MISSISSIPPI DIVISION OF MEDICAID

Job Aid

How to Partially Save a Recredentialing or Revalidation Application, and Identify and Resolve Errors

This document provides the steps to partially save a Recredentialing or Revalidation application and identify and resolve errors. Partial save functionality gives the providers the flexibility to finish the applications at their convenience and not lose the data if they need to suspend an application for some reason.

In Oct of 2022, the Mississippi Division of Medicaid moved to a new system. Since it is new and different system, there are different field requirements than the previous one, and some of the data required now was not required in the previous system. Because of that reason, the Recredentialing or Revalidation applications do not have all the required data already filed and providers get an error message when they try to partially save it without filling information in the required fields. To help with this change there are a few steps to follow.

The main fields that are required to be filled out now that weren't prior to the system change are:

- **Office hours**
- **Email address and Contact Information for addresses**
- **Ownership type code**
- **Percent of Ownership**
- **Medicare type**

Partial Save equals **Finish Later,** when **Finish Later** is selected the system saves the application with all the data that has been entered to that point but **not** attachments. Completing a partial save will prevent starting over when resuming the application.

Follow these steps to partially save and identify and resolve errors:

These steps begin after the provider has selected their revalidation or recredentialing hyperlink and are on the Request Information page. Finish Later button can be clicked on that page too but for this exercise we have entered the contact information and clicked on the Continue button to reach the Credentialing Information Page.

*All applicable data should be entered for each page on the application. But for partially saving the application, providers can/should fill in the minimum required information and spend time updating or adding new information once the application is partially saved successfully. This will save them from losing their hard work if they need to suspend their application due to some reason. *

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1. Select **Finish Later:**

Provider Enrollment: Credentialing Information
Welcome
Request Information
Credentialing Information
Provider Identification
Addresses
Credentialing Information
Enter Credentialing Delegate Agency Name and Date.
Credentialing Delegate Agency Name
Credentialing Date
Continue Finish Later Cancel

Clicking on Finish Later will take the user to the Credentials page where they can save the application by providing a password and clicking on the Submit button.

In doing that step a list of errors will populate in the left-hand corner displaying what fields must be completed before the application can technically be saved. The errors are a result of the system change mentioned above. Next, are the steps it takes to rectify the errors so the application can be saved.

Error
A failure occurred during a database insert.
Contact Name is required.
Email is required.
Ownership Type Code is required.
Percent Ownership must be greater than or equal to 5.00.

Provider Enrollment: Credentials
Welcome
Request Information
Credentialing Information
Provider Identification
Addresses
Languages
Other Information
Applicant History
Disclosure
Supporting Documentation / Attachments and Fees
Facility Attestation /

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.

Your enrollment application will be suspended for ## days, pending completion. Upon expiration, you will need to reinitiate a new enrollment application.

Please provide the following information, which 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 is provided, if already contained within your provider enrollment application.

Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number along with the following information, will be used as your credentials to resume your suspended enrollment application.

* Indicates a required field.

Tax ID *********
*Password
*Confirm Password

2. Since a partial save could not be completed, we are still in the application. Select the **Credentialing Information Page link** on the left or click on the Cancel button to start where you left off. Select **Continue** to move to the next page.

Provider Enrollment: Credentialing Information
Welcome
Request Information
Credentialing Information
Provider Identification
Addresses
Credentialing Information
Enter Credentialing Delegate Agency Name and Date.
Credentialing Delegate Agency Name
Credentialing Date
Continue Finish Later Cancel

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3. Review the **Provider Identification Page**, enter all required information and select **Continue.** If you receive the error **Medicare Type is required** (as seen below) then the **Medicare Type** must be selected. Medicare Type is a required field if a Medicare # is entered, see below. You cannot move to the next page until this error is resolved.

In this example, the Medicare # was available on the previous system but Medicare Type was not.

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

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

Add Reset

Medicare Participation

Medicare # 4302740571 Effective Date 02/12/1996 Medicare Type

Medicare Type is a required field if Medicare # is entered.

4. Select the drop down to select the appropriate **Medicare Type**.

Medicare Type

- Medicare A
- Medicare B
- Medicare C
- Medicare D
- Medicare A and B
- Medicare A and C
- Medicare A and D
- Medicare B and C
- Medicare B and D
- Medicare C and D
- Medicare A, B and C
- Medicare A, B and D
- Medicare B, C and D
- Medicare A, B, C and D

5. Select **Continue.**
6. Review the **Address Page**, enter all required information and select **Continue.** If you receive any of these errors:
   - Corporate Office Contact Name is a required field.

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- Corporate Office Primary Email is a required field
- Corporate Office Confirm Email is a required field
- Error On Office Hour List

This information must be entered to resolve the errors and continue to the next page. Your application might be missing some other required information. Address the errors and click on the Continue button.

Error
Corporate Office Contact Name is a required field.
Corporate Office Primary Email is a required field.
Corporate Office Confirm Email is a required field.
Error On Office Hour List

Provider Enrollment: Addresses

Welcome
Request Information
Credentialing Information
Provider Identification
Addresses
Languages
Other Information
Applicant History
Disclosure
Supporting Documentation / Attachments and Fees
Facility Attestation / Authorization and Release

* Indicates a required field.

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
+		Corporate Office	PO BOX 919214	DALLAS	Texas	NA
+	MISTY CLARK	Mail To	1650 S PRICE RD STE 100	CHANDLER	Arizona	NA
+	AMBER EKRE	Pay To	105 OFFICE DR	PHILADELPHIA	Mississippi	NA
+	AMBER EKRE	Servicing	105 OFFICE DR.	PHILADELPHIA	Mississippi	NA

Continue | Finish Later | Cancel

7. **Select +** to expand the row to enter the Corporate Contact Name, Primary Email and Confirm the Primary Email.
8. Select **Save** to save the data you just entered.

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
−		Corporate Office	PO BOX 919214	DALLAS	Texas	NA

*Address Type: Corporate Office
*Name Type: Business Name / Personal Name
*Name: RCG MISSISSIPPI, INC.
*Address: PO BOX 919214
*City: DALLAS
*County: OUT OF STATE
*State: Texas
*Zip Code: 753919214
*Contact Name: LE
*Primary Email: ls@gmail.com
*Confirm Email: ls@gmail.com
*Phone: Office 6019233610 Ext
Phone: Ext
Phone: Ext
Phone: Ext

Save | Reset | Cancel

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9. **Expand** the **Servicing** location row to enter the Provider's operational hours. The system defaults Monday through Friday, 8:00am to 5:00pm. If your hours are different, please update them and provide hours for the weekend. Items with the * Red Asterisk must be filled out.
10. Select **Save.**
11. Select **Continue.**

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

12. Answer all the questions on the **Applicant History Page.**
13. Select **Continue.**

Applicant History
Disclosure
Supporting Documentation / Attachments and Fees
Facility Attestation / Authorization and Release
Agreement
Summary

pending.

Training

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

If No, please explain:

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

14. Review and make any necessary updates to the **Disclosure Page**.

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Addresses
Languages
Other Information
Applicant History
Disclosure
Supporting Documentation / Attachments and Fees
Facility Attestation / Authorization and Release
Agreement
Summary

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
+	1	FRESENIUS MEDICAL CARE BETEILIGUNGS	*****8426	0	Remove
+	2	FRESENIUS MEDICAL CARE HOLDINGS, IN	*****5482	0	Remove
+	3	FRESENIUS MEDICAL CARE NORTH AMERIC	*****4785	0	Remove
+	4	RENAL CARE GROUP, INC	*****8744	0	Remove
+	5	FRESENIUS MEDICAL CARE AG & CO. KGA	*****8869	0	Remove
+	Click to add Organization				

SECTION B-2
Individuals with Ownership Interest and/or Agents/Managing Control

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

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

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

	Row	Last Name	First Name	SSN	Birth Date	Action
+	1	MELLO	BRYAN	*****7174	11/05/1962	Remove
+	2	HAWKINS	JULIE	*****8346	11/26/1966	Remove

2. C... app... ate d... ses t... firm... ity o... above... ntion... rsons... entit... y sea... g the... of Ex... d 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 05/17/2023

Continue | Finish Later | Cancel

15. Select **"I accept**", and enter your name in the **Your Signature Field.**
16. Select **Continue.**

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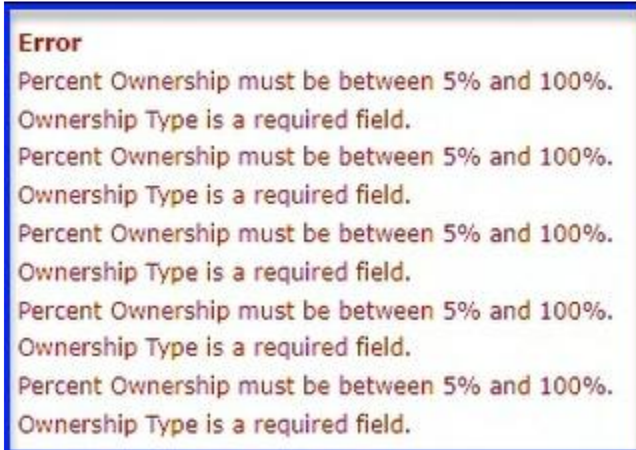
*If you receive these errors seen in the image below then, those errors must be corrected before you are able to continue.



17. Each row of your Direct/Indirect Owners or Managing Control Entities in Section B1 must have **the Percent Of Ownership and Ownership Type.** Owners in Section B2 also must have **the Percent Of Ownership and Ownership Type.**

Reminder that only the owners with **the percent of ownership** between **5%** and **100%** are required to be reported.

18. **Expand** each row and update **Percentage and Ownership Type**. After each update, **Save** must be selected.

*If there are additional questions on the Disclosure Page please view the **training video** and/or job aid on Sections **Updating Sections B1, B2, and E.**

*Any changes required on the existing information on B1 and B2 sections of the Disclosure page must have the corresponding pages filled out in the downloaded Disclosure Form and attached in PDF format.

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

	Row	Legal Business Name as Reported to the Internal Revenue Service	Employer Identification Number (EIN)	Percent Ownership	Action
⊟	1	FRESENIUS MEDICAL CARE BETEILIGUNGS	*****8426	5	Remove

*Legal Business Name as Reported to the Internal Revenue Service
FRESENIUS MEDICAL CARE BETEILIGUNGS

DBA Name
FRESENIUS MEDICAL CARE BETEILIGUNGS

*Employer Identification Number (EIN)
•••••••••

*Effective Date
11/30/2017

*Owner/Partner
5 Percent (5%) or More Ownership Inter

*Percent Ownership
5

*Ownership Type
Indirect

Addresses

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

	Row	Address	Primary	Action
⊞	1	920 WINTER ST, WALTHAM, Massachusetts, 02451-1457	Yes	Remove
⊞	Click to add address.			

Save Reset Cancel

20. Select **Finish Later.** Now your application will save since you have resolved the initial errors.

*I accept ☑ I have read and agree to the terms stated above
*Your Signature ls
Title Director
Date 05/23/2023
Continue | Finish Later | Cancel
Finish Later

21. Select **Yes.**

Suspend Incomplete Application
Do you want to suspend this application and resume later?
Yes | No

22. Create and enter a **Password.**
23. Enter **Password** again to confirm it's accurate.
24. Select **Submit.**

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.

Your enrollment application will be suspended for ## days, pending completion. Upon expiration, you will need to reinitiate a new enrollment application.

Please provide the following information, which 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 is provided, if already contained within your provider enrollment application.

Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number along with the following information, will be used as your credentials to resume your suspended enrollment application.

* Indicates a required field.

Tax ID *********
*Password •••••••••••••••
*Confirm Password •••••••••••••••

Submit | Cancel

25. Your application has been saved. Take note of your **ATN – Application Tracking Number**. You will also receive an email with the ATN. Also, you can select **Print Preview** to print this information.
    *Gainwell does not have access to this password so if lost you will have to start over.

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Print Preview

Provider Enrollment: Tracking Information

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

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

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

Exit

26. Select **Exit.**
27. Select your **Revalidate** or **Recredential hyperlink.**

All of the information that was entered, up to the Disclosure Page is saved.

28. Keep updating any outdated information and any new information applicable on each page and select **Continue** until you get to the **Supporting Documentation/Attachments and Fees Page. It is advisable to continue to frequently partially save the application.**

Now that the application is saved you can take your time and review each page to ensure accuracy.

29. Select the **Privacy Notice hyperlink** that will take you to the Notice of Privacy Practices on DOM's website, read and close.

Provider Enrollment: Supporting Documentation/Attachments And Fees

Welcome
Request Information
Credentialing Information
Provider Identification
Addresses

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

MISSISSIPPI DIVISION OF MEDICAID

About Services Quality Late Breaking News Job Openings Contact search...

Notice of Privacy Practices

30. Upload any **supporting documentation**, then **select Add**.
31. Select the drop down in the **Fee Payment Type field** and make the appropriate selection.
32. Select the **Attachment Attestation statement.**

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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.

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

Application Fee

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

*Fee Payment Type: Submitting Payment

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

Attachment Attestation

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

Continue Finish Later Cancel

33. Select **Continue** to the Facility Attestation/Authorization and Release Page.
34. Read the **Facility Attestation/Authorization and Release page**.

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 05/12/2023

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

Continue Finish Later Cancel

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35. Select the appropriate option.
36. Enter the name in the **Your Signature field.**
37. Select **Continue** to the **Agreement Page**.
38. If you are ready to submit your application, you will read the Agreement Page, select "**I accept**", enter the name in the **Signature Field** and if applicable, enter the Title in the Title field.

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 JANE DOE
(Entering your name in the box to the right will constitute your electronic signature.)
Title Director
Submission Date 04/14/2023

Submit | Finish Later | Cancel

39. Select **Submit.** This will take you to the **Enrollment Summary Page**.
40. On the **Enrollment Summary Page**, you can review the application one last time before submission. You can also **print** or **save** the application using the **Print Preview** option.

Provider Name LARRY HOOVER
Location 200001897 - LARRY HOOVER
Eligible Programs and CCO Affiliations Mississippi Medicaid
Role IDs 1528245438 (NPI)
Taxonomy 314000000X-Skilled Nursing Facility

Print Preview

Provider Enrollment: Summary
Welcome
Request Information
Credentialing Information
Request Information
Initial Enrollment Information
Enrollment Type Facility

41. Once you have saved or printed your application, review the application, when you get to the bottom of the page, select **"I Accept**" and **Confirm.** Application is submitted.

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 JANE DOE
Title Director
Agreement Date 04/14/2023

Instructions for Summary Page

If changes are required after reviewing the Summary Page, click the appropriate link on the Table of Contents panel for the section and make the needed corrections. When completed, you will be given the opportunity to review the Summary Page again. Once you have reviewed the contents of the application, click 'Confirm' to submit for processing. Please print a copy of this Summary Page for your records.

Note: If the enrollment type or taxonomy code is changed on the Request Information Panel, you will be required to re-enter all fields on the application.

Print Preview | Confirm | Finish Later | Cancel

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Change History

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

Version #	Published/ Revised	Author	Section/Nature of Change
1.0	8/1/2023	Gainwell	Initial Submission

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