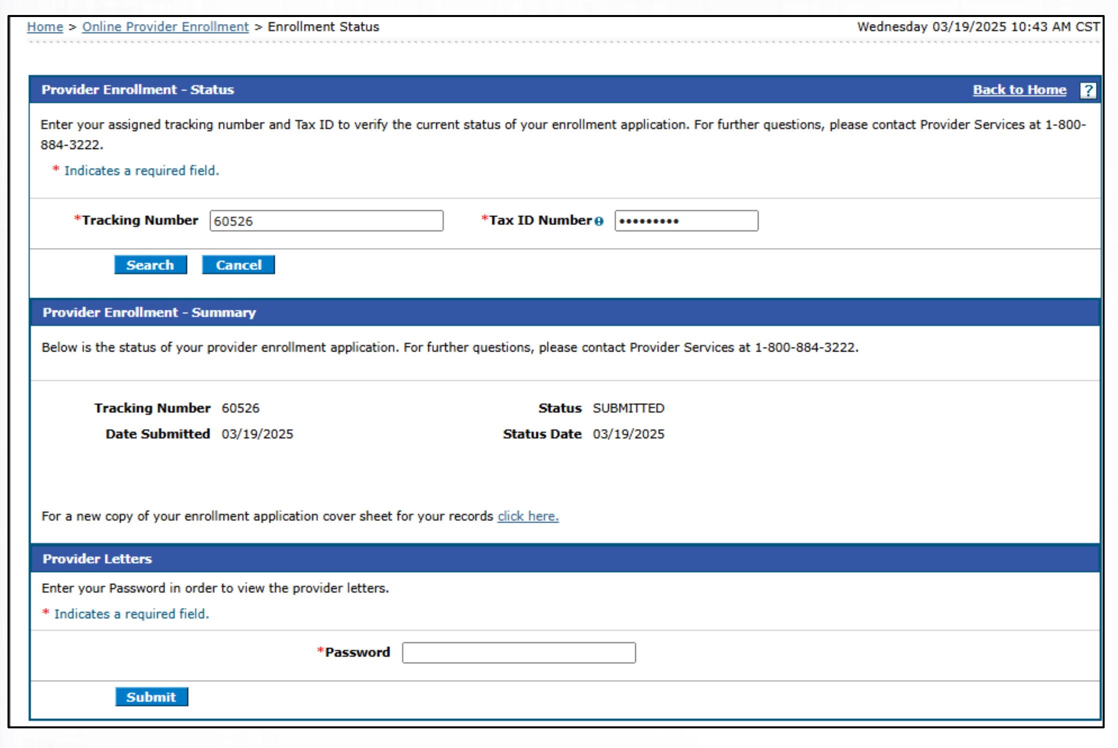
Copy Existing Submitted Application
To reduce provider burden, a previously submitted application may be copied to prevent the requirement of entering data multiple times. Please review the entire application to ensure that information contained is still accurate before submission to the agency.

Enrollment Status
Check the current status of an enrollment application.



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

View Application Status



- The **Provider Enrollment Summary** lists the application status and the date for the status and submission date.
- To view any **Provider Letters**, enter the password for the application submitted.