Provider Recredentialing

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Recredentialing Facts

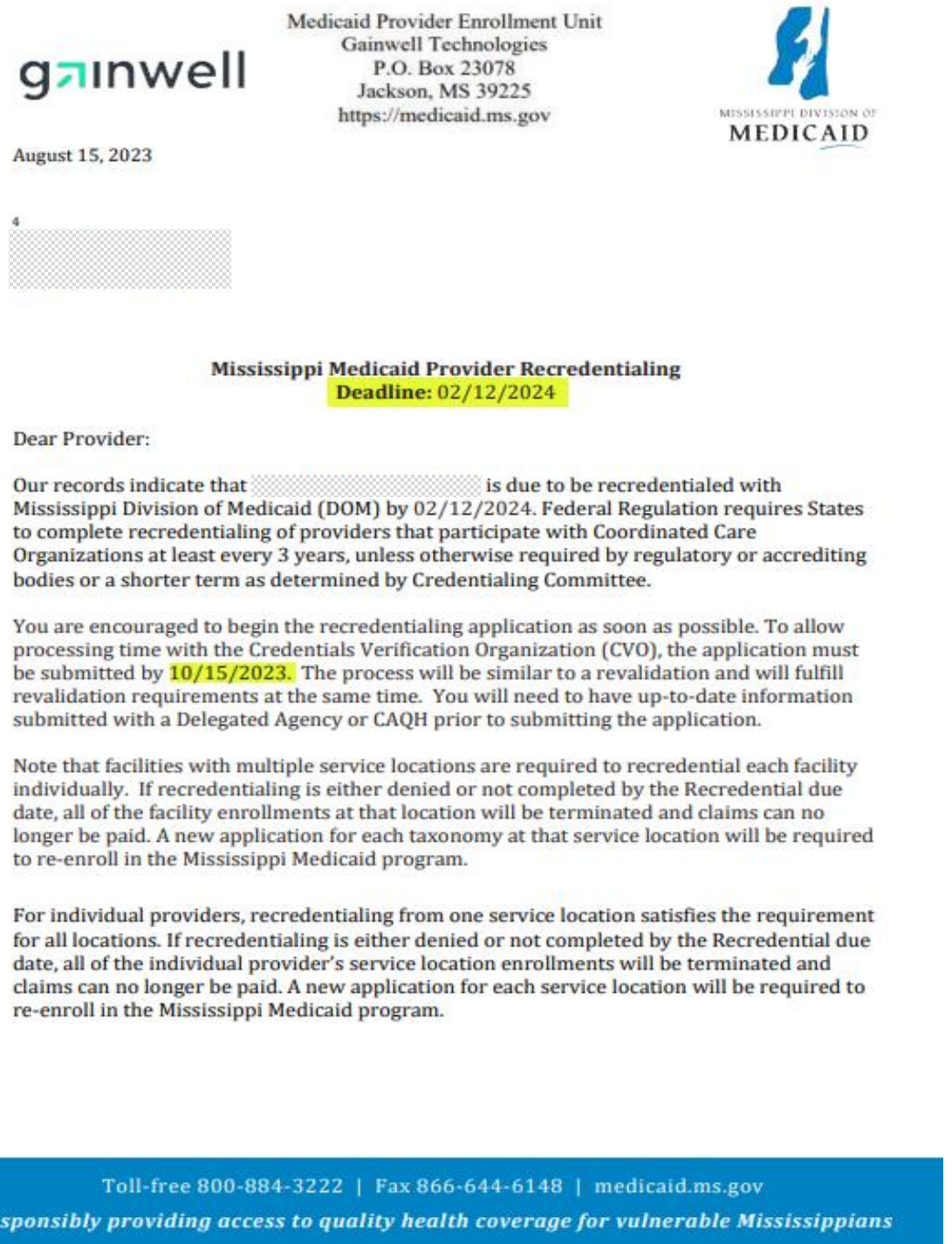
- The Mississippi Division of Medicaid is responsible for credentialing/recredentialing all providers that participate in the Managed Care programs (Mississippi Coordinated Access Network, **MSCAN**) and (Mississippi Children's Health Insurance Program, **MSCHIP**). During the 2021 Mississippi Legislative Session, Senate Bill 2799 was enacted into law requiring the Medicaid Coordinated Care Organizations (CCOs) to follow a uniform credentialing process for provider enrollment in the Managed Care Programs.
- Recredentialing is required every three years. Information on file should be reviewed for accuracy.
- A provider must be enrolled in **MSCAN** and/or **MSCHIP** to recredential.
- Providers will receive a letter **180** days prior to their recredential due date and their recredentialing link will be available on the Home Page of the MESA Provider Portal.
- **You will have 60 days to submit your recredentialing application.**
- The process incorporates a reverification and identification of changes to a provider's licensure, sanctions and certifications to ensure you still meet the National Committee on Quality Assurance (NCQA) standards.
- There is a list of providers that are due for recredentialing on the Division Of Mississippi Medicaid website. See link under Providers>Provider Six-Month License Due List**:** **Home - Mississippi Division of Medicaid (ms.gov)**
- **Providers that fail to recredential or submit supporting documentation by the deadline will be terminated and will no longer be able to participate in a Coordinated Care Organization (CCO) network.**
- **Ordering Referring Prescribing (ORP) providers** are not able to enroll in Managed Care Programs therefore do not require credentialing.

Application Tips

- Fields that are **grayed-out cannot** be updated. If any updates are needed for the grayed-out fields you can send a **Secure Correspondence** with proof of changes needed or contact Customer Service at 1-800-884-3222.
- 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.
- If the disclosing provider is an **individual** or **sole proprietor**, the application must be signed by the individual or sole proprietor.
- If the disclosing provider is a **group/organization**, the signature should be by the person legally authorized to sign on behalf of the group/organization.
- All application attachments must be in PDF format.

Sample Recredentialing Notice

- You will receive a letter 180 days prior to your recredentialing due date.
- The submission date noted in the body of the letter is the **recommended submission date** to allow time for processing before the deadline date. This date is the date you will see on the Provider Portal.
- **The final due date** is shown at the top of this letter.
- The letter contains important information regarding recredentialing.
- Also, the letter includes a link to the secure Provider Portal.



gainwell

Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 23078
Jackson, MS 39225
https://medicaid.ms.gov

MISSISSIPPI DIVISION OF MEDICAID

August 15, 2023

4

Mississippi Medicaid Provider Recredentialing
Deadline: 02/12/2024

Dear Provider:

Our records indicate that [redacted] is due to be recredentialed with Mississippi Division of Medicaid (DOM) by 02/12/2024. Federal Regulation requires States to complete recredentialing of providers that participate with Coordinated Care Organizations at least every 3 years, unless otherwise required by regulatory or accrediting bodies or a shorter term as determined by Credentialing Committee.

You are encouraged to begin the recredentialing application as soon as possible. To allow processing time with the Credentials Verification Organization (CVO), the application must be submitted by 10/15/2023. The process will be similar to a revalidation and will fulfill revalidation requirements at the same time. You will need to have up-to-date information submitted with a Delegated Agency or CAQH prior to submitting the application.

Note that facilities with multiple service locations are required to recredential each facility individually. If recredentialing is either denied or not completed by the Recredential due date, all of the facility enrollments at that location will be terminated and claims can no longer be paid. A new application for each taxonomy at that service location will be required to re-enroll in the Mississippi Medicaid program.

For individual providers, recredentialing from one service location satisfies the requirement for all locations. If recredentialing is either denied or not completed by the Recredential due date, all of the individual provider's service location enrollments will be terminated and claims can no longer be paid. A new application for each service location will be required to re-enroll in the Mississippi Medicaid program.

Toll-free 800-884-3222 | Fax 866-644-6148 | medicaid.ms.gov
Responsibly providing access to quality health coverage for vulnerable Mississippians

Sample Recredentialing Notice cont'd

To expedite the process, follow the instructions below to access the provider recredentialing page through the web portal on or before 10/15/2023. If you are not a registered user, you can find the registration instructions for becoming a web portal user by clicking the "Web Registration" link on the site.

To submit the recredentialing/revalidation, providers should do the following:

- Log onto the secure Portal at https://portal-mod.msxix.net/ms/provider
- Select the "Recredential Your Provider Enrollment" link under the 'Upcoming Actions' section on the left side of the secure log-in Home page.
- Follow the instructions to complete the Recredential application.

In accordance with Federal Regulation at 42 CFR 455.460 and 42 CFR 424.514, certain providers applying to participate in the Medicaid program are required to pay an application fee unless you meet one of the exemptions.

Additionally, if the recredentialing is not completed in the allotted time and the provider is also enrolled with one or all Mississippi Coordinated Care Organizations (CCO), Magnolia Health, United Healthcare Community Plan, and Molina Healthcare, enrollment with the CCO(s) will be terminated.

Providers are able to track the status of their recredentialing application after the materials are submitted by doing the following:

- Access Provider Portal at https://portal-mod.msxix.net/ms/provider
- Select Provider Enrollment Access link from the left-hand side of the page.
- Select Enrollment Status link under the Online Provider Enrollment section on the left-hand side of the Provider Enrollment page.
- Enter Application Tracking Number (provided after submitting the recredentialing application) to view the status of the application.

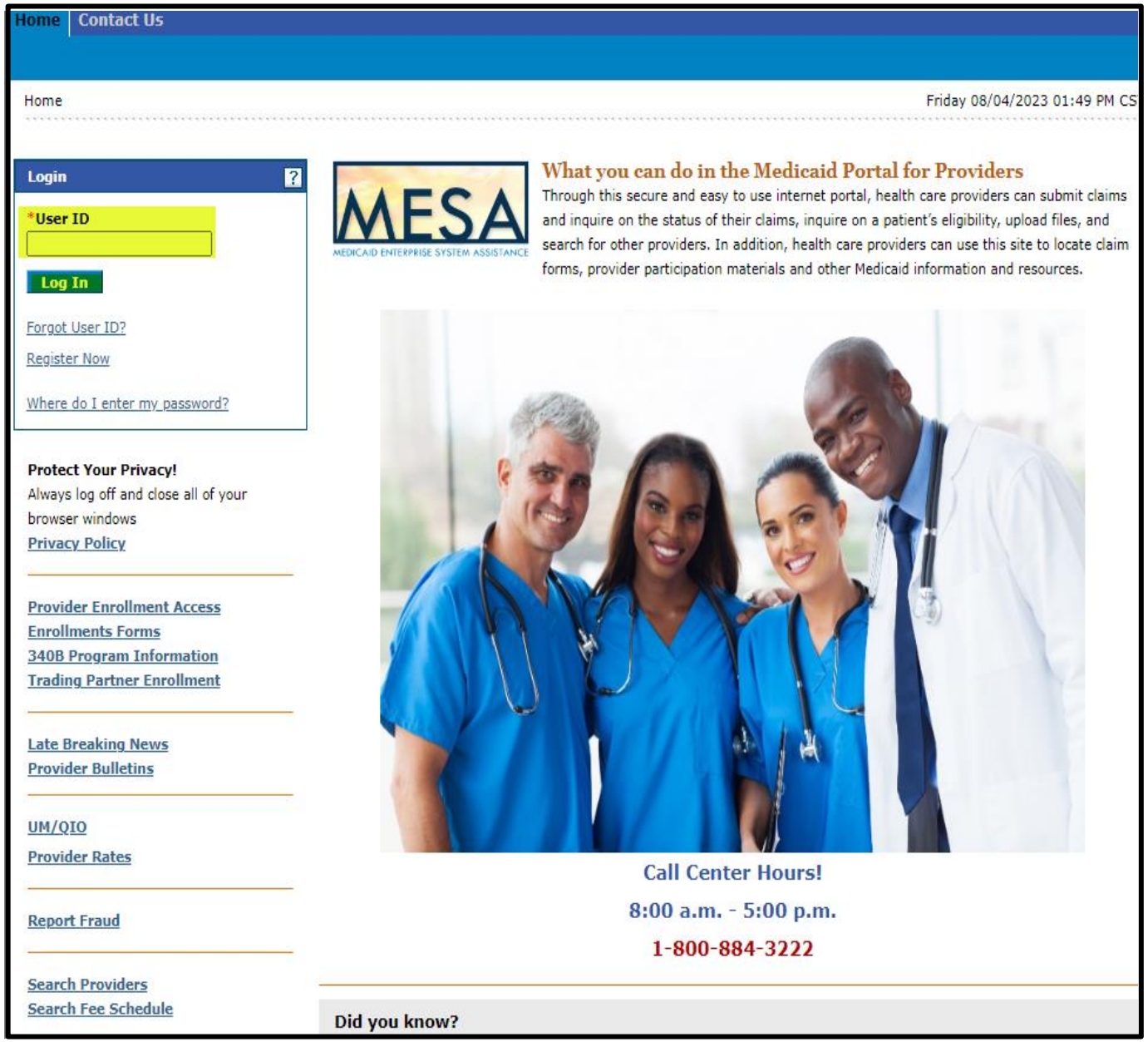
Thank you for your prompt response to this request. Please contact Provider Services staff at 1-800-884-3222 with any inquiries between the hours of 8:00 a.m. and 5:00 p.m. CST, Monday through Friday.

Sincerely,

Provider Services

Submitting a Recredentialing Application cont'd

- You have received your letter and now you are ready to log into the MESA Provider Portal.
- To get to the MESA Provider Portal use the link on DOM's website. Home>Provider Portal>Provider Log in **MESA Portal for Providers - Mississippi Division of Medicaid**
- On the MESA Provider portal homepage, enter your User ID and select "Log In"

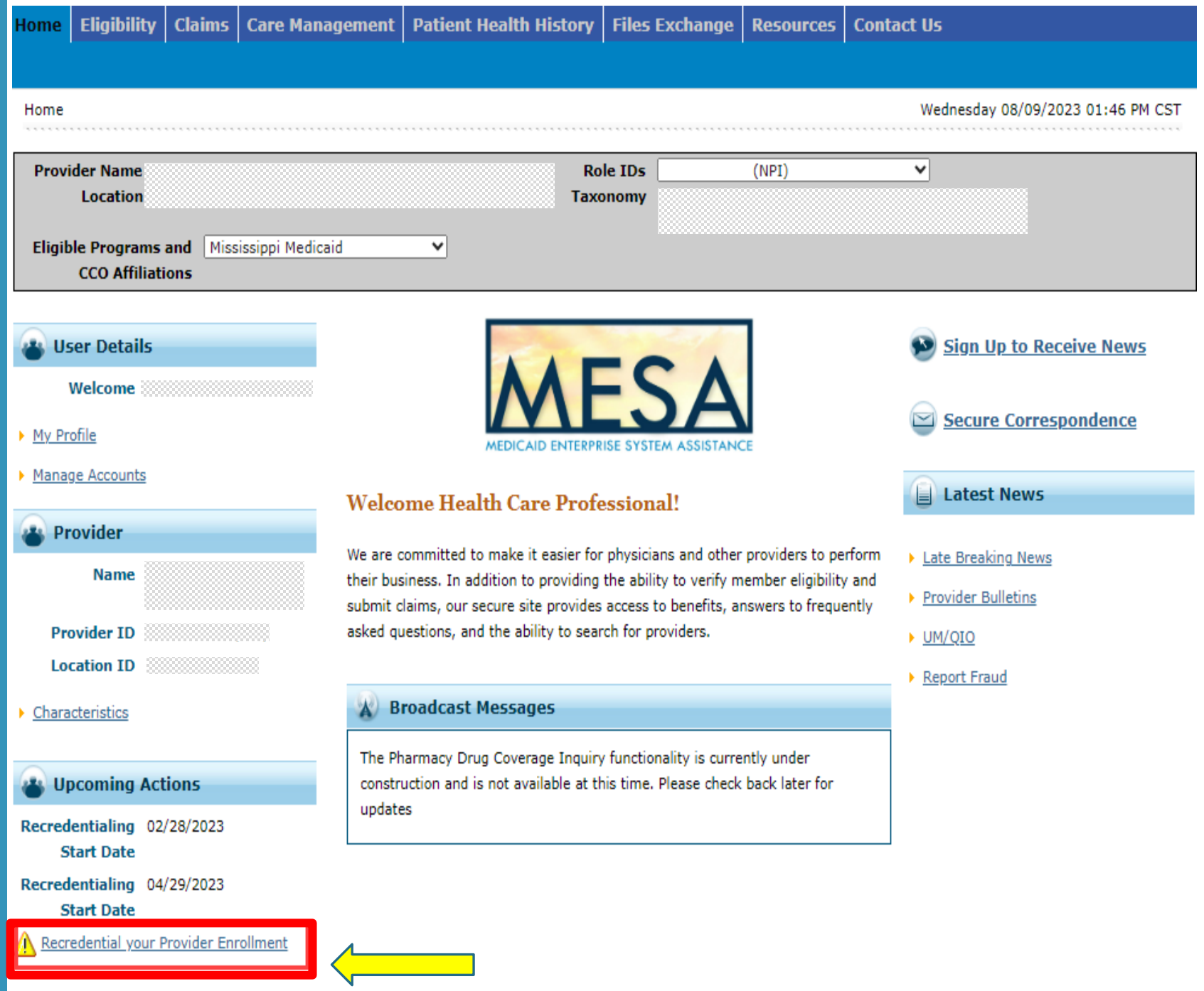


Submitting a Recredentialing Application cont'd

- Enter your **password** and select **"Sign In".**
- Make sure your site key picture and passphrase are correct.

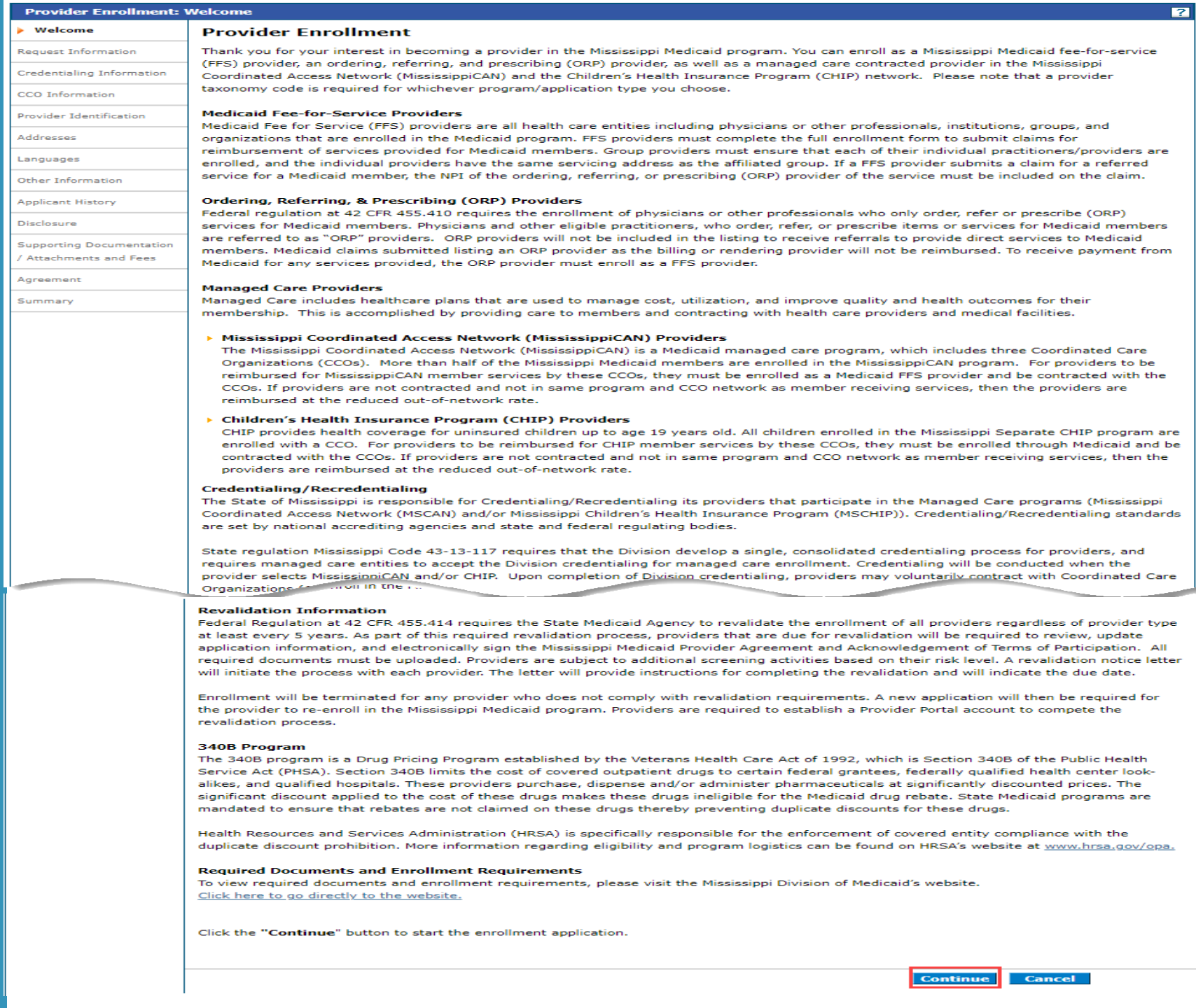
Submitting a Recredentialing Application cont'd

- After logging in, select the "**Recredential your Provider Enrollment**" link on the home page under Upcoming Actions.
- Reminder, if you have already submitted or you are past the due date this link will no longer be available.
- Facilities with more than one service location need to credential for each of the locations separately.
- This link will not be available for **Fee For Service (FFS) only** providers.



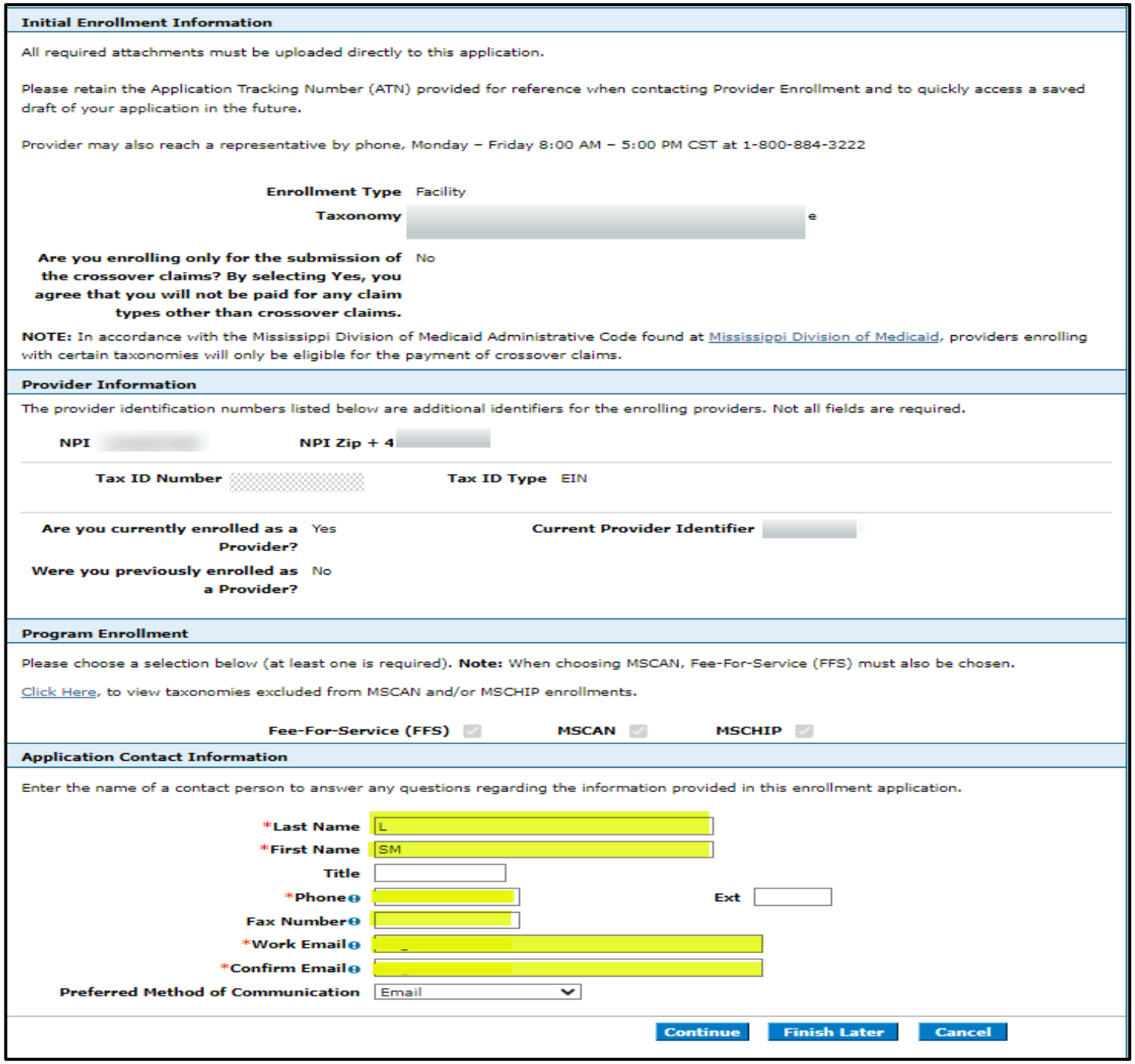
Welcome Page

- Review the information while scrolling to the bottom and select **Continue** to the **Request Information page.**



Request Information page

- Update the **Application Contact Information** and select **“Continue”** to the Credentialing Information page.
- This is the only portion on this page that must be updated.
- The red asterisk signifies fields that must be filled out.
- Next, are the steps to show you how to save the application before you finish, if needed.



Initial Enrollment Information

All required attachments must be uploaded directly to this application.

Please retain the Application Tracking Number (ATN) provided for reference when contacting Provider Enrollment and to quickly access a saved draft of your application in the future.

Provider may also reach a representative by phone, Monday – Friday 8:00 AM – 5:00 PM CST at 1-800-884-3222

Enrollment Type Facility

Taxonomy [redacted] e

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. 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 [redacted] **NPI Zip + 4** [redacted]

Tax ID Number [redacted] **Tax ID Type** EIN

Are you currently enrolled as a Provider? Yes **Current Provider Identifier** [redacted]

Were you previously enrolled as a Provider? 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 L

*First Name SM

Title

*Phone Ext

Fax Number

*Work Email

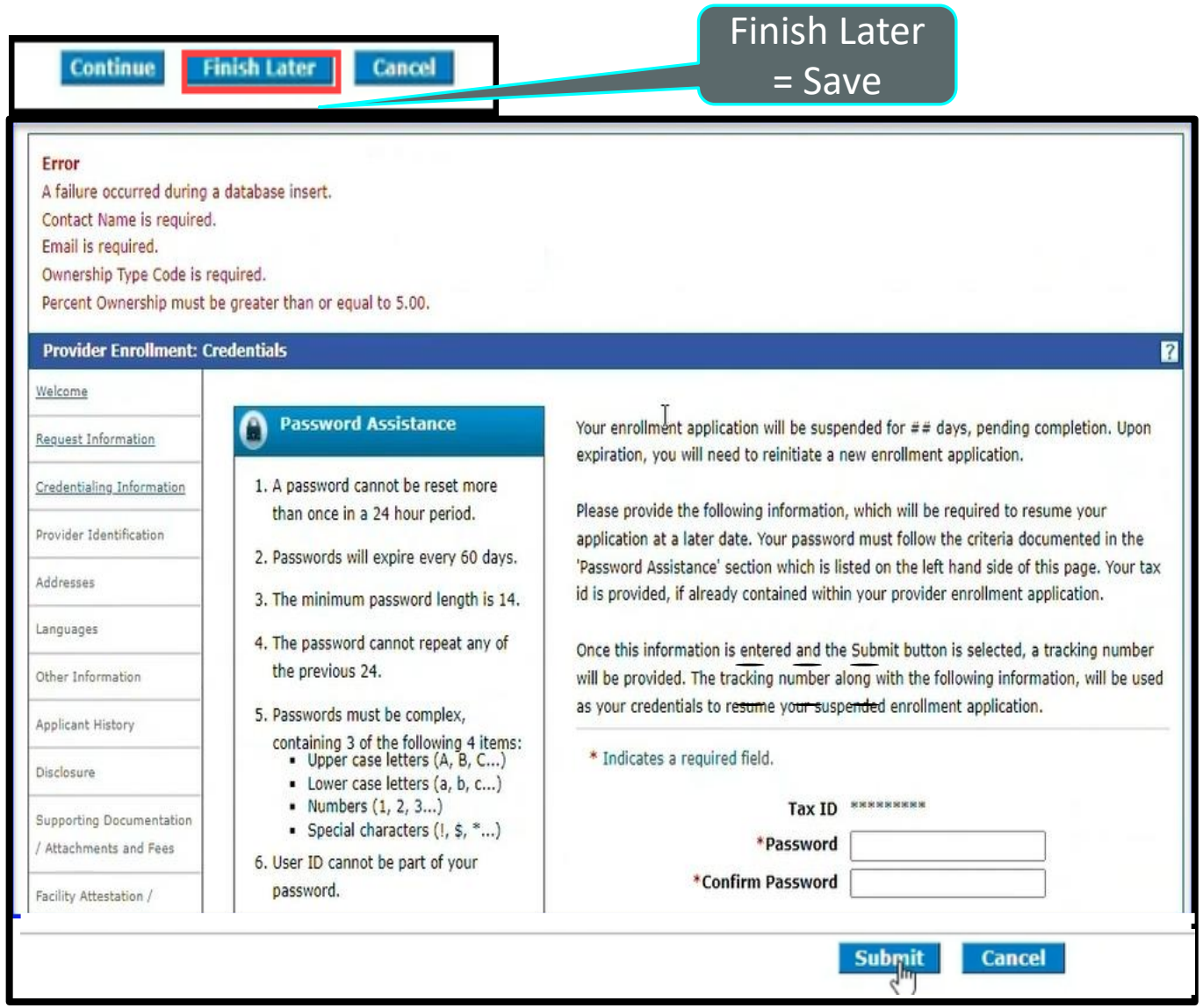
*Confirm Email

Preferred Method of Communication Email

Continue Finish Later Cancel

Saving the Application

- Because of the system change, Providers Profile is missing some of the required data in the new system that was not collected in the previous system. which, the application cannot be saved partially (finish later) until all the required data is provided. There could be some circumstances which might call for suspending an application midway because some information needs to be gathered or the person filling out the application needs to step away. If the missing data is not provided, then all the information filled in so far will get lost.
- Therefore, to avoid those situations it is recommended that providers should try to click on Finish Later as soon as they are in their application and once all the missing information has been saved, they can take time filling in and updating the remainder of the application.
- Upon clicking on Finish Later, the Credentials page will display, then you will create a password and select Submit. If any information is missing it will be shown in the top left corner. You will go through each page correcting/updating the required data, the error is also displayed on the top of the respective page. The application is not saved until the errors are corrected.
- Once all of the missing data is provided, create a password to save the application and select the Submit button.
- If no errors are displayed, then all of the required information is present, and you can log in and continue with the recredential application.



Saving the Application cont'd

Once you have corrected those errors you can now save it. Select **Finish later**.

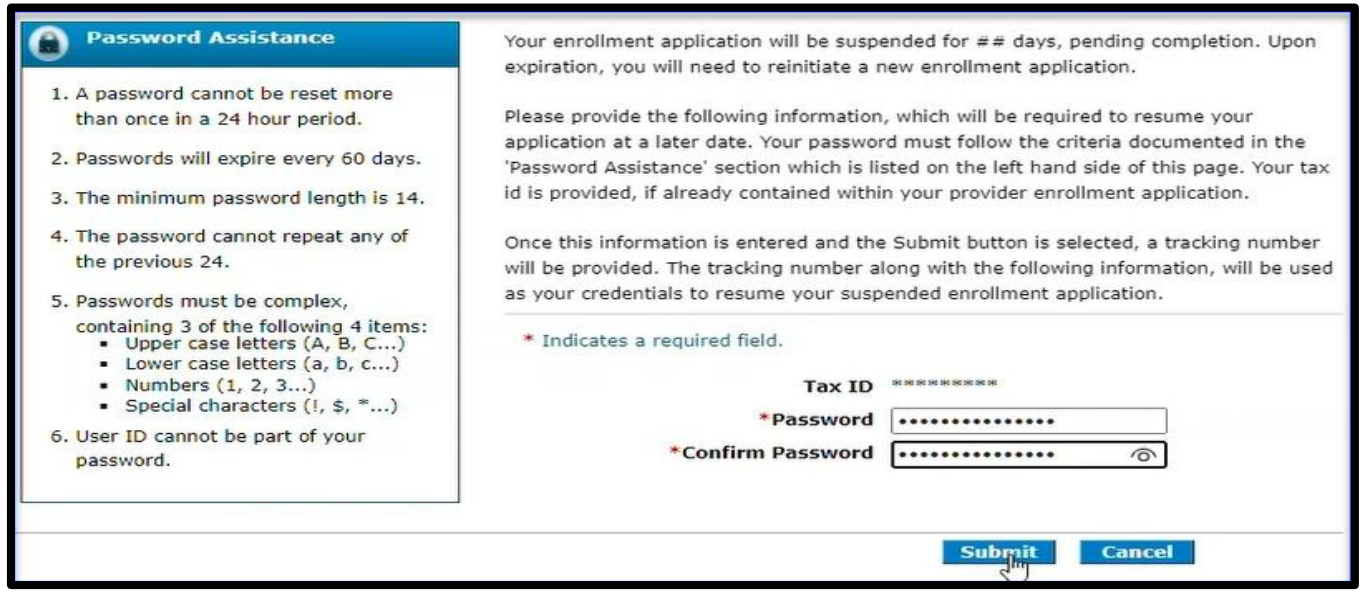
Select **Yes** to suspend the application.

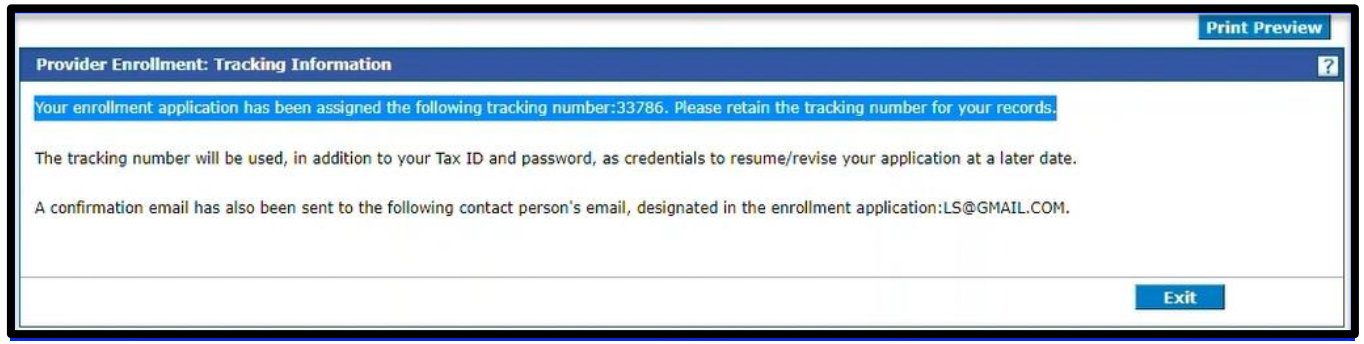
Create and enter a **Password**.

Enter the Password again to confirm it's accurate.

Select **Submit**.

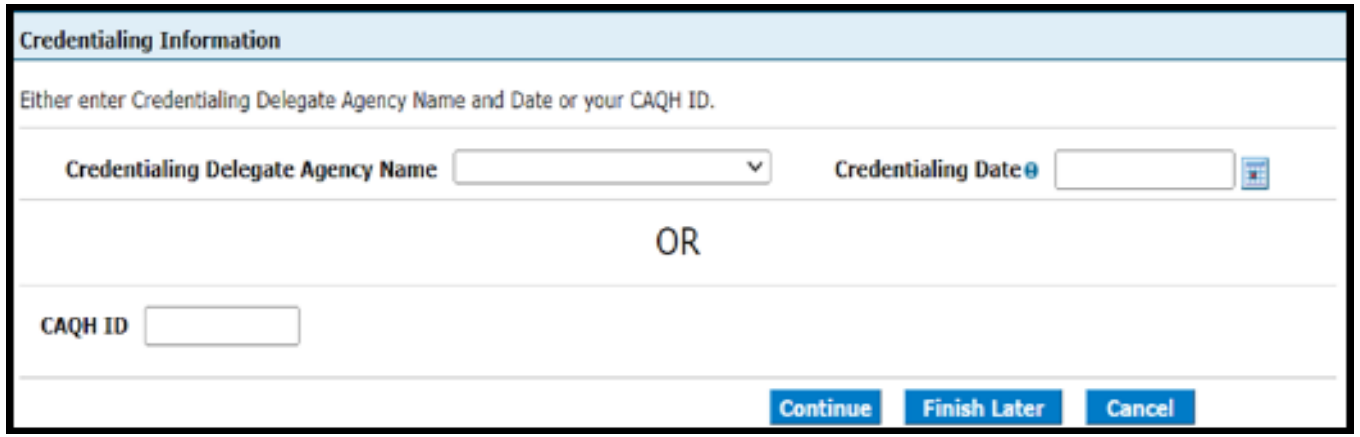
Your application has been saved. Take note of your **ATN – Application Tracking Number**. You will also receive an email with the ATN. You can select **Print Preview** to print this information.





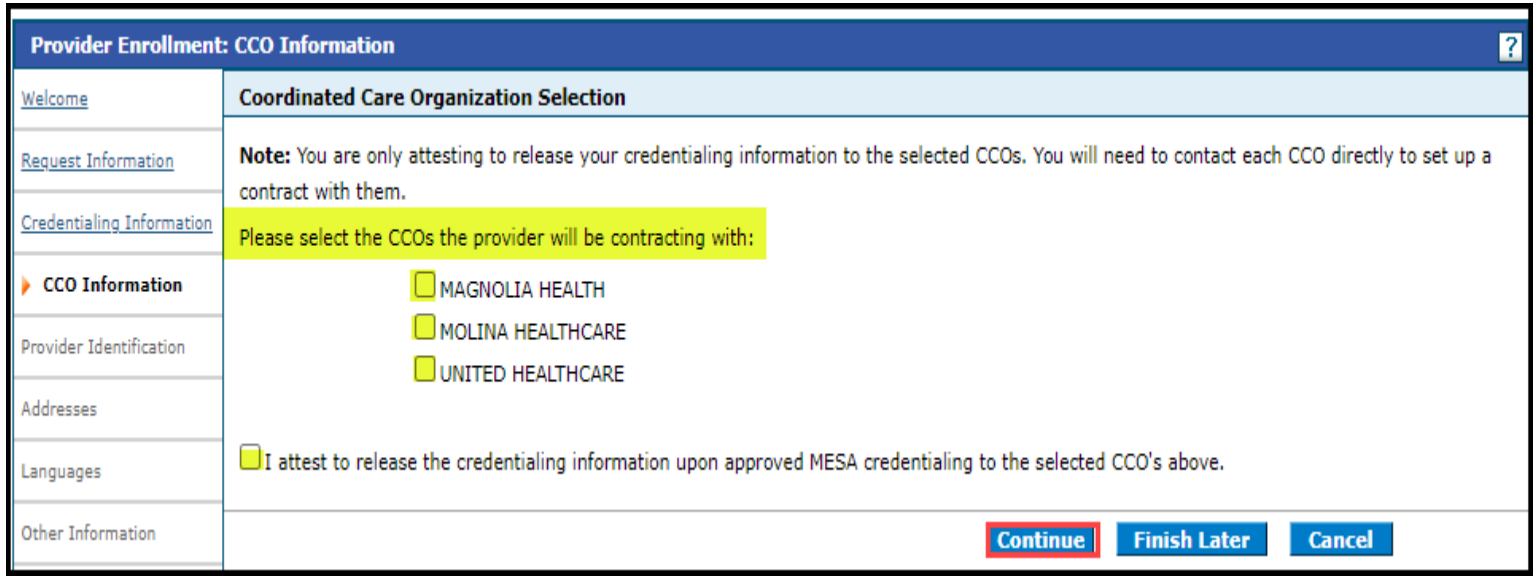
Credentialing Information Page

- Provide the **Credentialing Agency Name**, by selecting the drop-down arrow, if applicable. Otherwise, leave it blank.
- Ensure **the Credentialing Delegate Agency Name** and Credentialing **Date** are accurate.
- For individual providers that have not been credentialed by a Delegated Agency, the **CAQH ID** is required.
- For all other types of providers that have not been credentialed through a Delegated Agency select **Continue** to move to the next page.
- Select **Continue** to the **CCO Information Page.**



CCO Information Page

- Select the **CCO(s), Coordinated Care Organization(s),** you are contracted with or plan on contracting with to give permission to release your credentialing information to the selected CCOs.
- You must select at least one **CCO**.
- Select the **"Attestation statement"** and **Continue** to the Provider Identification page. **Note:** You are only attesting to release your credentialing information to the selected CCOs during this step. You must contact each CCO directly to contract with them.



Provider Identification Page

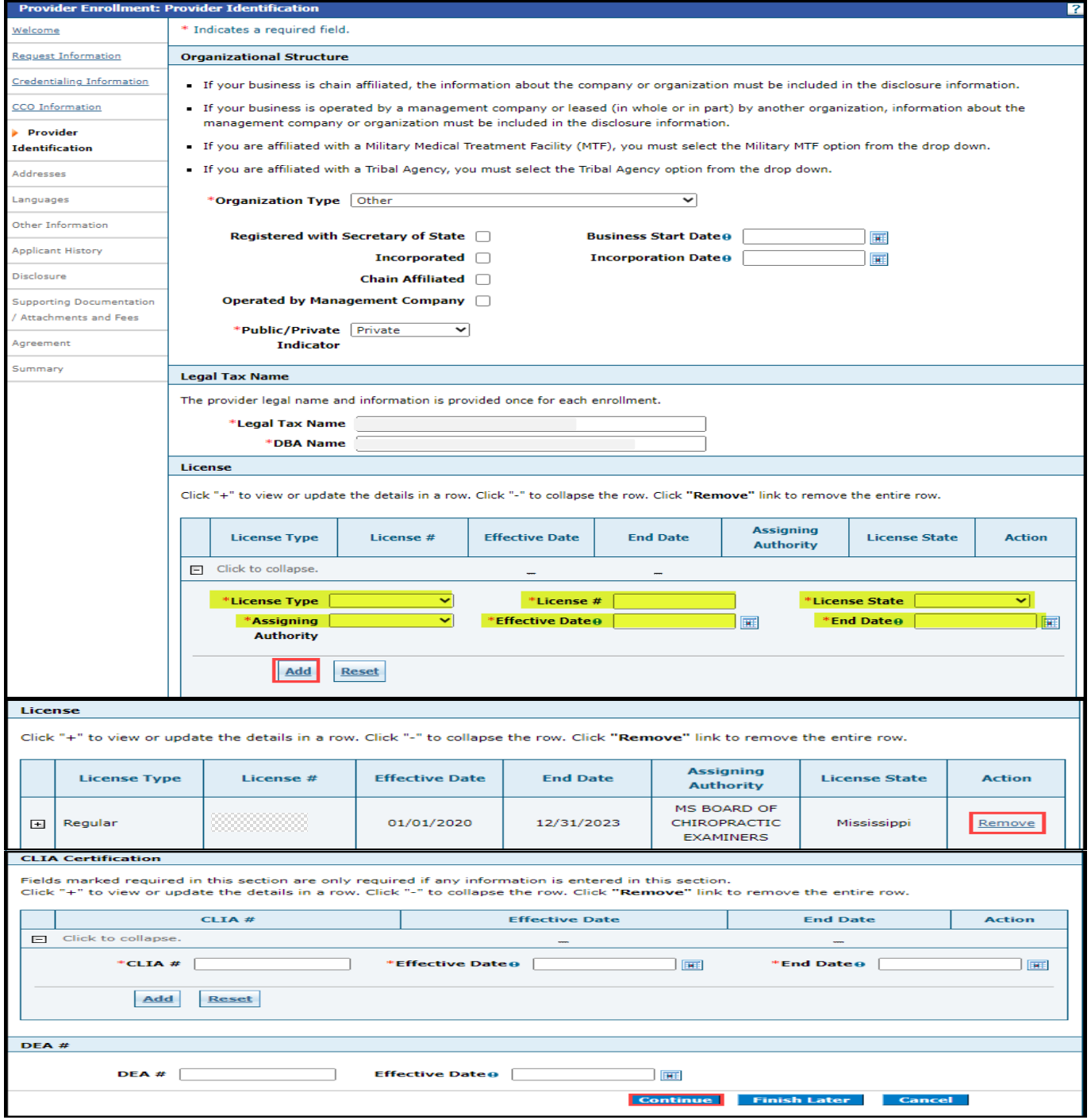
Make sure all the information is correct in each section and make any necessary updates.

If a license has been extended, please update the **End Date** for that License. Select "**+**" to expand that field and update the end date.

If you have a new license, make sure to add it in the license section. You must select "**Add**" after you have entered the required information.

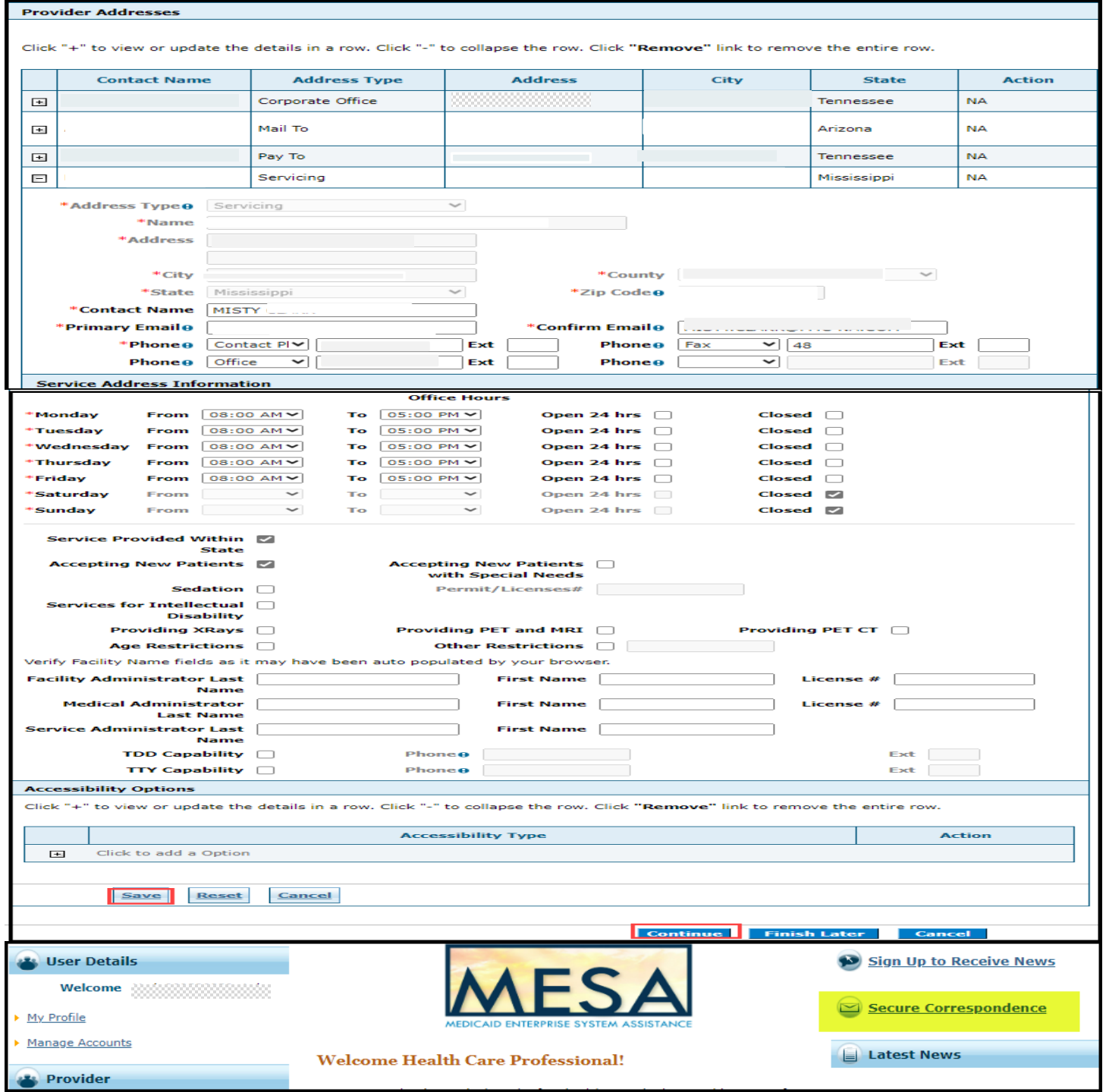
To remove a specific license, you will expand the section by clicking "**+**"and select the **"Remove"** link and that license will be removed.

Once all updated information has been entered, select **Continue** to the **Address** page.



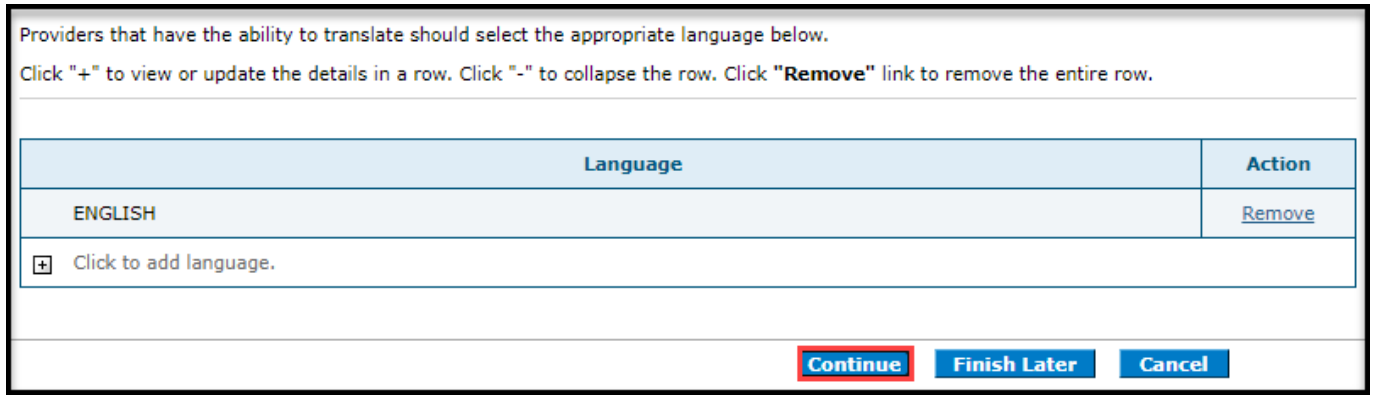
Address Page

- Make all updates to each section but the **Pay To** and **Servicing Address cannot** be updated on the application. If you need to update the **Pay To** or **Servicing Address**, please submit the filled-out Change of Address Form, using the “Secure Correspondence” link on the right-hand side of the Home page.
- Change of Address Form can be found here: medicaid.ms.gov/resources/forms
- The **primary contact information** for the **Servicing Address** can be updated as well as the other addresses, if applicable.
- After all updates have been made, you **must** select **“Save”** otherwise the data will not be saved.
- Select **Continue** to the **Language page**.



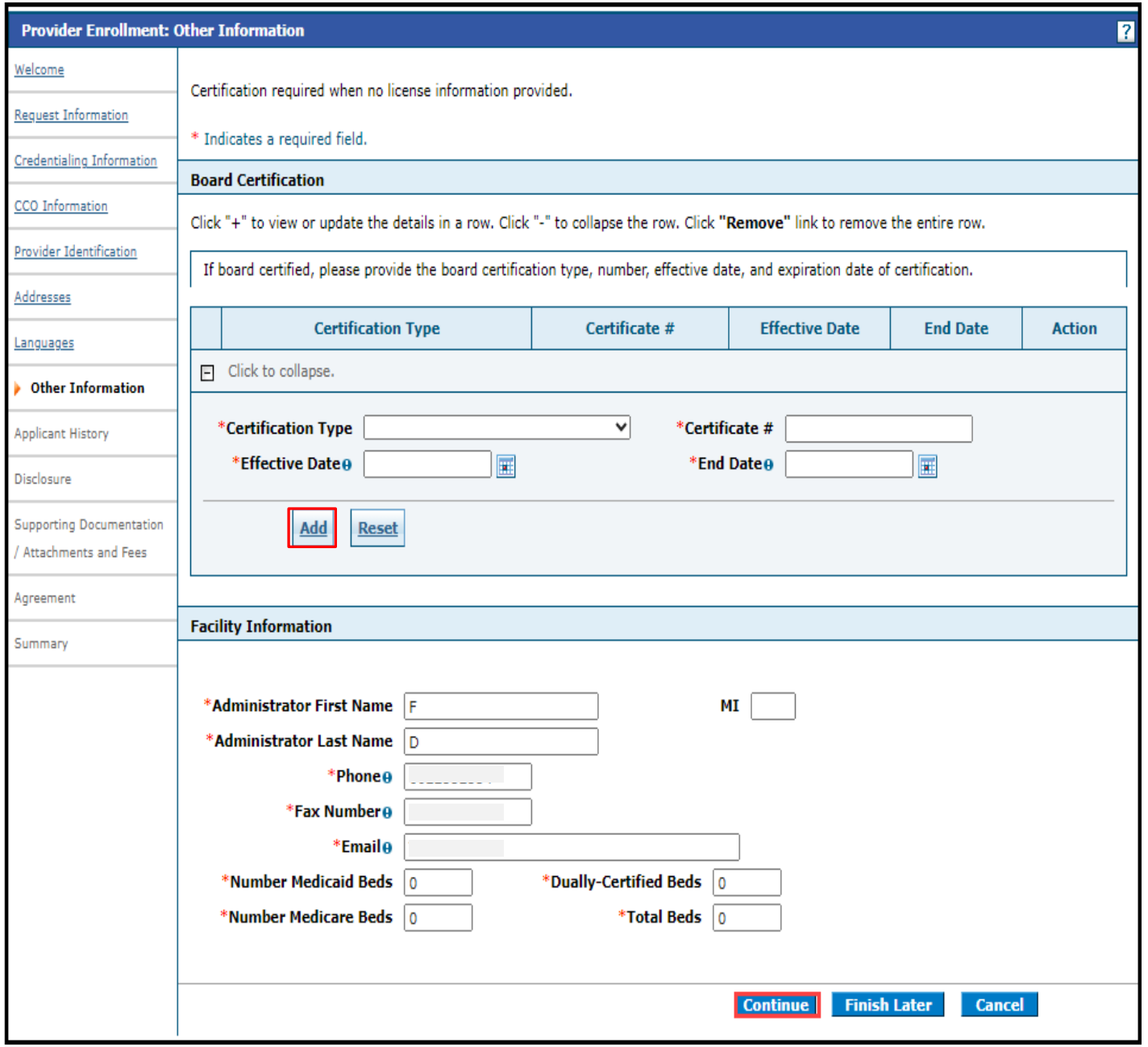
Languages page

- Make any necessary updates and select **Continue**, to the Other Information page.



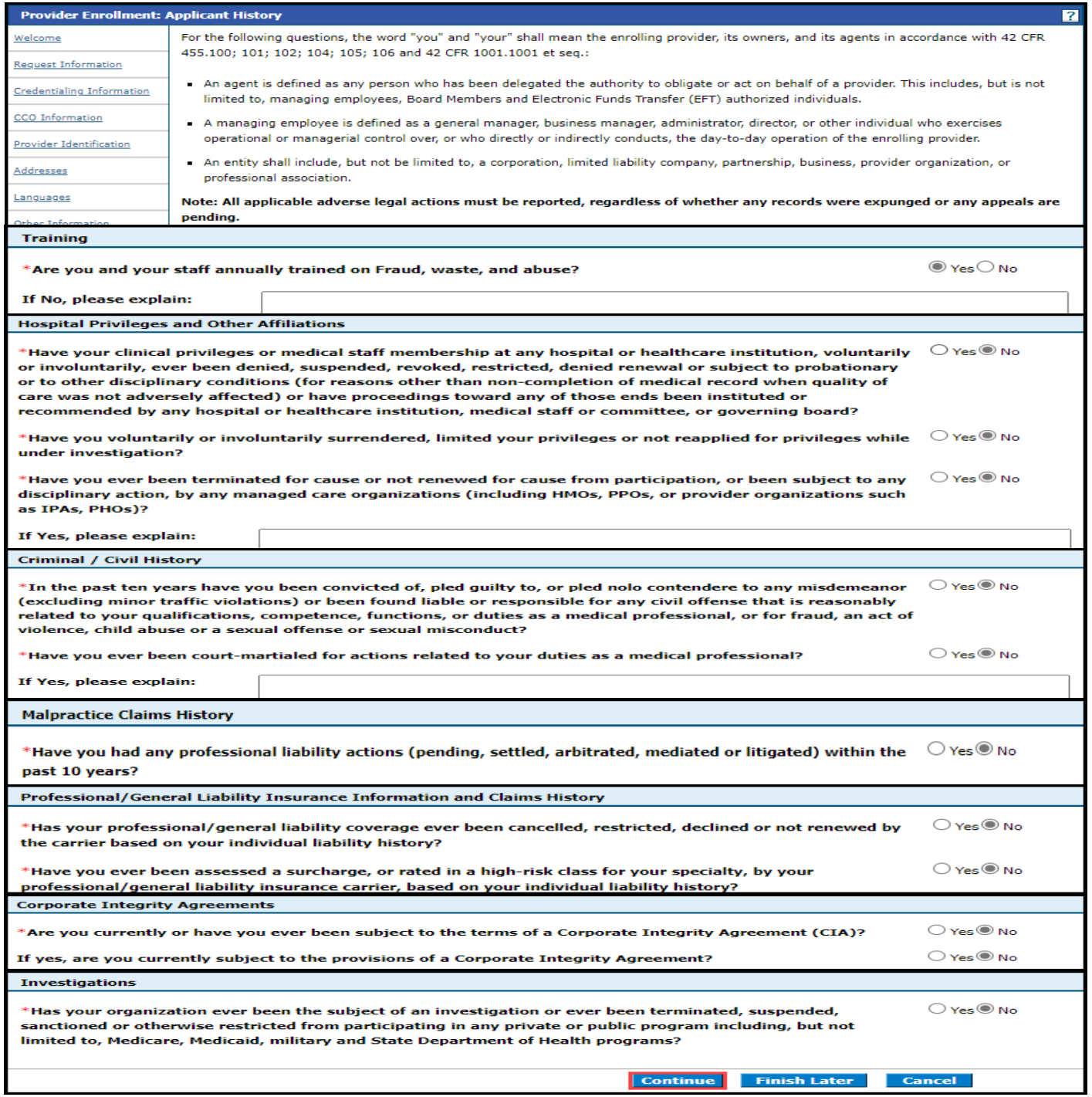
Other Information Page

- Make any updates needed to each section.
- If you have a certification type noted in the dropdown list that needs to be added, complete the fields, then select **Add.**
- **Facility Information** will only populate if you are a facility provider.
- Select **Continue** to the Application History page.



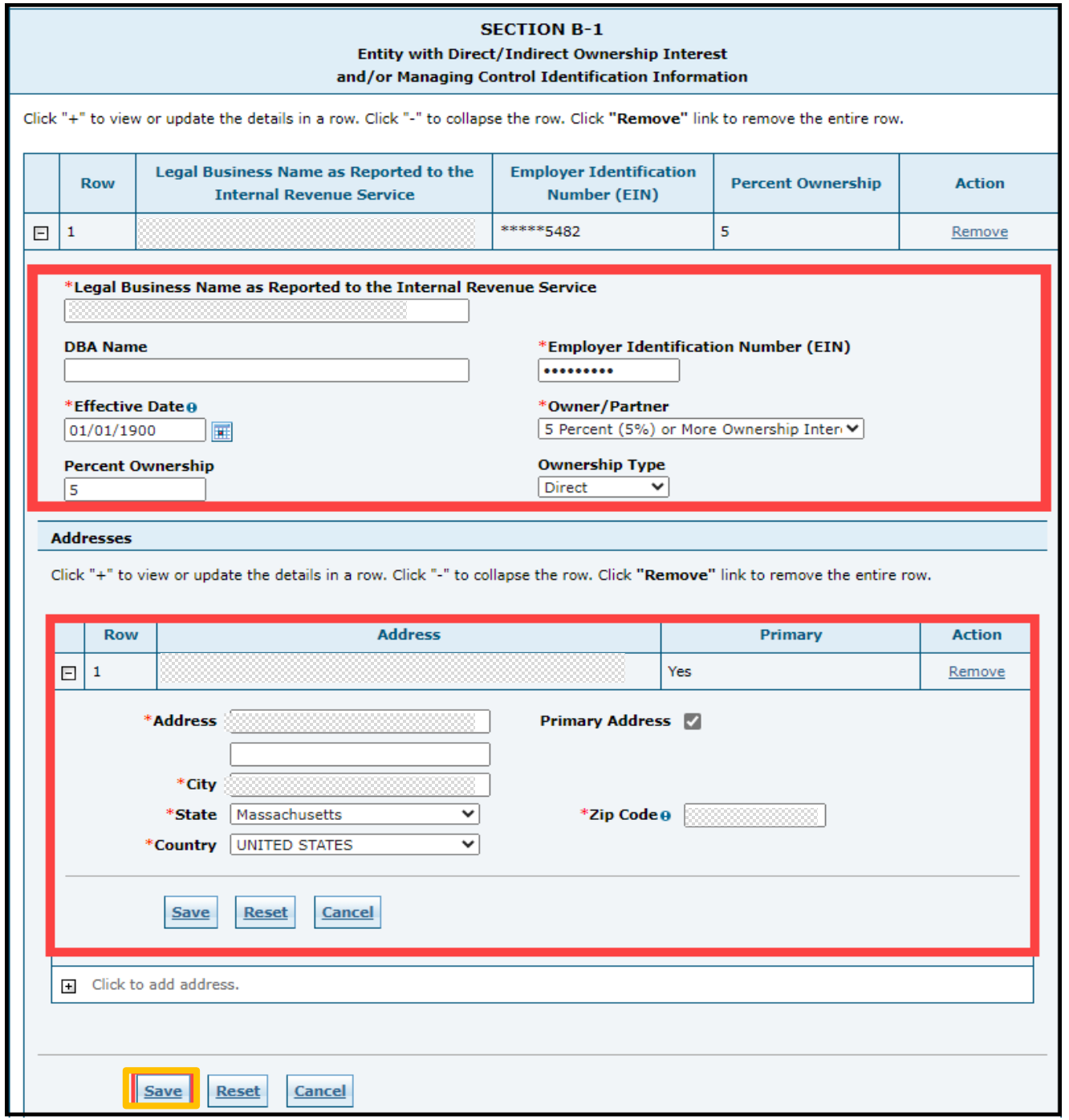
Applicant History Page

- Scroll down and answer each question appropriately and provide an explanation if required.
- Select **Continue** to the Disclosure page.



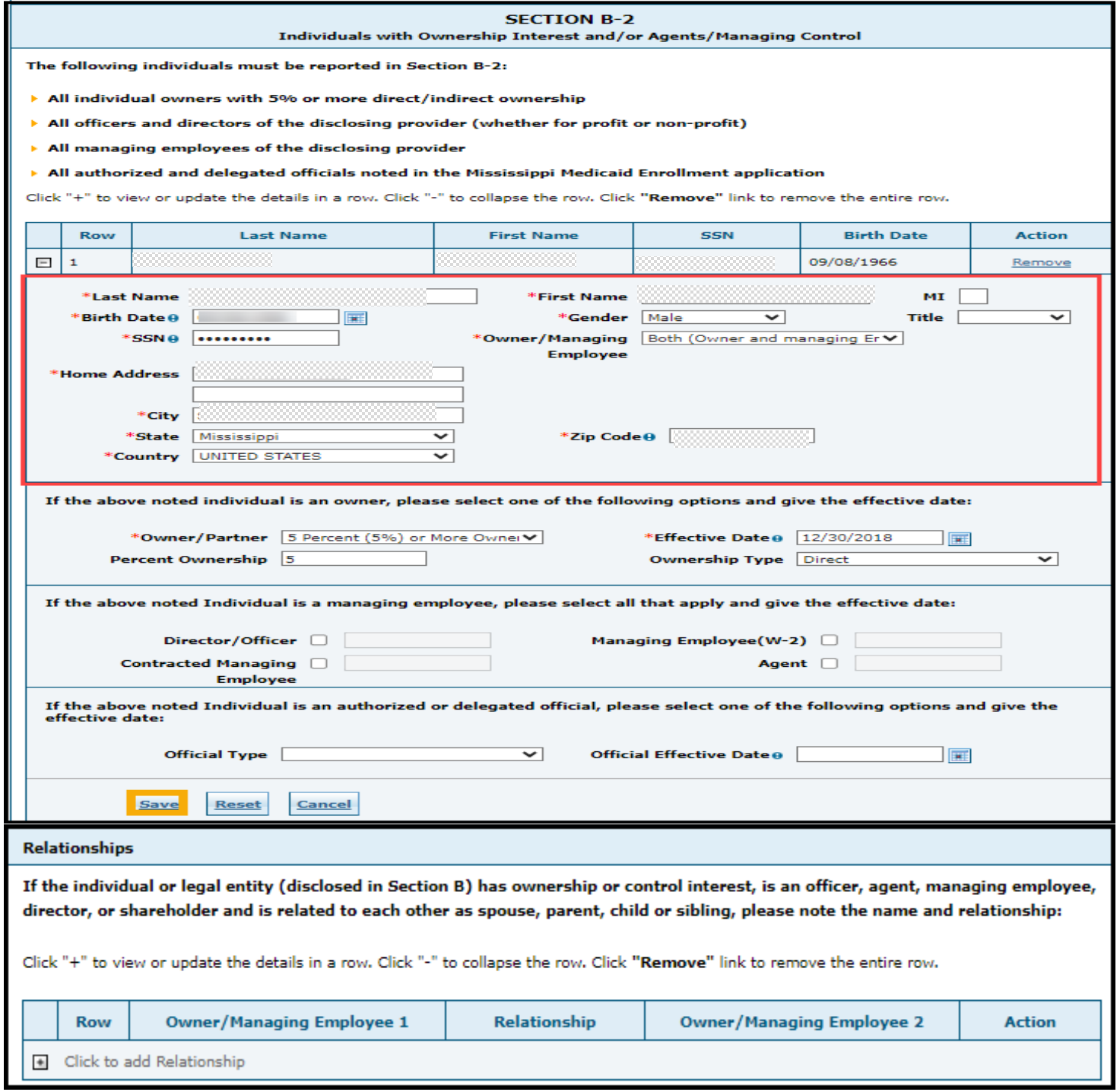
Disclosure Page, Section B-1.

- Check each section and make any necessary updates.
- To view or update a row select the **+** sign.
- To remove a row, select the **Remove** link.
- If any updates are required for the fields in the red highlighted box, then a PDF attachment is required. You must fill out the B-1 section of the Disclosure Form, as applicable, and upload the PDF document. The form can be found on the MS Division of Medicaid's website: Forms - Mississippi Division of Medicaid
- Gainwell is working on a solution, so the providers do not have to upload a PDF document for changes in the mentioned fields. Providers will be notified through Late Breaking News as soon as the change is implemented.
- **Save** must be selected after the updates have been made.



Disclosure Page, Sections B-2, C and D.

- Check each section and make any necessary updates.
- If any updates are required for the fields in the red highlighted box, then a PDF attachment is required. You must fill out the B-2 section of the Disclosure Form, as applicable and upload the PDF document. The form can be found on the MS Division of Medicaid's website: Forms - Mississippi Division of Medicaid
- Gainwell is working on a solution, so the providers do not have to upload a PDF document for changes in the mentioned fields. Providers will be notified through Late Breaking News as soon as the change is implemented.
- **Save** must be selected after any updates have been made.



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				09/08/1966	Remove

*Last Name | *First Name | MI
*Birth Date | *Gender: Male | Title
*SSN | *Owner/Managing Employee: Both (Owner and managing Er
*Home Address
*City
*State: Mississippi | *Zip Code
*Country: UNITED STATES

If the above noted individual is an owner, please select one of the following options and give the effective date:

*Owner/Partner: 5 Percent (5%) or More Owner | *Effective Date: 12/30/2018
Percent Ownership: 5 | Ownership Type: Direct

If the above noted Individual is a managing employee, please select all that apply and give the effective date:

Director/Officer | Managing Employee(W-2)
Contracted Managing Employee | Agent

If the above noted Individual is an authorized or delegated official, please select one of the following options and give the effective date:

Official Type | Official Effective Date

Save | Reset | Cancel

Relationships

If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing employee, director, or shareholder and is related to each other as spouse, parent, child or sibling, please note the name and relationship:

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

	Row	Owner/Managing Employee 1	Relationship	Owner/Managing Employee 2	Action
⊞	Click to add Relationship				

Disclosures Page, Sections C and D.

- Check each section and make any necessary updates.
- **Save** must be selected after any changes have been made.

SECTION C
Criminal Convictions and Other Sanctions

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

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

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

	Row	Name	Criminal/Sanction Info	Date	Action
⊞	Click to add Conviction/Sanction				

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

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

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

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

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

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

v. is an agent of the group/organization;

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

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

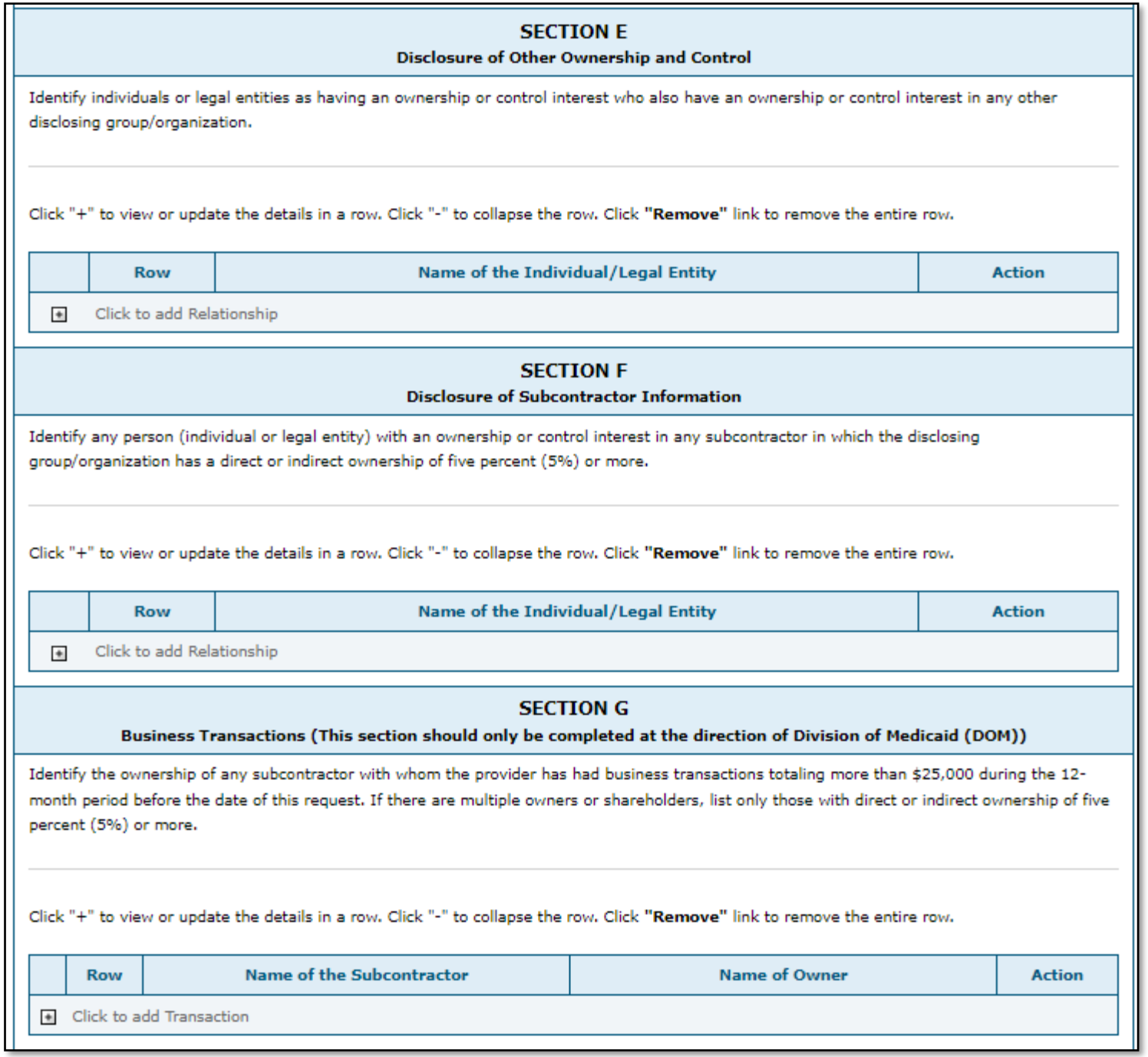
NOTE: Please refer to the Instructions for Provider Disclosure Form for applicable definitions.

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

	Row	Name	Relationship	Action
⊞	Click to add Relationship			

Disclosures Page, Sections E, F and G.

- Check each section and make any necessary updates.
- **Save** must be selected after any changes have been made.



SECTION E

Disclosure of Other Ownership and Control

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

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

	Row	Name of the Individual/Legal Entity	Action
⊞	Click to add Relationship		

SECTION F

Disclosure of Subcontractor Information

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

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

	Row	Name of the Individual/Legal Entity	Action
⊞	Click to add Relationship		

SECTION G

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

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

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

	Row	Name of the Subcontractor	Name of Owner	Action
⊞	Click to add Transaction			

Disclosures Page, Section H.

Once all updates are made in each section, read instructions and select **" I accept".**

Enter the required signature and title.

Select **Continue.**

SECTION H
Attestation and Signature of the Disclosing Provider

I certify that the information on this form, and any submitted statement(s) that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I sign under penalty of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

In addition, I understand that:

- In accordance with 42 CFR § 455.104(e), federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required.
- In accordance with 42 CFR § 455.106(c), DOM may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. Further, DOM may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under 42 CFR § 455.106(a).
- In accordance with Miss. Code Ann. § 43-13-121, Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These circumstances include failure to truthfully or fully disclose any and all information required on this form, or making a false or misleading statement to DOM relative to the Medicaid program.
- In accordance with 42 CFR § 455.436, the State Medicaid agency and all Medicaid contractors shall do the following:
  1. Confirm the identity and determine the exclusion status of providers and contractors/subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the provider or contractor/subcontractor through routine checks of federal databases; and,
  2. Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, revalidation, and no less frequently than monthly thereafter, to ensure that the State does not pay federal funds to excluded persons or entities.

NOTE: If the disclosing provider is 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 d

Title d

Date 03/22/2023

Continue | Finish Later | Cancel

Supporting Documentation/Attachment and Fees Page

The **Privacy Notice** link must be selected in order to continue to the next page. The link directs you to the Division of MS Medicaid page.

If all your documents are combined into one file, select **Attachment Type "All"** to add as one PDF document. When adding each document separately, choose the appropriate **Attachment Type** for each document. Select **"Other"** if adding Disclosure Forms.

Add must be selected to add the attachment(s).

Individual Providers must attach proof of Professional Liability Insurance.

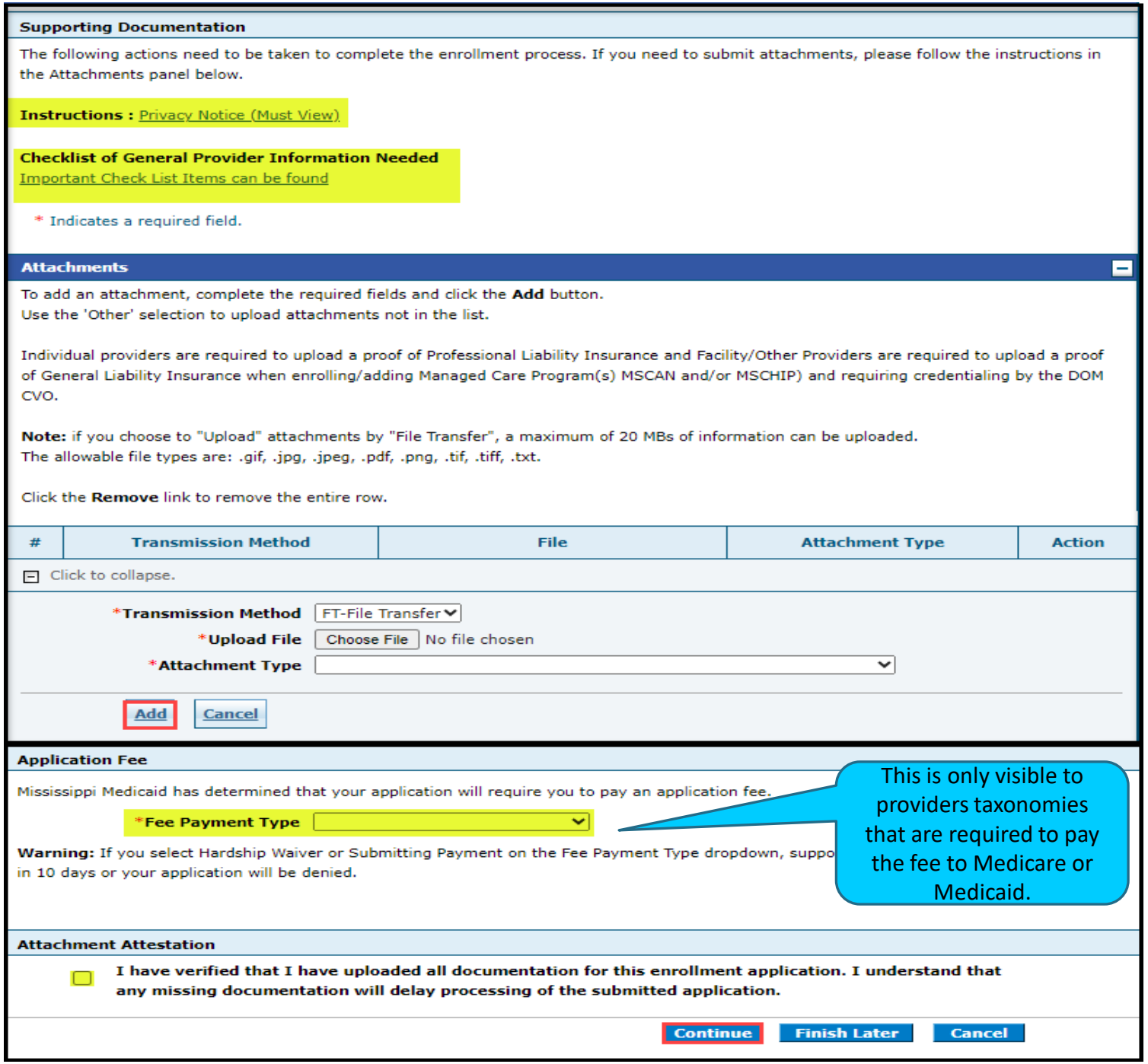
Facility and Other Providers must attach proof of General Liability Insurance.

All forms can be located at Forms - Mississippi Division of Medicaid

Select the appropriate ***Fee Payment Type.*** *Application Fee section will only be visible to providers taxonomies that are required to pay the fee to Medicare or Medicaid.*

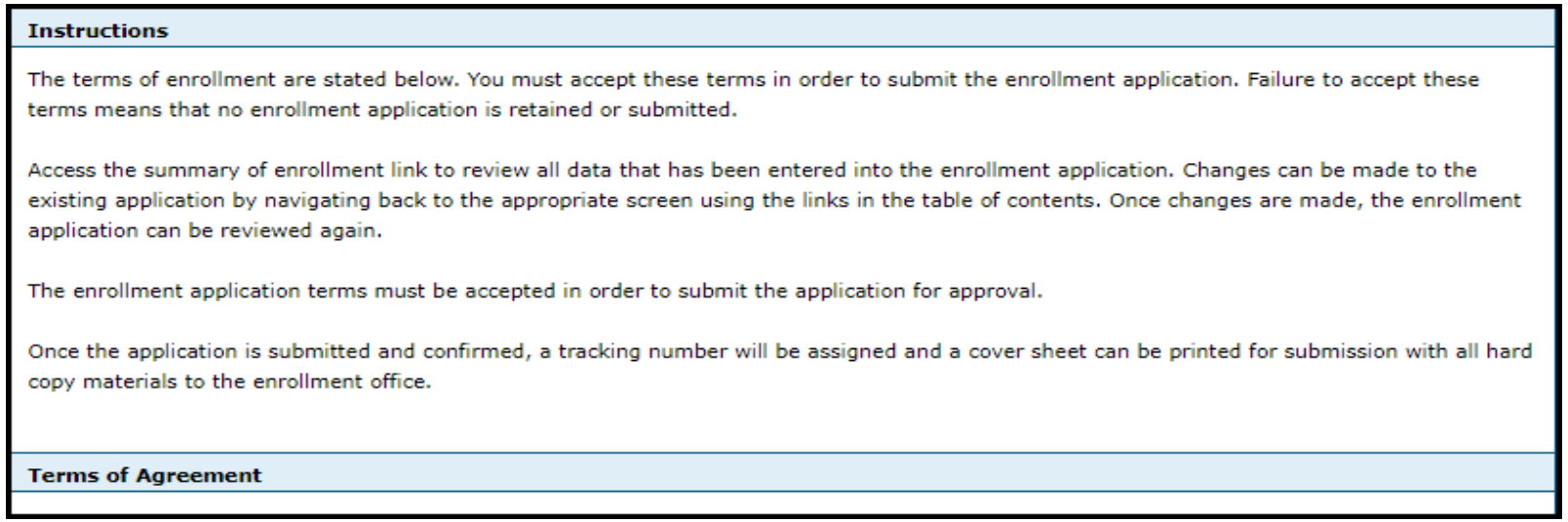
This link, Provider Enrollment Application Fee can be utilized to verify if your taxonomy code is required to pay an application fee.

Select the **Attestation Statement**, then **Continue** to the Agreement page.



Agreement Page

- Read all the instructions until you reach the bottom of the page.
- Select "**I Accept**".
- Enter the **Signature** of the **Provider or Authorized Representative.** Enter the **Title** (if applicable).
- Select **Submit** to advance to the **Summary** page.



Instructions

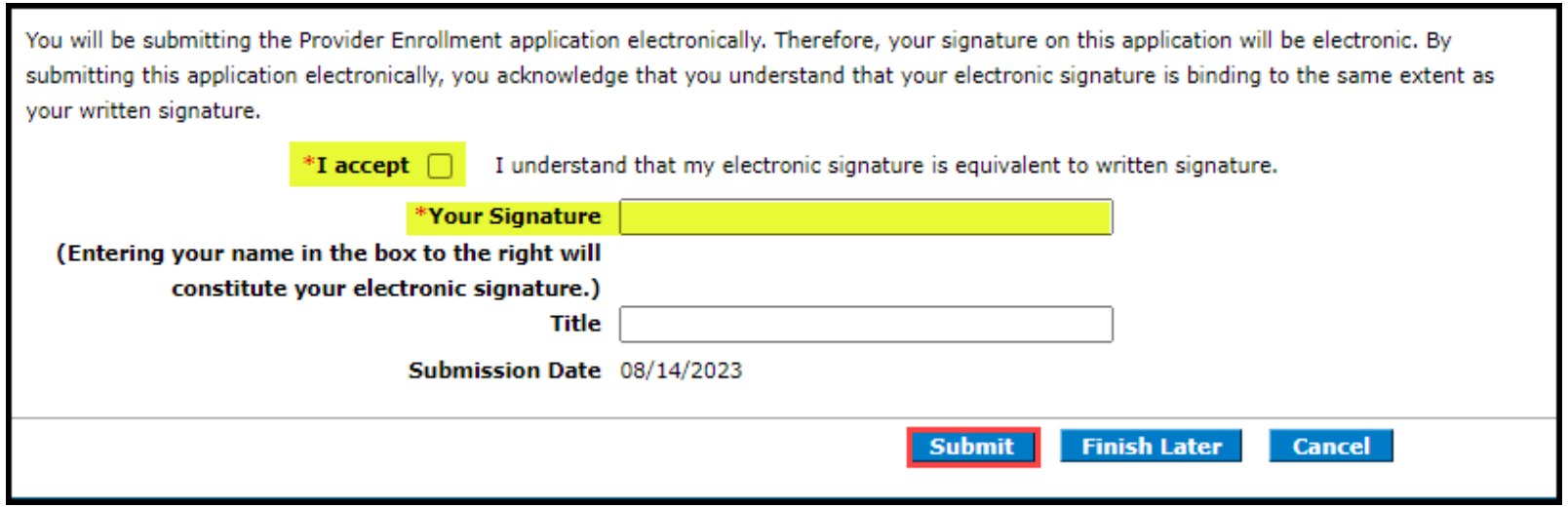
The terms of enrollment are stated below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.

Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.

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

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.

Terms of Agreement



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

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

*Your Signature

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

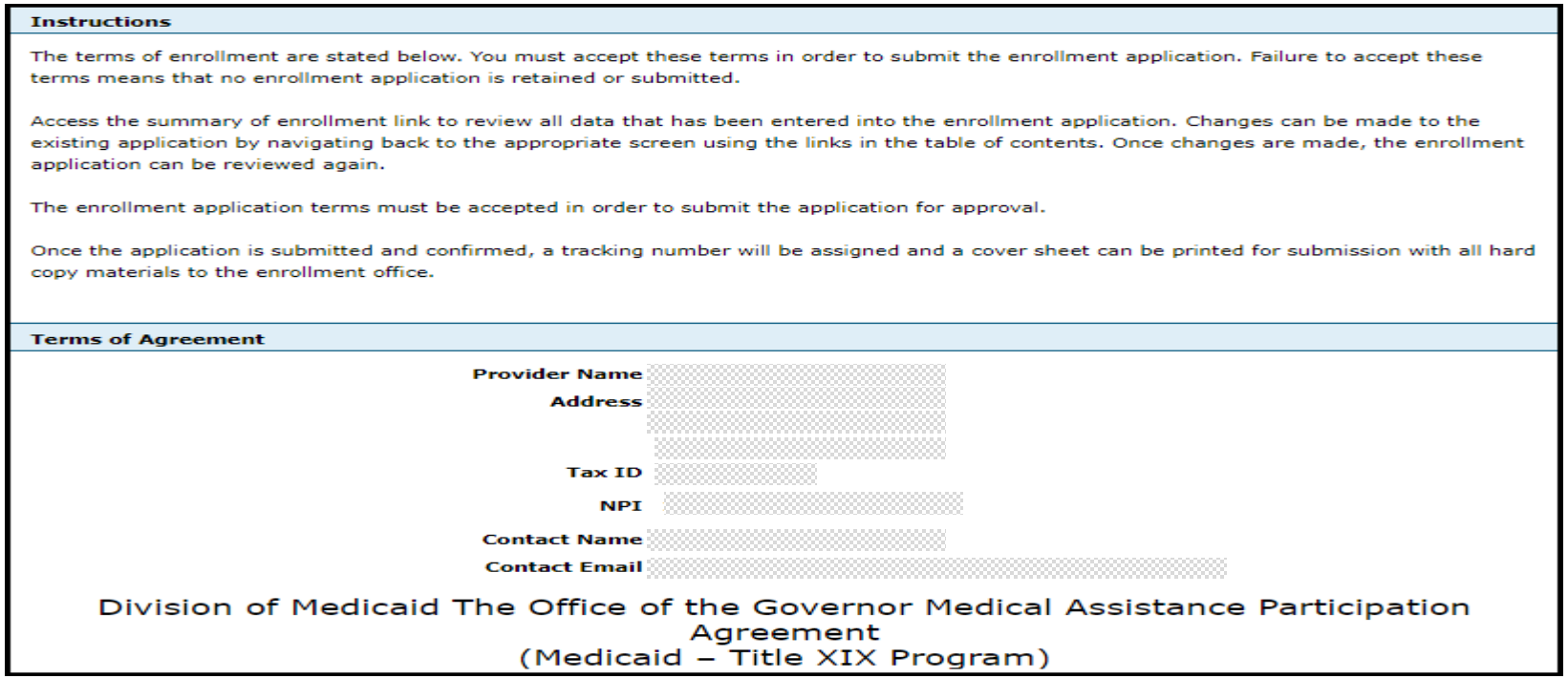
Title

Submission Date 08/14/2023

Submit | Finish Later | Cancel

Summary Page

- After reading all the Instructions and Terms of Agreement, Select **"I accept"** stating you agree with the terms of the enrollment application.
- Enter the **Signature** of the **Provider or Authorized Representative.** Enter the **Title** (if applicable).
- Select **Submit.**



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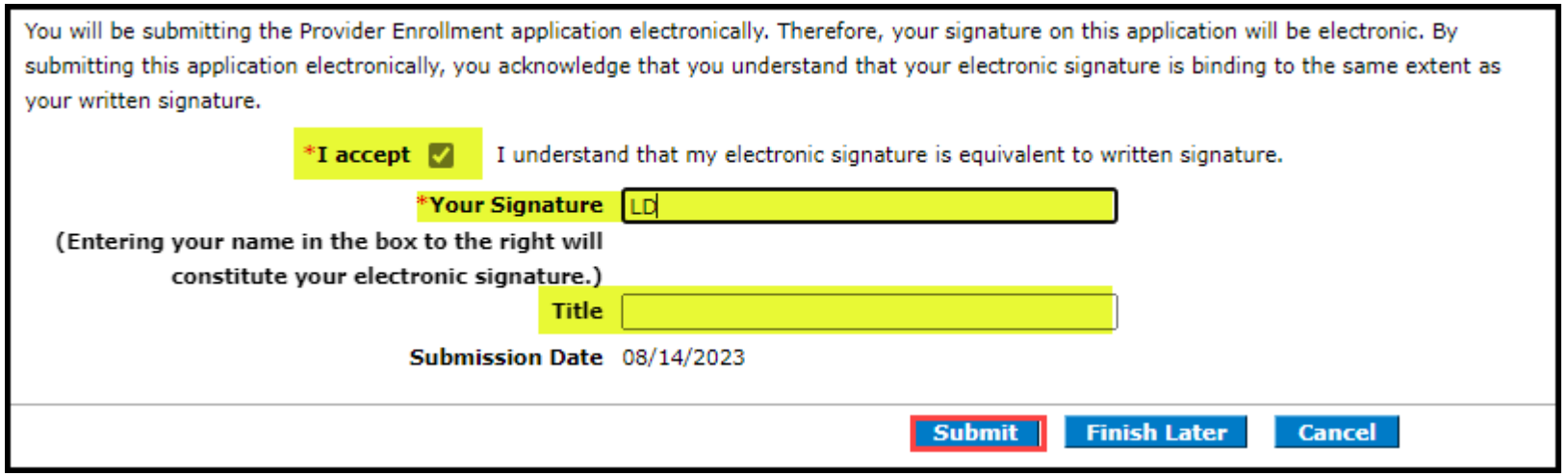
The enrollment application terms must be accepted in order to submit the application for approval.

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.

Terms of Agreement

Provider Name
Address
Tax ID
NPI
Contact Name
Contact Email

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



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

*Your Signature LD

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

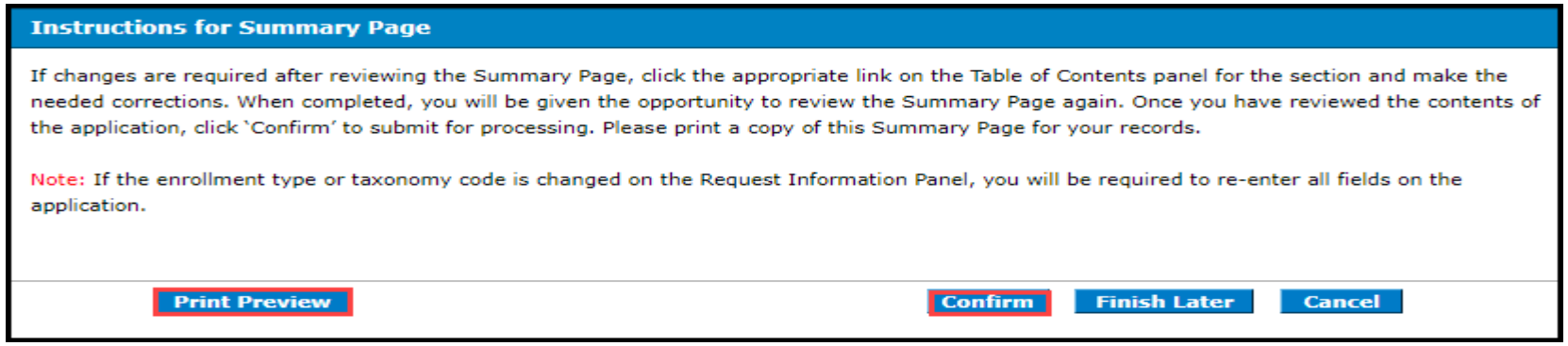
Title

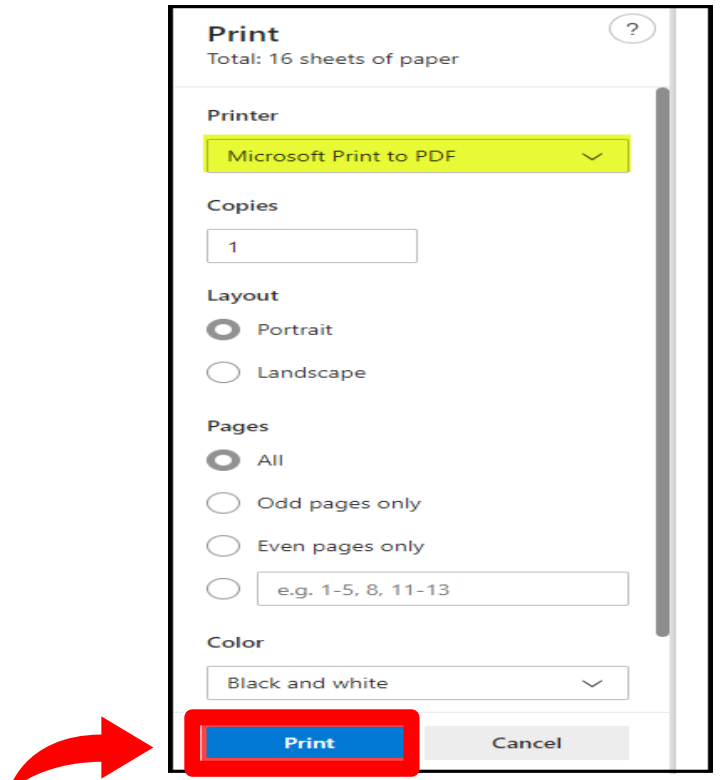
Submission Date 08/14/2023

Submit | Finish Later | Cancel

Summary Page Con't

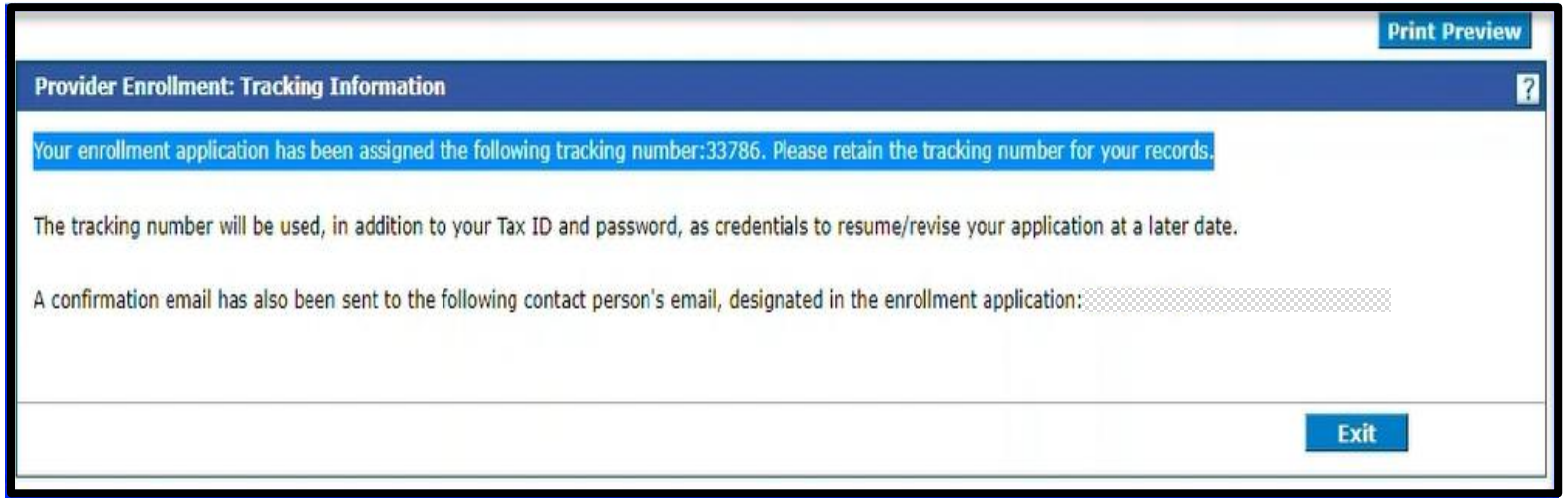
- Select **Print Preview** to review the content of the entire application before submitting. Also, Print Preview allows the chance to save or print the application for your record keeping before completing the submission.
- Select **Print** (blue box) on the right-hand side, change the Printer drop-down to a physical printer and print a physical copy. Or select "Microsoft Print to PDF" to save an electronic copy.
- To finish printing or saving a copy of the application, select **Print** (red box) at the bottom.
- It's imperative to select **Confirm** in order to submit the application completely so that an ATN (Application Tracking Number), is generated and provided.





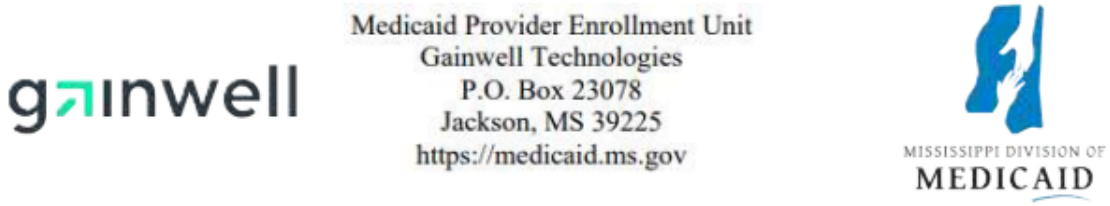
Summary Page Con't

- Your application has been submitted and you have been provided an **ATN, Application Tracking Number.**
- Take note of your **ATN.** Also, you will receive an email with the ATN.
- Select **Print Preview** to save or print this information.
- Your **ATN** can be used to check the status of your application and make updates requested from Gainwell through the Portal. Also, any documents you fax or mail to Gainwell in reference to your application should include your **ATN**.
- Select **Exit.**



Sample Recredentialing Approval Letter

- Once your Recredentialing Application has been approved, you will receive an approval letter with the date you are approved through.



Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 23078
Jackson, MS 39225
https://medicaid.ms.gov

MISSISSIPPI DIVISION OF MEDICAID

August 16, 2023

1

Dear Provider:

Mississippi Division of Medicaid (DOM) has approved the provider recredentialing and revalidation for provider ID through **08/16/2026**.

If you are an individual and have multiple service locations, they are all recredentialed until the date above. If you are a facility and have multiple provider IDs for the same location all of those provider IDs are recredentialed until the date above.

Thank you for your continued participation in the Mississippi Medicaid program. If you have questions or need assistance, contact Provider Services staff at 1-800-884-3222 with any inquiries between the hours of 8:00 a.m. and 5:00 p.m. CST, Monday through Friday.

Sincerely,

Provider Services