



# Montana Healthcare Programs

**Provider Enrollment User Guide** 

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### 1. Overview

Welcome to the enrollment module of the Montana Provider Portal, a self-service gateway for current and prospective Montana Healthcare Program Providers to interact with the Montana Department of Public Health and Human Services (DPHHS). This guide explains how in-state and out-of-state providers navigate through the enrollment process on the Montana Provider Portal. The Montana Provider Portal is a complete provider management solution for current and future Montana Healthcare Program providers. The portal helps providers streamline and improve their experience when interacting with the Montana DPHHS.

### 1.1. Audience

The *Provider Enrollment User Guide* is for providers enrolling in the Montana Healthcare Programs network.

### **1.2.** Accessing the Montana Provider Portal

Use the following link to access the Montana Provider Portal website: <a href="https://mtdphhs-provider.optum.com">https://mtdphhs-provider.optum.com</a>

**Note:** Refer to the *Montana Provider Portal User Guide* for portal registration and log in instructions.

For information on general site navigation, refer to Appendix C: Site Navigation.

### 1.3. Online Help

Help is available on all pages while using the Montana Provider Portal.

#### 1.3.1. From the government identification (GovID) Sign In page

If not yet logged in, registration and login help is available by clicking **Help** in the upper right corner of the screen. Refer to Figure 1-1.

	0	🕽 Language 🕨	⑦ Help
Optum GovID Sign In Optum GovID or email address Password	Additional options: Create Optum GovID Manage your Optum GovID What is Optum GovID?		
SIGN IN			

Figure 1-1: Help Icon on the GovID Sign In Page

The Help page displays frequently asked questions and answers about GovID. Refer to Figure 1-2.



Figure 1-2: GovID Help Page

**1.3.2.** When Logged into the Provider Portal

Help is also available from many of the Montana Provider Portal pages by clicking **Help** on each page. Refer to Figure 1-3.



Figure 1-3: Help icon on User Search Page



A pop-up window displays with a description of the fields. Refer to Figure 1-4.

Figure 1-4: User Search Help Text

#### 1.3.3. Additional Help Options

Support staff is also available to assist with portal questions. To contact support staff, click **Contact Us** at the top of any page within the portal. Refer to Figure 1-5. The Contact Us page lists email addresses and/or telephone numbers for Montana Program for Automating and Transforming Healthcare (MPATH) support representatives.



Figure 1-5: Contact Us Icon on the Homepage

## 2. Begin Enrollment

- 1. Access the Montana Provider Portal using the link provided in Section 1.2: Accessing the Montana Provider Portal.
- 2. Click **Provider**. Refer to Figure 2-1.



Figure 2-1: Montana Provider Portal Homepage

3. Click Login and Registration. Refer to Figure 2-2.



Figure 2-2: Provider Login and Registration button

On the Optum GovID Sign In page (refer to Figure 2-3), complete the following information:

- a. Enter the user's Optum GovID or email address in the box provided.
- b. Enter the Password in the box provided.
- c. Click **SIGN IN** to display the portal's secure landing page.

Optum GovID or email address	Additional options:
Password	Create Optum GovID Manage your Optum GovID
	\$ what is Optum GoviD?

Figure 2-3: Optum GovID Sign In

4. In myMenu, click the **Provider Enrollment** option. Refer to Figure 2-4.

r myMenu
Remittance Advice
Provider Directory
Provider Enrollment
Account Administration
File Transaction History

Figure 2-4: Provider Enrollment in myMenu

5. Navigate to the Provider Portal homepage to start the enrollment process.

**Note:** Before starting the application, the provider must answer pre-enrollment questions. This ensures the eligibility requirements are met prior to applying to the Montana Healthcare Programs network.

6. From the homepage, select the **Enrollment** link from the menu. Refer to Figure 2-5.

✓ Member Search
Find everything you need to know about a member with just one search!
Member Search Enter Member ID Go
✓ My Menu
Claims
Remittance Advice
Provider Directory
Enrollment

Figure 2-5: Enrollment Option

7. When the Enrollment sub-menu opens, click Before you begin. Refer to Figure 2-6.

Before you begin	
Begin Enrollment	
Re-Enrollment	
Additional Documents	
Update	
Revalidate	
Disenrollment	

Figure 2-6: Before You Begin

8. Click the **Checklist** link to view a list of materials and documents to gather before beginning an enrollment. Refer to Figure 2-7.

	<ul> <li>→ Before you begin</li> </ul>
Before you begin	- Checklist
Begin Enrollment	Provider Enrollment Checklist
Re-Enrollment	Click this link to download the checklist which is required to continue with the provider enrollment process Checklist.

Figure 2-7: Review the Checklist

9. Segments of the list of materials and documents are shown in Figure 2-8.

		Montana Healthcare Programs
		(Medicaid, HMK Plus/Children's Medicaid,
		HMK/CHIP) Provider Enrollment Checklist
r your co mpleted co	nvenie orrectly	nce, we are providing a checklist to ensure that your provider enrollment submission is y.
ll Medica	aid-On	ly Providers
	1.	Read and electronically sign the Montana Healthcare Programs Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign.
	2.	Complete the Screening and Enrollment Requirements disclosures section and all required fields.
	3.	Download and complete, sign and date the printed W-9 form.
	-1.	Committe Flastronic Funds Transfer FET) section of a lication
Medicai	id Pha	rmacy Providers Only
N	_ 1	. If you are enrolling due to a change in ownership or tax ID change and you assume the former provider's National Council of Prescription Drug Program (NCPDP) formerly known as the National Association of Boards of Pharmacy (NABP) number, you must indicate an effective date after the termination date for the previous provider.
Medicai	id and	Montana HMK/CHIP Providers (Dental Only)
Medicai In additi	id and on to tl	Montana HMK/CHIP Providers (Dental Only) ne above Medicaid-only requirements:
Medicai In additi	id and on to tl 1	Montana HMK/CHIP Providers (Dental Only) he above Medicaid-only requirements: . Read and electronically sign the HMK/CHIP Dental Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign.
Medicai In additi HMK/CI	id and on to th 1 HIP-On	Montana HMK/CHIP Providers (Dental Only) he above Medicaid-only requirements: . Read and electronically sign the HMK/CHIP Dental Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign. aly Dental Providers
Medicai In additi HMK/CI In additio	id and ion to th 1 HIP-On n to the	Montana HMK/CHIP Providers (Dental Only) he above Medicaid-only requirements: . Read and electronically sign the HMK/CHIP Dental Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign. aly Dental Providers e above Medicaid-only requirements:
Medicai In additi ——— HMK/CI In additio	id and ion to th 1 HIP-On n to the	Montana HMK/CHIP Providers (Dental Only) he above Medicaid-only requirements: . Read and electronically sign the HMK/CHIP Dental Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign. aly Dental Providers e above Medicaid-only requirements: Read and electronically sign the HMK/CHIP Provider Enrollment Agreement and
Medicai In additi HMK/CI In additio	id and ion to t 1 HIP-On n to the 1.	Montana HMK/CHIP Providers (Dental Only) he above Medicaid-only requirements: Read and electronically sign the HMK/CHIP Dental Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign. aly Dental Providers e above Medicaid-only requirements: Read and electronically sign the HMK/CHIP Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual

Figure 2-8: Enrollment Checklist Materials

10. To begin the enrollment process, select **Begin Enrollment**. Refer to Figure 2-9. The Pre-Questionnaire pop-up screen will open.

- Enrollment	
Before you begin	
Begin Enrollment	
Re-Enrollment	
Additional Documents	
Update	
Revalidate	
Disenrollment	

Figure 2-9: Begin Enrollment

### 2.1. Complete the Pre-Questionnaire

The first section of the enrollment application is the Pre-Questionnaire. This questionnaire is a series of questions used to identify the way a provider enrolls, determine if the provider meets basic provider enrollment eligibility rules and to meet the requirements to participate in the Montana Healthcare Programs network. There are also key participation questions to determine if the user meets state-specific requirements. The user selects the answers and clicks **Begin Enrollment**.

 Answer Yes or No to the Pre-Questionnaire items, then click Begin Enrollment. Refer to Figure 2-10.

Pre-Questionnaire	×
Please answer the following questions:	
Do you have a National Provider Identifier (NPI)? The National Provider Identifier	ifier (NPI) is a Health Insurance
Portability and Accountability Act (HIPAA) Administrative Standard. A NPI is a	unique identification number
for covered health care providers, created to improve the efficiency and effecti	iveness of electronic
transmission of health information. When enrolling, please be sure to choose a	an enumeration type of
Individual or Organization, when enrolling.	
	🔾 Yes 💿 No
Are you an Atypical Provider? Non health care providers do not require an NP	Pl. Montana Healthcare
Programs will issue non health care providers an Atypical Provider Identifier (A	API). When enrolling, choose
the enumeration of Atypical.	
	● Yes ○ No
Are you physically located in the state of Montana?	Yes O No
Thank you for your time please click on "Begin Enrollment" to continue with the	e enrollment process.
Clo	se Begin Enrollment

Figure 2-10: Pre-questionnaire

- 2. Read the Terms and Conditions that display.
- 3. Check the **Accept Terms and Conditions** checkbox, then click **OK**. Refer to Figure 2-11.

Terms and Conditions	×
OPTUM     Terms of Use     Agreement and Terms     These website Terms of Use ("Terms") describe the rules for using this website. These Terms constitute a legally     binding agreement between you, the person using this website, and Optum If you are helping another person use this     unshelping these Transes constitutes a legally binding agreement between you, the person using this website, and Optum If you are helping another person use this     unshelping these Transes constitutes a legally binding agreement between you.	^
Close	Ok

Figure 2-11: Terms and Conditions

The Pre-Enrollment pop-up screen opens. All providers are presented with preenrollment questions that help the system understand the type of provider enrolling. Provider responses to these questions will open the appropriate application in the Montana Provider Portal based on the provider's type and role as described in Section 2.2: Complete the Pre-Enrollment.

#### 2.2. Complete the Pre-Enrollment

After answering the Pre-Questionnaire items, the Pre-Enrollment section is enabled. In this section, providers indicate their Enumeration and Enrollment Type. The Enumeration and Enrollment Type determine the correct provider type and specialties available to the provider throughout the enrollment process. The Enumeration and Enrollment Type indicated at Pre-Enrollment must match how the provider is shown in the National Plan Provider Enumeration System (NPPES) to obtain a National Provider Identifier (NPI). Follow the steps below for pre-enrollment:

- 1. In the Pre-Enrollment window, select the enumeration type from the Enumeration drop-down. Refer to Figure 2-12. Select Individual, Organization or Atypical.
  - a. Select **Individual** if the provider is enrolling as a Sole Proprietor, Individual Rendering, or Individual Ordering, Prescribing, and Referring.

b. Select **Organization** if the provider is enrolling as a facility or a group provider.
 This requires an organization NPI.

Pre-Enrollment		:
Enumeration:*	Enrollment Type:*	
Select One	Select One	
Select One		
Individual		Confirm Cancel
Organization		
Atypical		

c. Select Atypical if the provider is enrolling without an NPI.

Figure 2-12: Enumeration Types

**Note:** Enumeration type is the same as NPI Type in the NPPES. Type 1 enumeration is an Individual and Type 2 enumeration is an Organization. The Atypical selection in the Montana Provider Portal can represent both an Individual and an Organization. When selected, the user specifies Individual or Organization in the Enrollment Type list.

2. Select the Enrollment Type.

**Note:** Enrollment types are based on enumeration types. This is used in determining which Provider Type/Specialty can enroll for each enrollment type and drives the variations of the enrollment application. Refer to Table 2-1 for the list of enrollment types based on enumeration type.

Table 2-1: Enumeration and Enrollment	<b>Type Associations</b>
---------------------------------------	--------------------------

Enumeration Type	Enrollment Type	Enrollment Type Description
Individual (Type 1)	Sole Proprietor	Owner/operator with no employees
Individual (Type 1)	Rendering Provider	A rendering provider on behalf of a group and would not be submitting claims for payment through the Montana DPHHS.

Enumeration Type	Enrollment Type	Enrollment Type Description
Individual (Type 1)	Ordering, Prescribing, Referring Provider	Refers and prescribes and will not be submitting claims to the Montana DPHHS for billing
Organization (Type 2)	Facility	An organization enrolling a single location under one NPI and Federal Employer Identification Number (FEIN) per enrollment
Organization (Type 2)	Group	An organization enrolling as a single NPI and FEIN per enrollment that has servicing provider affiliations
Atypical (Type 1 or Type 2)	Atypical Individual	Owner/operator with no employees and does not offer services that require an NPI under Center for Medicare & Medicaid Services (CMS) regulations
Atypical (Type 1 or Type 2)	Atypical Organization	Agency or Business with no employees and does not offer services that require an NPI under CMS regulations

**Note:** Providers enrolling as Type 1 (Individual) have assumed 100% control and ownership of their business. If the provider enrolling does not have complete ownership, the provider must enroll as Type 2 (Organization) and must have an organizational NPI. Providers enrolling as Type 2 are required to identify individuals who have ownership of 5% or more in the organization.

- For all provider enrollment types except Sole Proprietor or Atypical Individual, click Confirm and proceed to Section 3: Enrollment Application: Individual Provider. For Sole Proprietor or Atypical Individual provider enrollment types only, go to step 4 below.
- Determine if the Sole Proprietor or Atypical Individual has an FEIN. Select Yes or No from the list. Refer to Figure 2-13.

a. If **Yes**, the NPI and FEIN fields display. Enter the NPI and FEIN and reenter both in the corresponding **Confirm** fields. Refer to Figure 2-13. Click **Search**.

Pre-Enrollment	×
Enumeration: * (i) Enrollment Type: * (i) Do you have an FEIN Number?: * (i) Individual   Individual Provider (So  Yes	]
NPI: * (i) Confirm NPI: * (i)	-
FEIN: * (i)     Confirm FEIN: * (i)	
Search Confirm Cano	;el

Figure 2-13: Yes to FEIN Number

 b. If No, the NPI and Social Security Number (SSN)/Individual Taxpayer Identification Number (ITIN) fields display. Enter the NPI and SSN/ITIN and reenter both in the corresponding Confirm fields. Click Search. Refer to Figure 2-14.

Pre-Enrollment	×
Enumeration: * (i) Enrollment Type: * (i) Do you have an FEIN Number?: * (i) Individual • Individual Provider (So • No •	<sup>()</sup>
NPI: * (i)     Confirm NPI: * (i)       1122334455     1122334455	
SSN/ITIN: * () Confirm SSN/ITIN: * ()	
112-23-3445	
Search Confirm C	Cancel

Figure 2-14: Pre-Enrollment Search

This search serves the following purposes:

- i. It verifies the enrolling NPI or SSN/ITIN and FEIN have already been entered into the Montana Provider Enrollment Portal.
- ii. If the provider is newly enrolling, this step also retrieves information from NPPES for the NPI supplied. The NPI result pre-populates the information the provider used to register with NPPES.
- 5. Based on the situations below, take the appropriate action.
  - a. For Typical Providers, if the information retrieved from NPPES is correct for the enrolling provider, the information pre-populates in the Legal Name and Address page of the application. Click **Confirm** and go to Section 3: Enrollment Application: Individual Provider. Refer to Figure 2-15.

NPI: * (i)	Confirm NPI: * 🛈		
1122334455	122334455		
SSN/ITIN: * (i)	Confirm SSN/ITIN: * (	0	
112-23-3445	9 112-23-3445	۲	
Prefix: (i) First Name: (i) Sample	ML: () T.	Last Name: (i) Provider	Suffix: (i)
Address Line 1: (i) 610 Hope St			
City: (i)	State: (i)	Zip Code: (i)	County: (i)
Billings	MT	59101	Yellowstone
Phone Number: (i) Ext: (	Email Address: (i)		
		Search	Confirm

Figure 2-15: Data Pre-Populates

- b. For Atypical Providers, if no error messages display, click Confirm and go to Section 3.4: Atypical Provider.
- c. If the NPI or SSN/ITIN and FEIN already exist on the portal, the provider cannot enroll and receives a prompt to log in to the existing account.
- d. If the NPI supplied does not match to an active NPPES NPI, the provider cannot enroll.

The system redirects to the Provider Information section, which is the first section in the enrollment application. Refer to Figure 2-16.

Note: Some sections will require revision/addition for the next publication.

Sample T. Provider NPI#: 1122334455	Practice Information
Provider Information	Practice Information
Credentials	Required fields are marked with an aster
Financial Information	
Physical Location	test
Enrollment Units	
Final Submission	Type of Provider:* Add (i)

Figure 2-16: Provider Information Page Redirect

## 3. Enrollment Application: Individual Provider

The following sections outline the steps for a Sole Proprietor, an Individual Rendering or an Individual Ordering, Prescribing, Referring Provider to complete the application.

The enrollment application consists of seven different sections. Each section has its own sub-section of information. Throughout the application, the provider can move through the pages by selecting a page name in the navigation menu on the left. After each tab is completed, click the **Save and Continue** button at the bottom of the page to save and progress to next tab. If, for any reason, the enrollment process needs to be paused, select the **Save and Exit.** To log back in and continue with the enrollment application, see Appendix C: Site Navigation. The Provider Information section is the first part of the enrollment application and houses several sub-tabs depending on the type of provider enrolling. Refer to Table 3-1.

Application Page Name	Provider Type
Practice Information	All, including Organizational Providers
Legal Name & Address	All, including Organizational Providers
Ownership	Billing Providers
Disclosure Information	All, including Organizational Providers
Affiliations	Billing (during enrollment) and Rendering (after enrollment)

Table 3-1:	Application	Page	Name and	Provider	Type
	Application	i uge	Nume and	1 I O VIGCI	1 ypc

### 3.1. Individual Sole Proprietor

This section lists the steps for completing the enrollment application as a Sole Proprietor.

#### 3.1.1. Practice Information

Use the Practice Information tab to collect provider and specialty information and any state or waiver programs in which the provider wishes to participate. There are different processes for Individual and Organization providers.

- 1. Select **Provider Information** from the navigation menu and click the Practice Information tab.
- 2. Select the **Type of Provider** for which the provider is enrolling from the list of options. Refer to Figure 3-1.

Add Provider Type	×
Required fields are marked with an asterisk (* ).	
Type of Provider: * (i)	
Select Provider Type	~
Select Provider Type	
Benavioral Health & Social Service Providers	
Allopathic & Osteopathic Physicians	
Chiropractic Providers	
Dental Providers	
Dietary & Nutritional Service Providers	
Eye and Vision Services Providers	
Other Service Providers	Sava
Pharmacy Service Providers	Save Calicel
Podiatric Medicine & Surgery Service Providers	

Figure 3-1: Select Type of Provider

3. Click the Specialties **Add** button. Refer to Figure 3-2.

Provider Information	Practice Information
Credentials	
inancial Information	Required fields are marked with an asterisk (*).
Physical Location	
nrollment Units	
inal Submission	Type of Provider:* Add ()
Summary	Type of Provider
Demographic Maintenance	Allopathic & Osteopathic Physicians
My Menu	Specialties: Add ()

Figure 3-2: Add Specialties

- 4. In the Specialty window, complete the fields below. Refer to Figure 3-3.
  - a. Select a **Specialty** from the drop-down list.
  - b. The **Primary Specialty** checkbox defaults as checked when the first specialty is entered. This can be edited once another specialty has been entered.
  - c. Enter the Effective Date by clicking the calendar icon and choosing the effective date. The format for all dates is MM/DD/YYYY.
  - d. Select a **Subspecialty** from the list, if applicable. If no subspecialty is available under the selected specialty, this function is not available.

Required fields are marked with an asterisk (*).  Provider Type: * ①  Allopathic & Osteopathic Physicians  Specialty: * ②  Family Medicine - 207Q00000X  Click the button if this is your primary taxonomy/specialty: ③  Primary Specialty  Effective Date: * ③  Terminate Date: ③  Subspecialties: ③  Select One  Add Select One  Add Select One Additione Additione Additione Additione Cancel	Specialty					×
Provider Type: * () Allopathic & Osteopathic Physicians Specialty: * () Family Medicine - 207Q00000X Click the button if this is your primary taxonomy/specialty: () Primary Specialty Effective Date: * () Terminate Date: () Subspecialties: () Subspecialties: () Select One Add Select One Add Select One Add Select One Add Select One Add Select One Cancel	Required fields are ma	irked with an aste	erisk (* ).			
Allopathic & Osteopathic Physicians Specialty: * (i) Family Medicine - 207Q00000X Click the button if this is your primary taxonomy/specialty: (i) Primary Specialty Effective Date: * (i) Terminate Date: (i) Subspecialties: (i) Select One Add Select One Add Select One Add Select One Add Select One Add Select One Add Select One Add Select One Add Select One Cancel	Provider Type: * (	D				
Specialty: * (i)  Family Medicine - 207Q00000X  Click the button if this is your primary taxonomy/specialty:  Primary Specialty  Effective Date: * (i)  Terminate Date: (i)  Subspecialties: (i)  Subspecialties: (i)  Add Select One Addiction Medicine Addiction Medicine Addiction Medicine Chesity Medicine Geriatric Medicine Chesity Medicine Cancel	Allopathic & Osteopa	thic Physicians	•			
Family Medicine - 207Q00000X          Click the button if this is your primary taxonomy/specialty: ()         Primary Specialty         Effective Date: * ()         Terminate Date: ()         05/06/2021         *         MM/DD/YYY         Subspecialties: ()         Select One         Add         Select One         Additione         Additione         Additione         Select One         Additione         Additione         Additione         Additione         Cancel	Specialty: * (i)					
Click the button if this is your primary taxonomy/specialty: () Primary Specialty Effective Date: () Terminate Date: () OS/06/2021 () MM/DD/YYYY () Subspecialties: () Select One Addit Medicine Addit Medicine Addit Medicine Addit Medicine Centatric Medicine Cancel	Family Medicine - 20	7Q00000X			~	
Primary Specialty Effective Date:        Os/06/2021     Terminate Date:        Os/06/2021     MM/DD/YYYY       Subspecialties:        Select One     Add     Select One     Addiction Medicine     Addictione     Addictio	Click the button if	this is your pr	imary taxonomy/spec	cialty: 🕕		
Effective Date: * () Terminate Date: () 05/06/2021  X MWDDMYYY Subspecialties: () Select One Addiction Medicine Addiction Medicine Addiction Medicine Addiction Medicine Addiction Medicine Chesity Medicine Geriatric Medicine Cancel	Primary Speciality					
05/06/2021   X MM/DD/YYYY  Subspecialties:  Select One Add Select One Addiction Addiction Addiction Addiction Addiction Addiction Addiction Geriatric Medicine Geriatric Medicine Cheating Cancel	Effective Date: * G	Term	ninate Date: 🕜			
Subspecialties: () Select One  Add Select One Addiction Addiction Addiction Addiction Addit Medicine Addit Medicine Geriatric Medicine Geriatric Medicine Cancel	05/06/2021	• × MM				
Select One  Add Select One Addiction Medicine Addiction Medicine Adult Medicine Geriatric Medicine Geriatric Medicine Cancel	Subspecialties:	0				
Select One     Add       Select One     Adolescent Medicine       Addiction Medicine     Adult Medicine       Adult Medicine     Save       Geriatric Medicine     Save	Subspecialities.	0				
Select One Adolescent Medicine Addiction Medicine Adult Medicine Obesity Medicine Geriatric Medicine Cancel	Select One	~	Add			
Addicissent Medicine Addiction Medicine Adult Medicine Obesity Medicine Geriatric Medicine Cancel	Select One					
Adult Medicine Obesity Medicine Geriatric Medicine Cancel	Addiction Medicine	e				
Obesity Medicine Save Cancel	Adult Medicine					
	Obesity Medicine				Save	Cancel
Hospice and Palliative Medicine	Hospice and Palliat	ive Medicine				
Sports Medicine	Sports Medicine					_

Figure 3-3: Add Specialties

- 5. Click **Save**. The selected Specialty displays in the Specialties grid.
- 6. To add a secondary specialty, follow steps 4 through 6 above.
- 7. Scroll down to the State Program section and click Add. Refer to Figure 3-4.

State Programs: Add ()		
Program Name		

Figure 3-4: Add Button

8. Select the desired State Program from the drop-down menu. Refer to Figure 3-5.

Add State Program	د	<
Required fields are m	arked with an asterisk (* ).	
State Programs: * ()	Select State Program 🗸	iry
	Select State Program	
	PCP - Passport to Health	
Add 🕕	School Based Services - Comprehensive School and Community Treatment (CSC School Based Services - Individualized Education Plan (IEP) Services Targeted Case Management (TCM) Children with Special Healthcare Needs Targeted Case Management (TCM) Developmental Disability Targeted Case Management (TCM) Mental Health Targeted Case Management (TCM) Pregnant Women	T) Team Services

Figure 3-5: Select State Program

9. Click the **calendar icon** and select the date from the calendar provided. Refer to Figure 3-6.

ನ Add State Program					
Required fields are mark	ed with an asterisk (* ). ntana Medicaid (HMK Plus)				
Requested Date: * ()	Terminate Date: ①				

Figure 3-6: Requested Date for State Program

- 10. Scroll down to the Documents section to view any documentation required for the program.
- 11. To upload a document, click the **upload icon** in the Actions column. Refer to Figure 3-7.

**Note:** To download a document located under Available Documents, click the **document hyperlink**.
Available Documents (i)						
Upload Documents						
Rules for uploading documents:						
<ul> <li>Do not upload a file other than the supported format (docx, png,</li> <li>Do not upload a file beyond 50MB</li> <li>Do not upload a file which is password protected or an empty file</li> </ul>	pdf, xlsx, doc, jpg, jpeg, vsd, ppt, tif, an	d tiff)				
Document Name	Status	File Name	Upload Date	Other (Mail or Fax)	Actions	
Passport Agreement *	Required				<b>土</b>	
				Sav	e Cance	el



#### 12. Click Browse.

- 13. Search for the document to upload from the desktop or folder using the upload icon. Double-click the file name to select it. The document name shows in the Document grid. Users may also opt to mail/fax documentation. Once enrollment is complete, include your confirmation number on any documentation faxed or mailed.
- 14. Click Save. Refer to Figure 3-8.

Available Documents Upload Documents					
Rules for uploading documents:					
<ul> <li>Do not upload a file other than the support</li> <li>Do not upload a file beyond 50MB</li> <li>Do not upload a file which is password pro</li> </ul>	ed format (docx, ntected or an emp	, png, pdf, xlsx, doc, jpg, vsd, ppt, and tiff) pty file			
Document Name	Status	File Name	Upload Date	Other (Mail or Fax)	Actions
MT HMK/CHIP Dental Provider Agreement	Optional				<b>1</b>
				Save	Cancel



**Note:** Once the user selects the applicable state program, the information displays in the State Program Grid.

15. Scroll down to the Add Waiver Program section and click Add. Refer to Figure 3-9.



Figure 3-9: Add Waiver Program

16. Select the **Waiver Program** from the drop-down list if applicable based on specialty type. Refer to Figure 3-10.

Add Waiver Program		×
Required fields are ma	arked with an asterisk (* ).	
Waiver Programs: * 🛈	Select Waiver Program 🗸	
	Select Waiver Program	
_	Developmentally Disabled Waiver (DDP) Serious Disabling Mental Illness Waiver (SDMI)	_

Figure 3-10: Select a Waiver Program

17. Click the **calendar icon** and select the Requested Date from the calendar provided, then click the **Save** button. Refer to Figure 3-11.

Add Waiver Program	×
Required fields are marked with an asterisk (* ). Waiver Programs: * () Big Sky Waiver 🗸	
Requested Date: * () 05/06/2021   MM/DD/YYYY   Save	Cancel

Figure 3-11: Choose a Requested Date

### 3.1.2. Legal Name and Address

This tab houses the legal name and address information for the enrolling provider. All required fields are marked with a red asterisk. Fields displayed on this tab are based on enrollment type. For an Individual Sole Proprietor, follow the steps below to add the legal name and address information.

1. Select **Provider Information** from the navigation menu and click the Legal Name & Address tab. Refer to Figure 3-12.

Practice Information 📀	Legal Name & Address 🔿
Legal Name & Ad	dress
Required fields are ma	rked with an asterisk: (*)
Please enter in your Le	gal Name and Address informatio
needs to be validate ag	ainst the United States Postal Sei
confirm the information	provided.
Complete the Provider/	Organizational descriptive information
Enter in the Billing Add	ress information and the Mailing a
pre-populate the addre	ss information into this section. Ea
entered address.	
In order to update your	Legal Entity email, please naviga
SSN: ()	
	Ø

Figure 3-12: Legal Name and Address Tab

- 2. The SSN or FEIN field will auto-populate as read-only from the pre-enrollment screen.
- Verify or update the Legal Entity Address details. This information automatically displays because it was confirmed in the pre-enrollment process. It can be edited, where needed. Complete steps below. Refer to Figure 3-13.

**Note**: For Rendering and Ordering, Prescribing, Referring enrollment types, the Legal Entity Address section does not display. The enrolling providers only use the Individual Information and Mailing Address sections.

Verify or update each of the following fields:

- a. Address Line 1
- b. Address Line 2
- c. City
- d. State, using the drop-down list

- e. Nine-digit ZIP Code
- f. County, using the drop-down list

Legal Entity Address			
Address Line 1:*			
Address Line 2:			
City:*	State:*	Zip Code:*	County:*
	Select One	◄	Select One 🗸

Figure 3-13: Address Fields

- Enter the contact details for the provider by completing the steps below. Refer to Figure 3-14.
  - a. Enter the email address in the Email Address field.
  - b. Confirm the email address by entering the email address again in the Re-enter Email field.
  - c. Enter the provider's phone number in the Phone Number field and the extension in the Ext field, if applicable.
  - d. Enter the provider's fax number in the Fax Number field and extension in the Ext field, if applicable.

Email:*	Re-enter Email:*
Phone Number: Ext:	Fax Number: Ext:

Figure 3-14: Email Address, Phone and Fax Number Tab

5. Read the statement for address validation and click **Validate Address**. This checks the disclosed address against the United State Postal Service (USPS) to make sure it is a valid address. Refer to Figure 3-15.

Va	lidate Address*
Ве	aware that by not selecting a US Postal Service validated address, this could affect but is not limited to the following:
·C	credentialing Approval
· A	bility for your practice to be accurately located in the Provider Directory or other search engines.
	Validate Address

Figure 3-15: Legal Address Validation

6. From the list of valid addresses, select the radio button next to the correct suggested address, then click **Submit**. Refer to Figure 3-16.

Suggested Addresses:			×
555 Any St, Helena, MT 59860-5313			
	Cancel	Submit	Use Existing

Figure 3-16: Legal Address Validation Suggestion

**Note:** The legal address section updates with the new information. Refer to Figure 3-17.

Address Line 1:*					
6 13th St E					
Address Line 2:					
City.*	State:*		Zip Code:*	County:*	
Polson	MT	~	59601-0503	Lake	~
Email Address:*	Con	firm E	mail:*		
respada@getnada.com	res	pada	@getnada.co	m	
Phone Number: Ext.: Fa	ax Number	÷.	Ext.:		
(888)555-9565					
Validate Address*					
Be aware that by not selecting a · Credentialing Approval	US Postal	Servi	ce validated add	fress, this co	ould affect but is not limited to the following
Ability for your practice to be ac	curately lo	cated	in the Provider	Directory or	other search engines.

Figure 3-17: Legal Entity Address Section

Note: Figure 3-18 shows the provider enrolled with an FEIN.

FEIN				
33-3445566				
Legal Entity Address				
Address Line 1:*				
555 Any St				
Address Line 2:				
City:*	State:*	Zip Code:*	County:*	
Helena	MT	59860-0555	Lake	~
Email Address:*	Confirm	m Email:*		
PhysSamp@nonexst.com	Phys	Samp@nonexst.com		
Phone Number: Ext:	Fax Number:	Ext:		
(555)555-5555				

Figure 3-18: Example Sole Proprietor Enrolling with FEIN

#### 3.1.2.1. Individual Provider Information

 Complete the steps below to enter the provider's name and gender. Refer to Figure 3-19.

**Note:** If the user confirmed NPI information during pre-enrollment, the provider's first name, middle initial and last name automatically display here.

Prefix:	First Name:*	M.I.:	Last Name:*	Suffix:
Dr.	Sample		Physician	Select One V

Figure 3-19: Individual Provider Information

a. Select the provider's **Prefix** from the list of choices.

(First name, middle initial, and last name are already populated)

- b. Select the provider's **Suffix** from the list of choices.
- c. Select the enrolling provider's Gender. Click the Male or Female radio button.
- 2. Continue completing fields for Provider Information. Refer to Figure 3-20.
  - Select the provider's Race from the list of choices. Choose the best applicable value.
  - b. Select the provider's **Ethnicity** from the list of choices. Choose the best applicable value.
  - c. Indicate the provider's US citizenship status by selecting the Yes or No radio button. If No, a prompt is given to enter the provider's ITIN.
  - d. SSN/ITIN: If the provider is not a US citizen and answered No to the previous US citizen question, enter the ITIN in the field provided.
  - e. In the Date of Birth field, click the **calendar icon** and select the date from the calendar provided.

Race.	~
Ethnicity: Not of	Hispanic or, Latino/a, or Spanish origin 🔽
Are you a U.S. ci	tizen?* • Yes 🔿 No
Are you a U.S. ci SSN:*	tizen?* ● Yes ○ No Date of Birth:*

Figure 3-20: Ethnicity, Citizenship, SSN and Date of Birth

## 3.1.2.2. Billing Information

Individual Sole Proprietors and Organizational Facilities and Groups (Billing Providers) complete the Billing Information steps below.

- 1. Determine if the provider uses Electronic Claim Submissions.
  - a. If Yes, proceed to Step 2.
  - b. If No, proceed to Step 4.
- 2. Determine if the provider Employs a Clearinghouse.
  - a. If Yes, proceed to Step 3.
  - b. If No, proceed to Step 4.
- 3. Enter the Submitter ID in the field provided for any provider submitting claims through a clearinghouse. Refer to Figure 3-21.

Do you employ a cleari	nghouse?	* • Ye	s O	No	
Submitter ID:	I				

Figure 3-21: Legal Entity Address Section

- 4. If appropriate, select the checkbox for Billing Address: Same as your Legal Entity Address?
  - a. Selecting this checkbox populates the billing address with the address entered under Legal Entity Address. Proceed to Section 3.1.2.3: Mailing Address.
  - b. Not selecting this checkbox allows the user to enter a different billing address.
     Proceed to the next step.
- 5. To enter a new Billing Address, complete the steps below. Refer to Figure 3-22.

- a. Enter the primary billing address in the Address Line 1 field.
- b. Enter any additional address information in the Address Line 2 field.
- c. Enter the billing city in the City field.
- d. Click the **State** list and select the billing state.
- e. Enter the billing 9-digit ZIP code in the Zip Code field.
- f. Click the **County** list and select the appropriate county within the billing state.

555 Arty St				
Address Line 2:				
	State**	Zin Code**	County.*	
City:*	State.	Lip obde.	e e anny .	

Figure 3-22: Provider Billing Information

 Enter the required Email and phone number information in the appropriate fields. See Figure 3-23.

Email: *		Re-enter Email: *
PhysSamp@non	iexst.com	PhysSamp@nonexst.com
Phone Number: * E	Ext: Fax Nu	mber: Ext:
(406)238-2501		

Figure 3-23: Email and Phone Number

7. Validate the address by completing the steps below.

**Note:** If the Billing address is the same as the Legal address, address validation is not needed. If the Billing address is different, the address validation is required.

a. Read the statement for address validation and click Validate Address. This checks the address against the USPS to verify the address is valid. Refer to Figure 3-24.

Validate Address*	
Be aware that by not se	electing a US Postal Service validated address, this could affect but is not limited to the following
· Credentialing Approv	al
· Ability for your practic	e to be accurately located in the Provider Directory or other search engines.
Validate Address	

Figure 3-24: Legal Address Validation

b. From the list of valid addresses, select the radio button next to the correct suggested address and click **Submit**. The legal address section updates with the new information. Refer to Figure 3-25.

Suggested Addresses:			×
555 Any St, Helena, MT 59860-0555			
	Cancel	Submit	Use Existing

Figure 3-25: Legal Address Validation Suggestion

### 3.1.2.3. Mailing Address

All enrolling providers must complete this section.

 Mailing Address Same as: Select the radio button for the Billing Address, Legal Entity Address, or Other.

**Note:** Selecting the Legal Entity Address radio button automatically updates the Mailing Address with the address already entered under Legal Entity Address. Selecting No allows the user to enter a mailing address. This question does not display for non-billing providers.

2. If entering a new Mailing Address, complete the steps below. Refer to Figure 3-26.

- a. Enter the primary mailing address in the Address Line 1.
- b. Enter any additional address information in Address Line 2.
- c. Enter the mailing city in the City field.
- d. Click the **State** list and select the state from the list of options.
- e. Enter the mailing 9-digit ZIP code in the Zip Code field.
- f. Click the **County** list and select the appropriate county within the billing state.
- 3. Select the **Preferred Method of Communication** from the list of choices.

Note: If selecting email, use the legal entity email address.

Mailing Address: Same as:	Billing Address	s O Legal Enti	ty Address O Oth	her
Address Line 1:*				
555 Any St	1			
Address Line 2:				
City:*	State:*	Zip Code:*	County:*	Preferred Method of Communication:*
Helena	MT 🗸	58960-0555	Lake	Secured Email
Phone Number:* Ext: Fa	x Number:	Ext:		
(555)555-5555				
Validate Address* Be aware that by not selecting a U	JS Postal Servi	ce validated add	fress, this could affe	ect but is not limited to the following:
Credentialing Approval		- the Devider	0'	
Ability for your practice to be acc Validate Address	urately located	in the Provider i	Directory or other s	earch engines.

Figure 3-26: Mailing Address

 Verify that all required fields are completed, then select Save and Continue. Refer to Figure 3-27. Appendix C, Site Navigation, Figure 1 describes the other available actions.

Restart Enrollment	Save and Exit	Cancel	Previous	Save and Continue

Figure 3-27: Save and Continue

#### 3.1.3. Conviction

On this tab, review the statement and complete all fields as applicable. Required fields are marked with an asterisk. Providers enrolling as Type 1 (Individual) are assumed to have 100% control and ownership of their business. If the enrolling provider does not have complete ownership, please cancel this enrollment and enroll as a Type 2 (Organization) provider. Type 2 providers must have an organizational NPI. For more information, refer to Section 4.3: Organizational Providers Ownership.

- 1. Select **Provider Information** from the navigation menu and click the Conviction tab.
- 2. The following statement displays in the interface:

Has the enrolling provider ever been sanctioned, excluded, or convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, Waivers, Children's Health Insurance Program (CHIP), or the Title XX services (Social Services Act) since the inception of these programs? (41 CFR 455.106)

Select Yes or No to indicate if the enrolling provider has a conviction history. Refer to Figure 3-28.

	?
Practice Information Legal Name & Address Conviction Disclosure Information	
Conviction	? Help
Please be advised that entry of Ownership information is optional for Indian Health Services (IHS) & Tribal providers. To bypass the Ownership section sele	ct
"No" to save and continue.	
Has the enrolling provider ever been sanctioned, excluded, or convicted of a criminal offense related to their involvement in any program under Medicare,	
Medicaid, Waivers, CHIP, or the Title XX services (Social Services Act) since the inception of these programs? (42 CFR 455.106) * (	
Conviction: * 🕦 🗢 Yes 🖲 No	
Conviction Details:	

Figure 3-28: Ownership – Conviction Question

- a. Click No if there is no history of conviction, sanctions or exclusion as outlined.
- b. Click Yes if there is a history of conviction, sanctions or exclusion as outlined.
   Enter any additional details in the Conviction Details field.
- 3. Click Save and Continue to proceed to the Disclosure Information tab.

## 3.1.4. Disclosure Information

This tab houses the information regarding employees, sub-contractors, business transactions, controlling interest and other business relationships for the enrolling provider. Required fields are marked with a red asterisk. Fields displayed on this tab are based on enrollment type. For an Individual Sole Proprietor, access the Disclosure Information page, select **Provider Information** from the navigation menu and click the Disclosure Information tab. Refer to Figure 3-29.

Practice Information	Legal Name & Address	Conviction	Disclosure Information

Figure 3-29: Disclosure Information Tab

## 3.1.4.1. Agents, Officers, Directors and Board Members

Follow the steps below to complete the Agents, Officers, Directors, and Board Members section.

 List all applicable agents, officers, directors and board members by selecting the Add button. This opens the Agents, Officers, Directors, and Board Members window. Refer to Figure 3-30. Table 4-1 lists the roles and their definitions.

Required fields are marked wi	th an asterisk (*).		
First Name:*	M.I.:	Last Name:*	Date of Birth:*
			MM/DD/YYYY 💼
Select One:* O Agent	Officer Objector	O Board Member	
Begin Date:*	Terminate Date		
MM/DD/YYYY	MM/DD/YYYY		
SSN:*	SSN:*		

Figure 3-30: Agents, Officers, Directors, and Board Members Name

|--|

Role	Definition
Agent	A person with an ownership or control interest of a disclosing entity that is organized as a corporation
Officer	A person with an ownership or control interest of a disclosing entity that is organized as a corporation
Director	A person with an ownership or control interest of a disclosing entity that is organized as a corporation
Board Member	A member of the board of directors of a corporation.

- 2. Complete steps below to enter the individual's name.
  - a. Enter the individual's first name in the First Name field.
  - b. Enter the individual's middle initial in the M.I. field.
  - c. Enter the individual's last name in the Last Name field.
- 3. Click the **calendar** icon and select the Date of Birth from the calendar provided.

- 4. Click the radio button Agent, Officer, Director or Board Member.
- 5. Enter or click the **calendar** icon to select the date the individual began their role in the Begin Date field.

**Note:** After enrollment, use the Terminate Date to update or change an individual's role.

- 6. Use the radio buttons to indicate whether the individual has an SSN or an ITIN.
- 7. In the SSN or ITIN text field, enter the applicable identification number for the individual.
- 8. Complete the steps below to enter the individual's address. Refer to Figure 3-31.
  - a. Enter the individual's primary address in the Address Line 1 field.
  - b. Enter any additional address information in the Address Line 2 field.
  - c. Enter the individual's city in the City field.
  - d. Select the appropriate state from the **State** list.
  - e. Enter the individual's 9-digit ZIP code in the Zip Code field.
  - f. Click the **County** list and select the appropriate county within the state.
- 9. Click the Yes or No radio button to indicate whether the enrolling provider has a conviction history.
  - a. If No, the Conviction Details are not needed. Proceed to Step 10.
  - b. If Yes, type additional details in the Conviction Details field.

Segin Date. Terminat	Date	Marine and a streng worth	
Address Line 1:*			
Address Line 2:			
City:*	State:*	Zip Code:*	County.**
	-Select-		-Select-
onviction			
conviction:* O Yes O No			
conviction Details:*			

Figure 3-31: Agents, Officers, Directors, and Board Members Additional Information

10. Click Save. Refer to Figure 3-32.



Figure 3-32: Save

3.1.4.2. Managing Employees

This section is required for Type 2 providers.

1. From the Disclosure Information tab, complete the steps below to enter the Managing Employee Information. Refer to Figure 3-33.

ractice Information	Legal Name & Address	Conviction	isclosure Information					
Disclosure Infor	mation				( H			
Required fields are marked with an asterisk (*).								
Agents, Officers, [	Directors, and Board Mer	mbers Add						
List ALL agents, office	ers, directors who have expre-	ssed or implied aut	hority to act on behalf of the provider en	tity.				
First Name	M.I.	Last Name	Date of Birth	Address	Action			
First Name	M.I.	Last Name	Date of Birth	Address	Action			
First Name	M.I.	Last Name	Date of Birth	Address	Action			
First Name Managing Employ	M.I. Bes Add (j)	Last Name	Date of Birth	Address	Action			
First Name Managing Employ	M.I.	Last Name	Date of Birth	Address	Action			
First Name Managing Employ	M.I. ees Add () iployees who have expressed	Last Name d or implied authorit	Date of Birth ty to act on behalf of the provider entity.	Address	Action			
First Name Managing Employ List ALL managing err First Name	M.I. ees Add () iployees who have expressed M.I.	Last Name d or implied authorit	Date of Birth ty to act on behalf of the provider entity. Date of Birth	Address Address	Action       Action       Image: Action			

Figure 3-33: Managing Employees

2. Click **Add** to list all managing employees who have expressed or implied authority to act on behalf of the provider entity. Refer to Figure 3-34.

Managing Employees Add								
List ALL managing employees	List ALL managing employees who have expressed or implied authority to act on behalf of the provider entity.							
First Name	M.I.	Last Name	Date of Birth	Address	Action			
					N 🛍			

Figure 3-34: Add Managing Employees

 Complete the steps below to enter the individual's name and birthdate. Refer to Figure 3-35.

Managing Employees					
Required fields are marke	d with an asteris	< (* ).			
First Name: * (i)	M.I.:	Last Name: *	Date of Birth: *		
			MM/DD/YYYY		

Figure 3-35: Managing Employee Details

- a. Enter the first name in the First Name field.
- b. Enter the middle initial in the M.I. field.
- c. Enter the last name in the Last Name field.
- d. Click the **calendar icon** and select the Date of Birth from the calendar provided.
- 4. Enter or use the **calendar icon** to select the date the individual began their role in the Begin Date field. Refer to Figure 3-36.

**Note:** After enrollment, use the Terminate Date to update or change an individual's role.

- 5. Complete the remaining fields. Refer to Figure 3-36.
  - a. Click the appropriate radio button for SSN or ITIN.
  - b. In the SSN or ITIN text field, type the applicable identification number for the individual.
  - c. Complete the steps below to enter the service location where the individual acts as a managing employee.
    - i. Enter the primary address in the Address Line 1 field.
    - ii. Enter any additional address details in the Address Line 2 field.
    - iii. Enter the city in the City field.
    - iv. Select the appropriate state from the **State** list.
    - v. Enter the 9-digit ZIP code in the Zip Code field.
    - vi. Click the **County** list and select the appropriate county within the state.
- 6. Select the Yes or No radio button to indicate whether the enrolling provider has a conviction history.
  - a. If No, the Conviction Details are not needed. Proceed to Step 7.

Begin Date:*	Terminate Date				
5/1/2020	MM/DD/YYYY				
SSN:*	SN:* 555-44-3322	۲			
Address Line 1:*					
555 Any St					
Address Line 2:					
Citur*	State*		Zin Code*	County-*	
Helena		~	58960 0555		~
Conviction					
Conviction: * 🔿 Yes 💿 No					
Conviction Details:*					
					10.88
					Save

b. If Yes, type additional details in the Conviction Details field.

Figure 3-36: Managing Employees Details - continued

### 7. Click Save.

### 3.1.4.3. Managing Relationship

This section describes the correlation between individuals/organizations and their agents, officers, directors and employees.

- To manage the relationship, click the Yes or No radio button to indicate if there are any individuals listed in Ownership, Agents, Officers, Directors and Managing Employees sections who are related through blood or marriage. Complete the steps below.
  - a. If No, proceed to Section 3.1.4.4: Sub-Contractor.

Managing Relationships							
Indicate if any of the individuals listed in ownership, agents, officers, directors, and managing employees sections who are related through blood or marriage. *							
Yes No							
Add	Last Name	Date of Birth	Relationship	Action			

Figure 3-37: Add Managing Relationship

- b. Select Yes if the relationship must be entered in the Managing Relationship form, the click the Add button to open the form in a pop-up window. Refer to Figure 3-37 above.
- Search for any owners, agents, officers, board members, directors and managing employees previously entered to associate any relationship, where applicable, by entering First Name, Last Name, or Date of Birth. Click the Search button. Refer to Figure 3-38.

anagi	inaging Relationships								
Prima	ary Person	Search							
First Na	ime:	Last	Last Name: Date of Birth:		h:				
				MM/DD/Y	m 🗂	Search Clear			
Resul	Prefix	First Name	Middle Name	Last Name	Suffix	Date of Birth			
-		and the second se							
0		Sample		Manager 1		04/14/1977			
0		Sample Sample		Manager 1 Manager 2		04/14/1977 11/09/1988			

Figure 3-38: Managing Relationship Search

 After entering the search criteria, select the radio button of the first person in the relationship. Repeat Step 2 to search and add an additional individual. Refer to Figure: 3-39 for a sample result of the addition of managers.

isults								
	Prefix	First Name	Middle Name	Last Name	Suffix	Date of Birth		
0		Sample		Manager 1		04/14/1977		
0		Sample		Manager 2		11/09/1988		
۲		Sample		Manager 3		07/01/1983		

Figure 3-39: Add Managing Relationship from Search Results

- 4. In the Relations Search section (Figure 3-40 below), enter the name of the second individual in the relationship, then click the Search button.
- 5. From the Results section, select the radio button to identify the second individual in the relationship.
- 6. Select the relationship type from the **Relationship** dropdown list.

rst Name:		Last Name:		Date of Birth	n:	X SCHWARZ	1
					m 🔳	Search	Clear
sults							
Pre	fix First Name	Middle Name	Last Name	Suffix	Date of Birth	Rela	tionship
0	Sample		Manager 1		04/14/1977	C	hoose one: 🗸
۲	Sample		Manager 2		11/09/1988	C	hoose one: 🗸
0	Sample		Manager 3		07/01/1983	C	hoose one: 🗸

Figure 3-40: Relationship Drop-down Selection

#### 3.1.4.4. Sub-Contractor

The steps below describe how to add the Sub-Contractor information.

 Select the Yes or No radio button to indicate if this provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period. Refer to Figure 3-41.

Sub-Contractors
Indicate if this provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding twelve (12) month period. *
● Yes ○ No



- Select No if there were no business transactions with any subcontractor totaling more than \$25,000 during the preceding twelve-month period and proceed to Section 3.1.4.5: Business Transactions.
- 3. Select Yes if there were business transactions with any subcontractor totaling more than \$25,000 during the preceding 12\_-month period and complete the steps below.
  - a. Click Add to open the Sub-Contractors screen. Refer to Figure 3-42.
  - b. Click the radio button for Name or Business Name.
    - i. If Name was selected, enter the subcontractor's First Name, M.I., and Last Name.
    - ii. If Business Name was selected, enter the subcontractor's Business Name.
  - c. Use the **calendar icon** to enter the Transaction Date.
  - d. Enter primary address in the Address Line 1 field.
  - e. Enter any additional address details in the Address Line 2 field.
  - f. Enter the city in the City field.
  - g. Select the appropriate state from the State list.
  - h. Enter the 9-digit ZIP code in the Zip Code field.
  - i. Click the **County** list and select the appropriate county within the state.
  - j. Click Save.

Sub-Contractors				×
Required fields are marked w	ith an asterisk (* ).			
Name	O Business Name			
First Name: * 🧿	M.I.:	Last Name: *		
Transaction Date: *				
MM/DD/YYYY				
Address Line 1: *	, ,			
Address Line 2:		)		
City:*	State:*	Zip Code:*	County:*	
	-Select-		-Select-	
				Save

Figure 3-42: Sub-Contractors Screen

#### 3.1.4.5. Business Transactions

The steps below describe how to add Business Transactions.

 Select the Yes or No radio button to indicate if this provider had any significant business transactions with any wholly owned supplier or subcontractor during the preceding 5-year period. Refer to Figure 3-43.

Business Transactions
Indicate if this provider had any significant business transactions with any wholly owned supplier or subcontractor during the preceding five (5) year period?
•
○ Yes
○ No

Figure 3-43: Business Transactions Question

- Select No if there were no significant business transactions with any wholly owned supplier or subcontractor during the preceding 5-year period and proceed to Section 3.1.4.6: Controlling Interest.
- Select Yes if there were any significant business transactions with any wholly owned supplier or subcontractor during the preceding 5-year period and complete the steps below.
  - a. Select Add to open the Business Transaction screen, seen in Figure 3-44.
  - b. Select the radio button for Name or Business Name.
    - i. For Name, enter the subcontractor's First Name, M.I., and Last Name fields.
    - ii. For Business Name, enter the subcontractor's Business Name.
  - c. Use the **calendar icon** to enter the Transaction Date.
  - d. Enter the Transaction Details in the field provided.

Note: This field has a 1,000-character limit.

- e. Enter the primary address in the Address Line 1 field.
- f. Enter any additional address details in the Address Line 2 field.
- g. Enter the city in the City field.
- h. Select the appropriate state from the **State** drop-down list.
- i. Enter the 9-digit ZIP code in the Zip Code field.
- j. Select the applicable county from the **County** drop-down list.
- k. Click Save.

Business Transactions		×
Required fields are marked with an asterisk (* ).  Name Business Name		
First Name: * (i) M.I.:	Last Name: *	
Transaction Date: *		
Transaction Details: *		]
1000 characters remaining.		
Address Line 1: *		
Address Line 2:		
City:* State:*	Zip Code:* County:*	
-Jelerie	-Jolicu-	Save

Figure 3-44: Business Transactions Screen

### 3.1.4.6. Controlling Interest

The steps below describe how to add the Controlling Interest.

 Select the Yes or No radio button to indicate if any owner or board member has ownership or controlling interest in another organization that bills for Medicaid services. Refer to Figure 3-45.

Controlling Interest
Does any owner or board member have ownership or controlling interest in another organization that bills for Medicaid services?*
⊖ Yes
○ No

Figure 3-45: Controlling Interest Question

- Select No if no owners or board members have ownership or controlling interest in another organization that bills for Medicaid services and proceed to Section 3.1.4.7 Questions.
- 3. Select Yes to indicate that an owner or board member has ownership or controlling interest in another organization that bills for Medicaid services. This means that the Controlling Interest information must be provided. Complete the steps below.
  - a. Click the **Add** button to open the form in a pop-up window and complete the steps below, as required. Refer to Figure 3-46.
  - b. Enter the Business Name.
  - c. Enter the FEIN.
  - d. Select the applicable radio button for Medicaid ID or NPI and enter the respective number in the associated field.
  - e. Enter the primary address in the Address Line 1 field.
  - f. Enter any additional address details in the Address Line 2 field.
  - g. Enter the city in the City field.
  - h. Select the appropriate state from the State drop-down list.
  - i. Enter the 9-digit ZIP code in the Zip Code field.
  - j. Select the applicable county from the **County** drop-down list.
  - k. Click Save.

Controlling Interest					×
Required fields are marked wit	h an asterisk (*).				
Business Name:*		1			
FEIN:*	Medicaid ID:*	Medicaid ID: *			
	O NPI:*				
Address Line 1:*					
Address Line 2:					
City:*	State:*	~	Zip Code:*	County:*	
L	(				
					Save

Figure 3-46: Controlling Interest Screen

### 3.1.4.7. Questions

Below the Controlling Interest section of the screen are questions. Answers to all questions are required by selecting a Yes or No radio button. Refer to Figure 3-47.

- 1. If an answer is Yes, a text box opens to provide additional details.
  - a. Do you or any owner or employee owe any money to Medicare, Medicaid or CHIP that has not been paid?
  - b. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of any health related crimes?

c. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of a crime involving the abuse of a child or elderly adults?

1. Do you or any owner or employee owe any money to Medicare, Medicaid or CHIP that has not been paid?*
• Yes
O No
2. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of any health related crimes? *
O Yes
○ No
3. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of a crime involving the abuse of a child
or elderly adult? *
○ Yes
O No

Figure 3-47: Enrollment Attestation Questions

 If selecting No to all questions, proceed to Section 3.1.4.8 Authorized Official Attestation.

### 3.1.4.8. Authorized Official Attestation

The steps below describe how to complete the authorized official attestation.

1. Attest either as the provider or on behalf of the provider to the statement provided in this section by clicking the I Attest checkbox. Refer to Figure 3-48.

Authorized Official Attestation:
By checking the box below, I attest that I have searched and continue to search on a monthly basis the (OIG) Office of Inspector General List of Excluded
Individuals/Entities prior to enrolling in any State or Federal program, before hiring new employee and employing contractors. I attest the provider, all
owners, managers, employees and contractors are not excluded from participation in Medicare, Medicaid, CHIP or other federal health care programs and
agree to immediately notify any exclusion information to the State Medicaid Agency. *
☑ I Attest

#### Figure 3-48: Authorized Official Attestation

2. Click **Save and Continue** at the bottom of the page. Refer to Figure 3-49.

Save and Exit	Cancel	Previous	Save and Continue

Figure 3-49: Save and Continue

### 3.1.5. Credentials

This page stores provider licenses, board certifications and accreditations. Required fields are marked with an asterisk. Requirements vary depending provider type and specialty selected. This screen also houses provider hospital privileges, Drug Enforcement Agency (DEA) or Drug Enforcement Agency X (DEAX).

Note: The X refers to the certification to prescribe addiction treatment drugs.

### 3.1.5.1. Hospital Privileges

Complete the following steps to enter Hospital Privilege information.

- Select Credentials from the navigation menu to go to the Licensing, Certifications & Accreditations tab.
- 2. Select the Yes or No radio button to answer whether the doctor has hospital privileges. Refer to Figure 3-50.

**Note:** This question is meant to capture physician privileges at any facility the provider performs services. This information is for tracking purposes for Montana, providers can optionally upload their delineations of privileges in this section. This question appears based on the provider type and specialty as configured by the Montana DPHHS Fiscal Agent.



Figure 3-50: Licensing, Certifications & Accreditations

- a. If No, proceed to Section 3.1.5.2: DEA/DEAX.
- b. If Yes, click Add to search for the hospital by NPI and proceed to Step c. Refer to Figure 3-51.



Figure 3-51: Add Hospital Privileges

- c. Enter the Hospital NPI in the field provided and click **Search**. The hospital name automatically displays.
- d. Click the **calendar icon** to select Effective and the Terminate Dates.
- e. Click the **Save** button. Refer to Figure 3-52.

Add Hospital		×
Hospital NPI:*	Result	
Hospital Name:	Effective Date:*	Terminate Date:
	12/9/2019	MM/DD/YYYY

Figure 3-52: Add Hospital

3. To upload supporting documentation, click **Upload Document**. Refer to Figure 3-53.

_			
Add	Upload Document	Other (Mail or	Fax

Figure 3-53: Add a New Document

a. In the Add Document window, verify the Document Type populates as expected. Refer to Figure 3-54.

Note: The Document Type populates based on the type of document uploaded.

dd Document			
-	 _	ş	

Figure 3-54: Document Type Selection

- b. Click Browse.
- c. Navigate to the document on the computer's desktop or folder location. Doubleclick on the file name to select it. The document displays and uploads into the record. Refer to Figure 3-55.

Attachment	Document Type	Upload Date	Remove
License.jpg	License	03/05/2020	

Figure 3-55: Upload Details

- d. Click Close.
- e. Proceed to Section 3.1.5.2: DEA/DEAX.

### 3.1.5.2. DEA/DEAX

This section lists questions for collecting DEA or DEAX numbers. This displays if information is required based on the provider type and specialty selected. Complete the following steps to enter DEA/DEAX information:

- 1. Select **Credentials** from the navigation menu to go to the Licensing, Certifications & Accreditations tab.
- Answer the questions shown under the Hospital Privileges heading. If the answer to all questions is no, select the No radio button and proceed to Section 3.1.5.3: Licenses, Certifications and Board Certifications.
- If any answer to questions 1 through 3 is yes, select the Yes radio button. Refer to Figure 3-56.

Licensing, Certification	ns & Accreditations
Licensing, Certifi	cations & Accreditations
Hospital Privilege	S:
Does this provider have h	ospital privileges? * 🔿 Yes 🔎 No
Questions:	
1) Do you prescribe N	lethadone & Buprenorphine? * 🔿 Yes 🔎 No
2) Do you Prescribe	Buprenorphine Only? *   Yes O No
DEAX LICENSE #	(format: AA9999999)*     Upload Document     Other (Mail or Fax)     Type: *     Select One •       MM/DD/YYYY     Terminate Date: *     MM/DD/YYYY     Image: *     Select One •

Figure 3-56: DEA License Information

- 4. The user will then be asked to provide DEA and/or DEAX license information. Refer to Figure 3-57.
  - a. For each Yes answer, enter the DEA or DEAX number, effective date, and termination date.
  - b. Select the schedule from the **Type** drop-down list.
  - c. Upload certification by clicking **Upload Document**.

DEAX LICENSE # (format: A99999999) *	Upload Document	Other (Mail or Fax) Type: * Select One 🔻
Effective Date: * MM/DD/YYYY	Terminate Date: * MM/DD/YYYY 💼	



d. Click **Browse** to search, add the document and then click **Close**. Refer to Figure 3-58.

Add Document			×					
Document Type: DEAX	✓ Browse							
Rules for uploading documents:								
<ul> <li>Do not upload a file other than the supported format (docx, png, pdf, xlsx, doc, jpg, jpeg vsd, ppt, tif, and tiff)</li> </ul>								
Do not upload a file be	yond 50MB							
Do not upload a file wh	ich is password protected or an e	empty file						
Attachment	Document Type	Upload Date	Remove					
No documents found.	1							
			Close					

Figure 3-58: Add Document Box

 e. If the response to questions 1 through 3 is No, the provider does not have a DEAX, enter the DEA License number Effective Date/Terminate Date, and Type schedule required using the list provided. Refer to Figure 3-59.



Figure 3-59: Required Fields for DEA

# 3.1.5.3. Licenses, Certifications and Board Certifications

In this section, users enter their State Medical License information, Board Specialty Certification information, discipline specific certifications and a copy of each document, if applicable. Complete the steps below to add Licenses, Certifications and Board Certifications.

- 1. Select **Credentials** from the navigation menu to go to the Licensing, Certifications & Accreditations tab.
- 2. Under the Licenses, Certifications, Board Certifications sections, add the appropriate document(s) by clicking **Add**. Refer to Figure 3-60.

Licensing, Certification	ns & Accreditations							
Licensing, Certifications & Accreditations								
Hospital Privileges:								
Does this provider have hospital privileges? * O Yes O No								
Add     Upload Document     Other (Mail or Fax)								
License #	Specialty	State	Effective Date	Terminate Date	Issuing Party Identifier	Actions		
Certifications:	Specialty	State	Effective Date	Terminate Date	Issuing Party Identifier	Actions		
Board Certifications:								
Certification #	Specialty	State	Effective Date	Terminate Date	Issuing Party Identifier	Actions		
				Save and Exit	Cancel Previous	Save and Continue		

Figure 3-60: Licenses and Certifications Workbench

- Complete the following fields in the window and click Save when complete. Refer to Figure 3-61.
  - a. License # or Certification # or Board Certification #: Enter the number in the field provided in alphanumeric format.
  - b. State: Click the **State** list and select the issuing state from the list of choices.
- c. Click the **calendar icon** and select the Effective and Terminate Dates from the calendar provided.
- d. Issuing Party Identifier: Click the **Issuing Party Identifier** list and select the identifier from the list of choices. The identifier differs based on the accreditation type.

Add			×
Required fields are marke • Format for License is A Provider Type: * Allopathic & Osteopathic Specialty: * Family Medicine - 207Q	d with an asterisk (* ). IphaNumerics. c Physicians 00000X		~ ~
License#: *	State: * Select One	Select One	•
Effective Date: *	Terminate Date: *		Save

Figure 3-61: Add Licenses

4. Select **Save** at the bottom of the page.

## 3.1.6. Financial Information

This page houses Insurance and Banking information.

## 3.1.6.1. Insurance

Required coverage types can vary depending on state and/or provider specialty type. Complete the steps below to enter insurance information.

Select Financial Information from the navigation menu to go to the Insurance tab.

- 1. If users have multiple insurance companies representing different policies, the first section of the Insurance tab allows the user to enter and manage each insurance company.
- 2. Click Add to add the insurance company information. Refer to Figure 3-62.

hage Insurance Companies		

Figure 3-62: Add Insurance Grid

3. Enter the Insurance Company, Agent Name, and Contact Number in the Add Insurance Company window, then click the **Save** button. Refer to Figure 3-63.

Add Insurance Company	×
Required fields are marked with an asterisk (*).	
Insurance Company:*	
Agent Name:	
Contact Number:	
	Save

Figure 3-63: Add Insurance Company Screen

 To add or manage policies, select the insurance company from the Manage Policies drop-down list, then click Add. Refer to Figure 3-64.

5	[		
Manage Policies	Choose one:		Add
	Any Insurance Co		
		21	

Figure 3-64: Add Insurance Company Screen

- 5. In the Manage Policy window, complete the steps below. Refer to Figure 3-65.
  - a. Click the **Policy Type** drop-down and select from the available options.
  - b. In the Policy Number field, enter the insurance policy number.
  - c. In the Effective Date field, click the **calendar icon** and select the date from the calendar provided.
  - d. In the Terminate Date field, click the **calendar icon** and select the date from the calendar provided.
  - e. Click Save.

Edit Manage Pol	icies			х
Required fields are n	narked with an as	terisk (*).		
Other (Mail or Fax)				
Policy Type:*	Professional L	iability 🗸		
Policy Number.*	A555555			
Effective Date:*		Terminate Date:*		
12/8/2019	<b>x</b>	9/30/2020	<b>×</b>	
				Save

Figure 3-65: Add Insurance Company Screen

- 6. On the Insurance Tab, do one of the following. Refer to Figure 3-66:
  - a. Upload the policy document(s) by clicking the **upload** icon.
  - b. Click the Other (Mail or Fax) checkbox.

Manage Policies Bobs Ins	S		•				Add
Policy Type	Policy Number 个	Policy Coverage Limit	Per Claim/Aggregate Amount	Effective Date	Terminate Date	Other (Mail or Fax)	Actions
Professional Liability	A67D8GFG	\$1,000,000.00	\$100,000.00	2021-05-01	2022-05-01		I 🛈 🗘
			[	Save and Exit	Cancel	Previous	Save and Continue

Figure 3-66: Upload or Mail/Fax Information

7. On the Manage Policies page, click Save and Continue. Refer to Figure 3-67.

Manage Policies Bobs In	S		•				Add
Policy Type	Policy Number 个	Policy Coverage Limit	Per Claim/Aggregate Amount	Effective Date	Terminate Date	Other (Mail or Fax)	Actions
Professional Liability	A67D8GFG	\$1,000,000.00	\$100,000.00	2021-05-01	2022-05-01		e 🖞 🕹
			[	Save and Exit	Cancel	Previous	Save and Continue

Figure 3-67: Manage Insurance Policy Screen

#### 3.1.6.2. Banking

Complete the information on the Banking tab to indicate whether the provider wishes to enroll in Electronic Funds Transfer (EFT) program or wants to receive check by mail. Required fields are marked with an asterisk. Complete the steps below to enter banking information for provider enrollment.

- 1. Select **Financial Information** from the navigation menu and click on the Banking tab.
- 2. If the provider prefers to enroll in the EFT program, complete the steps below:
  - a. Select the Type of Account. Choose from Checking or Savings. Refer to Figure 3-68.

Banking
Required fields are marked with an asterisk: (*)
Please complete this form below for Electronic Funds Transfer reimbursement.
As part of a quarterly regulation update CMS-0028IFC Final Rule), The Centers for Medicare &
Medicaid Services (CMS) has implemented a final rule of Federal Regulation 45 CFR Part 162,
requiring the use of Electronic Funds Transfers (EFT) for all providers.
Type of Account:*
○ Checking ○ Savings

Figure 3-68: Banking Information

- b. Enter the routing number in the Financial Institution Routing Number field and confirm it by typing it again in the Re-enter Financial Institution Routing Number field. Refer to Figure 3-69.
- c. Enter the account number in the Account Number field and confirm it by typing it again in the Re-enter Account Number field.
- d. Enter the Account Holder Name in the field provided.
- e. Enter the Financial Institution Name in the field provided.
- f. Enter the primary address in the Address Line 1 field.
- g. Enter any additional address details in the Address Line 2 field.
- h. Enter the City in the field.
- i. Click the **State** drop-down list and select the appropriate state.
- j. Enter the 9-digit ZIP code in the Zip Code field.
- k. Enter the Phone Number and Ext (if applicable) in the fields provided.
- I. Enter the Fax Number and Ext (if applicable) in the fields provided.

Account Number:*	Re-enter Account Nu	umber:*
	9	<b></b>
Account Holder Name:*		
Financial Institution Name		
Address Line 1:*		
Address Line 1:*		
Address Line 1:* Address Line 2:		
Address Line 1:* Address Line 2: City:* State:*	Zip Code:*	

Figure 3-69: Additional Banking Information

- 3. Complete the optional Bank Contact Information. Refer to Figure 3-70:
  - a. Bank Contact Title
  - b. Bank Contact First Name
  - c. Bank Contact Lat Name
  - d. Bank Contact Email Address

Bank Contact Information:	
Bank Contact Title:	
Manager	
Bank Contact First Name:	Bank Contact Last Name:
Walter	Williams
Bank Contact Email Address:	
wwilliams@bbank.com	

Figure 3-70: Bank Contact Information

4. Click Save and Continue. Refer to Figure 3-71.



Figure 3-71: Save and Continue

## 3.1.7. Physical Location

Complete the steps in the following subsections as outlined.

#### 3.1.7.1. Address

Complete the following steps to add the physical location address.

- 1. Select **Physical Location** from the navigation menu to go to the Location screen.
- 2. Click the **Add** button to open the address form. Required fields are marked with an asterisk. Refer to Figure 3-72.

Sample Physician NPI#: 5554433221	Location
Provider Information	
Credentials	
Financial Information	
Physical Location	

Figure 3-72: Add Physical Location

**Note:** The first physical location might already exist if the user selected the billing address as a physical location. The addresses grid displays this location, or a user can add it using the **Add** button.

- 3. To add a new address, proceed to Step 5.
- 4. To edit an existing address, complete the steps below.
  - a. Click the **pencil icon**. Refer to Figure 3-73.

0.0	Address 0	City 0	State 0	County 0	Action
001	555 Any St	Helena	MT	Lake	1

Figure 3-73: Edit Physical Location

- b. This selection automatically populates the following fields.
  - i. Service Location Name
  - ii. Address Line 1
  - iii. City
  - iv. State

v. ZIP Code

- vi. County
- vii. Phone Number and Ext

viii.Fax Number and Ext

**Note:** The provider must use the **calendar icon** to populate the Terminate Date field if the specific address needs to be terminated later.

c. Click Validate Address. Refer to Figure 3-74.

Location# 001					
Service Location Name	e: <b>*</b>				
Physician's Practice					
Physical Practice Locati Address Line 1:*	ion Address:*				
555 Any St	]				
Address Line 2:					
City:*	State:*	Zip Code:*	County:*	Terminate Date:	
Helena	MT	✓ 59860-0555	Lake 🖌		
Phone Number:* E	xt: F	ax Number:	Ext:		
(555)555-5555					
Validate Address*					
Be aware that by not s	electing a US I	Postal Service valid	lated address, this	could affect but is not lim	ited to the following:
Credentialing Approva	al				

Figure 3-74: Validate Address

**Note:** If address validation was already completed when adding Practice Information, the Validate Address button displays as inactive or grayed out. Refer to Figure 3-75.



Figure 3-75: Address Previously Validated

- 5. Complete the steps below to add a new address. Refer to Figure 3-76.
  - a. Enter the Service Location Name in the field provided.
  - b. Enter the primary address in the Address Line 1 field.
  - c. Enter any additional address details in the Address Line 2 field.
  - d. Enter the city in the City field.
  - e. Click the **State** drop-down list and select the appropriate state.
  - f. Enter the 9-digit ZIP code in the Zip Code field.
  - g. Click the **County** list and select county that corresponds to the state selected.
  - h. Enter the Phone Number and Ext (if applicable) in the fields provided.
  - i. Enter the Fax Number and Ext (if applicable) in the fields provided.
  - j. Using the calendar icon, enter the Terminate Date.
  - k. Click Validate Address.

ocation# 001					
ervice Location Name	*				
hysical Practice Locati	on Address:*				
ddress Line 1:*					
Address Line 2:					
City:*	State:*	Zip Code:*	County:*	Terminate Date:	
	<b>`</b>	0.12	Ľ	MM/DD/YYYY	
Phone Number:* E>	d: Fax	Number:	Ext:		
/alidate Address*					
Be aware that by not se	electing a US Po	stal Service valid	ated address, this	could affect but is r	not limited to the following:
	22				

Figure 3-76: Address Information

- 6. Select Upload Location Business License to open the Document Upload window.
- 7. Click **Browse** to locate the license.
- 8. Select the license and click **Open** to upload it to the system. The Add Document screen shows the uploaded document. Refer to Figure 3-77.

Add Document					×
Document Type:	Locatio ading d	n Business License 🗸	Browse		
<ul> <li>Do not upload tiff)</li> <li>Do not upload</li> <li>Do not upload</li> </ul>	1 a file othe 1 a file bey 1 a file whic	r than the supported forma ond 50MB ch is password protected or	t (docx, png, pdf, x an empty file	lsx, doc, jpg, jpeg	vsd, ppt, tif, and
Attachment		Document Type	Upload Dat	e	Remove
No documents f	ound.				
					Close

Figure 3-77: Add Location Business License Screen

9. Click **Close**, as shown in Figure 3-77.

Note: The license displays in the Attachment Grid. Refer to Figure 3-78.

Add Document			×
Document Type: Locatio	n Business License  Iocuments:	srowse	vsd opt tif and
tiff)		or, priz, por, nor, coo, jpg, jpog	100, ppt, tit, and
Do not upload a file bey	ond 50MB		
Do not upload a file which	ch is password protected or an e	empty file	
File successfully upload	led		
Attachment	Document Type	Upload Date	Remove
SAMPLE document.docx	Cost Settlement Rpt	05/07/2021	Ŵ
			Close

Figure 3-78: Add License

- 10. Answer the question regarding laboratory services provided at this location. Yes or No are required.
  - a. If No, continue to Section 3.1.7.2: Provider Types, Specialties, and Programs.
  - b. If Yes, provide the required Clinical Laboratory Improvement Amendments (CLIA) number, Type, and Effective Date information, then either upload the pertinent document(s) or choose the Mail or Fax option. Refer to Figure 3-79.

Questions:	
1) Do you provide laboratory services at this location? * <ul> <li>Yes</li> </ul>	○ No
CLIA NUMBER (format: 99A9999999) *	Upload Document <b>V</b> Other (Mail or Fax)
Type: * Select One	Effective Date: * MM/DD/YYYY
Terminate Date: MM/DD/YYYY	



# 3.1.7.2. Provider Types, Specialties, and Programs

Complete the steps below to select provider types, specialties and programs available for a given location if and when applicable.

- 1. On the Address tab, the provider types and specialties selected at the beginning of the enrollment application display.
- 2. Select the Specialties provided at this physical location. Select all that apply. Refer to Figure 3-80.

peciali	ties"				
	Type of Provider	¢	Speciality	\$ Taxonomy	¢
8	Hospital		Acute Care	282N00000X	
0	Laboratories		Pathology	291U00000X	

Figure 3-80: Specialties at the Physical Location

 Select the Program Name(s) serviced at this location. Select all that apply. Refer to Figure 3-81.



Figure 3-81: Programs at the Physical Location

**Note**: These fields are present so that when the provider is located using the Directory, members can see what type of provider and program services are at that location.

 Answer the Service Counties question at the bottom of the screen. Answering Yes or No is required.

- a. If the answer is No, continue to Step 5.
- b. If the answer is Yes, highlight counties where services are provided in the Available Counties menu on the left of the screen. Use the Add> button to populate the Selected Counties field on the right. To move all county names to the right, use the Add All>> button. The **Keyboard Help** link is also available if needed. Refer to Figure 3-82.

Service Counties	*					
Do you provide se NOTE- Please se	rvices in counties near lect at least one count	this location	which you do not h	ave a physical locati	ion?* 🖲 Yes 🔿 N	10
Available Countie	es (55)			Selected Countie	s (1)	Keyboard Help
State Select One	County	<b>^</b>	Add > Add All >>	State Select One 🗸	County	
мт	Lake Liberty	•	< Remove	MT	Lewis and Clark	-

Figure 3-82: Service Counties

#### 5. Click Save.

#### 3.1.7.3. Hours

This section captures the business hours for the specific location. Complete each field allocated for each day of the week the business is open by selecting the times from the drop-down boxes or checkboxes. The two examples below show how to complete the practice hours.

- 1. Select Physical Location from the navigation menu and click the Hours tab.
- 2. Refer to Figure 3-83 for two examples on how to complete the practice hours.
  - a. Example 1 shows the office is open daily from 8:00 a.m. to 12:00 p.m. and then again from 1:00 p.m. to 6:00 p.m. This indicates the office is closed daily between the hours of 12:00 p.m. and 1:00 p.m.

- b. Example 2 shows the office is closed on Thursday because the user selected the Closed checkbox. The user can also select if the location is open 24 hours on a certain day by selecting the Open 24 hours checkbox, as displayed for Friday.
- c. Once the hours have been entered select 'Save and Continue'

Hours		
Office Hours:		
Monday: *	8:00 AM 🖌 12:00 PM 🖌 🗆 Closed	
	1:00 PM  6:00 PM  Open 24 hours	\$
Tuesday: *	8:00 AM 🖌 12:00 PM 🖌 🗆 Closed	
	1:00 PM 🖌 6:00 PM 🖌 🗆 Open 24 hours	3
Wednesday: *	8:00 AM 🖌 12:00 PM 🖌 🗆 Closed	
	1:00 PM 🖌 6:00 PM 🖌 🗆 Open 24 hours	\$
Thursday: *	✓ ✓ Closed	
	Open 24 hours	3
Friday: *	12:00 AM	
	✓ 11:59 PM ✓ Open 24 hours	3

Figure 3-83: Practice Hours

# 3.1.7.4. Languages

This tab shows all languages spoken at the location. Complete the steps below to select Languages.

1. Select **Physical Location** from the navigation menu and click the Languages tab.

2. Click the box in front of the available language as appropriate. Refer to Figure 3-84.

Lan	guages
Pleas	se select spoken languages supported at this location:
	English
	Spanish
8	French
	Arabic
	German
	Hmong
	Mandarin
8	Other

Figure 3-84: Languages

## 3. Click Save.

## 3.1.7.5. Medicare/Medicaid

This tab is required to be completed if the provider is currently enrolled or has ever been enrolled in a Medicare and/or a state Medicaid program. Required fields are marked with an asterisk (\*).

 For Medicare History, select Yes or No if the provider has ever been enrolled in Medicare.

**Note:** Additional questions may display based on the selection.

- a. Select No if the provider was never enrolled in a Medicare and/or a state Medicaid program. Proceed to Step 2.
- Select Yes if the provider is currently enrolled or was previously enrolled in a Medicare and/or a state Medicaid program and complete the additional steps below. Refer to Figure 3-85.

Medicare/Medicaid	
Required fields are marked with an asterisk (*).	
Have you ever been enrolled in Medicare? * 💿 Yes 🔿 No	
Medicare Status: * Medicare ID: *	Enrollment Date: *
Active V 4556	03/02/2021
Has this Provider paid an application fee to Medicare? * 🔘 Yes	○ No
Fee Payment Date: * 03/05/2021	

Figure 3-85: Medicare/Medicaid Questions

- i. Select Yes or No to answer the question, Have you ever been enrolled in Medicare?
- ii. Select the current status from the Medicare Status list.
- iii. Enter the Medicare ID in the box provided.
- iv. Click the **calendar icon** and select the Enrollment Date from the calendar provided.
- v. Indicate whether the NPI paid an application fee to Medicare by selecting Yes or No.
- For Medicaid History, select Yes or No if the provider has ever been enrolled in a Medicaid and/or CHIP in any state. Refer to Figure 3-86.
  - a. Select **No** if the provider was never enrolled in a Medicaid and/or CHIP in any state.
  - b. Select Yes if the provider has ever been enrolled in a Medicaid and/or CHIP in any state. Click Add and complete the steps below.

Have you ever been enrolled in Medicaid/CHIP in another state? * 💽 Yes 🔿 No	]
Past Enrollment*	
Add	

Figure 3-86: Medicaid/CHIP Enrollment in Another State

- i. The Add Medicaid Details window displays. Refer to Figure 3-87.
- ii. Select the current status from the Medicaid Status drop-down list.
- iii. Enter the Medicaid ID in the box provided.
- iv. Click the **calendar icon** and select the Enrollment Date from the calendar provided.
- v. Select the appropriate state from the **State** drop-down list.
- vi. Select Yes or No if the provider paid a Medicaid enrollment fee previously.
- vii. Click Save.

d Medicaid Details					2
Medicaid Status: * M Select Status 🗸	ledicaid ID: *	State: *	•		
Enrollment Date: *					
Has this Provider paid an applica Add Document Rules for uploading do Do not upload a file other Do not upload a file beyon	ation fee to Medicaid in this state? * <b>ocuments:</b> than the supported format (docx, pr nd 50MB	○ Yes ○ I	No 5, jpg, jpeg, vsd, pj	pt, tif, and tiff)	
Do not upload a file which Document Type	Attachment	file	Upload Date	Other (Mail or Fax)	Action
Medicaid/CHIP Fee Rece	eipt				<u>1</u>
Medicaid/CHIP Provider A	Agr				<u>1</u>
					Save

Figure 3-87: Add Medicaid Details

**Note:** For more information on the revalidation question, refer to the Completing a Revalidation section in the *PNRM User Guide*.

#### 3.1.7.6. Services Provided

The Services Provided tab lists a series of location-specific questions. These questions capture additional information about services the provider offers at a physical location. The information collected on this page is specific to Montana Healthcare Programs. The steps below describe how to add the services provided.

- 1. Select **Physical Location** from the navigation menu and click the Services Provided tab.
- 2. Answer the questions that display on the Services Provided page. Questions marked with an asterisk require a response. Refer to Figure 3-88.

Serv	ices Provided
Please	select all values that apply (e.g., all services provided, languages, etc)
1.	Are you accepting new patients? * (i) O Yes O No
2.	Do you accept siblings of established patients? * (i) O Yes O No
3.	Are oral interpretation services available? * (i) O Yes O No
4.	Is Braille supported? * () O Yes O No
5.	Is sign language supported? * 🕧 🔿 Yes 🔿 No
6.	24 Hour Office Phone
7.	Services - Family Practice ()
8.	Services - General Practice ()
9.	Services - Internal Medicine ()
10.	Services - Obstetrics ()

Figure 3-88: Services Provided

3.Select the specific Services that apply by clicking the applicable checkbox(es). Be sure to select all that apply and click **Save**.

## 3.1.7.7. Customized Tabs

Customized tabs display in the application based upon selections made by the user. Custom tabs are based upon the following:

- The provider type selected
- The state or waiver program selected
- Service-specific information provided

Figure 3-89 is an example of a Facility Information custom tab because the enrollment type Facility was selected.

Address	Hours Languages Medicare/Medicaid Services Provided	Facility Information
Facili	ty Information	
1.	Fiscal Year End Date (Please attach a copy of the cost settlement report below	Month Day N): * 01 • •
2.	Hospital Type - Teaching	
3.	Hospital Type - Teaching - Effective Date	
4.	Hospital Type - Teaching - Terminate Date MM/DD/YYYY	
5.	Hospital Type - Rural	
6.	Hospital Type - Rural - Effective Date	
7.	Hospital Type - Rural - Terminate Date	
8.	Hospital Type - Urban	
9.	Hospital Type - Urban - Effective Date	
10.	Hospital Type - Urban - Terminate Date	
11.	Hospital Type - Critical Access	
12.	Hospital Type - Critical Access - Effective Date	
13.	Hospital Type - Critical Access - Terminate Date	]
14.	Hospital Type - Swing Bed	

Figure 3-89: Custom Facility Information Tab

## 3.1.8. Enrollment Units

An Enrollment Unit is a separate provider record that is generated based on how certain provider information is captured. Enrollment Units are automatically created when the user discloses specific information within the enrollment application. For example, an enrollment unit is created for each physical location added by the user. The Enrollment Unit section captures detailed information applicable to that physical location, Users validate licensing, certification, or accreditation information, provider taxonomy, State and Waiver Programs, additional address information (such as a remittance address), and contact information. As stated above, an Enrollment Unit is created when multiple physical locations are disclosed. Additionally, Enrollment Units are created when certain state or waiver programs are selected as well as provider type, specialty and taxonomy selected. An Enrollment Unit is composed of the following data elements:

- NPI or API
- Provider Name
- Location
- Address
- City/State/Zip
- Associated State Programs/Waiver Programs
- Taxonomy Provider type/Specialty/Effective Date/Terminate Date
- Licensing, Certifications & Accreditations
- Communications Contact Information
- Contact Name/Phone/Email/Contact Type

Follow the steps below to see and complete the Enrollment Units detail:

1. Select the Enrollment Units tab from the navigation menu. Refer to Figure 3-90.

	Sample Provider NPI# 999999999
Provider	nformation
Credentia	ls
Financial	Information
Physical I	ocation
Enrollme	nt Units
Final Sub	mission
Summary	

Figure 3-90: Enrollment Units

From the Enrollment Unit main page, the user selects the **pencil icon** to manage the Enrollment unit(s). Refer to Figure 3-91.

Enrollment Units										
									C	? elp
Enrollment Units are compor	nents/sections of the a	pplication that are c	reated to capture a	additional info	rmation. Items t	hat make up an	enrollment ur	nit are, additional	physical	
locations, particular state pro	grams, or a combinat	ions of location and	program. within the	e enrollment i	unit additional ir	formation is cor	nfirmed or cap	tured. The enrollr	ment applicat	ion
will create each enrollment u	nit automatically and i	nformation from pre-	vious sections will	populate with	in the Enrollme	nt Unit. This wo	rkbench will d	isplay all enrollme	ent units for th	nis
enrollment application, pleas	e complete each as a	pplicable.								
		Туре: 🚺	Select One	✓ Filter y	vour results (i)	Search		Search (j)	Clear	D
Enrollment Unit	Program	Specialty	Service Location Name	Team Name	Team Number	Effective Date	Terminate Date	System Status	Actions	•
0001650961	<ul> <li>Montana Medicaid (HMK Plus)</li> </ul>	• Anesthesiology	test			11/23/2021		Pending	ø	
0001650972	<ul> <li>Montana Medicaid (HMK Plus)</li> </ul>	• Dermatology	test			11/02/2021		Pending	(di)	Ŧ

Figure 3-91: Enrollment Units - Edit

**Note**: The Enrollment Unit Detail screen is pre-populated with information previously entered by the user. Refer to Figure 3-92.

Enrollment Unit D	Petail					
Enrollment detail						
Enrollment Unit deta	ail for 0001826956					
NPIJAPI:	9999999999 0					
Provider Name:	Sample Provider ()					
Location:	001 - Location 1 🕥					
Address 1:	123 Bob Lane 🕧					
City ST Zip+4:	Bobville MT 50911 ()					
State Programs (	)					
Program Name			Effective Date		Terminate Date	
Montana Medicaid (F	HMK Plus)					
Waiver Programs	0					
Program Name			Effective Date	B	Terminate Date	į.
		No	Valver Programs found.			
Taxonomy ()						
Type of Provider	Taxonomy	Specialty		Effective Date		Terminate Date
Allopathic & Osteopa Physicians	athic 207Q00000X	Family Medicin	10	05/06/2021		

Figure 3-92: Enrollment Unit Detail

- 2. To complete the Enrollment Unit Detail section, add the identifying information requested by entering the following elements. Refer to Figure 3-92:
  - a. Licensing, Certifications & Accreditations
  - b. Address
  - c. Communications Contact Information
  - d. Contact Name/Phone/Email/Contact Type
- 3. Licensing, Certification, and accreditation information will pre-populate within the enrollment unit. Verify if the license is applicable for the enrollment unit. If it is not applicable, select the **trashcan** icon in the Action column. If the license, certification, or accreditation is removed in error, select the license, certification, accreditation information from the drop-down to re-apply this information. Refer to Figures 3-92 and 3-93.

Licensing, Certifications & Accreditations	Address	Communications	



Lisonsos ()												
	-Vehic Lineare											
Licenses Available. Select Ava	allable Licenses											1.
License #	Specialty	St	ate	Effect	ive Date	Termin	ate Date	Issuing Party Identifi	er	Primary	Action	
999999999	Family Medicine	м	т	05/06	2021	05/31/	/2021 💼 🗙	Federation of State Boards	Medical	۲	Û	
Other Certifications (i)												
Other Certifications Available:	Select Available Other	Certifications	✓ (i)									
Certification Type		Certification #			Effective Date		Terminate Date		Туре		Actions	^
			1	No Othe	r Certifications fou	nd						ļ
Certifications (i)												1
Certifications Available: Select	ct Available Certifications	<b>`</b>	()									
Certification #	Specialty	st	ate	Effect	ive Date	Termin	ate Date	Issuing Party Identifi	er	Primary	Action	Â
CG4587SG44	Family Medicine	U	S	05/05	2021	05/02/	2022 <b>x</b>	CMS Facility Design	ation	۲	Û	
Board Certifications ()	Board Certifications ()											
Board Certifications Available	Select Available Boar	d Certifications	✓ (i)									
Certification #	Specialty		State		Effective Date		Terminate Date	Issuing Party Identifi	er	Primary	Action	^

Figure 3-94: Select License Information

4. On the Address tab use the drop-down menu to select and assign the applicable Address for each address type. Refer to Figure 3-94.

Licensing, Certifications & Accredit	tations Address	Communications				
Required fields are marked with a	n asterisk (*).					
Туре 🕈	Address Line 1		Address Line 2	City	State	Zip Code
Billing*	123 bob lane	~		bobville	MT	50911
Mailing*	123 bob lane	~		bobville	MT	50911
Remittance*	Add New 801 N 29th St			bobville	MT	50911
Other	123 bob lane 335 bob st 123 Bob Lane			bobville	MT	50911
	345 bob st 456 Bob Ln					



5. On the Communications tab use the **Available Contacts** drop-down menu to select and assign information. Refer to figure 3-95.

Licensing, Certifications & Accreditations	Address Commu	unications			
Required fields are marked with an aste Available Contacts: * ① Select Add New	erisk (*).	Select "Search	By" Column Select One 🔍 Searc	h Criteria Search	Search Clear
Joseph,V,Condon,(555)444-3333,,mtprovide Joseph,V,Condon,(555)333-4444,,mtprovide	st Name	Phone Number	Email	Contact Type	Actions
Joseph	Condon	(555)444-3333	mtproviderenrollment@getnada.com	Office Manager	Ø 🗓
<ul> <li>Joseph</li> </ul>	Condon	(555)333-4444	mtproviderenrollment@getnada.com	Office Manager	Ø 🗓

Figure 3-96: Select Contact Information

 Open the Licensing, Certifications & Accreditations tab. If all information is correct, answer Yes to the attestation question. Then click the Save button. Refer to Figures 3-96 and 3-97.

Licensing, Certifications & Accreditations	Address Communications
Required fields are marked with an asterisk (*	*).
Do you accept the information on this screen a	s presented? * (i) ● Yes ○ No
Licenses (j)	
Licenses Available: Select Available Licenses	✓ (i)

Figure 3-97: Answer the Attestation Question



Figure 3-98: Save Button

 After clicking the Save button, the status will change from pending to complete and the user will be returned to the Enrollment Units screen. Click Save and Continue to continue. Refer to Figure 3-98.

Sample Provider NPI#: 999999999	Enrollment l	Jnits	-	-			-		-	
Provider Information	Screen open help	1								(?) Help
Financial Information			Type: 🥡	Select One	✓ Filter	r your results	(i) Search		Search 🤇	Clear
Physical Location Enrollment Units Final Submission	Enrollment Unit	Program	Specialty	Service Location Name	Team Name	Team Number	Effective Date	Terminate Date	System Status	Actions
Summary Demographic Maintenance	0001826956	<ul> <li>Montana Medicaid (HMK Plus)</li> </ul>	<ul> <li>Family</li> <li>Medicine</li> </ul>	Location 1			05/06/2021		Complete	<b>A</b>
My Menu						Save	and Exit Ca	ncel Previ	ious	and Continue

Figure 3-99: Save and Continue

### 3.1.9. Final Submission

The final submission page holds the Montana Healthcare Program's Terms and Agreements and collects the W9 form and fees, as applicable.

#### 3.1.9.1. Terms and Agreements

The Terms and Agreements requires an electronic signature authorizing the provider to enter the Montana Healthcare Programs. Users can also download the form and mail it. The steps below describe how to electronically sign the application and agree to the terms.

- 1. Select **Final Submission** from the navigation menu to go to the Terms and Agreements tab.
- 2. Click E-Sign. Refer to Figure 3-99.
- 3. The portal redirects the user to the DocuSign electronic provider agreement.

Terms and Agreements	N-9						
Terms and Agreement	is						
Required fields are marked w	/ith an asterisk (*). This is f	to certify:					
Provider Name: Sam	iple Provider						
NPI: 9999	99999						
Please click the hyper link sh	own below to review, dow	nload, and print,	the most recent 1	Terms & Agreer	ment form. The	e document i	must be
printed signed, scanned/imag	jed and uploaded using th	e upload Terms 8	& Agreement butt	ton before the a	application can	be submitte	d for
final review							
Rules for uploading doc	uments:						
Do not upload a file oth	er than the supported form	nat (docx, png, pr	df, xlsx, doc, jpg,	jpeg, vsd, ppt,	tif, and tiff)		
Do not upload a file bey	ON 50MB	• • •					
Do not upload a file whi	ch is password protected (	or an empty file					
Document Name	Document Type	E-Sign The Document	Upload Signed Documents	Other (Mail or Fax)	File Name	Upload Date	Actions
★ Terms and Agreements ★	Terms And Agreement	E-Sign	Upload				
			Save and E	xit Cance	I Previous	Save a	and Continue

Figure 3-100: Terms and Agreements

- a. Review, then scroll to the end of the document.
- b. Click in the Signature of Authorized Representative field and enter the name of the authorized representative. Refer to Figure 3-100.

I understand that payment of claims concealment of a material fact may be p	s will be from federal and state funds and that any falsification or prosecuted under federal and state law.
Printed Name of Individual Practitioner	
Signature of Individual Practitioner	Date
Or for facilities and non-practitioner or Printed Name of Authorized Representativ Address Signature of Authorized Representative	rganizations: veTitle/Position Telephone Number Date
SIGN	Montana Provider Relations P.O. Box 4936 Helena, MT 59604

#### Figure 3-101: Terms and Agreements

### c. Click Finish.

#### 3.1.9.2. W-9

Follow the instructions to complete or upload a Federal W-9 form. This is required for all providers submitting claims as the billing provider in the Montana Healthcare Programs.

- 1. Select Final Submission from the navigation menu and click the **W-9** tab.
- 2. Click **Upload W-9** and complete the steps below. Refer to Figure 3-101.

Terms and Agreements W-9
W-9
Provider Enrollment W-9
Click this link to download the most recent version of the Federal W-9 Form .
This is required for all billing providers. Name and Tax ID must be exactly as reported to the IRS. The Signer of the W9 must be listed in the
Managing/Directing section of the enrollment application.
Please complete and attach the completed document with your application.
Upload W-9 Cther (Mail or Fax)
Save and Exit Cancel Previous Save and Continue

Figure 3-102: W-9 Tab

- a. Click **Browse** in the Add Document window.
- b. Navigate to the document on the computer's desktop or folder location. Doubleclick on the file name to select it. The document displays and uploads into the record. Refer to Figure 3-102.

Attachment	Document Type	Upload Date	Remove
W9 SamplePhys	PDF	03/05/2020	

Figure 3-103: Upload Details

- c. Click Close.
- d. Click Save and Continue.

#### 3.1.9.3. Summary

This page allows the provider to review all information completed on the application. Each gray heading in screen matches a page name in the enrollment application.

- 1. Select **Summary** from the navigation menu.
- 2. Click the arrow next to each page heading and then click **Edit** next to each section name to review or edit the section.

3. Complete any required items not yet completed. The page heading displays with a red outline to indicate missing information on that tab. Refer to Figure 3-103.

- Review Your Enrollment			
		Show All	O Show Missing
Provider Information			
Credentials			
- Financial Information			
Insurance	Edit		
Banking	Edit		
Physical Location			
Enrollment Units			
<ul> <li>Final Submission</li> </ul>			
Enrollment Documents			

Figure 3-104: Sample of Incomplete Application – Enrollment Summary

4. When all required application items are present, click **Submit**. Refer to Figure 3-104.

**Note:** The Submit button is not available unless all required items have been provided.

- Review Your Enrollment		
	Show All	○ Show Missing
Provider Information		
Credentials		
Financial Information		
Physical Location		
Enrollment Units		
Final Submission		
Enrollment Documents		
	Cancel Pr	evious

Figure 3-105: Sample of a Complete Application – Enrollment Summary

## 3.1.10. Demographic Maintenance

If a provider's location is not providing services, either temporarily or permanently, the user can navigate to Demographic Maintenance to adjust the status.

 Select **Demographic Maintenance** from the navigation menu. Refer to Figure 3-105.

Provider Information				
Credentials				
Financial Information				
Physical Location				
Enrollment Units				
Final Submission				
Summary				
Demographic Maintenance				

Figure 3-106: Select Demographic Maintenance

2. Change the status of a location to Active or Inactive. Refer to Figure 3-106.

De	emographic Maintenance							
Ac	ddresses							
_								
	Address Line 1 🛧	Address Line 2	City	State	Zip Code	County	Usage	*
	67787		Helena	MT	78777	Fergus	Active	
	123 Provider Lane		Sample City	MT	59110	Gallatin	Active	
	333 Service Rd		Sample City	MT	59110	Gallatin		•
							Cancel	Save

Figure 3-107: Addresses in Demographic Maintenance

3. The user can also change the status of a contact. Refer to Figure 3-107.

D	Demographic Maintenance										
A	Addresses Contacts										
	First Namo 🛧	м	Last Namo	Dhono Numbor	Fax Number	Fmail	Contact Tuno	lleago	A		
	That Name 1	WII	Last Name	Those Walliber	T ax Number	Linai	Contact Type	Usage			
	М		S	(555)555-1111		me@me.com	Legal Phone Number	Active	~		
								Cancel	Save		

Figure 3-108: Contacts in Demographic Maintenance

**Note:** Once a location or contact is set to inactive status it is removed from the selection pool within the application.

## 3.1.11. FEIN Management

The FEIN Management option on the left-menu is available for those providers who have enrolled using their FEIN. Refer to figure 109.

	- Enroliment				
	Before you begin				
	Begin Enrollment				
	Continue Enrollment				
Re-Enrollment					
	Additional Documents				
	Update				
	Revalidate				
	Disenrollment				
	Manage Affiliations				
	FEIN Management				
	Correspondence History				

Figure 3-109: FEIN Management

In this section the user can make changes to the information displayed. If any updates are made to the information the user will also have the ability to download/upload the W-9 form. Once completed click 'Save and Continue'

## 3.1.12. Correspondence History

Correspondence History provides a centralized location for a provider to access any letters that have been sent to them by DPHHS, as well as any documents that have been uploaded. To access letters and documents, select **Correspondence History** from the Enrollment Workbench menu. Providers can search by the document's name or the year the correspondence was uploaded or received. Refer to Figures 3-110 and 3-111.

Continue Enrollment				
Re-Enrollment				
Additional Documents				
Update				
Revalidate				
Disenrollment				
Manage Affiliations				
FEIN Management				
Correspondence History				

Figure 3-110: Select Correspondence History

Corresp	ondence History		
NPI/AI Provid	PI: 1336183813 Ier Name: Kent Smith	Use	er Guide
		Select "Search By" Column : Year Search Criteria 2021 Search	Clear
Action	Date 🗸	Document Name	*
		No matching Correspondence History found.	~
		Items per page 10	>
			Exit

Figure 3-111: Correspondence History Page

# 3.2. Individual Rendering Provider

Follow the subsections below for instructions on completing the enrollment application as an Individual Rendering Provider.

### 3.2.1. Individual Rendering Provider Practice Information

For steps on how to complete the Practice Information tab, refer to Section 3.1.1: Practice Information.
# 3.2.2. Individual Rendering Provider Legal Name and Address

For all individual providers (non-sole proprietor), complete the steps below to add legal name and address information.

- Select Provider Information from the navigation menu and click the Legal Name & Address tab.
- Complete the steps below to enter the provider's name and gender. Refer to Figure 3-108.

**Note:** If the user confirmed NPI information during pre-enrollment, the provider's first name, middle initial and last name automatically display here.

- a. Select the provider's **Prefix** from the list of choices.
- b. Enter the provider's first name in the First Name field.
- c. Enter the provider's middle initial in the M.I. field.
- d. Enter the provider's last name in the Last Name field.
- e. Select the provider's **Suffix** from the list of choices.
- f. Select the Male or Female radio button to indicate the enrolling provider's Gender.

Prefix:	First Name:*	M.I.:	Last Name:*	Suffix:
Dr.	Sample		Physician	Select One 🗸

Figure 3-112: Individual Provider Information

- Complete the steps below to provide additional provider demographic information. Refer to Figure 3-109.
  - a. Select the provider's **Race** from the list of choices. Choose the best applicable value.
  - b. Select the provider's **Ethnicity** from the list of choices. Choose the best applicable value.
  - c. Indicate the provider's US citizenship status by selecting Yes or No. If No, a prompt displays to enter the provider's ITIN.
  - d. SSN/ITIN: If the provider is not a US citizen and selected No to the previous US citizen question, enter the ITIN in the field provided.
  - e. Click the Calendar icon and select the Date of Birth from the calendar provided.

Race: White	~
Ethnicity: Not of H	Hispanic or, Latino/a, or Spanish origin 🔽
Are you a U.S. cit	tizen?* 🖲 Yes 🔿 No
Are you a U.S. cit SSN:*	tizen?*

Figure 3-113: Ethnicity, Citizenship, SSN and Date of Birth

#### 3.2.2.1. Billing Information

Refer to section 3.1.2.2: Billing Information for instructions on completing this tab.

#### 3.2.2.2. Individual Rendering Provider Mailing Address

For instructions on how to complete the mailing address, refer to Section 3.1.2.3: Mailing Address.

## 3.2.3. Individual Rendering Provider Conviction Information

For instructions on how to complete the Conviction tab, refer to Section 3.1.3: Conviction.

## 3.2.4. Individual Rendering Provider Disclosure Information

For instructions on how to complete the Disclosure tab, refer to Section 3.1.4: Disclosure Information.

### 3.2.5. Individual Rendering Provider Credentials

Refer to Section 3.1.5: Credentials and complete all steps in the following subsections:

- Section 3.1.5.1: Individual and Individual Rendering Provider Hospital Privileges
- Section 3.1.5.2: Individual and Individual Rendering Provider DEA/DEAX
- Section 3.1.5.3: Licenses, Certifications and Board Certifications

### 3.2.6. Individual Rendering Provider Financial Information

For information on how to complete the financial information, refer to Section 3.1.6: Financial Information and complete the following:

- Sections 3.1.6.1: Insurance
- Section 3.1.6.2: Banking

# 3.2.7. Individual Rendering Provider Enrollment Units

For information on how to complete the atypical provider enrollment units, refer to Section 3.1.8 Enrollment Units and complete all subsections.

### 3.2.8. Individual Rendering Provider Final Submission

Refer to Section 3.1.9: Final Submission and complete all steps in the following subsections:

- Section 3.1.9.1: Terms and Agreements
- Section 3.1.9.2: W-9
- Section 3.1.9.3: Summary

# 3.3. Individual Ordering, Prescribing, Referring Provider

Follow the subsections below for instructions on completing the enrollment application as an Individual Ordering, Prescribing, Referring Provider.

### 3.3.1. Individual Ordering, Prescribing, Referring Provider Practice Information

For steps on how to complete the Practice Information tab, refer to Section 3.1.1: Practice Information.

# 3.3.2. Individual Ordering, Prescribing, Referring Provider Legal Name and Address

Refer to Section 3.2.2: Individual Rendering and Individual Ordering, Prescribing, Referring Provider Legal Name and Address.

**3.3.2.1.** *Individual Ordering, Prescribing, Referring Provider Billing Information* Refer to section 3.1.2.2: Billing Information for instructions on completing this tab.

**3.3.2.2.** Individual Ordering, Prescribing, Referring Provider Mailing Address For steps on how to complete the mailing address, refer to Section 3.1.2.3: Mailing Address.

### 3.3.3. Individual Ordering, Prescribing, Referring Provider Conviction Information

For instructions on how to complete the Conviction tab, refer to Section 3.1.3: Conviction.

# 3.3.4. Individual Ordering, Prescribing, Referring Provider Disclosure Information

Refer to Section 4.4: Disclosure Information and complete the following subsections:

- Section 4.4.3: Managing Relationship (Not applicable to Rendering Provider [RP] or Ordering, Prescribing, Referring [OPR] provider)
- Section 4.4.4: Sub-Contractor (Not applicable to RP or OPR)
- Section 4.4.5: Business Transactions (Not applicable to RP or OPR)
- Section 4.4.6: Controlling Interest (Not applicable to RP or OPR)
- Section 4.4.7: Questions (Applicable to RP and OPR)
- Section 4.4.8: Authorized Official Attestation (Applicable to RP and OPR)

#### 3.3.5. Individual Ordering, Prescribing, Referring Provider Credentials

Refer to Section 3.1.5: Credentials and complete the following sections:

- Section 3.1.5.1: Hospital Privileges
- Section 3.1.5.2: DEA/DEAX
- Section 3.1.5.3: Licenses, Certifications and Board Certifications

#### 3.3.6. Individual Ordering, Prescribing, Referring Provider Financial Information

For information on how to complete the financial information, refer to Section 3.1.6: Financial Information and complete the following:

- Sections 3.1.6.1: Insurance
- Section 3.1.6.2: Banking

#### 3.3.7. Individual Ordering, Prescribing, Referring Provider Enrollment Units

For information on how to complete the atypical provider enrollment units, refer to Section 3.1.8 Enrollment Units and complete all subsections.

## 3.3.8. Individual Ordering, Prescribing, Referring Provider Final Submission

Refer to Section 3.1.9: Final Submission and complete the following sections to complete the enrollment application:

- Section 3.1.9.1: Terms and Agreements
- Section 3.1.9.2: W-9
- Section 3.1.9.3: Summary

# 3.4. Atypical Provider

Atypical providers are providers that do not provide health care, as defined under Health Insurance Portability and Accountability Act (HIPAA) 45 CFR section 160.103. Montana considers the following provider types to be atypical as of May 15, 2020:

- 11 Home Health
- 12 Personal Care Agency
- 13 Home Dialysis Attendant
- 23 Taxi
- 24 Transportation Non-Emergency
- 28 Home and Community Based Services
- 42 Social Worker
- 61 Therapeutic Group Home
- 64 Therapeutic Foster Care
- 82 Developmental Disabilities Program
- 83 Medicare Advantage (Part C)
- 84 Family Education and Support

**Note:** Refer to Section 2, Begin Enrollment, for pre-enrollment instructions. This includes steps for selecting the Atypical provider type.

# 3.4.1. Atypical Provider Practice Information

For information on how to complete the Practice Information tab, refer to Section 3.1.1: Practice Information.

# 3.4.2. Atypical Provider Legal Name and Address

For information on how to complete the Legal Name and Address tab, refer to Section 3.1.2: Legal Name and Address.

### 3.4.2.1. Billing Information

Refer to section 3.1.2.2: Billing Information for instructions on completing this tab.

### 3.4.2.2. Atypical Provider Mailing Address

For information on how to complete the atypical provider mailing address, refer to Section 3.1.2.3: Mailing Address.

### 3.4.3. Atypical Provider Conviction Information

For instructions on how to complete the Conviction tab, refer to Section 3.1.3: Conviction.

### 3.4.4. Atypical Provider Disclosure Information

For information on how to complete the atypical provider disclosure information, refer to Section 4.4: Organizational Providers Disclosure Information and complete all subsections.

### **3.4.5. Atypical Provider Credentials**

For information on how to complete the atypical provider credentials, refer to Section 3.1.5: Credentials and complete Section: 3.1.5.3: Licenses, Certifications and Board Certifications.

# **3.4.6.** Atypical Provider Financial Information

For information on how to complete the atypical provider financial information, refer to Section 3.1.6: Financial Information and complete the following:

- Sections 3.1.6.1: Insurance
- Section 3.1.6.2: Banking

# 3.4.7. Atypical Provider Physical Location

For information on how to complete the atypical provider physical location, refer to Section 3.1.7 Physical Location and complete all subsections.

### 3.4.8. Atypical Provider Enrollment Units

For information on how to complete the atypical provider enrollment units, refer to Section 3.1.8 Enrollment Units and complete all subsections.

#### 3.4.9. Atypical Provider Final Submission

Refer to Section 3.1.9: Final Submission and complete the following sections to complete the enrollment application:

- Section 3.1.9.1: Terms and Agreements
- Section 3.1.9.2: W-9
- Section 3.1.9.3: Summary

# 4. Enrollment Application: Organization

The following sections instruct the Organizational Provider on completing the enrollment application.

# 4.1. Organizational Providers Practice Information

Use the Practice Information tab to collect provider and specialty information and any state or waiver programs in which the provider wishes to participate. There are different processes for Individual and Organization providers. The portal allows providers to define multiple provider types and specialties for those providers who do not subpart enumerate. Organizations with a single NPI but multiple business segments that bill under that single NPI, use the steps below for their enrollment submission.

 Choose the applicable provider from the **Type of Provider** drop-down list. Refer to Figure 4-1. Providers with subparts select their primary provider types/specialty with an effective date and then add additional provider types/specialties with effective date. After selecting the provider type, click **Save**.

Add Provider Type		×
Required fields are marked with an asteris	ik (*).	
Select Provider Type Agencies Ambulatory Health Care Facilities Hospital Hospital Units Laboratories Nursing & Custodial Facilities Nursing Service Related Providers Other Service Providers Residential Treatment Facilities Respite Care Facility Suppliers Transportation Services	te:	Save

Figure 4-1: Organizational Provider Types

**Note**: If each business segment bills independently, the provider must enroll with separate NPIs for each business segment.

2. Add any additional provider types as needed. Additional provider types display in the Type of Provider grid. Refer to Figure 4-2. If no additional provider types are needed, proceed to the next step.

Type of Provider:* Add 🛈	
Type of Provider	Effective Date
Hospital	05/09/2021
Laboratories	05/11/2021

Figure 4-2: Organizational Type Grid

 Add the Specialties for the provider types listed. To add the specialties, click the Add button. Refer to Figure 4-3.

Specialties:* Add	0
Type of Provider	Specialty
Hospital	General Acute Ca

Figure 4-3: Specialty Add Button

**Result:** The Specialty window displays.

4. In the Specialty window, select the provider's type from the **Provider Type** list. Refer to Figure 4-4.

Specialty	
Required fields a	re marked with an asterisk (* ).
Provider Type	: · ①
Thermaler type	0
Select One v	]
Select One V	]

Figure 4-4: Select a Provider Type from the List

5. Select a specialty from the **Specialty** drop-down list. The user will be required to add specialties for all provider types selected. Refer to Figure 4-5.

~

Figure 4-5: Specialty Drop-Down Box

6. Select the Primary Specialty checkbox if this is the primary taxonomy/specialty. Refer to Figure 4-6.



Figure 4-6: Primary Specialty Checkbox

7. Click the **calendar icon** to add the specialty Effective Date. Refer to Figure 4-7.

Effective Date: * ()	Terminate Date: ()	
Subspecialties: ()	4	
Select One 🗸 Add		
		Save

Figure 4-7: Effective Date

8. Click Save.

**Note:** Please disregard the Subspecialties section (Fig. 4-7) as it not applicable for this state.

In order to add additional specialties, please follow steps 3 thru 8.

- Answer the question, Do you have Subparts of the organization sharing this NPI, which are different Provider Types than the Primary one selected? Refer to Figure 4-8.
  - a. Select Yes for the following question to disclose multiple provider types and specialties: Return to Step 3.
  - Select No if the provider does not have a subpart. Proceed to Section 4.2:
     Organizational Providers Legal Name and Address.

Do you have Subparts of the organization sharing this NPI,	which are a different Provider Type than the Primary one selected? * ()	💽 Yes	O No
bo you have bubparts of the organization sharing this for i,	which are a uncreater toward type than the trainery one selected t	-	

Figure 4-8: State Program Segment

- 10. For steps on how to complete the Program Type, refer to Step 8 of Section 3.1.1: Practice Information.
- 11. For steps on how to complete the Add Waiver Program, refer to Step 16 of Section3.1.1: Practice Information.

# 4.2. Organizational Providers Legal Name and Address

This tab houses the legal name and address information for the enrolling organizational provider. All required fields are marked with a red asterisk. Fields displayed on this tab are based on enrollment type. The following sections explain the steps needed for the provider types.

Complete the fields as prompted or select the Yes or No radio button for each of the steps below. Required fields are marked with an asterisk. Refer to Figure 4-9.

- Select Provider Information from the navigation menu and click the Legal Name & Address tab.
- 2. Verify the Legal Entity Name.

**Note**: The Legal Entity Name automatically displays if the user confirmed the NPPES information on the pre-enrollment screen. If it does not display, enter the Legal Entity Name as entered on the business income tax return.

- 3. Verify the FEIN. This number is read-only and populates based on what was entered during the pre-enrollment process.
- 4. Select the **Type of Business Entity** for the enrolling organization from the list provided.
- 5. Select the **Business Entity Profit Status** for the enrolling organization from the list provided.

Family Hospital	Practice Information Leg	al Name & Address	Ownership	Disclosure In
Provider Information	Required fields are marked v	with an asterisk (*).		
Provider information	Legal Entity Name*	FEIN		
Credentials				
Financial Information	Family Hospital	88-888888	38	
Physical Location	Type of Business Entity: *	Business	Entity Profit St	atus: *
	Corporation	✓ Private to	or Profit	~

Figure 4-9: Legal Name & Address Tab

6. Verify or update the Legal Entity Address details, as shown in Figure 4-10.

In this example, the provider enrolled as an Organization so the user must verify the Legal Entity Address. This information automatically displays because it was confirmed in the pre-enrollment process. It can be edited, where needed.

- a. Verify or update the information in the Address Line 1 field.
- b. Verify or update the information in the Address Line 2 field.
- c. Verify or update the City.
- d. Verify or update the State. Use the list to select the appropriate state
- e. Verify or update the ZIP Code, including the 4-digit ZIP extension.
- f. Verify or update the **County**. Using the list to select the county.

Legal Entity Address			
Address Line 1:*			
Address Line 2:			
City:*	State:*	Zip Code:*	County:*
	Select One	<b>Y</b>	Select One 🗸

Figure 4-10: Legal Entity Address Fields

- 7. Verify or update the additional contact details and refer to figure 4-11 for the steps below:
  - a. Enter the email address in the Email Address field.
  - b. Re-type the email address in the Confirm Email field.
  - c. Enter the phone number in the Phone Number field and the extension in the Ext field, if applicable.
  - d. Enter the fax number in the Fax Number field and extension in the Ext field, if applicable.

Email Address:*		Confirm	n Email:*
Phone Number:	Ext.:	Fax Number:	Ext.:
	)		

Figure 4-11: Email Address and Phone/Fax Numbers

 After completing the Legal Entity Address section, read the statement for address validation and click Validate Address. This checks the disclosed address against the USPS to make sure it is a valid address. Refer to Figure 4-12.



Figure 4-12: Legal Address Validation

9. From the list of valid addresses, select the radio button next to the correct suggested address and click **Submit**. Refer to Figure 4-13.

Suggested Addresses:			×
555 Any St, Helena, MT 59860-0555			
	Cancel	Submit	Use Existing

Figure 4-13: Legal Address Validation Suggestion

The Legal Address section updates with the new information. Refer to Figure 4-14.

Address Line 1: *				
555 Any St				
Address Line 2:				
City:*	State:*	Zip Code:*	County:*	
Helena	MT	59860-0555	Lake	~

Figure 4-14: Legal Entity Address Section

#### 4.2.1. Billing Information

Refer to section 3.1.2.2: Billing Information for instructions on completing this tab.

#### 4.2.2. Mailing Address

Refer to section 3.1.2.3: Mailing Address for instructions on completing this tab.

# 4.3. Organizational Providers Ownership

On this tab, review the statement and complete as applicable. All required fields are marked with an asterisk. Providers enrolling as Type 2 (Organizational Providers) are required to identify individuals that have direct or indirect ownership of 5% or more in the organization. Type 2 providers must complete the following enrollment questions.

1. Select **Provider Information** from the navigation menu and click the Ownership tab.

2. Select Yes or No to identify if there are individuals who own 5% or more of the organization. Refer to Figure 4-15.

**Note:** If No, go to Step 5. If Yes, select **Add** and a window displays with required fields for adding individual owners. Go to Step 3.

Ownership							
Please be advised the	at entry of Ownership info	rmation is optional for In	idian Health Services (IHS) &	Tribal providers. To by	pass the Ownership section	select "No" to save and cont	inue.
Federal Medicaid reg	ulations (42 CFR 455.100	)106) require that all 1	Medicaid providers must attes	t and disclose identifyin	ng information for each perso	n and organizations having	direct or
indirect ownership int	erests or control interest e	equal to or more than 5%	6 or more value of the disclos	ing entity. I attest: * 🛈			
Yes means there	ARE person(s) or organ	ization entity(s) that have	e 5% or more direct and/or in	direct ownership. Pleas	e Note: Agents, Officers, Bo	ard Members, Directors and	at least one man
employee must also	be reported if applicable.						
O No means there a	re NO persons or organiza	tional entities that have 59	% or more direct and/or indirect	ownership. Please Not	te: If No, at least one manag	ing employee must be rep	orted (on the
Disclosure tab). Agen	ts, Officers, Board Member	rs and Directors must also	be reported if applicable.				
list any norson(s) or	organizational entity(s) th	at owns 5% or more inte	rest in the entity listed on this	enrollment application	c *		
cist any person(s) or							
Add ()							
Add () ndividual Owner							

Figure 4-15: Ownership Attestation

3. Complete the following fields in the **Ownership** window. Refer to Figure 4-16.

Image: Name   Bestness Name   First Name: *   ML:   Last Name: *   Date of Birth: *   Sample   Provider   Other   Begin Date:   Terminate Date:   MMDDD/YYYY   Image: SSN*   State: *   Zip Code: *   County: *   Helena   MT   SSN*   SN   Orwiction: *   Yes   No   Conviction: Details:*	wnership					×
First Name: *       M.L:       Last Name: *       Date of Birth: *         Sample       Provider       05/10/2021       Image: Constraints         Begin Date:       Terminate Date:       Image: Constraints       Image: Constraints         MMDDD/YYY       Image: Constraints       Image: Constraints       Image: Constraints       Image: Constraints         Image: Constraints       Image: Constraints       Image: Constraints       Image: Constraints       Image: Constraints       Image: Constraints         Conviction: *       Image: Conviction Details:*       Image: Conviction Details:*       Image: Conviction Details:*         Percentage of Ownership: *       Image: Conviction Details:*       Image: Conviction Details:*	Name	O Business Na	me			
Sample         Provider         05/10/2021         Image: Constraints           Begin Date:         Terminate Date:         MMDD/YYYY         Image: Constraints         Image: Cons         Image: C	First Name: *	M.L:	Last N	ame: "	Date of Birth:	
Begin Date:       Terminate Date:         MMDD/YYY       Image: Ima	Sample		Provi	Ser	05/10/2021	Ē
MMDD/YYY       Immod D/YYYY         SSN*       SSN #: *         SSN*       SSN #: *         TITN*       123-45-6789         Address Line 1: *       123-45-6789         123 Provider Lane       Immod Provider Lane         Address Line 2:       Immod Provider Lane         City: *       State: *       Zip Code: *       County: *         Helena       MT       59901-3129       Lake       Immod Provider Lane         City: *       State: *       Zip Code: *       County: *         Helena       MT       59901-3129       Lake       Immod Provider I Lake         Conviction: *       Sign On Conviction Details:*       Immod Provider Lane       Immod Provider I Lake       Immod Provider I Lake </td <td>Begin Date:</td> <td>Terminate Date:</td> <td></td> <td></td> <td></td> <td></td>	Begin Date:	Terminate Date:				
SSN*         SSN #. *           ITIN*         123-45-6789           vidress Line 1: *         123 Provider Lane           123 Provider Lane	MM/DD/YYYY	MWDDIYYYY	(A)	)		
ITIN*       123-45-6789         Address Line 1: *         123 Provider Lane         Address Line 2:         City: *       State: *       Zip Code: *       County: *         Helena       MT       \$59901-3129       Lake          Conviction: *       State: *       Sign County: *          Percentage of Ownership: *       10	SSN"	SSN#				
Address Line 1: *  123 Provider Lane  Address Line 2:  Dty: * State: * Zip Code: * County: * Helena MT  S9901-3129 Lake  Conviction: *  Yes  No Conviction Details:*  Percentage of Ownership: *  10	O ITIN*	123-45-6789		۲		
Address Line 2: City: * State: * Zip Code: * County: * Helena MT V 59901-3129 Lake V Conviction: * O Yes  No Conviction Details:* Percentage of Ownership: * 10	Address Line 1: *			1		
City: * State: * Zip Code: * County: * Helena MT V 59901-3129 Lake V Conviction: * Yes  No Conviction Details:* Percentage of Ownership: * 10	Address Line 2:			)		
Helena MT v 59901-3129 Lake v Conviction: * O Yes  No Conviction Details:* Percentage of Ownership: * 10	City: *	State: *		Zip Code: •	County: *	
Conviction: *  Yes  No Conviction Details:*  Percentage of Ownership: *  10	Helena	MT	~	59901-3129	Lake	~
Ves No Conviction Details:" Percentage of Ownership: " 10	Conviction: *					
Conviction Details:* Percentage of Ownership: * 10	O Yes 💌 No					
Percentage of Ownership: * 10	Conviction Details:*					
Percentage of Ownership: * 10						
Percentage of Ownership: * 10					0	
10	Percentage of Ownership: *					
	10					

Figure 4-16: Ownership Details

- 4. Steps a through g refer to information regarding an individual with 5% or more direct and/or indirect ownership. If an organization has 5% or more direct and/or indirect ownership, the Name fields (a-c) will be replaced with Business Name, there will be no Birth Date field (e), and the SSN/ITIN fields (g) will read Federal Tax ID #.
  - a. Enter the first name in the First Name field.
  - b. Enter the middle initial in the M.I. field.
  - c. Enter the last name in the Last Name field.
  - d. Click the **calendar icon** to enter the Begin Date.

**Note:** The Terminate Date is only required if submitting a change of individual owners and ownership has ended. For more information, please see the *Provider Maintenance Updates User Guide*.

- e. Click the **calendar icon** to enter the Date of Birth.
- f. For the Federal Tax ID, SSN or ITIN, select the type of identification number and then enter the number in the box provided.
- g. Complete the address fields below for the individual owner.
  - i. Enter the primary address in the Address Line 1.
  - ii. Enter any additional address information in Address Line 2.
  - iii. Enter the city in the City field.
  - iv. Select the state from the State drop-down list.
  - v. Enter the 9-digit ZIP code in the Zip Code field.
  - vi. Select the applicable county from the **County** drop-down list.
- h. Select Yes or No to identify if the enrolling provider has a conviction history.
  - vii. If No, the Conviction Details is not needed. Proceed to Step j to enter the amount of ownership.

viii.If Yes, type additional details in the Conviction Details field.

- i. Enter the amount of ownership the individual has in the organization.
- 5. If no individuals or organizations have 5% or more ownership, directly or indirectly, click the No radio button. Refer to Figure 4-17.

**Note:** If the user selects No, at least one managing employee must be reported on the Disclosure tab. Agents, Officers, Board Members and Directors must also be reported if applicable.

6. Select Save and Continue.

Practice Information	Legal Name & Address	Ownership	Disclosure Information
Ownership			
Please be advised th	at entry of Ownership informa	ition is optional f	or Indian Health Services (IHS) & Tribal providers. To bypass the Ownership section select "No" to save and continue.
Federal Medicaid reg	ulations (42 CFR 455.100:	106) require that	all Medicaid providers must attest and disclose identifying information for each person and organizations having direct or
indirect ownership in	terests or control interest equ	al to or more that	n 5% or more value of the disclosing entity. I attest: * 🕜
O Yes means then	e ARE person(s) or organizati	ion entity(s) that	have 5% or more direct and/or indirect ownership. Please Note: Agents, Officers, Board Members, Directors and at least one managing
employee must also	be reported if applicable.		
💽 No means there	are NO persons or organization	al entities that ha	ve 5% or more direct and/or indirect ownership. Please Note: If No, at least one managing employee must be reported (on the
Disclosure tab). Age	nts, Officers, Board Members a	ind Directors must	also be reported if applicable.
			Save and Exit Cancel Previous Save and Continue

Figure 4-17: No Ownership

# 4.4. Organizational Providers Disclosure Information

This tab is required for all enrolling Organizational providers to complete.

To access the Disclosure Information page, select **Provider Information** from the navigation menu, then click the Disclosure Information **t**ab. Refer to Figure 4-18.



Figure 4-18: Disclosure Tab

#### 4.4.1. Agents, Officers, Directors and Board Members

Complete the steps below:

 If applicable, list all agents, officers, directors and board members by selecting the Add button. This opens a new window for collecting this information. Refer to Figure 4-19. Table 4-1 lists the roles and their associated definitions.

Required fields are marked wi	th an asterisk (*).		
First Name:*	M.I.:	Last Name:*	Date of Birth:*
			MM/DD/YYYY 💼
Select One:* O Agent	Officer Objrector	O Board Member	
Begin Date:*	Terminate Date		
MM/DD/YYYY	MM/DD/YYYY		
• SSN:*	SSN:*		

Figure 4-19: Agents, Officers, Directors, and Board Members Name

Role	Definition
Agent	A person with an ownership or control interest of a disclosing entity that is organized as a corporation
Officer	A person with an ownership or control interest of a disclosing entity that is organized as a corporation
Director	A person with an ownership or control interest of a disclosing entity that is organized as a corporation
Board Member	A member of the board of directors of a corporation.

- 2. Enter the individual's First Name, M.I, and Last Name.
- 3. Click the **calendar icon** to enter the Date of Birth.
- 4. Select the radio button to identify if the role of the individual an Agent, Officer, Director or Board Member.
- 5. Click the **calendar icon** and select the individual's Begin Date from the calendar provided.

**Note:** After enrollment, use the Terminate Date to update or change an individual's role.

- 6. Indicate whether the individual has an SSN or an ITIN.
- 7. In the SSN or ITIN text field, enter the applicable identification number for the individual.
- 8. Complete the steps below to enter the individual's address. Refer to Figure 4-20.
  - a. Enter the individual's primary address in the Address Line 1 field.
  - b. Enter any additional address information in the Address Line 2 field.
  - c. Enter the individual's city in the City field.
  - d. Select the appropriate state from the State list.
  - e. Enter the individual's 9-digit ZIP code in the ZIP Code field.
  - f. Select the applicable county from the County list.
- 9. Indicate Yes or No to answer whether the enrolling provider has a conviction history.
  - a. If No, the Conviction Details are not needed. Proceed to Step 10.
  - b. If Yes, enter additional details in the Conviction Details field.

Segin Date. Terminate	Date	Marine Marine and	and the second have
Address Line 1:*	n" 1,2 ,5 ,6 ,800		
Address Line 2:			
City:*	State:*	Zip Code:*	County:*
	-Select-	<b>~</b> ]	-Select-
Conviction			
Conviction:* O Yes O No			
Conviction Details:*			

Figure 4-20: Agents, Officers, Directors, and Board Members Additional Information

10. Click Save. Refer to Figure 4-21.



Figure 4-21: Save

#### 4.4.2. Managing Employees

This section is required for Type 2 providers.

1. From the Disclosure Information tab, complete the steps below to enter the Managing Employee Information. Refer to Figure 4-22.

ractice mormation	Legal Name & Address	Ownership	Disclosure Information	Medicare/Medicaid	
Required fields are m Federal Regulations 4 sections. List ALL agents, office	arked with an asterisk (*). I5 CFR 455 requires State N ers, directors who have expre	ledicaid Agencies to essed or implied au	o collect Disclosure Informat thority to act on behalf of the	tion for all enrolling providers. a provider entity.	Please complete the be
Agents, Officers, Direct First Name	ctors, and Board Members M.I.	Add Last Name	Date of Birth	Address	Action
List ALL managing en	nployees who have expresse	ed or implied author	ity to act on behalf of the pr	ovider entity.	
Managing Employees	Add			8	
Table in the later of the second second		Last Name	Date of Birth	Address	Action

Figure 4-22: Managing Employees

2. Click **Add** to list all managing employees who have expressed or implied authority to act on behalf of the provider entity. Refer to Figure 4-23.

ALL managing empic	byees who have expr	essed of implied additionty	o act on behan of the provider	enuty.	
naging Employees	Add				

Figure 4-23: Add Managing Employees

- 3. Enter the individual's first name in the First Name, M.I., and Last Name.
- 4. Click the **calendar icon** and select the individual's Date of Birth from the calendar provided. Refer to Figure 4-24.

Anaging Employee	s		
Required fields are marked	l with an asterisk (*).		
First Name:*	M.I.:	Last Name:*	Date of Birth:*
Sample		Physician	3/10/1990 💼 🗙

Figure 4-24: Managing Employee Details

5. Click the **calendar icon** and select the individual's Begin Date from the calendar provided. Refer to Figure 4-25.

**Note:** After enrollment, use the Terminate Date to update or change an individual's role.

Begin Date:* 5/1/2020	Terminate Date				
SSN:* S	SN:* 555-44-3322	) 👁			
OTTIN:* Address Line 1:*					
555 Any St					
Address Line 2:					
City:*	State:*		Zip Code:*	County.*	
Helena	MT	•	58960-0555	Lake	•
Conviction					
Conviction: * 🔿 Yes 🖲 No					
Conviction Details:*					

Figure 4-25: Managing Employees Details - continued

- 6. Click the appropriate radio button for SSN or ITIN.
- 7. In the SSN or ITIN text field, enter the applicable identification number for the individual.
- 8. Complete the steps below to enter the service location where the individual acts as a managing employee.
  - a. Enter the primary address in the Address Line 1 field.
  - b. Enter any additional address details in the Address Line 2 field.
  - c. Enter the city in the City field.

- d. Select the appropriate state from the State list.
- e. Enter the 9-digit ZIP code in the ZIP Code field.
- f. Select the applicable county from the County list.
- 9. Indicate Yes or No to answer whether the enrolling provider has a conviction history.
  - a. If No, the Conviction Details are not needed. Proceed to Step 10.
  - b. If Yes, Enter additional details in the Conviction Details field.

10. Click Save.

### 4.4.3. Managing Relationship

This section describes the correlation between individuals/organizations and their agents, officers, directors, and employees.

- To manage the relationship, click the Yes or No radio button to indicate if there are any individuals listed in Ownership, Agents, Officers, Directors and Managing Employees sections who are related through blood or marriage. Complete the steps below.
  - a. Select Yes if the relationship must be entered in the Managing Relationship form.
     Select the Add button to open the form in a pop-up window. Refer to Figure 4-26.
     Proceed to Step 2.
  - b. If No, proceed to Section 4.4.4: Sub-Contractor.

Managing Relationship	Managing Relationships				
Indicate if any of the individuals listed in ownership, agents, officers, directors, and managing employees sections who are related through blood or marriage. *					
●Yes ○ No					
Add					
First Name	Last Name	Date of Birth	Relationship	Action	
	•			1	

Figure 4-26: Add Managing Relationship

 Search for any owners, agents, officers, board members, directors and managing employees previously entered to associate any relationship, where applicable, by entering First Name, Last Name or Date of Birth. Click the **Search** button only for a list of all the above. Refer to Figure 4-27.

anagi	ng Relatio	nships				
Prima	ny Person	Search				
irst Na	me:	Last	Name:	Date of Birt	th:	
				MM/DD/Y	YYY 🛅	Search Clear
Resul	Prefix	First Name	Middle Name	Last Name	Suffix	Date of Birth
0		Sample		Manager 1		04/14/1977
0		Sample		Manager 2		11/09/1988
		and the second se		AND TO A DATA OF A		0000 0000 00000000000000000000000000000

Figure 4-27: Managing Relationship Search

3. After entering the search criteria, select the radio button of the first person in the relationship. Follow the same steps to pull the same information to identify the second person in the relationship. Refer to Figure 4-28.

sul	ts					
	Prefix	First Name	Middle Name	Last Name	Suffix	Date of Birth
0		Sample		Manager 1		04/14/1977
0		Sample		Manager 2		11/09/1988
۲		Sample		Manager 3		07/01/1983

Figure 4-28: Add Managing Relationship from Search Results

- 4. From the list of relationship search results, select the radio button to identify the second individual in the relationship.
- Select the corresponding relationship type from the Relationship list. Refer to Figure 4-29.

Name	e:		Last Name:		Date of Birth	n 👘	Search	Clear
sults	5							
	Prefix	First Name	Middle Name	Last Name	Suffix	Date of Birth	h Rela	tionship
0		Sample		Manager 1		04/14/1977	C	hoose one: 🗸
۲		Sample		Manager 2		11/09/1988		hoose one: 🗸
0		Sample		Manager 3		07/01/198:	3 0	hoose one: 🗸

Figure 4-29: Relationship Drop-down Selection

#### 4.4.4. Sub-Contractor

The steps below describe how to add the Sub-Contractor information.

 Select the Yes or No radio button to indicate if this provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period. Refer to Figure 4-30.

Sub-Contractors
Indicate if this provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding twelve (12) month period. *
Yes
○ No

Figure 4-30: Add Sub-Contractor Question

- 2. Select Yes if there were business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period and complete the steps below.
  - a. Click Add to open the Sub-Contractors screen. Refer to Figure 4-31.

ub-Contractors						3
Required fields are marked with an asterisk (*).						
O Name   Business Name						
Business Name."						
MM/DD/YYY						
Address Line 1.*						
Address Line 2:						
	Chala *	]	Tip Code 1	Country		
	-Select-	~	Zip Code.	-Select-	~	
						Sauo
						Save

Figure 4-31: Sub-Contractors Screen

- b. Click the radio button for Name or Business Name.
  - i. If Name was selected, enter the subcontractor's First Name, M.I., and Last Name.
  - ii. If Business Name was selected, enter the subcontractor's Business Name.
- c. Click the calendar icon and select the Transaction Date from the calendar provided.

- d. Enter primary address in the Address Line 1 field.
- e. Enter any additional address details in the Address Line 2 field.
- f. Enter the city in the City field.
- g. Select the appropriate state from the State list.
- h. Enter the 9-digit ZIP code in the ZIP Code field.
- i. Select the applicable county from the **County** list.
- j. Click Save.
- Select No if there were no business transactions with any subcontractor totaling more than \$25,000 during the preceding twelve-month period and proceed to Section 4.4.5: Business Transactions.

#### 4.4.5. Business Transactions

The steps below describe how to add Business Transactions.

 Select the Yes or No radio button to indicate if this provider had any significant business transactions with any wholly owned supplier or subcontractor during the preceding 5-year period. Refer to Figure 4-32.



#### Figure 4-32: Business Transactions Question

 Select No if there were no significant business transactions with any wholly owned supplier or subcontractor during the preceding 5-year period and proceed to Section 4.4.6: Controlling Interest.

- Select Yes if there were any significant business transactions with any wholly owned supplier or subcontractor during the preceding 5-year period and complete the steps below.
  - a. Select Add to open the Business Transaction screen. Refer to Figure 4-33.

Business Transactio	ns				×
Required fields are marked	with an asterisk (* ). O Business Name				
First Name: * (i)	M.I.:	Last Name: *			
Transaction Date: *					
Transaction Details: *					]
1000 characters rem	aining.				
Address Line 1: *					
Address Line 2:					
City:*	State:*	Zip Code:*	County:*		
		<u> </u>	-Select-	~	Save

Figure 4-33: Business Transactions Screen

- b. Select the radio button for Name or Business Name.
  - i. For Name, enter the subcontractor's First Name, M.I., and Last Name fields.
  - ii. For Business Name, enter the subcontractor's Business Name.
- c. Click the **calendar icon** and select the Transaction Date from the calendar provided.

d. Enter the Transaction Details in the field provided.

Note: This field has a 1,000-character limit.

- e. Enter the primary address in the Address Line 1 field.
- f. Enter any additional address details in the Address Line 2 field.
- g. Enter the city in the City field.
- h. Select the appropriate state from the State list.
- i. Enter the 9-digit ZIP code in the Zip Code field.
- j. Select the applicable county from the County list.
- k. Click Save.

#### 4.4.6. Controlling Interest

The steps below describe how to add the Controlling Interest.

 Select the Yes or No radio button to indicate if any owner or board member has ownership or controlling interest in another organization that bills for Medicaid services. Refer to Figure 4-34.

Controlling Interest	
Does any owner or board member have ownership or controlling interest in another organization that bills for Medicaid services?*	
○ Yes	
○ No	

#### Figure 4-34: Controlling Interest Question

- Select No if no owners or board members have ownership or controlling interest in another organization that bills for Medicaid services and proceed to Section 4.4.7 Questions.
- Select Yes to indicate that an owner or board member has ownership or controlling interest in another organization that bills for Medicaid services. This means that the Controlling Interest information must be provided. Complete the steps below.

a. Click the **Add** button to open the form in a pop-up window and complete the steps below, as required. Refer to Figure 4-35.

ontrolling Interes	st				>
Required fields are man	rked with an asterisk (*).				
Business Name:*					
FEIN:*	Medicaid ID:*	Medicaid ID: *			
Address Line 1:*			)		
Address Line 2:					
City:*	State:*		Zip Code:*	County:*	
	-Select-	~		-Select-	
					Save

Figure 4-35: Controlling Interest Screen

- b. Enter the Business Name.
- c. Enter the FEIN.
- d. Select the Medicaid ID or NPI radio button and enter the appropriate number in the associated field.
- e. Enter the primary address in the Address Line 1 field.
- f. Enter any additional address details in the Address Line 2 field.
- g. Enter the city in the City field.
- h. Select the appropriate state from the **State** list.

- i. Enter the 9-digit ZIP code in the Zip Code field.
- j. Select the applicable county from the **County** list.
- k. Click Save.

#### 4.4.7. Questions

Below the Controlling Interest section of the screen are the following questions. Answers to all questions are required by selecting a Yes or No radio button.

- If selecting No to all questions, proceed to Section 4.4.8 Authorized Official Attestation.
- If any answer is Yes, a text box opens to provide additional details. Refer to Figure 4-36.
  - a. Do you or any owner or employee owe any money to Medicare, Medicaid or CHIP that has not been paid?
  - b. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of any health-related crimes?
  - c. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of a crime involving the abuse of a child or elderly adults?

1. Do you or any owner or employee owe any money to Medicare, Medicaid or CHIP that has not been paid?*
• Yes
○ No
2. Have you or any owner or employee identified in the Ownership and Control Interest Section over been convicted of any health related crimes? *
2. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of any nearin related crimes /
○ Yes
○ No
3. Have you or any owner or employee identified in the Ownership and Control Interest Section ever been convicted of a crime involving the abuse of a child
or elderly adult? *
○ Yes
O No

Figure 4-36: Enrollment Attestation Questions

#### 4.4.8. Authorized Official Attestation

The steps below describe how to complete the authorized official attestation.

1. Attest either as the provider or on behalf of the provider to the statement provided in this section by clicking the I Attest checkbox. Refer to Figure 4-37.

Authorized Official Attestation:
By checking the box below, I attest that I have searched and continue to search on a monthly basis the (OIG) Office of Inspector General List of Excluded
Individuals/Entities prior to enrolling in any State or Federal program, before hiring new employee and employing contractors. I attest the provider, all
owners, managers, employees and contractors are not excluded from participation in Medicare, Medicaid, CHIP or other federal health care programs and
agree to immediately notify any exclusion information to the State Medicaid Agency. *
☑ I Attest

Figure 4-37: Authorized Official Attestation

2. Click Save and Continue at the bottom of the page. Refer to Figure 4-45.



Figure 4-38: Save and Continue

# 4.5. Organizational Providers Credentials

Refer to Section 3.1.5.3: Licenses, Certifications and Board Certifications to complete the credentials for an Organizational Provider.

# 4.6. Organizational Providers Financial Information

For information on how to complete the financial information, refer to Section 3.1.6: Financial Information and complete the following:

- Sections 3.1.6.1: Insurance
- Section 3.1.6.2: Banking.

# 4.7. Organizational Providers Physical Location

Refer to Section 3.1.7: Physical Location and complete the steps outlined in Section 3.1.7.1: Address.

# 4.7.1. Lab Credentialing

This section only applies to providers who offer laboratory services at this office location. Complete each field as prompted. Required fields are marked with an asterisk.

Determine if the location provides laboratory services.

- Select No if the location does not provide laboratory services and proceed to Section 4.7.2: Provider Type, Specialties & Programs.
- Select Yes if the location provides laboratory services and complete the steps below. Refer to Figure 4-39.
| Questions:      | _                                |                       |                 |            |   |
|-----------------|----------------------------------|-----------------------|-----------------|------------|---|
| 1) 🖲 Yes 🔍 No   | Do you provide laboratory servic | es at this location?* |                 |            |   |
| CLIA NUMBER (   | format: 99A9999999) *            | Upload Docu           | ment            |            |   |
| Schedule Type:  | select                           | •                     | Effective Date: | MM/DD/YYYY | Ē |
| Terminate Date: | MM/DD/YYYY                       |                       |                 |            |   |

Figure 4-39: Laboratory Service at the Physical Location

- a. Enter the CLIA number in the CLIA NUMBER field.
- b. Click **Upload Document** to attach and upload the applicable CLIA certificate.
- c. Select the Schedule Type from the list provided.
- d. In the Effective Date field, click the **calendar icon** and select the date from the calendar provided.
- e. In the Terminate Date field, click the **calendar icon** and select the date from the calendar provided.

### 4.7.2. Organizational Provider Type, Specialties & Programs

For information on how to complete this section, refer to section 3.1.7.2, Provider Types, Specialties & Programs.

### 4.7.3. Organizational Rendering Provider Affiliations

The affiliation process allows a Group or Facility to bill and receive payments for services rendered by an Individual Provider. The Group or Facility that bills on behalf of services rendered by a provider must add that rendering provider to their enrollment. After entering all the physical locations, rendering provider affiliations can be entered and associated with each physical location. Group Providers are required to submit at least one rendering provider affiliation with their initial enrollment. Facility Providers billing on behalf of a Rendering Provider must also enroll the Rendering Provider.

To begin the affiliations process, click **Manage Affiliation** located on the Physical Location page. Refer to Figure 4-40, then proceed to Section 4.7.3.1: Search for Provider Tab.

Add					Manage Affilations
ID	Address	City	State	County	Action
001	555 Any St	Helena	МТ	Lake	ø
002	333 My Pl	Helena	MT	Lake	1

Figure 4-40: Manage Affiliations Tab

### 4.7.3.1. Search for Provider Tab

The steps below describe how to add affiliations on the Search for Provider tab.

1. To add affiliations on the Search for Provider tab, search for a Rendering Provider using the provider's First Name, Last Name or NPI/Atypical ID.

**Note:** When searching by first and last name, enter at least three characters of the name to produce results. The three-character limit allows the Provider Portal to display a smaller list of results. Refer to Figure 4-41.

earch fo	r Providers	Pending Approval	Requested Affiliations	Existing Affiliations		
Search f	or Provider					
First Nam	ne	Last Na	ame	NPI/Atypical ID		
		Add			Search	
	First Name	Last Name	NPI/Atypical ID	Last 4 digits of SSN/ITIN*	Actions*	File Name
	Thomas	Addicon	1971504754		+	

Figure 4-41: Searching for a Rendering Provider

 From the list of results, select the radio button next to the provider's details Refer to Figure 4-42.

earch for Providers	Pending Approval	Requested Affiliation	s Existing Affiliations		
earch for Provider					
First Name	Last Na	me	NPI/Atypical ID		
	add			1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	
				earch	
First Name	Last Name	NPI/Atypical ID	Last 4 digits of SSN/ITIN*	Actions*	File Name
First Name O Thomas	Last Name	NPI/Atypical ID 000000001	Last 4 digits of SSN/ITIN*	Actions*	File Name

Figure 4-42: Provider Radio Button

 Enter the last four digits of the provider's SSN in the Last 4 digits of SSN/ITIN field. Refer to Figure 4-43.

	First Name	Last Name	NPI/Atypical ID	Last 4 digits of SSN/ITIN*	Actions*	File Name
۲	Thomas	Addison	000000001	9475	1	

Figure 4-43: Last Four Digits of Provider SSN

 Click the **upload icon** to upload the Montana Billing Agreement. Refer to Figure 4-51.

	First Name	Last Name	NPI/Atypical ID	Last 4 digits of SSN/ITIN*	Actions*	File Name
۰	Thomas	Addison	000000001	9475	2	

Figure 4-44: Upload the Montana Billing Agreement

When the radio button is selected, the Group/Facility physical locations display.

5. Select the checkboxes next to the address line where this Rendering Provider provides services. Refer to Figure 4-45.

**Note:** When an Assigned Locations checkbox is selected, the pencil/edit icon is enabled.

					CAISUNG ANNIAUOUS			
earch f	or Provider							
irst Nan	ne	Last N	ame		NPI/Atypical ID			
		Add				Search	]	
	First Name	Last Name	NPI/Atypical ID	Last	4 digits of SSNITIN"		Actions*	File Name
٠	Thomas	Addison	000000001	9	475		×	Billing Agre
ssigne	d Locations							
-								
		0.0000000000000000000000000000000000000						

Figure 4-45: Assign Addresses where the Rendering Provider Performs Services

6. Select the **pencil icon**. Refer to Figure 4-46.

1	
1	

Figure 4-46: Pencil Icon

7. Indicate the programs the Rendering Provider serves at this physical location. Select all programs that apply and select **Save**.

**Note:** The application only displays programs that both the Group and the Rendering Provider have in common. If the Group selected to participate in additional programs, the Rendering Provider must also enroll with the same programs for them to appear for selection. Refer to Figure 4-47.

555 Any St			
Program Name	Effective Date	Termination Date	Select
Montana Medicaid (HMK	(Pl		8
PCP - Passport to Health	1		

Figure 4-47: Assign Programs to the Address the Rendering Provider Performs Services

8. To add the affiliation, click Add and Continue. Refer to Figure 4-48.

earch fo	or Providers	Pending Ap	proval	Requested Affiliation	ons i	Existing Affiliations			
Search f	for Provider								
First Nar	me		Last Na	ime		NPI/Atypical ID			
			Add				Search	1	
								-	
	First Name	Last Na	me	NPI/Atypical ID	Last 4	digits of SSN/ITIN*		Actions*	File Name
	Thomas	Addiso	n	000000001	947	5		×	Billing Agre
Assigne	d Locations								
		Address Line							
2		310 Sunnyv	view Ln			(and			
		350 Heritag	e Way			1			

Figure 4-48: Saving the Rendering Provider Affiliation

### 4.7.3.2. Pending Approval Tab

After selecting **Add and Continue**, the Rendering Affiliation moves to the Pending Approval tab. This is a view only tab to review the Rendering Provider details. To review the program information, select the **magnifying glass** icon. The affiliation request stays in this tab until the enrollment application is approved and the Group/Facility provider is enrolled. Refer to Figure 4-49.

Search for	Providers	Pending Approval	Requested Affiliations	Existing A	filiations	
Pending	Approval Ou	tbound Verifications				
	First Nan	ne Last	Name N	PI/Atypical ID	Status	
۰	Sample	Rend	ering 1	112233445	Add	
ssigned	Locations					
		Address Line				
8		333 My Pl			Q	
		555 Any St			Q	

Figure 4-49: Pending Approval Tab

## 4.7.3.3. Requested Affiliation Tab

Groups/Facilities must be active and enrolled to edit the Requested Affiliations tab. When enrolled, the Group/Facility information will be searchable within the enrollment application for an enrolled Rendering Provider to request an affiliation. The Rendering Provider will initiate the affiliation request within its enrollment application and once submitted will appear in the Group/Facility enrollment application in the Requested Affiliations tab. Refer to the *Provider Maintenance Updates User Guide* for instructions on accepting or denying a requested affiliation. Refer to Figure 4-50.



Figure 4-50: Requested Affiliations Tab

## 4.7.3.4. Existing Affiliations Tab

Groups/Facilities must be active and enrolled to edit the Existing Affiliations tab. In this tab, Groups/Facilities can manage their Rendering Provider affiliations. Refer to the

*Provider Maintenance Updates User Guide* for instructions on managing Rendering Provider affiliation. Refer to Figure 4-51.



#### Figure 4-51: Existing Affiliations Tab

### 4.7.4. Remaining Tabs on Physical Location

Complete the remaining tabs for Physical Location by referring to the following sections:

- Section 3.1.7.3: Hours
- Section 3.1.7.4: Languages
- Section 3.1.7.5: Medicare/Medicaid
- Section 3.1.7.6: Services Provided

# 4.8. Organizational Providers Enrollment Units

For information on how to complete the atypical provider enrollment units, refer to Section 3.1.8 Enrollment Units and complete all subsections.

# 4.9. Organizational Providers Final Submission

### 4.9.1.1. Terms and Agreements

Refer to Section 3.1.9: Final Submission and complete Section 3.1.9.1: Terms and Agreements

### 4.9.1.2. Fee Collection

Providers who are required to pay a fee and have not paid a Medicaid fee may do so through this tab. Providers categorized as high-risk also pay a fee for fingerprint-based criminal background check. High-risk providers and owners must complete the fingerprint process and pay a \$10.00 fee for each. The enrollment fee is set by CMS on a yearly basis and must be paid unless the provider/owner is seeking a hardship waiver

disclosure. If a provider feels he or she qualifies for a fee waiver, the provider may also request the waiver here by selecting the checkbox and completing the details section to support the request. All requests will be reviewed by DPHHS partners and CMS to determine waiver fee eligibility and will be notified in writing of the results.

 Select the Fee Collection tab from the Final Submission section. Refer to Figure 4-52.

Terms and Agreements	W-9	Fee Collection	
	12140 03		

Figure 4-52: Fee Collection Tab

2. Select the applicable **Payment Type** from the list of choices. Refer to Figure 4-53.

Fee Collection							() He	) elp
Required fields are marked with a	n asterisk (*).							
*Important For Providers using Ma	ail-In for Fee payment, Mail to th	he address below	v within 7 to 10 busine	ss days.				
Medicaid Enrollment	Fees							
Application Fee								
Application Fees Comment								
*Important For Providers using Ma	ail-In for Fee payment, Mail to th	he address below	v within 7 to 10 busine	ss days.				
DPHHS								
Quality Assurance Division								
SURS UNIT/Enroliment App Fee								
2401 Colonial Drive								
PO Boy 202953								
Helena MT 59620								
Thank you								
Eingerprint based Criminal Bac	karound Check, Finger Print h	ased Backgroup	d Comment					
r ngerprint based criminal bac	Aground Check Thige Thinks		o comment					
Request Hardship Fee Waiv	er Upload Hardship Fee Waiver							
Waiver Reason:								
	li							
Required Fees:								
Fee Туре	Fee Description	Fee Amount	Number of Owners	Total				
Application Fee	Application Fee	\$595.00	1	\$595.00	1			
			Tetal Due	8505.00	-			
			lotal Due	\$080.00				
Payment Type*								_
			s	ave and Exit	Cancel	Previous	Save and Continue	

Figure 4-53: Fee Collection Screen

a. Select **Credit Card** and **Pay Fee** if payment is by credit card, then complete the steps below. Refer to Figure 4-54.

Payment Type:*	e
Credit Card V	Pay Fee

Figure 4-54: Pay Fee Button

b. On the Fee Collection Confirmation screen, click **Confirm** to be redirected to a third-party website to proceed with the payment. Refer to Figure 4-55.





c. Review the Transaction Detail Grid and the Transaction Summary. Refer to Figure 4-56.

1 Payı	ment Type 2 Cus	stomer Info 3	Payment Info	Submit Payment	Transaction Sum	mary
Trans	action Detail				Application Fee	\$595.00
					Service Fee	\$14.04
SKU	Description	Unit Price	Quantity	Amount	TOTAL 📀	\$609.04
1	Application Fee	\$595.00	1	\$595.00		
Total				\$595.00		
					Need Help?	
Pavm	ent				Please complete the Customer I	ntormation Section
Paym	ent Type			1		
		Credit Card				

Figure 4-56: Transaction Detail and Transaction Summary

d. Enter the Customer Information in the required fields and then click **Next**. Refer to Figure 4-57.

Country			Complete all required fields
United States	~		
First Name *		Last Name *	
Sample	0	Physician	<b>Ø</b>
Company Name			
			<b>e</b>
Address *			
555 Any St			0
Address 2			
			0
City *		State	
Helena	0	MT - Montana	~ V
ZIP/Postal Code *			
59860-0555	0		
Phone *			
(555)555-5555	0		
Email 🍘			
physsampl@nonexst.com	×		

Figure 4-57: Customer Information

- e. Complete the Payment Information section by completing the Credit Card Number, Expiration Month, Expiration Year and the Name on Credit Card.
- f. Click Next. Refer to Figure 4-58.

Customer Information	4
Address Sample Physician 555 Any St Helena, MT 59860-0555	Edit 95555555555
Country United States	Email Address physsampl@nonexst.com
Payment Info	
Credit Card Number * 🍘	Complete all required fields [*] Credit Card Type
Expiration Month *	Expiration Year *
Select a Month ~	Select a Year V
	Next >

Figure 4-58: Payment Information

g. Read the Terms and Conditions, click the checkbox indicating Yes, I authorize this transaction and click the I'm not a robot reCAPTCHA checkbox. Click
 Submit Payment. Refer to Figure 4-59.

ayment Info		1
		Edi
Credit Card	Name on Account	
Test Credit	Sample Physician	
Terms and Conditions	Open a new window to print	
<ol> <li>I understand the Originatin sure your banking institutin to ensure successful payn</li> <li>I (we) agree that ACH tran NACHA Rules and all app state.</li> </ol>	ng ID for this transaction is "1234567890". Please make on has released any debit blocks (if applicable) for this ID nent. Isactions I (we) authorized comply with all applicable licable US Iaw and the laws governing DPHHS MPATH's	
Yes, I authorize this transaction	an.	
/erification		
V I'm not a robot	reCAPTCHA Privacy-Terms	
Cancel	Submit Pa	iyment

Figure 4-59: Terms and Conditions and Submit Payment

h. Click **Save and Continue** when redirected back to the Fee Collection screen. Refer to Figure 4-60.

Fee Collection				
Required fields are marked with an asteri	sk (*).			
Medicaid Enrollment Fees				
Application Fee				
Application Fees Comment				
Fingerprint based Criminal Backgroun	d Check Finger Print based Background Comment			
Request Hardship Fee Waiver	pad Hardship Fee Waiver			
Waiver Reason:				
Required Fees:				
Fee Type	Fee Description	Fee Amount	# of Owners	Total
Application Fee	Application Fee	\$595.00	1	\$595.00
			Total Due	\$595.00
Paymont Type*				
Credit Card > Pay Fee				
	Save	nd Exit Cance	Previous	Save and Continue

Figure 4-60: Save and Continue on Fee Collection Screen

i. Select **eCheck** and click **Pay Fee** if payment is by electronic check. Refer to Figure 4-61.

		t Type:*	Payment
eCheck 🗸 Pay Fee	Pay Fee	~	eCheck

Figure 4-61: eCheck and Pay Fee Button

i. On the Fee Collection Confirmation screen, click **Confirm** to be redirected to a third-party website to proceed with the payment. Refer to Figure 4-62.



Figure 4-62: Fee Collection Confirmation

j. Review the Transaction Detail Grid and the Transaction Summary.

Note: If the payment is funded by a foreign bank source, select the checkbox.

k. Click the **Next** button. Refer to Figure 4-63.

1 Pay	rment Type 2 Cu	stomer Info 3	Payment Info	4 Submit Payment	Transaction Summa	ary
rans	action Detail				Application Fee	\$595.00
					Service Fee	\$2.00
SKU	Description	Unit Price	Quantity	Amount	TOTAL 🕜	\$597.00
I	Application Fee	\$595.00	1	\$595.00		
otal				\$595.00		
Paym	nent Type					
	ſ	Payment Type *	~			
Inte	Select if this payment IS bein ernational ACH Transaction ("I	ng funded specifically by a F	OREIGN source (bank	: or company), an		

Figure 4-63: Transaction Detail and Summary

 On the Payment Information Screen, enter the Name on Account, Routing Number, and Account Number. Re-enter the Account Number and choose the radio button for Checking or Savings. Click the Next button. Refer to Figure 4-64.

Name on Account *	Complete all required held
Sample Physician	
This is a business account.	
Routing Number *	Account Number * 🍘
123456789	98765432
	Re-enter Account Number *
Pay	98765432
	Checking      Savings
012345678 01234567890 Routing Number Account Number	

Figure 4-64: Payment Info Screen

m. Read the Terms and Conditions, click the checkbox for Yes, I authorize this transaction and click the reCAPTCHA checkbox I'm not a robot. Click Submit Payment. Refer to Figure 4-65.

Payment Inf	o	1
		Edit
Electronic Cheo	ck Name on Account Sample Physician	
Terms and Co autho 7. I und sure to en 8. I (we NAC state Verification	onditions       Open a new window to print         prization, I may contact DPHHS MPATH at.       erstand the Originating ID for this transaction is "1234567890". Please make your banking institution has released any debit blocks (if applicable) for this ID sure successful payment.         agree that ACH transactions I (we) authorized comply with all applicable HA Rules and all applicable US law and the laws governing DPHHS MPATH's         thorize this transaction.	
Cancel	Submit	Payment

Figure 4-65: Terms and Conditions and Submit Payment

n. Click **Save and Continue** when redirected back to the Fee Collection screen. Refer to Figure 4-66.

Fee Collection						? Help
Required fields are marked wit	h an asterisk (*).					
*Important For Providers using	Mail-In for Fee payment, Mail t	to the address below	v within 7 to 10 busine	ess days.		
Medicaid Enrollme	nt Fees					
Application Fee						
Application Fees Comment						
*Important For Providers using	Mail-In for Fee payment, Mail I	to the address below	within 7 to 10 busine	ess days.		
DPHHS						
Quality Assurance Division						
SURS UNIT/Enrollment App F	ee					
2401 Colonial Drive						
PO Box 202953						
Helena, MT 59620						
These burgers						
Thank you						
Fingerprint based Criminal E	Background Check Finger Pri	nt based Backgroun	d Comment			
Request Hardship Fee W	aiver Upload Hardship Fee Wai	101				
Waiver Reason:						
	0					
Required Fees:						
Fee Type	Fee Description	Fee Amount	Number of Owners	Total		
Application Fee	Application Fee	\$595.00	1	\$595.00		
			Total Due	\$595.00		
Payment Type:						
eCheck V Pay Fee						
eCheck V Pay Fee						
eCheck V Pay Fee						

Figure 4-66: Save and Continue on Fee Collection Screen

- o. Select Mail-In if payment will be mailed in and complete the steps below.
  - i. The Submit Document via Mail screen displays with instructions for mailing the payment. Review and click the **Close** button. Refer to Figure 4-67.

	~
Submit document via Mail	
You have selected to Mail-In your Medicaid Enrollment Fee(s). Please mail your payment along with a copy of your printed enrollment summary tracking purposes within 7 to 10 business days to the attention of -	/ page for
The Provider Relations Department, P.O. Box 4936, Helena, MT 59604	
	Close



ii. Click Save and Continue. Refer to Figure 4-68.

Fee Collection						(?) Help
Required fields are marked	d with an asterisk (*).					
"Important For Providers u	sing Mail-In for Fee payment, Mail to	the address below	v within 7 to 10 busine	es days.		
Medicaid Enrolln	nent Fees					
Application Fee						
Application Fees Comment	t					
*Important For Providers u	sing Mail-In for Fee payment, Mail to	the address below	v within 7 to 10 busine	ss days.		
DPHHS						
Quality Assurance Division						
SURS UNIT/Enrollment Ap	p Fee					
2401 Colonial Drive						
PO Box 202953						
Helena, MT 59620						
Thank you						
Thenk you						
Fingerprint based Crimin	al Background Check Finger Prin	t based Backgroun	d Comment			
Request Hardship Fee	e Walver Upload Hardship Fee Walv	or in the second se				
Walver Beason						
marrer Reason.						
	6					
Required Fees:						
Fee Type	Fee Description	Fee Amount	Number of Owners	Total		
Application Fee	Application Fee	\$595.00	1	\$595.00		
			Total Due	\$595.00		
Payment Type:* ()						
eCheck Y Pay Fee						
				no and Eul	Canadi	Street and Contract
			3	ave and Exit	Previous	Save and Continue

Figure 4-68: Save and Continue on the Fee Collection Screen

# 4.9.1.3. Summary

Refer to Section 3.1.9: Final Submission and complete Section 3.1.9.3: Summary.

# 5. Roles & Responsibilities

The following sections describe the roles and responsibilities as they relate to the Montana Provider Portal.

# 5.1. Montana DPHHS Fiscal Agent

A DPHHS Fiscal Agent is the state partner who owns the Optum Medicaid Management Services (OMMS) product for managing its state Medicaid program(s). The Montana DPHHS Fiscal Agent has provided Optum<sup>®</sup> with their program(s) rules and the requirements expected of their provider enrollment process.

The OMMS program has been designed to follow the rules and requirements provided by the Montana DPHHS Fiscal Agent. Each Montana DPHHS Fiscal Agent will have the ability to manage and design certain aspects of the program through the OMMS Montana Provider Portal by accessing the SMA Workbench. The SMA workbench will allow each user to perform specific roles based on the permission level assigned to the SMA user.

# 5.1.1. DPHHS User Roles

A user role is assigned to any authorized Montana DPHHS Fiscal Agent to access the SMA Workbench within the Montana Provider Portal. User roles are outlined in Table 5-1 below.

DPHHS Role	Definition
SMA Administrator	The SMA Admin will be the first State user to register and log in to the OMMS Montana Provider Portal. This Individual will have access to all SMA functionality. This Individual will be the only user role that can add and manage SMA users associated to OMMS Montana Provider Portal account.
SMA User	This user must be added by the SMA Admin. The SMA User role will have access to all SMA workbench functionality except adding and managing SMA users associated to the OMMS Montana Provider Portal account.

### Table 5-1: DPHHS User Roles

# 5.2. Provider

A Provider is defined as an individual physician, group or facility organization enrolling in the State Medicaid program(s). The provider or person(s) authorized to act on behalf of the provider is the end user of the Montana Provider Portal. The end user will be responsible for ensuring the accuracy of the provider demographic information completed and any attachments submitted in the online portal. Completing and submitting an application in the OMMS Montana Provider Portal does not guarantee approval for credentialing or contracting with the Montana DPHHS Fiscal Agent or becoming an active provider in any Medicaid program(s) offered by the Montana DPHHS Fiscal Agent. All providers are required to adhere to a credentialing or validation process performed by Optum as regulated by the Montana DPHHS Fiscal Agent. Completing an online application (or submitting an approved paper application where applicable) will initiate the credentialing and validation process:

# 5.2.1. Provider User Roles

Table 5-2 describes roles assigned to providers when registering for an Optum ID

Provider Role	Definition
Montana Provider Portal Authorized Administrator (Super User)	Assigned to an individual who is completing the provider enrollment on behalf of the individual physician, group or facility. This role can create users, delegate roles, submit provider applications, and perform maintenance on submitted applications.
Montana Provider Portal Delegated Administrator	This user must be added by the Authorized Administrator. The Delegated Administrator role will have access to all Montana Provider Portal functionality except adding and managing users associated to provider portal account.

## Table 5-2: Provider User Roles

# 5.3. Optum

Optum works with the Montana DPHHS Fiscal Agent and providers to manage provider enrollment and claim processing within the state's Medicaid program. Enrollment specialists within the Montana Provider Portal team assist providers with their initial enrollment process while also performing ongoing monitoring and support.

Optum also has teams designed to work with claim submission, program development with their state partners and member enrollment. For provider enrollment, teams have different user levels to assist with the functions of the enrollment portal.

### 5.3.1. Optum User Roles

Table 5-3 describes Optum's user roles.

#### Table 5-3: Optum User Roles

Optum Role	Definition
Optum Provider Enrollment (PE) Admin	The Optum PE Admin will be the first Optum user to register and log in to the Montana Provider Portal. This Individual will have access to all portal functionality (Provider and SMA). This Individual will be the only user role that can add and manage Optum users associated to provider/SMA Enrollment portal account.
Optum PE User	The Optum Admin. must add this user. The SMA User role will have access to all Montana Provider Portal functionality except adding and managing Optum users associated to the portal account.

Appendices

# Appendix A – Acronyms

Acronym	Term
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Center for Medicare & Medicaid Services
DEA	Drug Enforcement Administration
DEAX	Drug Enforcement Administration X (where "X" refers to the certification to prescribe addiction treatment drugs)
DPHHS	Department of Public Health and Human Services
EFT	Electronic Funds Transfer
FEIN	Federal Employer Identification Number
FFS	Fee for Service
GovID	Government Identification
ITIN	Individual Taxpayer Identification Number
HIPAA	Health Insurance Portability and Accountability Act
MPATH	Montana Program for Automating and Transforming Healthcare
NPI	National Provider Identifier
NPPES	National Plan Provider Enumeration System
OMMS	Optum Medicaid Management Services
OPR	Ordering, Prescribing, Referring provider

The following is a list of acronyms used within this document.

Acronym	Term
PE	Provider Enrollment
RP	Referring Provider
SMA	State Medicaid Agency
SSN	Social Security Number
USPS	United States Postal Service

# Appendix B – Glossary

Term	Definition
Children's Health Insurance Program (CHIP)	Low-cost or no-cost health coverage to children (and in some states, pregnant women) in families that earn too much money to qualify for Medicaid.
Clinical Laboratory Improvement Amendments (CLIA)	The Clinical Laboratory Improvement Amendments of 1988 are United States federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research.
Center for Medicare & Medicaid Services (CMS)	A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, CHIP, and health insurance portability standards.
Drug Enforcement Administration (DEA)	A federal law enforcement agency under the United States Department of Justice, tasked with combating drug trafficking and distribution within the United States.
Department of Public Health and Human Services (DPHHS)	A cabinet-level executive branch department of the U.S. federal government with the goal of protecting the health of all Americans and providing essential human services.
Electronic Funds Transfer (EFT)	The electronic transfer of money from one bank account to another, either within a single financial institution or across multiple institutions, via computer-based systems, without the direct intervention of bank staff.
Enrollment Type	Type of provider to include: Sole Practitioner, Rendering non-billing, Ordering Referring non-billing, Organizational-Facility, Organizational- Group, Atypical Individual, and Atypical Organization.
Enumeration Type	Individual (1) or Organization (2)
Individual/Type 1	Sole Proprietor (not an incorporated individual)
Organization/Type 2	These are group health care providers. Organizational providers may have a single employee or thousands of employees

Term	Definition
Atypical	CMS defines atypical providers as providers that do not provide health care (e.g., taxi services, home or vehicle modification or respite services).
Federal Employer Identification Number (FEIN)	A unique nine-digit number assigned by the Internal Revenue Service to business entities operating in the United States for the purposes of identification.
Fee for Service	A payment model where services are unbundled and paid for separately.
Government Identification	State or federally issued identification, typically a driver's license, identity card, Social Security card or passport.
Individual Taxpayer Identification Number (ITIN)	A nine-digit tax processing number only available for certain nonresident and resident aliens, their spouses, and dependents who cannot get a Social Security Number
Legal Entity	An individual, company or organization that has legal rights and obligations.
Montana Program for Automating and Transforming Healthcare (MPATH)	A series of projects to implement modules and services to replace the State's legacy Medicaid Management Information System (MMIS).
Montana Provider Portal	A web portal that provides the tools and resources to help healthcare providers conduct business electronically.
National Provider Identifier	A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services.
National Plan Provider Enumeration System (NPPES)	Provisions intended to improve the efficiency and effectiveness of the electronic transmission of health information. CMS has developed the NPPES system to assign unique identifiers.
Optum Medicaid Management Services	A Software-as-a-Service and Business Process-as-a-Service model that enables Medicaid agencies to purchase only the IT, administrative and clinical services they need to effectively manage their programs.
Provider Portal	A web-based portal available exclusively to healthcare providers, allowing them to conduct business electronically.

Term	Definition
State Medicaid Agency (SMA)	A program that helps with medical costs for some people with limited income and resources.
Subpart	A part of a larger, parent organization. If the subpart conducts any of the HIPAA standard transactions separately from the "parent" it must have its own unique NPI.

# Appendix C – Site Navigation

The following buttons as seen in Appendix Figure 1 can be found throughout the application:

- **Restart Enrollment** does not save the application; takes user back to the beginning of enrollment.
- Save and Exit saves the application and exits.
- **Cancel** does not save the application; cancels the current section. The application will only contain data from the last save.
- **Previous** does not save the application; takes the user to the previous page on the application.
- Save and Continue saves the application and takes the user to the next page on the application.

Restart Enrollment	Save and Exit	Cancel	Previous	Save and Continue

Appendix Figure 1: Navigation Buttons

To stop the application process any time during enrollment, click **Save and Exit**. Any progress completed is saved and available for when the provider logs back into the portal. Refer to Appendix Figure 2.



Appendix Figure 2: Save and Exit

To continue the provider enrollment process, log in to the Montana Provider Portal as indicated in Section 2: Begin Enrollment of this user guide and as follows:

 Select Enrollment from the navigation menu to access the Enrollment Workbench. 2. Select the radio button to update the selected profile and then select the **pencil icon** to continue editing the application. Refer to Appendix Figure 3.

- Enrollment	- Enrollment	Workbench		
Before you begin				
Begin Enrollment			1	
Re-Enrollment	Actions	Туре	Status	Tn
Additional Documents	• • <b>#</b>	Enrollment	InProgress	
Update				
Revalidate				
Disenrollment	- Printable Er	nrollment Form	s	

Appendix Figure 3: Continuing Enrollment Application

# Appendix D – Error Messages

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
Provider Enrollment Workbench					This transaction is currently being updated and cannot be edited. This transaction is currently being updated and cannot be deleted. Requested enrollment do not exist. So, redirecting back to the enrollment workbench; Requested enrollment is not in "In-Progress" state and no modifications are allowed. So, redirecting back to the enrollment workbench; Requested enrollment doesn't belong to this provider. So, redirecting back to the enrollment workbench;
	lf yes, (Begin Enrollment)				Thank you for your time and please click on Begin Enrollment to continue with the enrollment process.
	Enumeration				Please select enumeration.
	Enrollment Type				Please select enrollment type.
	Do you have an FEIN number?				Please select FEIN number option
		Yes			Provider with given Provider ID does not exist
		No			Username already exists. Try with a different username
		If yes,	NPI		Please enter NPI. Entered NPI should be of 10 digits. Invalid NPI entered NPI is already enrolled. Please re-check the entered NPI and click on search button.
			FEIN		Please enter FEIN Please enter FEIN in 9 digits. FEIN is not found There is an existing enrollment already in progress for this FEIN.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
			Confirm NPI		Please enter confirm NPI. Please enter Confirm NPI in 10 digits. NPI and Confirm NPI should be the same.
			Confirm FEIN		Please enter confirm FEIN. Please enter Confirm FEIN in 9 digits. FEIN and Confirm FEIN should be the same.
		lf No,	NPI		Please enter NPI. Invalid NPI entered NPI is already enrolled. Please re-check the entered NPI and click on search button.
			SSN/ITIN		Please enter SSN. Please enter SSN in 9 digits.
			Confirm NPI		Please enter confirm NPI. Please enter Confirm NPI in 10 digits NPI and Confirm NPI should be the same
			Confirm SSN/ITIN		Please enter confirm SSN. Please enter Confirm SSN in 9 digits. SSN and Confirm SSN should be the same.
	Do you have Subparts of the organization sharing this NPI, which are a different Provider Type than the Primary one selected?	Yes			The question related to having subparts of the organization must be answered Subparts Response Change
	lf Yes, Add (Multiple)	Type of Provider Name			Provider type selection is required Type of provider is required There must be more than one type of provider selected when the answer is yes to the question related to subparts of the organization
		Effective Date			Effective Date is required Effective date cannot be less than Terminate date

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Terminate Date			Terminate Date is required (Note: This is only if required on UI)
	Specialties				Provider must add at least one Specialty at the Practice Information
	Add	Provider Type			Please select provider type
		Specialty Name			Please select specialty type Specialty is required A specialty must be added for each provider type selected
		Primary Specialty			At least one primary specialty is required
		Effective Date			Effective Date is required
		Terminate Date			Terminate Date is required for specialty (Note: This is only if required on UI) Termination Date cannot be less than Effective Date
		Actions			Changing this data field can impact subsequent data which has already been, collected due to different requirements, (i.e., removal of sub-specialties, data at address level, other data etc.). Would you like to continue?
		Subspecialty			
		Add	Subspecialty Name		Please select subspecialty type
		Specialty			Effective Date is required for specialty
	PCP Number				PCP is required
	State Programs				Provider must add at least one Program at the Practice Information At least one state program must be selected Programs updated successfully
	Add,	Program Name			Program name is required Please enter valid value in Program Name field

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Requested Date			Requested Date is required Requested date for Medicaid state program is required Requested date for CHIP state program is required
		Termination Date			Terminate Date cannot be before Effective Date Terminate date cannot be less than Requested date
		Document/ Mail in			Please upload the document Document description is required Document type is required Please enter valid value in Document Description field File uploaded successfully File upload failed Failed to upload file File upload is in progress Please upload a file of size within 2MB File is successfully uploaded Please refer below rules for uploading documents Requested file did not get uploaded successfully, please remove and upload the file once again Uploading Documents Uploading Document Error in removing file, document is attached to some other program No document uploaded Document have not been uploaded for required supporting document row
	Waiver Programs				Provider must add at least one Program at the Practice Information At least one state program must be selected Programs updated successfully
	Add	Waiver Programs Name			Please select a waiver program
		Requested Date			Requested Date is required
		Termination Date			Terminate Date cannot be before Effective Date Terminate date cannot be less than Requested date

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Document/ Mail in			Requested Date is required Requested date for Medicaid state program is required Requested date for CHIP state program is required
	Legal Entity Address	Address Line 1			Address 1 is required.
		City			City is required.
		State			State is required.
		ZIP Code			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		County			County is required.
		Email			Email address is required. Email address is invalid.
		Confirm Email			Email ids are not matching.
		Phone Number			Phone number is required. Phone Number must be of 10 digits.
		Fax Number			Fax Number must be of 10 digits.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
		First Name			First Name is required
		Middle Name			Please enter proper middle initial
		Last Name			Last Name is required
		Are you a U.S Citizen?	Yes		Citizen is required.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Add Corporate Business License			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
		Address Line 1			Address 1 is required.
		City			City is required.
		State			State is required.
		ZIP Code			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		County			County is required.
		Email			Email address is required. Email address is invalid.
		Re-enter Email			Email ids are not matching.
		Phone Number			Phone number is required. Phone Number must be of 10 digits.
		Fax Number			Fax Number must be of 10 digits.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
		Fax Number			Fax Number must be of 10 digits.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
Ownership					Error in saving ownership
	If Yes, ADD	First Name			First Name is required
Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
------------------------	------------------------	------------------------	------------------------	------------------------	--
		M.I.:			Please enter proper middle initial
		Last Name			Last Name is required
		Date of Birth			Date of Birth is required
		Address Line 1			Address 1 is required.
		City			City is required.
		State			State is required.
		ZIP			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		County			County is required.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
		First Name			First Name is required
		Middle Name			Please enter proper middle initial
		Last Name			Last Name is required
		DOB			Date of Birth is required
		Select one	Agent		Please assign the role for the contact as Agent/Officer/Director/Board Member
		Begin Date			Begin Date is required
		Termination Date			Terminate Date cannot be before the begin date
			SSN#		SSN is required SSN must be 9 digits

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
			ITIN#		ITIN is required SSN/ITIN must be 9 digits
		Address Line 1			Address 1 is required.
		City			City is required.
		State			State is required.
		ZIP			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		County			County is required.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
		Conviction	Yes		Conviction is required
		lf Yes,	Conviction Details		Conviction Details are required
		First Name			First Name is required
		Middle Name			Please enter proper middle initial
		Last Name			Last Name is required
		DOB			Date of Birth is required
		Begin Date			Begin Date is required
		Termination Date			Terminate Date cannot be before the begin date
			SSN#		Please enter SSN. Please enter SSN in 9 digits.
			ITIN#		ITIN is required SSN/ITIN must be 9 digits

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Address Line 1			Address 1 is required.
		City			City is required.
		State			State is required.
		ZIP			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		County			County is required.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
		Conviction	Yes		Conviction is required
		If Yes,	Conviction Details		Conviction Details are required
	Managing Relationship				Error in saving managing relationships
	Sub- Contractor				Error in saving subcontractor
			First Name		First Name is required
			Middle Name		Please enter proper middle initial
			Last Name		Last Name is required
			Transaction Date		Transaction Date is required
			Address Line 1		Address 1 is required.
			City		City is required.
			State		State is required.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
			ZIP		ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
			County		County is required.
			Validate Address		Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
			Business Name		Business Name is required
			Transaction Date		Transaction Date is required
			Address Line 1		Address 1 is required.
			City		City is required.
			State		State is required.
			ZIP		ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
			County		County is required.
			Validate Address		Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
	Business Transaction				Error in saving business transactions
			First Name		First Name is required
			Middle Name		Please enter proper middle initial
			Last Name		Last Name is required

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
			Transaction Date		Transaction Date is required
			Transaction Details		Transaction Details are required
			Address Line 1		Address 1 is required.
			City		City is required.
			State		State is required.
			ZIP		ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
			County		County is required.
			Validate Address		Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
		Business Name			Business Name is required
			Business Name		Business Name is required
			Transaction Date		Transaction Date is required
			Transaction Details		Transaction Details are required
			Address Line 1		Address 1 is required.
			City		City is required.
			State		State is required.
			ZIP		ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
			County		County is required.
			Validate Address		Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
	Controlling Interest				Error in saving Controlling Interest
	lf yes, ADD	Business Name			Please enter Business Name
		Federal Tax ID			Please enter FEIN FEIN must be of 9 digits
			Medicaid ID #		Please enter Medicaid Id Medicaid ID must be 9 digits
			NPI #		Please enter NPI Id NPI ID must be 10 digits
		Address Line 1			Address 1 is required.
		City			City is required.
		State			State is required.
		ZIP			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		County			County is required.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
Medicare and Medicaid					Error in saving Medicaid

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
	Have you ever been enrolled in Medicare?				Medicare: Please select an option.
	lf Yes,	Medicare Status			Medicare Status is required.
		Medicare ID			Medicare ID is required.
		Enrollment Date			Enrollment Date is required.
		Inactive Date			Inactive date is required. Inactive Date cannot be lesser than Enrollment Date.
	lf Yes,	Fee payment Date			Last Fee Payment date is required.
		Document (Medicare Fee Receipt)			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
	If No,	Have you ever been enrolled in Medicaid/ CHIP in any state?	Yes		Medicaid: Please select an option.
		lf Yes, Add Past Enrollment	Medicaid Status		Please add a past enrollment.
				Document Type (Medicare Fee Receipt)	Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
	If Yes, Add (Multiple)	Hospital Name			The Hospital Privileges for this Hospital already exist. The dates entered overlap another entry for this Hospital.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		NPI			This Hospital NPI cannot be found in our records Hospital NPI is required
		Effective Date			Effective Date is required
		Termination Date			Terminate Date is required (Note: This is only if required on UI) Terminate Date cannot be before Effective Date
		Upload Document			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
			Effective Date		Effective Date is required
			Terminate Date		Terminate Date is required (Note: This is only if required on UI) Terminate Date cannot be before Effective Date
			Upload Document		Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
			Effective Date		Effective Date is required
			Terminate Date		Terminate Date is required (Note: This is only if required on UI) Terminate Date cannot be before Effective Date
			Upload Document		Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
	Add	License#			License License#: Enter only numbers License# is required `License \$CredentialScreenConstants.VALUE_DOES _NOT_MATCH_WITH_THE_FORMAT`,
		State			CredentialScreenConstants.STATE
		Effective Date			CredentialScreenConstants.EFFECTIVE_DATE

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Expiration Date			CredentialScreenConstants.EXPIRATION_DATE ErrorMessages.EXPIRY_NOT_LESS_EFFECTIVE _ERROR
		Issuing Party Identifier			CredentialScreenConstants.ISSUING_PARTY _IDENTIFIER `Issuing Party Identifier \$CredentialScreenConstants.VALUE_DOES_NOT _MATCH_WITH_THE_FORMAT`
		Upload Document			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
		Action			Certification
	Add	Certification#			Certification# Enter only numbers Certification# is required `Certification\$CredentialScreenConstants.VALUE _DOES_NOT_MATCH_WITH_THE_FORMAT`,
		State			CredentialScreenConstants.STATE
		Effective Date			CredentialScreenConstants.EFFECTIVE_DATE
		Expiration Date			CredentialScreenConstants.EXPIRATION_DATE ErrorMessages.EXPIRY_NOT_LESS_EFFECTIVE _ERROR
		Issuing Party Identifier			CredentialScreenConstants.ISSUING_PARTY _IDENTIFIER `Issuing Party Identifier \$CredentialScreenConstants.VALUE_DOES_NOT _MATCH_WITH_THE_FORMAT`
		Upload Document			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
	Board Certifications				Board Certification

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
	Add	Certification#			Board certification# Enter only numbers Board certification# is required `Board Certification\$CredentialScreenConstants. VALUE_DOES_NOT_MATCH_WITH_THE _FORMAT`,
		State			CredentialScreenConstants.STATE
		Effective Date			CredentialScreenConstants.EFFECTIVE_DATE
		Expiration Date			CredentialScreenConstants.EXPIRATION_DATE ErrorMessages.EXPIRY_NOT_LESS_EFFECTIVE _ERROR
		Issuing Party Identifier			CredentialScreenConstants.ISSUING_PARTY _IDENTIFIER `Issuing Party Identifier \$CredentialScreenConstants.VALUE_DOES _NOT_MATCH_WITH_THE_FORMAT`
		Upload Document			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
	Accreditations				Accreditation
	Add	Accreditation#			Accreditation# Enter only numbers Accreditation# is required `Accrediation\$CredentialScreenConstants. VALUE_DOES_NOT_MATCH_WITH_THE _FORMAT`,
		State			CredentialScreenConstants.STATE
		Effective Date			CredentialScreenConstants.EFFECTIVE_DATE
		Expiration Date			CredentialScreenConstants.EXPIRATION_DATE ErrorMessages.EXPIRY_NOT_LESS _EFFECTIVE_ERROR

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Accrediting Organization			CredentialScreenConstants.ISSUING_PARTY _IDENTIFIER `Accrediting Organization \$CredentialScreenConstants.VALUE_DOES _NOT_MATCH_WITH_THE_FORMAT`
		Upload Document			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
Financial Information					Error in saving financial information
Insurance					Error in saving insurance
	Add	Insurance Company			Name of insurance company is required
		Agent Name			Insurance agents name is required
		Contact Number			Phone number is required. Phone number must be of 10 digits.
		Action			Error in saving policy
	Add	Policy Type			Policy Type is required
		Policy Number			Policy number is required Please enter valid policy number
		Terminate Date			Terminate Date cannot be less than Effective Date
		Upload Document			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
Banking					Prefer Electronic Funds Transfer for Reimbursement is required. Error in saving banking Financial Institution Routing Number and Re-enter Financial Institution Routing Number doesn't match

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
	Type of Account	Current			Type of Account is required.
	If Current or Saving,	Financial Institution Routing Number			Financial Institution Routing Number is required. Financial Institution Routing Number must be exactly 9 digits long
		Reenter Financial Institution Routing Number			Re-enter Financial Institution Routing Number is required.
		Account Number			Account Number is required. Account number must be of minimum 5 digits.
		Re-enter Account Number			Re-enter Account Number is required. Account Number and Re-enter Account Number doesn't match. Re-enter account number must be of minimum 5 digits.
		Account Holder Name			Account Holder Name is required.
		Financial Institution Name			Financial Institution Name is required.
		Address Line 1			Address is required.
		City			City is required.
		State			State is required.
		ZIP			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		Phone Number			Phone number is required. Phone number must be of 10 digits.
		Fax Number			Fax Number must be of 10 digits.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
		Upload Document			Error Message same as listed in State Program field- Line item 81
Physical Location					Error in saving physical location
Location					Error in getting Physical Location Error exists for location Please select at least one location Error in deleting location
ADD,	Service Location Name				Service Location is required
	Physical Practice Location Address 1				Address 1 is required.
	Termination Date				Terminate Date is required (Note: This is only if required on UI)
	City				City is required.
	State				State is required.
	ZIP Code				ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
	County				County is required.
	Phone Number				Phone number is required. Phone number must be of 10 digits.
	Fax Number				Fax Number must be of 10 digits.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
	Validate Address				The Physical Location Address must be validated. Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
	Website				Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
		Upload Document			Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
	Based on the date this application is being submitted, has this service location had an approved site visit conducted by another State's Medicaid or CHIP Agency?				Site Visit question is required
	lf yes,	State of Visit			State of Visit is required
		Date of Visit			Date of Visit is required
	Specialty Workbench				Provider must select at least one Specialty at the Physical Location level
	Program Workbench				Provider must select at least one Program at the Physical Location level
Location Workbench	ID				Error in deleting location Location has been deleted successfully This location has an affiliation associated with it. Please remove the affiliation before removing this location from the enrollment application

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Add	First Name		Error in saving contact
			Term Date		Term Date is required (Note: This is only if required on UI)
			Phone Number		Phone number is required. Phone number must be of 10 digits.
			Fax Number		Fax Number must be of 10 digits.
			Validate Address		Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address
			Contact Email Address		Email address is required. Email address is invalid.
			Re-enter Email Address		Email ids are not matching.
			Phone Number		Phone number is required. Phone number must be of 10 digits.
		Monday	TO & FROM TO & FROM		Please enter a valid Morning Start Time and Evening End Time for Please enter a valid Morning Start Time and Morning End Time for Please enter a valid Morning End Time and Evening Start Time for Please enter a valid Evening Start Time and Evening End Time for Please enter valid office hours in military time format for the highlighted fields
	Search for Provider				Search Failed Already Affiliated No affiliate found for given search parameters
		First Name			Enter First name or Last name or NPI for searching
		Last Name			

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		NPI/atypical ID			Enter valid NPI/Atypical ID
	Requested Affiliations				Request for affiliations failed Request for affiliation failed as SSN/ITIN entered does not match SSN/ITIN for NPI requested
		NPI			Enter valid NPI/Atypical ID
		NPI			npi => `Do you want to deactivate the affiliation for the NPI
	Assign Programs to provider for Location	Program Name			Provider must select at least one Program at the Physical Location level
Final Submission					Error in saving final submission
	Are you signing electronically?	Yes			Electronic signature of provider is required. You must sign the terms and agreement Signature Done Successfully
	Document Upload				Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required Please contact SMA for getting the Terms and Conditions document Please upload signed Terms and Agreement document(s) or select Other to mail or fax documents in.
	Upload W-9 form				Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required
	Upload Document				Requested Date is required; Requested date for Medicaid state program is Required; Requested date for CHIP state program is required

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
	Pay Fee (Selection redirects to Vendor portal)				You will be redirected to a third party website. Please do not close this window, refresh the page, or click the browsers back button. As a result, you may have to log back into the application. Fee Collection Confirmation
FEIN Management					FEIN updated successfully FEIN Deactivation successfully
	Legal Entity Name				Legal Entity Name is required.
	Federal TAX ID				Federal Tax ID is required.
	Type of Business Entity				Type of Business Entity is required.
	Business Entity Profit Status				Business Entity Profit Status is required. Status is required.
	Effective Date				Effective Date is required
	Terminate Date				Terminate Date is required (Note: This is only if required on UI) Terminate Date cannot be before Effective Date
		Address Line 1			Address 1 is required.
		City			City is required.
		State			State is required.
		ZIP Code			ZIP Code is required. ZIP Code must be in a 5 or 9 digit format.
		County			County is required.
		Email			Email address is required. Email address is invalid.

Provider UI Field 1	Provider UI Field 2	Provider UI Field 3	Provider UI Field 4	Provider UI Field 5	Error Messages
		Re-enter Email			Email ids are not matching.
		Phone Number			Phone number is required. Phone number must be of 10 digits.
		Fax Number			Fax Number must be of 10 digits.
		Validate Address			Address Validation Unsuccessful Not selecting the suggested USPS validated address can result in a negative impact on other functionalities which may require a validated address

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