MISSISSIPPI DIVISION OF
MEDICAID

Job Aid

Provider Enrollment Panels

This document displays the panels presented on the Provider Portal enrollment application, as well as those in the MESA Provider area for enrollment.

Welcome Page

The **Provider Enrollment** section on the **Welcome** page discusses the enrollment process for each provider type along with the process for credentialing, recredentialing and revalidation. section discusses credentialing requirements and processes. See

Figure 1: Welcome Page Section.

Figure 1: Welcome Page

Provider Enrollment: Welcome

Welcome
Request Information
Taxonomies
Provider Identification
Addresses
Affiliated Providers
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EFT Enrollment
Other Information
Disclosure
Supporting Documentation / Attachments and Fees
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Summary

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 the individual providers have the same servicing address as the affiliated 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.

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Figure 2: Credentialing/Recredentialing/Revalidation Section

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.

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The **340B Program** message explains the drug pricing program for applicable providers. See Figure 3: 340B section.

Required Documents and Enrollment Requirement link directs users to the Department of Mississippi Medicaid's website.

Figure 3: 340B Section and Required Documents and Enrollment Requirements

340B Program

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

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

Required Documents and Enrollment Requirements

To view required documents and enrollment requirements, please visit the Mississippi Division of Medicaid's website.

Click here to go directly to the website.

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

Continue Cancel

At the bottom of each page, users must select **Continue** to move forward in the application. Each time a user exits the application and returns, they must start at the Welcome page and click **Continue** to move forward through the pages.

Request Information Page

On the **Request Information** page, applicants can access lists of primary taxonomies for each application type. In the **Initial Enrollment Information** panel, an applicant must select the Additional Requirements Enrollments Checklist link in order to move forward in the application process. The applicant will select the appropriate Enrollment Type, enter the Taxonomy and enter the Requesting Enrollment Effective Date.

The applicant can change the date of the **Requesting Enrollment Effective Date** field, which is set to the current date.

Figure 4: Request Information – Initial Enrollment Information

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Provider Enrollment: Request Information

- Welcome
- **Request Information**
- Taxonomies
- Provider Identification
- Addresses
- Affiliated Providers
- Languages
- EFT Enrollment
- Other Information
- Disclosure
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- Agreement
- Summary

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

All required attachments must be uploaded directly to this application.

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

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

Click the Additional Enrollment Requirements Checklist link to select a taxonomy.
Additional Enrollment Requirements Checklist (Must View)

***Enrollment Type** Individual
***Taxonomy**
***Requesting Enrollment Effective Date** 12/12/2023
***Are you enrolling only for the submission of the crossover claims? By selecting Yes, you agree that you will not be paid for any claim types other than crossover claims.** ○ Yes ◉ No

NOTE: In accordance with the Mississippi Division of Medicaid Administrative Code found at Mississippi Division of Medicaid, providers enrolling with certain taxonomies will only be eligible for the payment of crossover claims.

The page menu on the left will update to reflect the selected enrollment type and primary taxonomy after the applicant selects **Continue** on this page.

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Figure 5: Request Information – Provider and Program Information

Provider Information

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

*NPI *NPI Zip + 4 394017246

*SSN

*Are you currently enrolled as a Provider? Yes No

*Were you previously enrolled as a Provider? Yes No

Program Enrollment

Please choose a selection below (at least one is required). **Note:** When choosing MSCAN, Fee-For-Service (FFS) must also be chosen.

Click Here, to view taxonomies excluded from MSCAN and/or MSCHIP enrollments.

Fee-For-Service (FFS) MSCAN MSCHIP

Application Contact Information

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

*Last Name D
*First Name L
Title
*Phone Ext
Fax Number
*Work Email
*Confirm Email
Preferred Method of Communication Email

Continue Finish Later Cancel

In the **Provider Information** panel, the applicant must enter the provider's National Provider Identifier (NPI), the ZIP Code, plus found for the service location applicable to the NPI, and the Social Security Number (SSN) or Tax ID of the provider. The applicant must also indicate whether the provider is enrolled in Medicaid or was previously enrolled.

In the **Program Enrollment** panel, the applicant must select at least one program to enroll in. If MSCAN and/or MSCHIP is selected, the provider is subject to credentialing.

In the **Application Contact Information** panel, the applicant should enter their contact information. Questions about the application will be addressed to this person at the provided phone, fax, or email contacts. For example, the Application Tracking Number (ATN) will be sent to the email address for this contact.

CHOW Ownership Panel

Facilities have the additional **Change of Ownership (CHOW)** panel to indicate if the applicant is taking over an existing facility (see **Error! Not a valid bookmark self-reference.**).

If the applicant indicates they are assuming ownership by selecting Yes, they must indicate whether they are assuming the previous provider's NPI. If so, they must provide the NPI as part of the

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application in the **Provider's Medicaid ID** field. The applicant must then indicate the **Effective Date of Ownership.**

Figure 6: Request Information – Provider and Program Information for Facility with CHOW

Summary

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
*Requesting Enrollment Effective Date: 08/01/2022
*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: EIN

*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
*Are you assuming previous Provider's NPI? Yes / No
*Provider's Medicaid ID?
*Effective Date of Ownership: 08/01/2022

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: JONES
*First Name: JOHN
Title
*Phone
Ext
Fax Number
*Work Email
*Confirm Email
Preferred Method of Communication: Email

Continue | Finish Later | Cancel

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When the applicant clicks **Continue**, the pages of the enrollment update according to the selections entered. For enrollments in MSCAN and MSCHIP, the Credentialing Information page is inserted before the Taxonomies page. The Hospital Admittance and Applicant History pages have been inserted between the Other Information and Disclosure pages. Due to credentialing requirements, the Other Information page will now include the Insurance panel.

Credentialing Information Page

At the **Credentialing Information** page, individual applicants enrolling in MSCAN or MSCHIP must either select a Credentialing Delegate Agency and credentialing date, or a Council for Affordable Quality Healthcare® (CAQH) ID. See Figure 7: Credentialing Information Page.

Figure 7: Credentialing Information Page

Taxonomies Page

At **Taxonomies** page, the applicant can add other taxonomies within the same family of taxonomies. Each of these will be assigned its own Medicaid ID when the application is approved and finalized, but additional taxonomies will not change the content of the application.

Figure 2: Additional Taxonomies Page

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Provider Identification Page

At the **Provider Identification** page, the applicant must enter information about the provider, the organizational structure of the business, and add licenses, CLIA certifications, and DEA information. If the provider has already participated in Medicare, the number, type, and effective dates must be added here. See

Figure 9: Provider Identification Page

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Figure 9: Provider Identification Page

Provider Enrollment: Provider Identification

* Indicates a required field.

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: Individual

Registered with Secretary of State
Business Start Date
Incorporated
Incorporation Date
Chain Affiliated
Operated by Management Company
*Public/Private Indicator: Public

Individual Providers

*Gender: Male
*Birth Date

License

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

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

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

Add Reset

Medicare Participation

Medicare #
Effective Date
Medicare Type

CLIA Certification

Fields marked required in this section are only required if any information is entered in this section.
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **"Remove"** link to remove the entire row.

	CLIA #	Effective Date	End Date	Action
⊟	Click to collapse.			

*CLIA #
*Effective Date
*End Date

Add Reset

DEA #

DEA #
Effective Date

Continue Finish Later Cancel

Addresses Page

At the **Addresses** page, the applicant must enter at least a service location address. They can also add a Mail-To, Pay-To, and Corporate Office address. These four addresses are required in MESA. If any addresses are missing, MESA copies the service location address to the missing address fields.

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If the applicant selects Service Location from the **Address Type** drop-down list, the page updates with additional information and panels (see Figure 10: Addresses Page – Service Location).

The service location must be a physical address. The system verifies the ZIP Code as well as the State-County combination. The applicant can specify up to four phone numbers. Only one phone number is required, and the type must be Office.

In the **Service Address Information** panel, applicants must indicate hours for each day of the week. The system offers the ability to indicate if the location is open 24 hours or if it is closed all day, such as on weekends.

The applicant should also indicate here if the provider is accepting new patients, and if there are any patient restrictions. New patient information appears with provider data on the Member Portal provider search results page.

If there are any administrators at the location, they should be listed here. If a Facility or Medical Administrator is listed, an entry is required in the **License #** field.

If the service location has Telecommunication Device for the Deaf (TDD) or teletypewriter (TTY) capabilities, the applicant can indicate it here. If a check box is selected, the system requires the applicable phone number for the device. This information is also included on the Member Portal.

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Figure 10: Addresses Page – Service Location

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

⊟ Click to collapse.

*Address Type: Servicing
*Name Type: ○ Business Name ◉ Personal Name
*Last Name:
*First Name:
Middle: Title:
*Address:
*City: Marks *County: QUITMAN
*State: North Carolina *Zip Code: 686461142
*Contact Name:
*Primary Email: *Confirm Email:
*Phone: Office 6015551212 Ext Phone: Ext
Phone: Ext Phone: Ext

Service Address Information

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

Office Hours

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

Accepting New Patients ☑ Accepting New Patients with Special Needs ☑
Sedation ☑ Permit/Licenses# 123456789
Services for Intellectual Disability ☑
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: Bob First Name: Jones License #: 123456
Medical Administrator Last Name: First Name: License #:
Service Administrator Last Name: First Name:
TDD Capability ☐ Phone Ext
TTY Capability ☐ Phone Ext

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Finally, the Accessibility Options panel offers the ability to indicate if the service location offers any of these types. The applicant can add any or all of these types. They will appear in the Accessibility Type data list for the service location. See Figure 11: Addresses Page – Accessibility Options Panel.

Figure 11: Addresses Page – Accessibility Options Panel

Providers can add as many locations as applicable for the provider. If the applicant adds multiple service locations, each service location will be assigned an ATN. All non-service locations will be attached to each service location record in MESA. See Figure 12: Addresses – Provider Addresses.

Figure 12: Addresses – Provider Addresses

Affiliated Providers Page

At the **Affiliated Providers** page, the applicant may add Affiliated Providers. If the applicant chooses not to affiliate with a Group, the system will allow the applicant to select **Continue** to the next page.

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Figure 13: Affiliated Providers Page

To add an Affiliated Provider, select the **Add tab.** Enter the NPI of the provider and tab to the magnifying glass. The information will auto populate. The applicant can change the date of the affiliation here.

Select **Add** to save the Affiliated Provider. Repeat the same steps to add additional Affiliated Providers.

The date noted for the Requested Affiliation Effective Date is not guaranteed. The date is dependent on the approval date of the enrolling provider. The system will only permit past effective dates to be up to one year old or up to the provider's approved effective date, whichever is most recent. If a past date specified for affiliation effective date overlaps with past affiliations between the same entities, then the system will give and error message.

The system will allow gaps between affiliations between the same entities. The system will not allow affiliation between two Group providers or allow Group providers to affiliate with ORP/Other/Facility providers.

Figure 14: Affiliated Provider Add Page

If the NPI is not known, a search can be performed by selecting the magnifying glass. The **Search by ID** and **Search by Organization** tabs will populate. The **Search by ID** tab allows the applicant to change the Provider ID Type to NPI, MCD or Medicaid ID. Select the Provider ID Type drop-down box to change the Provider ID Type.

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Figure 15: Provider ID Type Search

Select the **Search by Organization** tab to search by the **Organization Name.**

Figure 16: Organization Search

A list of the added Affiliated Providers displays on the **Summary** page. If finished, select **Continue** to the **Language** page.

If the applicant would like to remove an Affiliated Provider, select the **Remove** link found under the **Summary** tab or Select the corresponding number in the # column. This will direct the applicant to the **Edit** tab. Select **Delete** to remove that Affiliated Provider.

Languages Page

At the **Languages** page, the applicant must indicate at least one language. The languages indicated here appears on the Member Portal and are searchable by members looking for a provider with translation options. See Figure 17: Languages Page.

Figure 17: Languages Page

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EFT Information Page

At the **EFT Information** page, banking information is required. The applicant must also include EFT documentation with the attachments for the application. See Figure 18: EFT Information Page.

Figure 18: EFT Information Page

Provider Enrollment: EFT Information

Welcome
Request Information
Credentialing Information
Taxonomies
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Languages

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: Bank of Banks
*ABA Routing Number
*Type of Account at Financial Institution: Checking
*Provider's Account Number with Financial Institution
*Confirm Account Number

Continue | Finish Later | Cancel

Other Information Page

The **Other Information** page includes an **Insurance** panel if the application requires certification, see Figure 19: Other Information Page – Insurance Panel Entry Fields. Applicants can add multiple insurance records. See Figure 20: Other Information Page with Facility Information for a view of the page with a listed insurance record.

Figure 19: Other Information Page – Insurance Panel Entry Fields

Provider Enrollment: Other Information

* Indicates a required field.

Insurance

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

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

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

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

Name	Policy #	Effective Date	Expiration Date	Action

Click to collapse.

*Carrier or Self-Insured Name
*Policy Number
*Address: 1900 E Woodrow Wilson Ave
*City: Jackson
*County: HINDS
*State: Mississippi
*Zip Code: 39216
*Effective Date: 01/01/2020
*Expiration Date: 01/01/2025
*Do you have unlimited coverage with this insurance carrier? Yes No
*Amount of Coverage Per Occurrence: 100000000.00
*Amount of Coverage Per Aggregate: 1000000.00

Add | Reset

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The **Board Certification** panel offers the opportunity to indicate if the provider is board-certified.

For hospital applications, this page includes the **Facility Information** panel to indicate the administrator's name and contact information as well as bed count.

Figure 20: Other Information Page with Facility Information

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
+	CLIA CERTIFICATION LETTER FROM CMS		05/01/2022	05/01/2025	Remove
+	Click to add board certification.				

Facility Information

*Administrator First Name: Fran　MI:
*Administrator Last Name: Jones
*Phone:
*Fax Number:
*Email:
*Number Medicaid Beds: 20　*Dually-Certified Beds: 20
*Number Medicare Beds: 20　*Total Beds: 20
*Effective Date: 05/01/2022　*End Date: 05/01/2025

Continue　Finish Later　Cancel

Hospital Admittance Page

The **Hospital Admittance** page only appears for individual providers enrolling in MSCAN/MSCHIP or facility providers. If the page doesn't apply to the provider, the applicant selects **Neither**. If the applicant indicates there is an admitting plan or alternate arrangement, the system disables the Admitting Privileges panel and opens the Admitting Plan/Alternate Arrangement panel. Documentation of the plan or arrangement agreement must be included with the application. See Figure 3: Hospital Admittance Page.

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Figure 3: Hospital Admittance Page

Provider Enrollment: Hospital Admittance

Hospital Admittance

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

	Admitting Type	Hospital	Address	City	State	Action

Click to collapse.

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

Admitting Privileges

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

Admitting Plan / Alternate Arrangement

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

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

Add Reset

Continue Finish Later Cancel

A hospital admittance record can be added for each applicable hospital.

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Applicant History Page

The **Applicant History** page requires answers to several statements about the provider's history.

Figure 22: Applicant History Page for Individuals, part 1

Provider Enrollment: Applicant History

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

- An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.
- A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.
- An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Ability to Perform Job

Question	Answer
*Are you NOT able to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? If you answer YES, you will be asked to describe why you are NOT able to perform.	Yes ◉ No
*Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	Yes ◉ No
*Do you currently or did you in the last two years engage in the unlawful use of drugs, including the improper use of prescription drugs?	Yes ◉ No
If Yes, please explain:	

Education and Board Certification

Question	Answer
*Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you even been placed on probation, disciplined, formally reprimanded, suspended, or asked to resign?	Yes ◉ No
*Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes ◉ No
*Have any of your board certifications or eligibility ever been revoked?	Yes ◉ No
*Have you ever chosen not to re-certify or voluntarily surrendered your board certifications(s) while under investigation?	Yes ◉ No
If Yes, please explain:	

Training

Question	Answer
*Are you and your staff annually trained on Fraud, waste, and abuse?	◉ Yes No
If No, please explain:	

Hospital Privileges and Other Affiliations

Question	Answer
*Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	Yes ◉ No
*Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	Yes ◉ No
*Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	Yes ◉ No
If Yes, please explain:	

Criminal / Civil History

Where required, the applicant must enter an explanation for their answer before continuing.

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Figure 23: Applicant History Page for Individuals, part 2

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:

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 | Finish Later | Cancel

Figure 24: Applicant History Page for Facilities, Part 1

Provider Enrollment: Applicant History

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

- An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.
- A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.
- An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Training

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Figure 25: Applicant History Page for Facilities, Part 2

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

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:

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 | Finish Later | Cancel

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Disclosure Page

There are two versions of the **Disclosure** page. The short version is for Individual and ORP Individuals. The long version is for Facility, Group and Other enrollment types. See Figure 26: Disclosure Page – Short Version.

Figure 26: Disclosure Page – Short Version

Welcome

Final Adverse Legal Action History

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

Convictions

1. Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,
2. Has been convicted of a crime reference in Miss. Code Ann. § 43-13-121(7)(c)-(h), or
3. Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c)-(h).

Exclusions, Revocations or Suspensions

1. Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,
2. Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,
3. Has had his/her/its license or certification revoked, or
4. Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.

Final Adverse Legal Action History

***Has the enrolling provider, under any current or former name or business identity, ever had a final adverse legal action imposed?**

Yes No

If yes, report each final adverse legal action, when it occurred, the Federal or State Agency or the court/administrative body that imposed the action, and the resolution, if any.

Provide a copy of the final adverse legal action documentation and resolution.

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

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

Continue | Finish Later | Cancel

The long version includes the sections shown in Figure 27: Disclosure Pate – Sample from Long Version, as well as:

- Section D, Relationship to Excluded, Penalized, or Convicted Persons
- Section E, Disclosure of Other Ownership and Control
- Section F, Disclosure of Subcontractor Information
- Section G, Business Transactions
- Section H, Attestation and Signature of the Disclosing Provider

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Figure 27: Disclosure Pate – Sample from Long Version

Provider Enrollment: Disclosure

Instructions for Mississippi Medicaid Provider Disclosure Form (Section C-2)

Click to View Instructions

SECTION B
Direct/Indirect Ownership Interest and Managing Control Identification Information

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
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	Jones	Robert	*****4025	05/01/1990	Remove
Click to add Individual						

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					

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

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Supporting Documentation/Attachments and Fees

In addition to the **Attachments** panel, this page includes an **Application Fee** panel for providers who must pay an enrollment fee. If the applicant selects **Submitting Hardship Waiver** from the **Fee Payment Type** drop-down list, they must include supporting documentation with the attachments.

Figure 28: Supporting Documentation Page

Provider Enrollment: Supporting Documentation/Attachments And Fees

Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit attachments, please follow the instructions in the Attachments panel below.

Instructions : Privacy Notice (Must View)

Checklist of General Provider Information Needed
Important Check List Items can be found

* Indicates a required field.

Attachments

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

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
1	FT-File Transfer	Medicaid.pdf (43K)	Medicare Certification	Remove
2	FT-File Transfer	FEIN SSN W9.pdf (43K)	Copy of W9 for FEIN	Remove
3	FT-File Transfer	License.pdf (43K)	All	Remove

Click to add attachment.

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

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Facility Attestation/Authorization Page

This page displays when the enrollment type is Facility or Other; MSCAN and/or MSCHIP are selected; and no delegate agency is reported on the **Credentialing Information** page.

Figure 29: Facility Attestation/Authorization and Release Page

Provider Enrollment: Facility Attestation / Authorization and Release

Mississippi Division of Medicaid / Centralized Credentialing Verification Organization (CVO)
Facility Attestation / Authorization and Release

As part of my application for credentialing submitted to the CVO (my "Application"), I hereby acknowledge, understand, consent, and agree as follows:

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").
4. I hereby authorize any and all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, corporations, agencies, licensing authorities, boards, plans, insurers, and other organizations of any type, including, but not limited to, those with which I have been associated, who have information which may bear on my Qualifications to consult with, report to, and release, exchange and share information and documents with the CVO for the purpose of the CVO's evaluation of my Application and my Qualifications.
5. I consent to and hereby authorize the CVO's inspection of records and documents (including medical records and peer review information) that may be material to the CVO's evaluation of my Application and Qualifications and my ability to carry out the services which I may perform in the event my Application is approved. I hereby authorize each and every individual and organization with custody of those records and documents to permit the CVO's inspection and copying of them as may be reasonably necessary for the CVO's evaluation of my Application. I agree to appear before the CVO for interviews regarding the CVO's evaluation of my Application.
6. I consent to and hereby authorize the CVO's release of records, documents, and related information to healthcare entities, care management organizations and interested persons on their request for such information concerning my Qualifications (including, but not limited to, peer review information), provided that the CVO's release of such information is done in good faith and without malice. I hereby release the CVO and its authorized representatives and agents from liability for any claim for damages of any nature for the good faith release of records, documents, or other related information.
7. I hereby release the CVO and its authorized representatives and agents from liability for their acts when performed in a reasonable manner with respect to the investigation and evaluation of my Application and my Qualifications, and I hereby waive any and all claims of any nature against the CVO and its authorized representatives and agents acting in good faith and without malice in connection with the evaluation of my Application and my Qualifications.
8. I acknowledge and understand that any investigations, actions, and recommendations by the CVO (including the CVO's Credentialing Committee) with respect to the evaluation of my Application and my Qualifications and any further reappraisals or evaluations will be undertaken by the CVO as a medical review and/or peer review committee are consistent with the CVO's obligations (under applicable law or otherwise) to conduct such reviews and are, therefore, entitled to application protections provided by law.
9. I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating practitioner by CVO, DCH or a Care Management Organization under contract with DCH.
10. I understand that I have the right to review and correct erroneous information obtained by the CVO to evaluate my Application. This includes information obtained from primary sources (e.g., malpractice insurance carriers, state licensing boards and National Practitioner Data Bank). The review must take place within six (6) months of the date of this Application and my proposed corrections must be submitted in writing to the CVO within thirty (30) days of commencement of the review. The CVO is not required to allow a practitioner to review references or recommendations or other information that is peer-review protected.
11. I understand that if my Application is rejected for reasons relating to my professional conduct or competence, CVO may report the rejection to the appropriate state licensing board, the National Practitioner Data Bank, and/or the Health Care Integrity and Protection Data Bank.
12. I certify that (i) the information provided in or attached to my Application is accurate and complete; (ii) I have adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state financial responsibility requirements; (iii) I hold a full, unrestricted license to practice in the state(s) in which I practice or I have indicated on this application the limitations and/or restrictions imposed; and (iv) I have reported any loss or limitation of hospital privileges or any disciplinary activity to the CVO.

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** 07/27/2022

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

Continue | Finish Later | Cancel

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Agreement Page

The **Agreement** page lists the terms of the enrollment for the applicant to accept and sign.

Figure 30: Agreement Page

Terms of Agreement

Provider Name L D
Address

Tax ID
NPI
Contact Name
Contact Email

Programs selected for application:

- Fee-For-Service (FFS)
- MSCAN

This image only shows part of the terms for the Medicaid provider are listed, there are 21 total.

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.
4. To take no action or adopt any procedure that would circumvent or deny freedom of choice to any eligible recipient of medical assistance under the Medicaid program.
5. To refrain from offering or purporting to give any reimbursement, premium, or other free merchandise as a trade inducement to an eligible recipient.

You will be submitting the Provider Enrollment application electronically. By submitting this application electronically, you acknowledge that you understand that your written signature.

This image only shows part of the terms for the Division and Medicaid and the provider mutual terms are listed, there are 9 total.

***I accept** ☑ I understand that my electronic signatu

***Your Signature**
(Entering your name in the box to the right will constitute your electronic signature.)
Title
Submission Date 12/12/2023

Submit **Finish Later** **Cancel**

Tracking Information Page

When the application is submitted and confirmed, the system returns a page with the Assigned Tracking Number (ATN). This number is required to log in and check status and/or submit additional information.

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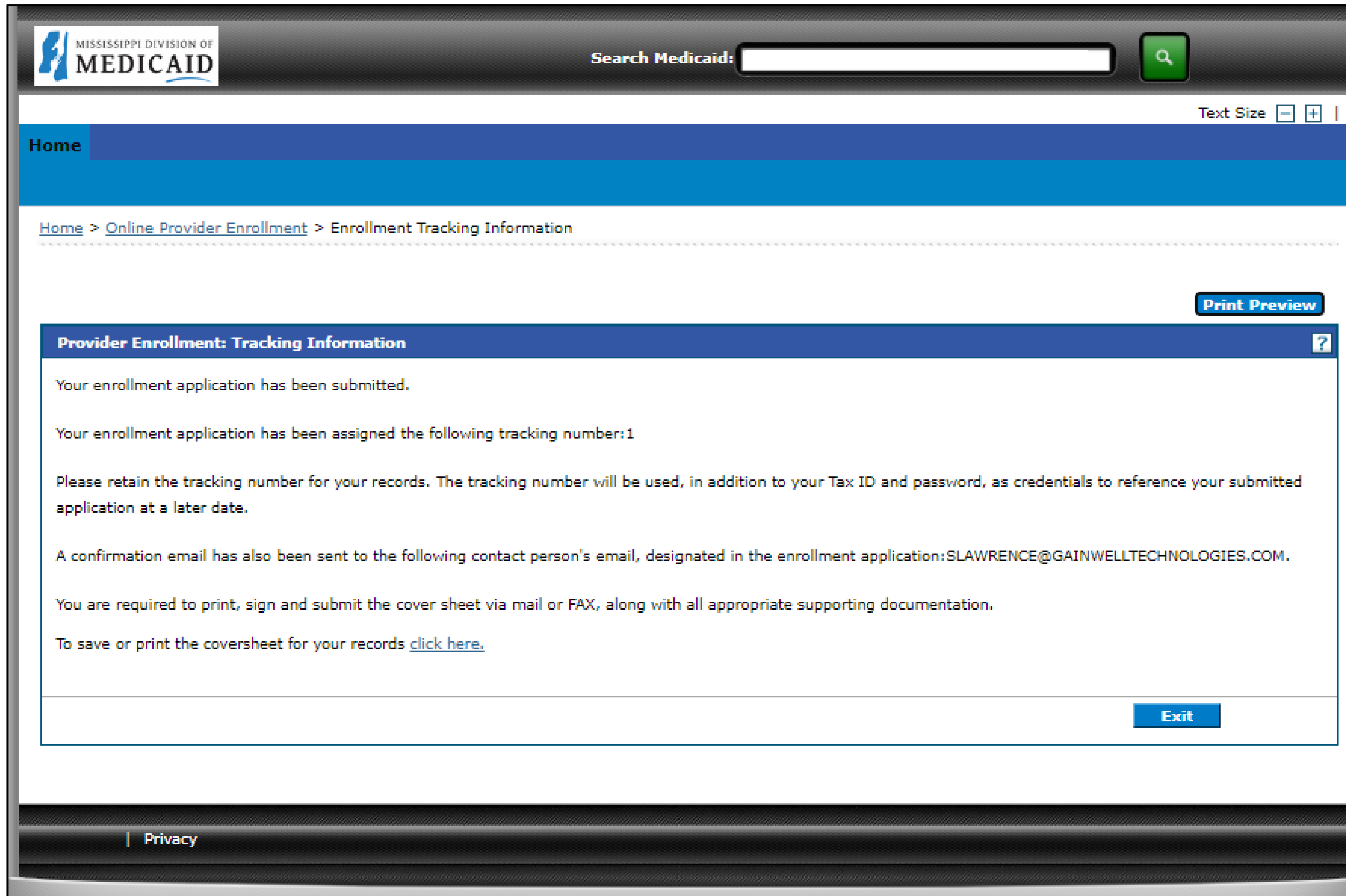
Figure 31: Tracking Information Page



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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	07/xx/2022	Gainwell	Initial submission
1.1	12/13/2023	Gainwell	Added affiliated providers information per CR 1678

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