

Office of the Governor | Mississippi Division of Medicaid

**Other Provider**

**Initial Enrollment  
MSCAN/M SCHIP Application**

May 19, 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

- **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).
- **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.
- 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.

### Login


\*User ID

[Log In](#)

[Forgot User ID?](#)


[Register Now](#)

[Where do I enter my password?](#)



### What you can do in the Medicaid Portal for Providers

Through this secure and easy to use internet portal, health care providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files, and search for other providers. In addition, health care providers can use this site to locate claim forms, provider participation materials and other Medicaid information and resources.



**Call Center Hours!**  
8:00 a.m. - 5:00 p.m.

**Protect Your Privacy!**  
Always log off and close all of your browser windows  
[Privacy Policy](#)

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[Provider Enrollment Access](#)  
[Enrollments Forms](#)  
[340B Program Information](#)  
[Trading Partner Enrollment](#)

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[Late Breaking News](#)  
[Provider Bulletins](#)

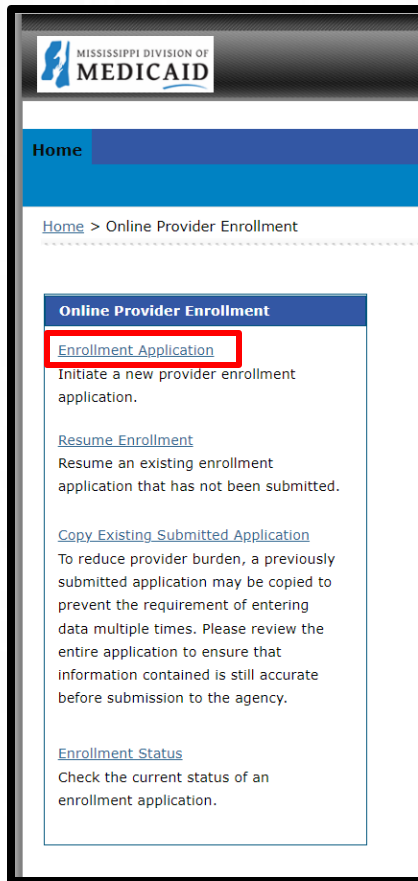
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[UM/QIO](#)  
[Provider Rates](#)

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[EHR Incentive Program](#)

# 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](http://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

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 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    
\*Taxonomy   
\*Requesting Enrollment Effective Date    
\*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   
\*Tax ID Number  Tax ID Type   
\*Are you currently enrolled as a Provider?  Yes  No  
\*Were you previously enrolled as a Provider?  Yes  No

**Change of Ownership (CHOW)**

\*Are you assuming ownership?  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   
\*First Name   
Title   
\*Phone  Ext   
Fax Number   
\*Work Email   
\*Confirm Email   
Preferred Method of Communication

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**.

### Change of Ownership (CHOW)

\*Are you assuming ownership?  Yes  No

\*Are you assuming previous Provider's NPI?  Yes  No

\*Provider's Medicaid ID?

\*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.

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

Mississippi Medical Assistance Portal <DoNotRepl  
To: [redacted]

Retention Policy 3 Year Delete (Entire Mailbox) (3 years) Expires 11/14/2027 Thu 11/14/2024 9:48 AM

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: [redacted].

The following link has been provided for your convenience.

<https://portal-mod.msix.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.

# Credentialing Information

This is only applicable to providers who chose to credential with CCO plan.

Provider Enrollment: Credentialing Information		ATN: 60595 ?
<a href="#">Welcome</a>	<b>Credentialing Information</b>	
<a href="#">Request Information</a>	Enter Credentialing Delegate Agency Name and Date.	
<b>Credentialing Information</b>	Credentialing Delegate Agency Name <input type="text"/>	Credentialing Date <input type="text"/>
<a href="#">CCO Information</a>	<input type="button" value="Continue"/> <input type="button" value="Exit"/>	

- Select the Credentialing Delegate Agency Name from the dropdown list.

- 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 who chose to credential with CCO plan.

Select the CCOs the provider will be contracting with.

Select the attestation statement box.

Select **Continue** to the next 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.
- ▶ 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  Business Start Date

Incorporated  Incorporation Date

Chain Affiliated

Operated by Management Company

\*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
<input type="checkbox"/> Click to collapse. <span style="float: right;">- -</span>							
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>*License Type <input type="text"/></p> <p>*Assigning Authority <input type="text"/></p> </div> <div style="width: 30%;"> <p>*License # <input type="text"/></p> <p>*Effective Date <input type="text"/></p> </div> <div style="width: 30%;"> <p>*License State <input type="text"/></p> <p>*End Date <input type="text"/></p> </div> </div> <div style="display: flex; justify-content: center; margin-top: 10px;"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </div>							

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**Medicare Participation**

Medicare #  Effective Date  Medicare Type

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**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
<input type="checkbox"/> Click to collapse. <span style="float: right;">- -</span>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>*CLIA # <input type="text"/></p> </div> <div style="width: 30%;"> <p>*Effective Date <input type="text"/></p> </div> <div style="width: 30%;"> <p>*End Date <input type="text"/></p> </div> </div> <div style="display: flex; justify-content: center; margin-top: 10px;"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </div>				

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**DEA #**

DEA #  Effective Date

# Provider Address

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.

**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.					
<p>*Address Type <input type="text" value="Servicing"/></p> <p>Name Type <input type="text" value="Mail To"/></p> <p>*Last Name <input type="text" value="Servicing"/></p> <p>*First Name <input type="text" value="Corporate Office"/></p> <p>Middle <input type="text"/></p> <p>Title <input type="text"/></p> <p>*Address <input type="text"/></p> <p>*City <input type="text"/></p> <p>*State <input type="text"/></p> <p>*Contact Name <input type="text"/></p> <p>*Primary Email <input type="text"/></p> <p>*Phone <input type="text"/> Ext <input type="text"/></p> <p>Phone <input type="text"/> Ext <input type="text"/></p> <p>*County <input type="text"/></p> <p>*Zip Code <input type="text"/></p> <p>*Confirm Email <input type="text"/></p> <p>Phone <input type="text"/> Ext <input type="text"/></p> <p>Phone <input type="text"/> Ext <input type="text"/></p> <p><input type="button" value="Add"/> <input type="button" value="Reset"/></p> <p><input type="button" value="Continue"/> <input type="button" value="Exit"/></p>					

**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.

# 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.

The screenshot shows a web form with the following fields and controls:

- \*First Name:
- Middle:
- Title:
- \*Address:
- \*City:
- \*State:
- Verify Address** button (highlighted with a red box)
- \*Contact Name:
- \*Primary Email:
- \*Confirm Email:
- \*Phone:   Ext
- Phone:   Ext

A red callout box with a red arrow pointing to the State dropdown menu contains the text: "Must select Verify Address before the address can be added."

# Verify Address Cont'd

To continue, select one of the options below.

**Original Address**

\*\*Original address may be undeliverable.

Line 1

Line 2

City Ridgeland

State Mississippi Zip Code 39157-2079

County MADISON

**Suggested Address**

Click on **SELECT** to load the address.

Address	City, State	County	ZipCode	Action
HIGHLAND COLONY PKWY	RIDGELAND, Mississippi	MADISON	39157-2073	<b>Select</b>

Unable to match address.

To continue, select one of the options below.

**Original Address**

\*\*Original address may be undeliverable.

Line 1

Line 2

City Ridgeland

State Mississippi Zip Code 39157-2079

County MADISON

**Use Original Address**

- 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			
*Monday	From	08:00 AM	To
		05:00 PM	
			Open 24 hrs <input type="checkbox"/>
			Closed <input type="checkbox"/>
*Tuesday	From	08:00 AM	To
		05:00 PM	
			Open 24 hrs <input type="checkbox"/>
			Closed <input type="checkbox"/>
*Wednesday	From	08:00 AM	To
		05:00 PM	
			Open 24 hrs <input type="checkbox"/>
			Closed <input type="checkbox"/>
*Thursday	From	08:00 AM	To
		05:00 PM	
			Open 24 hrs <input type="checkbox"/>
			Closed <input type="checkbox"/>
*Friday	From	08:00 AM	To
		05:00 PM	
			Open 24 hrs <input type="checkbox"/>
			Closed <input type="checkbox"/>
*Saturday	From	09:00 AM	To
		03:00 AM	
			Open 24 hrs <input type="checkbox"/>
			Closed <input type="checkbox"/>
*Sunday	From	10:00 AM	To
		02:00 AM	
			Open 24 hrs <input type="checkbox"/>
			Closed <input type="checkbox"/>

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Service Provided Within State

\*Accepting New Patients       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

\*Website       URL

# 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.

The screenshot shows a web form for selecting ADA compliant options. At the top left, there is a dropdown menu labeled '\*ADA Compliant?' with 'Yes' selected. Below this are two columns of options. The left column, titled 'Available Options', contains a list of checkboxes: EXAM TABLE, GURNEYS/STRETCHERS, PARKING (checked), PATIENT LIFTS, PUBLIC TRANSPORTATION, ACCESS, RADIOLOGIC EQUIPMENT, RESTROOM (checked), SIGNAGE, WHEELCHAIR WEIGHT, and SCALE. The right column, titled 'Selected Options', contains a list of checkboxes: PARKING and RESTROOM. Between the columns are four buttons: 'Add >', 'Add All >>', 'Remove All <<', and 'Remove <'.

# 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. You must select “**Add**” after any data has been entered.
- Once all addresses have been added and saved, select “**Continue**” to move to the Languages 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.

- 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.

	Contact Name	Address Type	Address	City	State	Action
+	LD	Servicing			Mississippi	<a href="#">Copy</a> <a href="#">Remove</a>
+	Click to add address.					

Continue
Exit

# Languages page

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

Language	Action
[-] Click to collapse.	
*Language <input type="text" value="ENGLISH"/>	
<input type="button" value="Add"/>	

- ▶ 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 electronic direct deposit.
- EFT information is required and must be completed to continue.
- A voided check 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 <input type="text"/>	*Certificate # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

### Facility Information

\*Administrator First Name  MI

\*Administrator Last Name

\*Phone

\*Fax Number

\*Email

\*Number Medicaid Beds  \*Dually-Certified Beds

\*Number Medicare Beds  \*Total Beds

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.

Complete the fields under **Facility Information**. These fields must be filled in to continue.

Select “**Continue**” to the Applicant History page.

# Applicant history

This is only applicable to providers who chose to credential with CCO plan.

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 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 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.

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

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

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

Row	Legal Business Name as Reported to the Internal Revenue Service	Employer Identification Number (EIN)	Percent Ownership	Action																
<input type="checkbox"/> Click to collapse.																				
<p>* Legal Business Name as Reported to the Internal Revenue Service  <input type="text"/></p> <p>DBA Name <input type="text"/> * Employer Identification Number (EIN) <input type="text"/></p> <p>* Effective Date <input type="text"/> * Owner/Partner <input type="text"/></p> <p>Percent Ownership <input type="text"/> Ownership Type <input type="text"/></p>																				
<p><b>Addresses</b></p> <p>Click “+” to view or update the details in a row. Click “-” to collapse the row. Click “Remove” link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>Row</th> <th>Address</th> <th>Primary</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="4"> <input type="checkbox"/> Click to collapse.                             </td> </tr> <tr> <td colspan="4"> <p>* Address <input type="text"/> <input checked="" type="checkbox"/> <b>Primary Address</b></p> <p>* City <input type="text"/> * Zip Code <input type="text"/></p> <p>* State <input type="text"/> * Country <input type="text"/></p> <p><input checked="" type="button" value="Add"/> <input type="button" value="Reset"/></p> </td> </tr> <tr> <td colspan="4"> <p><input checked="" type="button" value="Add"/> <input type="button" value="Reset"/></p> </td> </tr> </tbody> </table>					Row	Address	Primary	Action	<input type="checkbox"/> Click to collapse.				<p>* Address <input type="text"/> <input checked="" type="checkbox"/> <b>Primary Address</b></p> <p>* City <input type="text"/> * Zip Code <input type="text"/></p> <p>* State <input type="text"/> * Country <input type="text"/></p> <p><input checked="" type="button" value="Add"/> <input type="button" value="Reset"/></p>				<p><input checked="" type="button" value="Add"/> <input type="button" value="Reset"/></p>			
Row	Address	Primary	Action																	
<input type="checkbox"/> Click to collapse.																				
<p>* Address <input type="text"/> <input checked="" type="checkbox"/> <b>Primary Address</b></p> <p>* City <input type="text"/> * Zip Code <input type="text"/></p> <p>* State <input type="text"/> * Country <input type="text"/></p> <p><input checked="" type="button" value="Add"/> <input type="button" value="Reset"/></p>																				
<p><input checked="" type="button" value="Add"/> <input type="button" value="Reset"/></p>																				

# 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
<input type="checkbox"/> Click to collapse.					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>*Last Name <input style="width: 90%;" type="text"/></p> <p>*Birth Date <input style="width: 80%;" type="text"/></p> <p>*SSN <input style="width: 80%;" type="text"/></p> <p>*Home Address <input style="width: 90%;" type="text"/></p> <p>*City <input style="width: 80%;" type="text"/></p> <p>*State <input style="width: 80%;" type="text"/></p> <p>*Country <input style="width: 80%;" type="text"/></p> </div> <div style="width: 45%;"> <p>*First Name <input style="width: 90%;" type="text"/> MI <input type="checkbox"/></p> <p>*Gender <input style="width: 80%;" type="text"/></p> <p>*Owner/Managing Employee <input style="width: 90%;" type="text"/></p> <p>*Zip Code <input style="width: 80%;" type="text"/></p> </div> </div>					
<p>If the above noted Individual is an authorized or delegated official, please select one of the following options and give the effective date:</p> <p>Official Type <input style="width: 80%;" type="text"/> Official Effective Date <input style="width: 80%;" type="text"/></p> <p style="text-align: center;"> <input style="border: 2px solid red; padding: 2px 5px;" type="button" value="Add"/> <input style="padding: 2px 5px;" type="button" value="Reset"/> </p>					

**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
<input type="checkbox"/> Click to collapse.				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>*Owner/Managing Employee 1 <input style="width: 90%;" type="text"/></p> <p>*Relationship <input style="width: 90%;" type="text"/></p> <p>*Owner/Managing Employee 2 <input style="width: 90%;" type="text"/></p> </div> </div>				
<input style="border: 2px solid red; padding: 2px 5px;" type="button" value="Add"/> <input style="padding: 2px 5px;" type="button" value="Reset"/>				

Only populates when Owner has been selected.

Only populates when Managing Employee has been selected.

# 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
<input type="checkbox"/> Click to collapse.				
	*Name <input type="text"/>	*Criminal/Sanction Info <input type="text"/>	*Date <input type="text"/>	
	*Agency/Court/Administrative Body <input type="text"/>	*Resolution <input type="text"/>		
<input type="button" value="Add"/> <input type="button" value="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
<input type="checkbox"/> Click to collapse.			
	*Name <input type="text"/>	*Relationship <input type="text"/>	*Relationship Status <input type="text"/>
	*Conviction Information (Crime) <input type="text"/>		*Date of Conviction <input type="text"/>
	*Reason for Penalty or Assessment Information <input type="text"/>		*Date Imposed <input type="text"/>
	*Reason for Medicare Exclusion Information <input type="text"/>		*Date Imposed <input type="text"/>
	*State Health Care Program Exclusion <input type="text"/>	*State Agency and Reason <input type="text"/>	*Date of Exclusion <input type="text"/>
<input type="button" value="Add"/> <input type="button" value="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															
<input type="checkbox"/> Click to collapse.																	
<p>*Name of the Individual/Legal Entity (noted in this application or Section B) <input type="text"/></p> <p>*Other Legal Entity Name <input type="text"/></p> <p>*Other Legal Entity Address <input type="text"/></p> <p>*EIN of the Other <input type="text"/></p> <p>*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? <input type="checkbox"/></p> <p>If yes, please provide the requested information for each (if more than 4 relationships for each individual are needed, please click 'Add' and select the same individual and add additional relationships):</p> <table border="1"> <thead> <tr> <th>Name</th> <th>Relationship</th> <th>Name listed in Section B (1 / 2)</th> </tr> </thead> <tbody> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>			Name	Relationship	Name listed in Section B (1 / 2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Relationship	Name listed in Section B (1 / 2)															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="button" value="Add"/> <input type="button" value="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															
<input type="checkbox"/> Click to collapse.																	
<p>*Name of the Individual/Legal Entity (noted in this application or Section B) <input type="text"/></p> <p>*Name of the Subcontractor <input type="text"/></p> <p>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.)</p> <p>*Address <input type="text"/></p> <p>*City <input type="text"/> County <input type="text"/></p> <p>*State <input type="text"/> *Zip Code <input type="text"/></p> <p>*SSN/EIN of the subcontractor <input type="text"/></p> <p>*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? <input type="checkbox"/></p> <p>If yes, please provide the requested information for each (if more than 4 relationships for each individual are needed, please click 'Add' and select the same individual and add additional relationships):</p> <table border="1"> <thead> <tr> <th>Name</th> <th>Relationship</th> <th>Name listed in Section B (1 / 2)</th> </tr> </thead> <tbody> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>			Name	Relationship	Name listed in Section B (1 / 2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Relationship	Name listed in Section B (1 / 2)															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="text"/>	<input type="text"/>	<input type="text"/>															
<input type="button" value="Add"/> <input type="button" value="Reset"/>																	

# Disclosure Section G and H

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

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

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

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

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

Row	Name of the Subcontractor	Name of Owner	Action
<input type="checkbox"/>	Click to collapse.		
	<p>*Name of the Subcontractor <input type="text"/></p> <p>*Address <input type="text"/></p> <p>*City <input type="text"/></p> <p>*State <input type="text"/></p>	<p>*SSN or EIN <input type="text"/></p> <p>County <input type="text"/></p> <p>*Zip Code <input type="text"/></p>	
	<p>*Name of Owner <input type="text"/></p> <p>*Address <input type="text"/></p> <p>*City <input type="text"/></p> <p>*State <input type="text"/></p>	<p>County <input type="text"/></p> <p>*Zip Code <input type="text"/></p>	

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".

\*

**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:
  - 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,
  - Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, revalidation, and no less frequently than monthly thereafter, to ensure that the State does not pay federal funds to excluded persons or entities.

**NOTE: If the disclosing provider is an individual or a sole proprietor, the application must be signed by the individual provider or sole proprietor. If the disclosing provider is a group/organization, the signature should be that of the person legally authorized to sign on behalf of the group/organization.**

\*I accept  I have read and agree to the terms stated above

\*Your Signature

Title

Date 10/18/2023

# 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 appropriate file to be added. Select the **“Attachment Type”** dropdown that matches your file attachment. If your documents are saved in one document, select **“All”** for the type. If not, select the appropriate 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 Facility Attestation and Release 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.

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**Attachments**

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

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

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

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

#	Transmission Method	File	Attachment Type	Action
<input type="checkbox"/> Click to collapse.				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>*Transmission Method <input type="text" value="FT-File Transfer"/></p> <p>*Upload File <input type="button" value="Choose File"/> No file chosen</p> <p>*Attachment Type <input type="text" value="All"/></p> </div> <div style="width: 45%; text-align: right;"> <p><input type="button" value="Add"/> <input type="button" value="Cancel"/></p> </div> </div>				
<p><b>Attachment Attestation</b></p> <p><input type="checkbox"/> 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.</p> <p style="text-align: right;"> <input type="button" value="Continue"/> <input type="button" value="Exit"/> </p>				
<input type="checkbox"/> Click to add attachment.				
#	Transmission Method	File	Attachment Type	Action
1	FT-File Transfer	JATCM.pdf (91K)	All	<a href="#">Remove</a>

# Facility Attestation/Authorization and Release

- Read the following portion 1-15 and Select the appropriate option.
- Enter the Signature of the Provider or Authorized Representative.
- Select “Continue” to the Agreement page.

**Mississippi Division of Medicaid / Centralized Credentialing Verification Organization (CVO)**

**Facility Attestation / Authorization and Release**

Only showing a portion of this section

As part of my application for credentialing submitted to the CVO (my "Application"), I hereby acknowledge, under the following:

1. Consistent with my Application, I have the obligation to and burden of submitting all information useful and necessary for proper evaluation of my Application.
2. I am responsible for addressing and resolving any and all issues, questions, and concerns regarding information provided to the CVO in my Application. I agree to provide information related to my Application and requested by CVO, including updated information. My failure to produce any information requested by the CVO may result in the CVO electing not to evaluate my Application or denying my Application.
3. The CVO may investigate any information included in my Application and I consent to all aspects of such investigation as part of the credentialing process. More specifically, I authorize the CVO to request, obtain, and act upon any information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health, emotional stability, utilization practices, professional licensure or certification, and other matter related to my qualifications or other information associated with my Application (my "Qualifications").

Select the appropriate option:

As a physician, I attest that I will continue to maintain active admitting and staff privileges at a CVO-participating hospital or I have otherwise indicated on this application.

As a health care professional requiring a supervising physician relationship, I attest that I have a written agreement with a physician who oversees my clinical decision in compliance with the professional licensing laws in the state(s) in which I practice.

I am not a physician or a health care professional who is required to have a supervising physician relationship.

13. The CVO does not discriminate on the basis of race, color, national origin, sex, religion, age or disability.

14. I have read and fully understand this Authorization and Release, which constitutes my written authorization and request to provide and release any and all relevant information (including supportive records and documents) regarding my Application and any further reappraisals and evaluations by the CVO. I agree to execute any additional releases as may be reasonably required by the CVO in connection with any further reappraisal and evaluations.

15. By signing below, I attest that I am the duly authorized representative of the Facility and have the proper authorization to execute this attestation with the intent to fully bind Facility to the truthfulness of its answers. I attest that all the information on this entire application is complete, accurate and current.

\*Your Signature  Date 11/10/2023

(Entering your name in the box to the right will constitute your electronic signature.)

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

Select “Continue”.

**Terms of Agreement**

Provider Name [Redacted]  
Address [Redacted]  
Tax ID [Redacted]  
NPI [Redacted]  
Contact Name DS L  
Contact Email [Redacted]

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** [Redacted]  
(Entering your name in the box to the right will constitute your electronic signature.)  
**Title** [Redacted]

**Submission Date** 10/18/2023

**Continue** **Exit**

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

# 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.

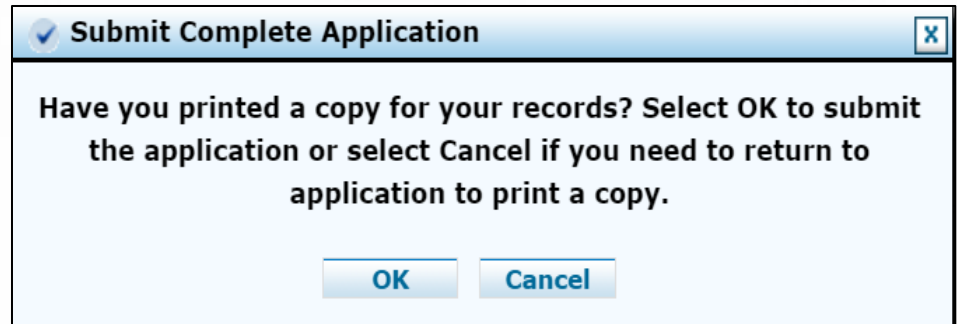
This screenshot shows the 'Request Information' section of the Summary page for an individual enrollment. It includes fields for 'Requesting Enrollment Effective Date' (10/25/2023), 'Enrollment Type' (Individual), and 'Taxonomy'. A question asks if the user is enrolling only for crossover claims, with a 'No' response. A note explains that providers enrolling with certain taxonomies are only eligible for crossover claims. Fields for 'NPI' and 'NPI Zip + 4' are present but redacted. At the bottom, there are two 'No' responses for 'Are you currently enrolled as a Provider?' and 'Were you previously enrolled as a Provider?'. A 'Print Preview' button is visible in the top right corner.

This screenshot shows the 'Request Information' section of the Summary page for a provider enrollment. It includes fields for 'Requesting Enrollment Effective Date' (02/14/2025) and 'Enrollment Type' (Facility). A 'Print' button is in the top right, and a yellow callout box highlights a 'Print or Save' button. The ATN number 60526 is also visible. A timestamp 'Wednesday 03/19/2025 10:23 AM CST' is at the top right.

This screenshot shows the 'Instructions for Summary Page' section. It provides guidance on how to handle changes, submit the application, and print a copy. A note states that if the enrollment type or taxonomy code is changed, all fields must be re-entered. At the bottom, there are buttons for 'Print Preview', 'Submit', and 'Exit', with the 'Submit' button highlighted by a red box.

# 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

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

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

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**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

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**Provider Enrollment - Summary**

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

<b>Tracking Number</b> 60526	<b>Status</b> SUBMITTED
<b>Date Submitted</b> 03/19/2025	<b>Status Date</b> 03/19/2025

For a new copy of your enrollment application cover sheet for your records [click here](#).

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**Provider Letters**

Enter your Password in order to view the provider letters.

\* Indicates a required field.

\*Password

- 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.