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: https://mtdphhs-provider.optum.com

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.

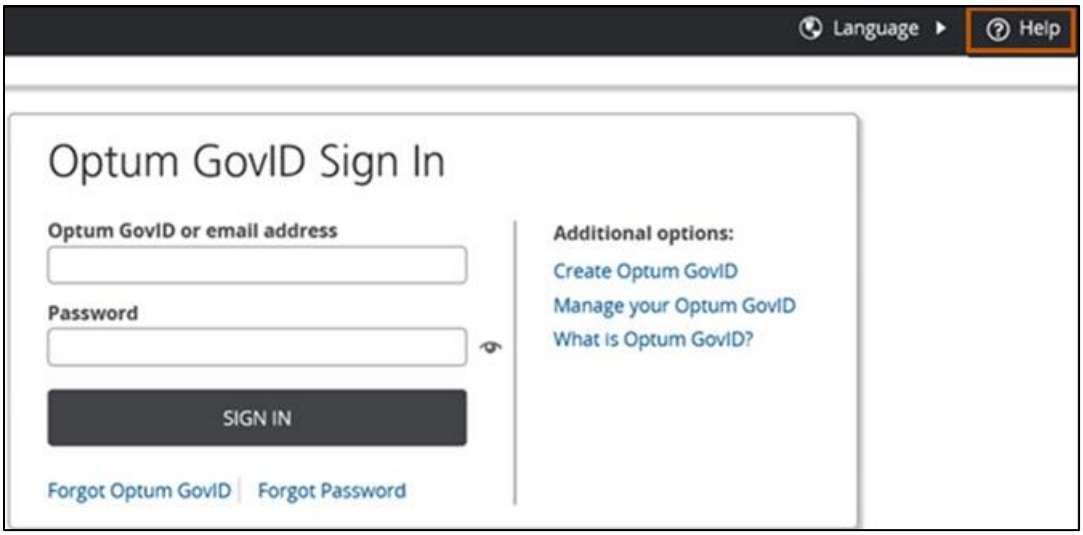


Figure 1-1: Help Icon on the GovID Sign In Page

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.

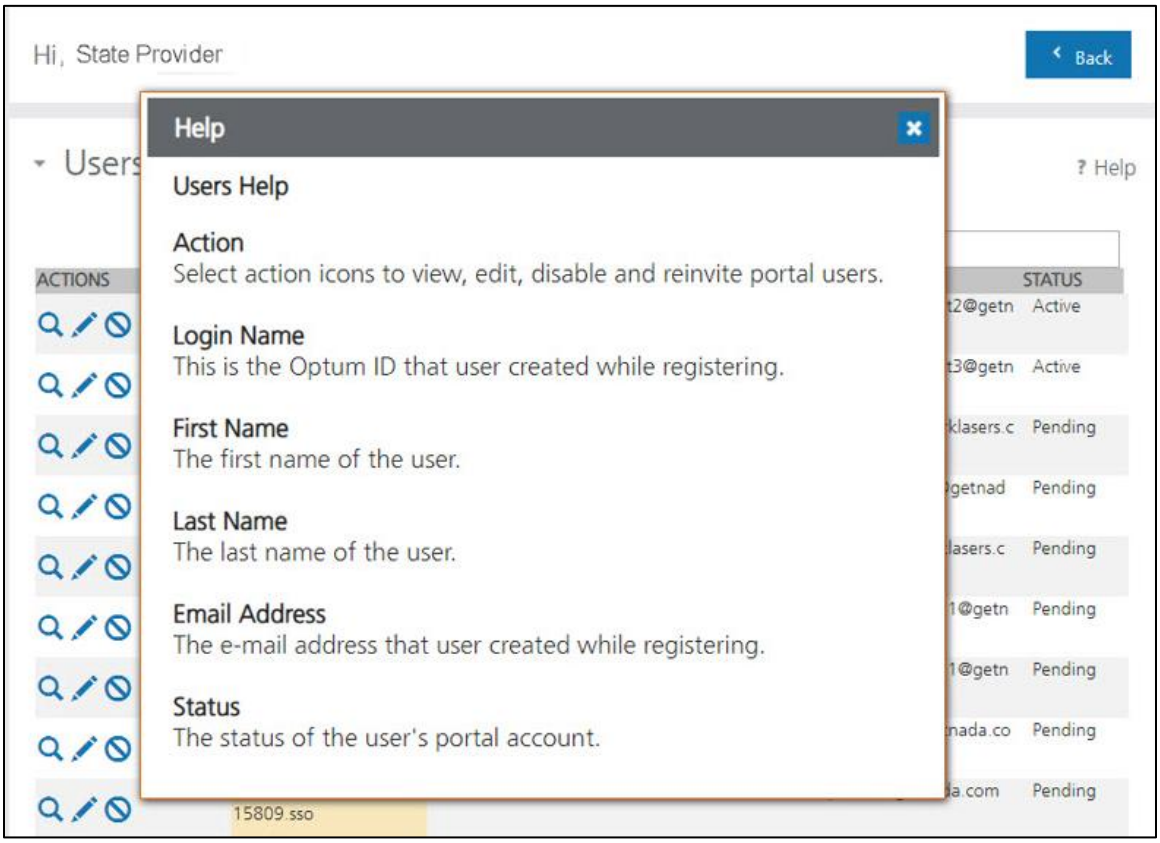


Figure 1-4: User Search Help Text

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.

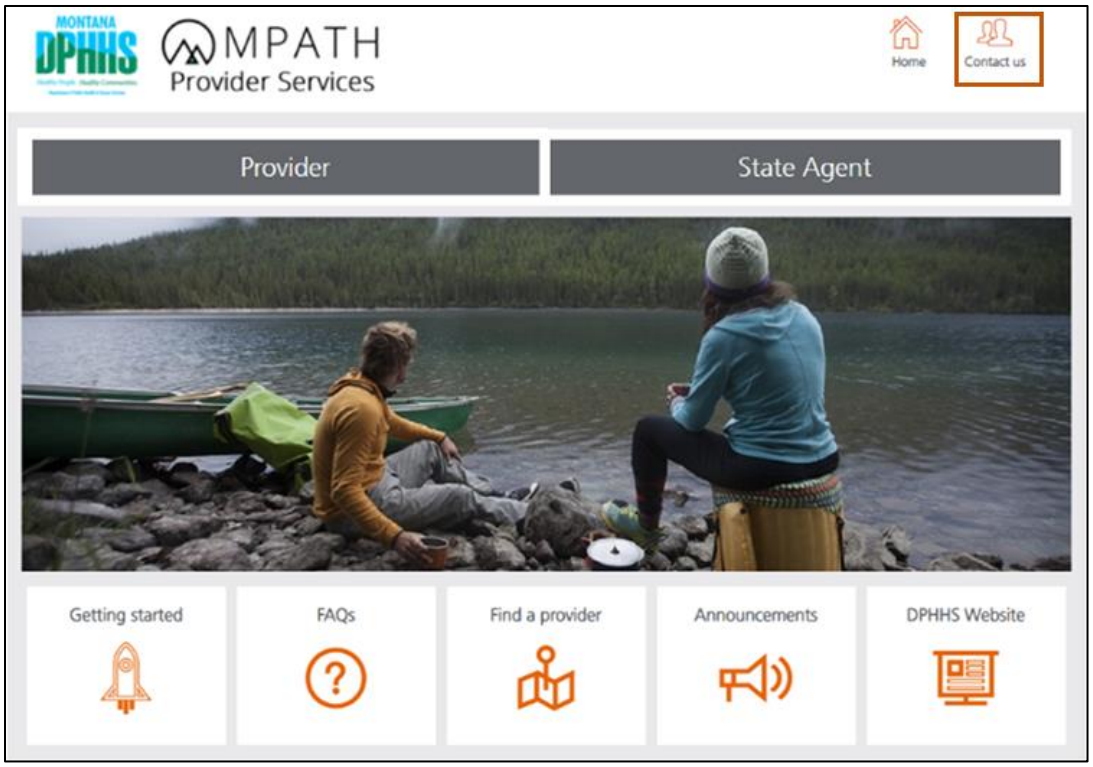


Figure 1-5: Contact Us Icon on the Homepage

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.

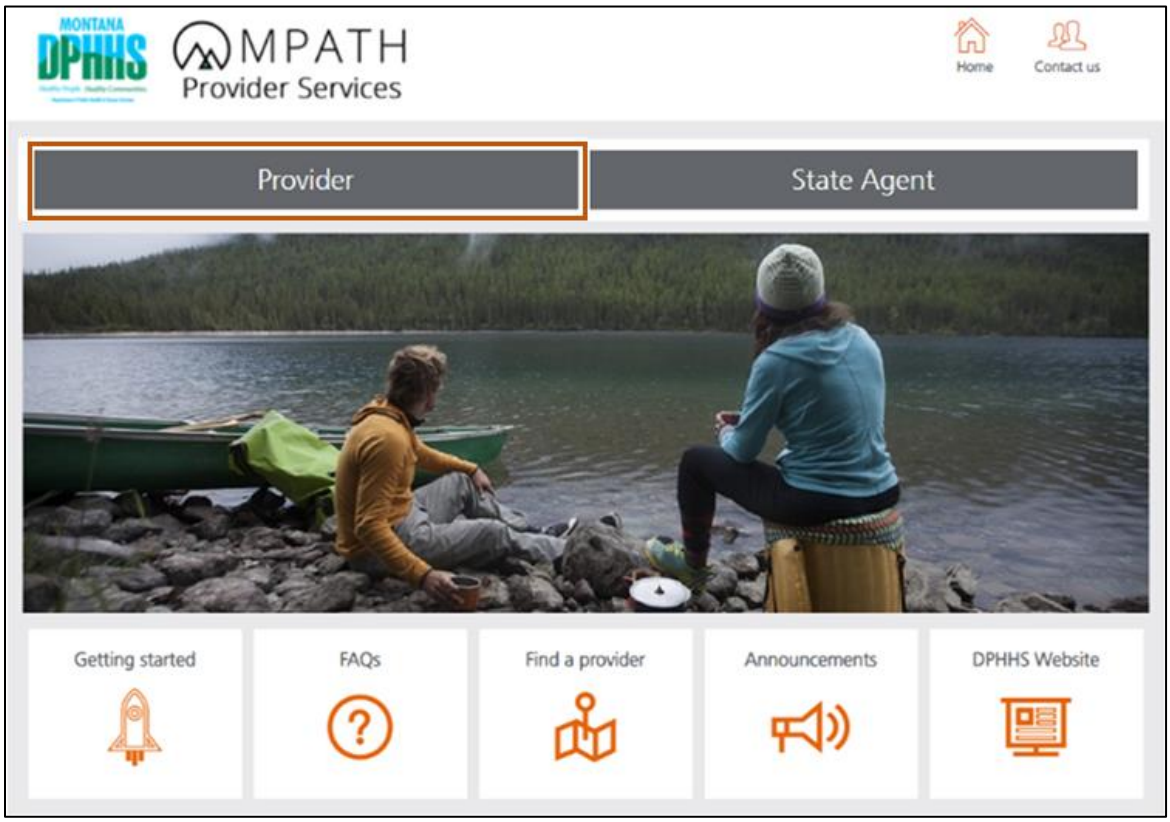


Figure 2-1: Montana Provider Portal Homepage

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.

Figure 2-3: Optum GovID Sign In

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

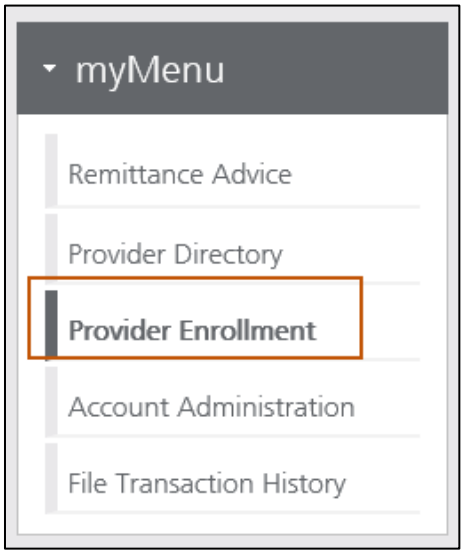


Figure 2-4: Provider Enrollment in myMenu

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.

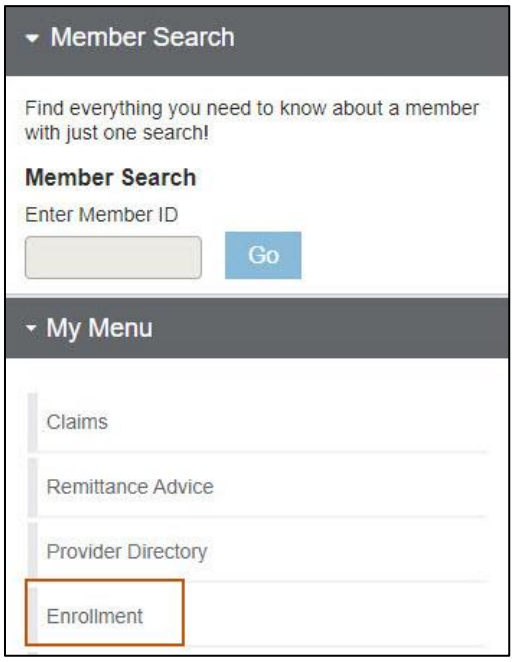


Figure 2-5: Enrollment Option

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

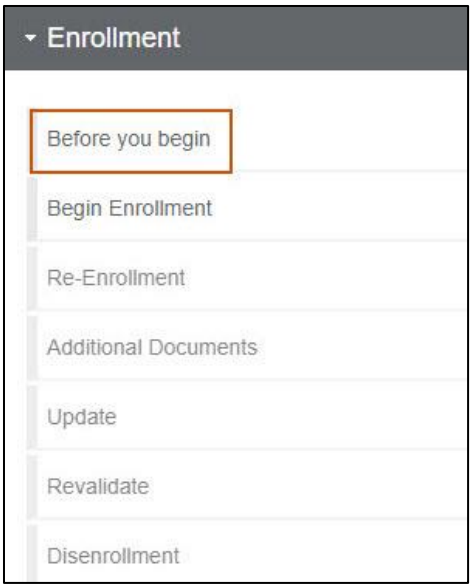


Figure 2-6: Before You Begin

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

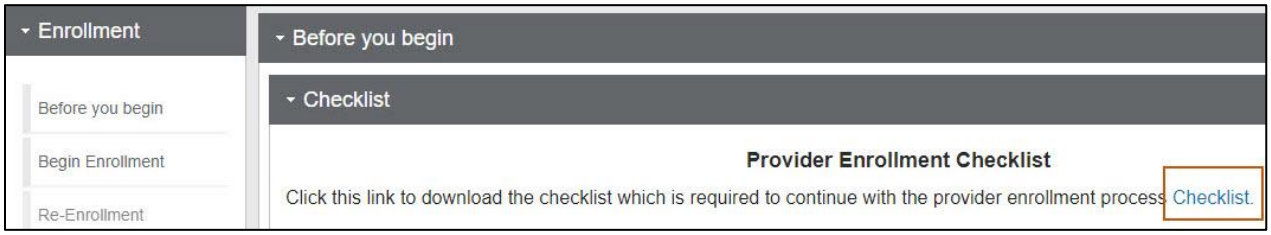
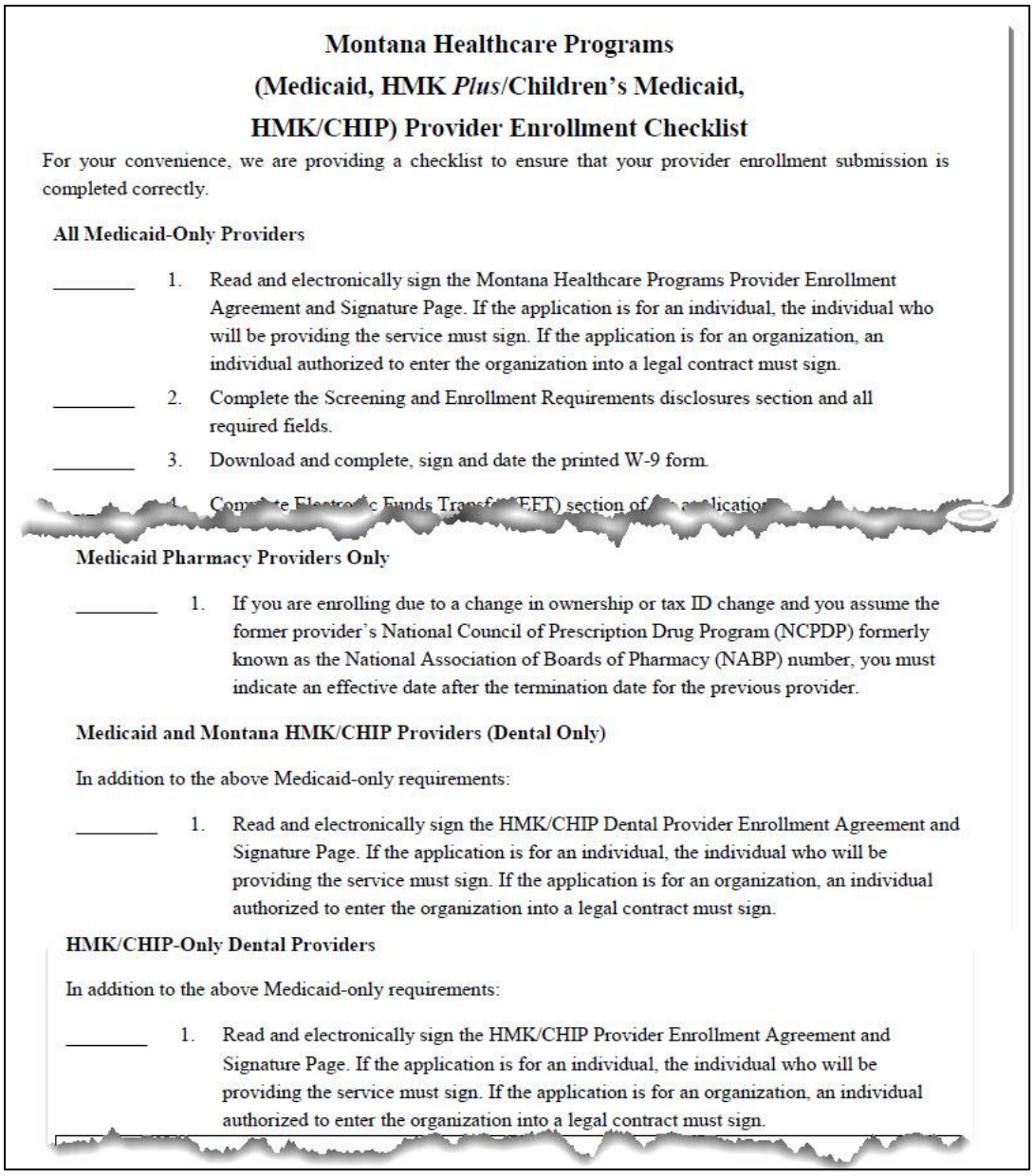


Figure 2-7: Review the Checklist

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

For your convenience, we are providing a checklist to ensure that your provider enrollment submission is completed correctly.

All Medicaid-Only 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.

_____ 4. Complete Electronic Funds Transfer (EFT) section of the application.

Medicaid Pharmacy Providers Only

_____ 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.

Medicaid and Montana HMK/CHIP Providers (Dental Only)

In addition to the above Medicaid-only requirements:

_____ 1. 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.

HMK/CHIP-Only Dental Providers

In addition to the above Medicaid-only requirements:

_____ 1. 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 authorized to enter the organization into a legal contract must sign.

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.

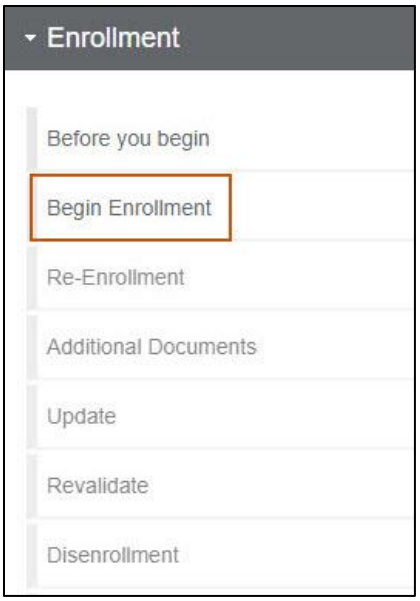


Figure 2-9: Begin Enrollment

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**.

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

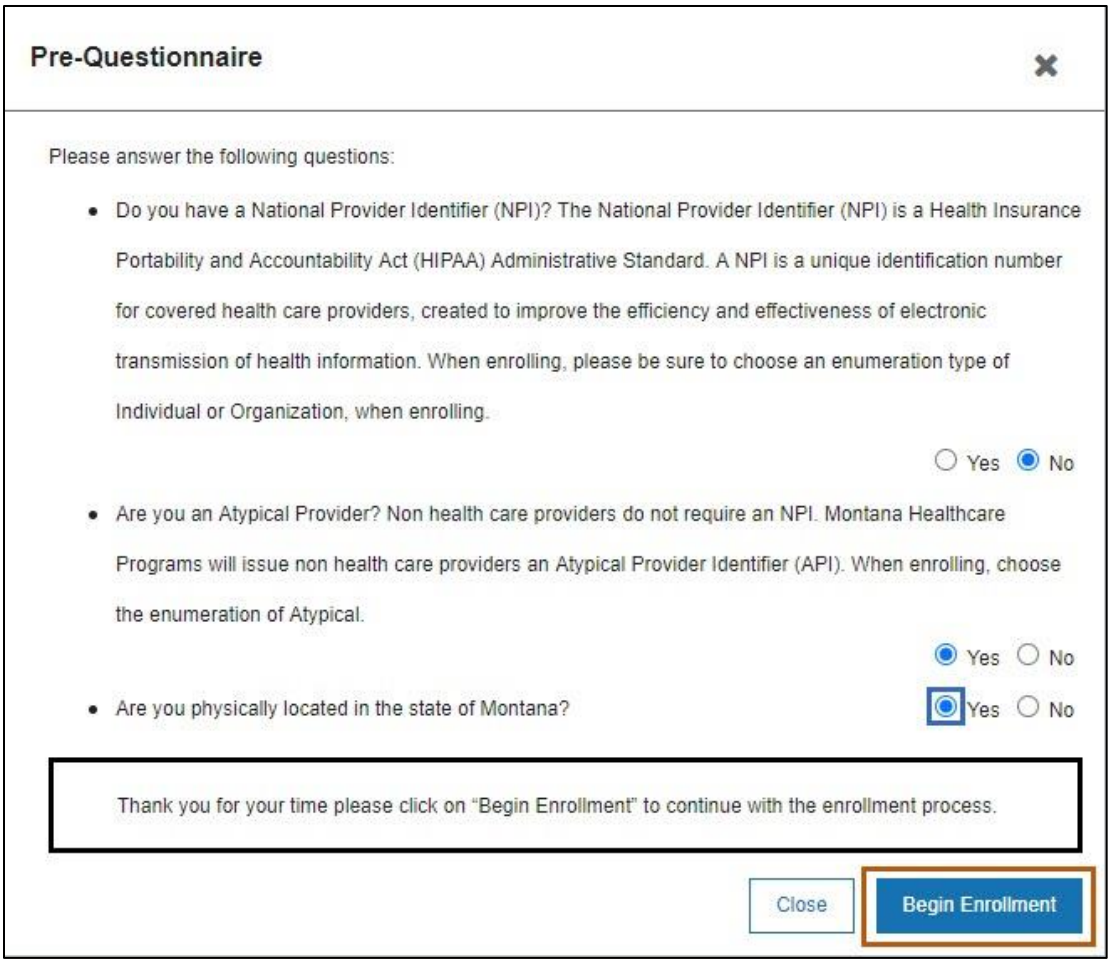


Figure 2-10: Pre-questionnaire

2. Read the Terms and Conditions that display.

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

Figure 2-11: Terms and Conditions

The Pre-Enrollment pop-up screen opens. All providers are presented with pre-enrollment 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.

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

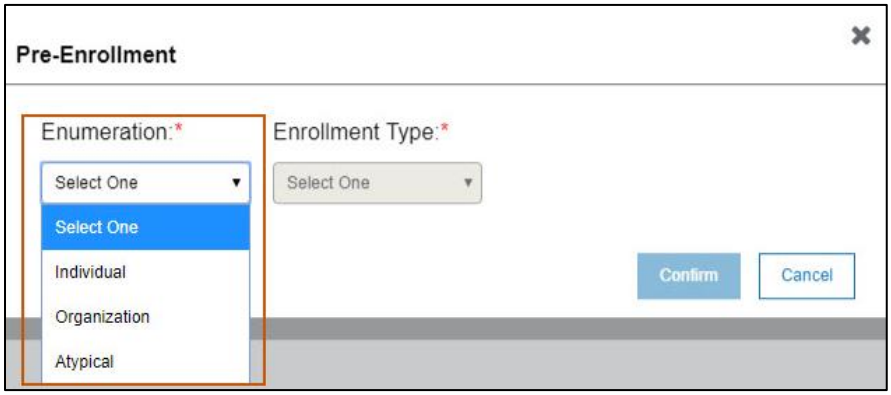


Figure 2-12: Enumeration Types

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 Type Associations

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.

3. 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.

4. 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.**

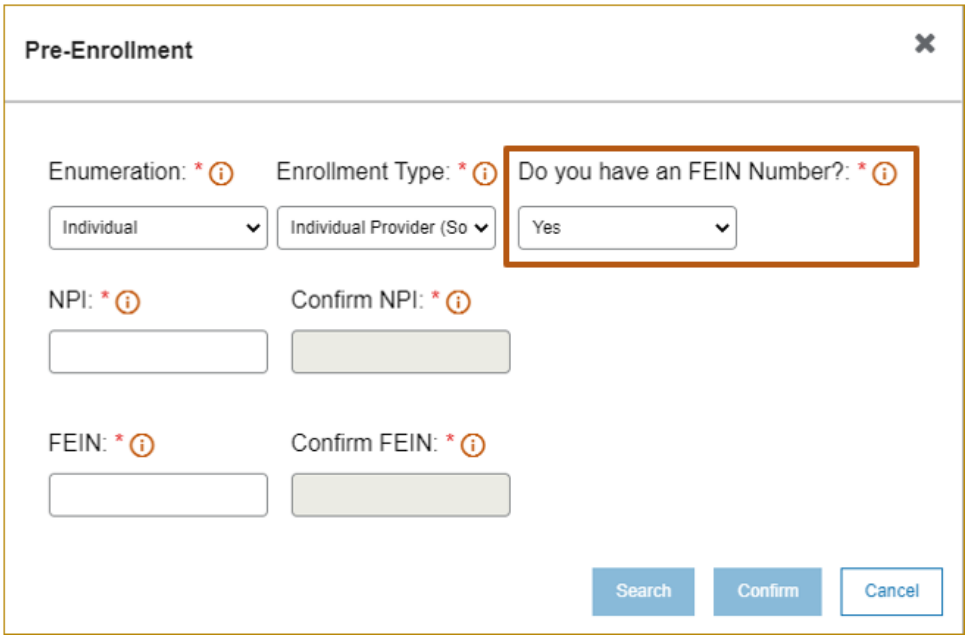


Figure 2-13: Yes to FEIN Number

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.

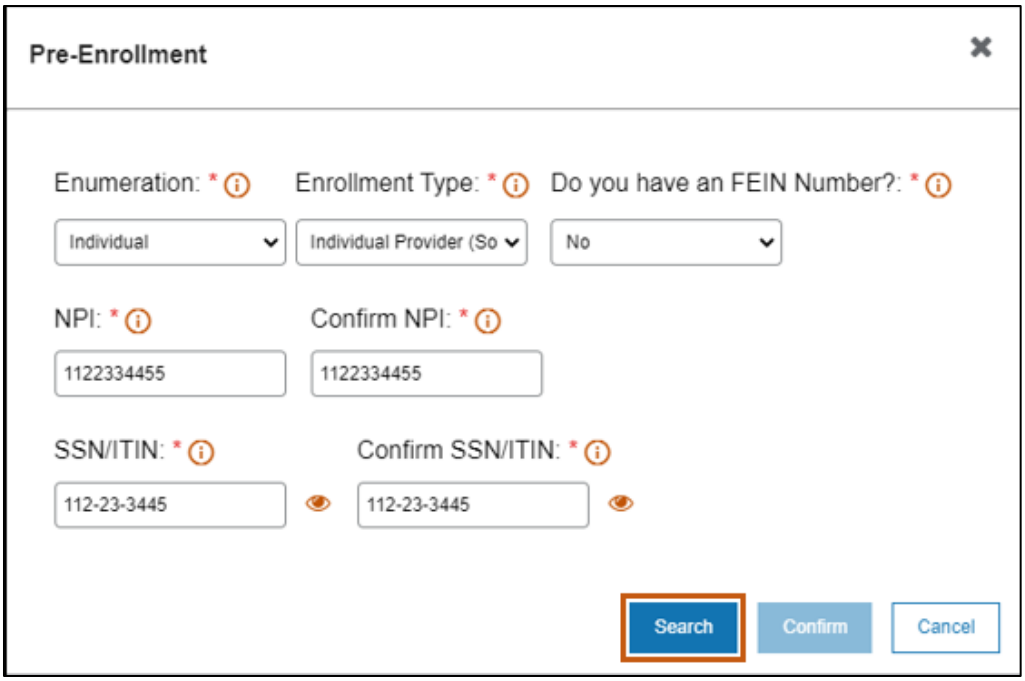


Figure 2-14: Pre-Enrollment Search

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.

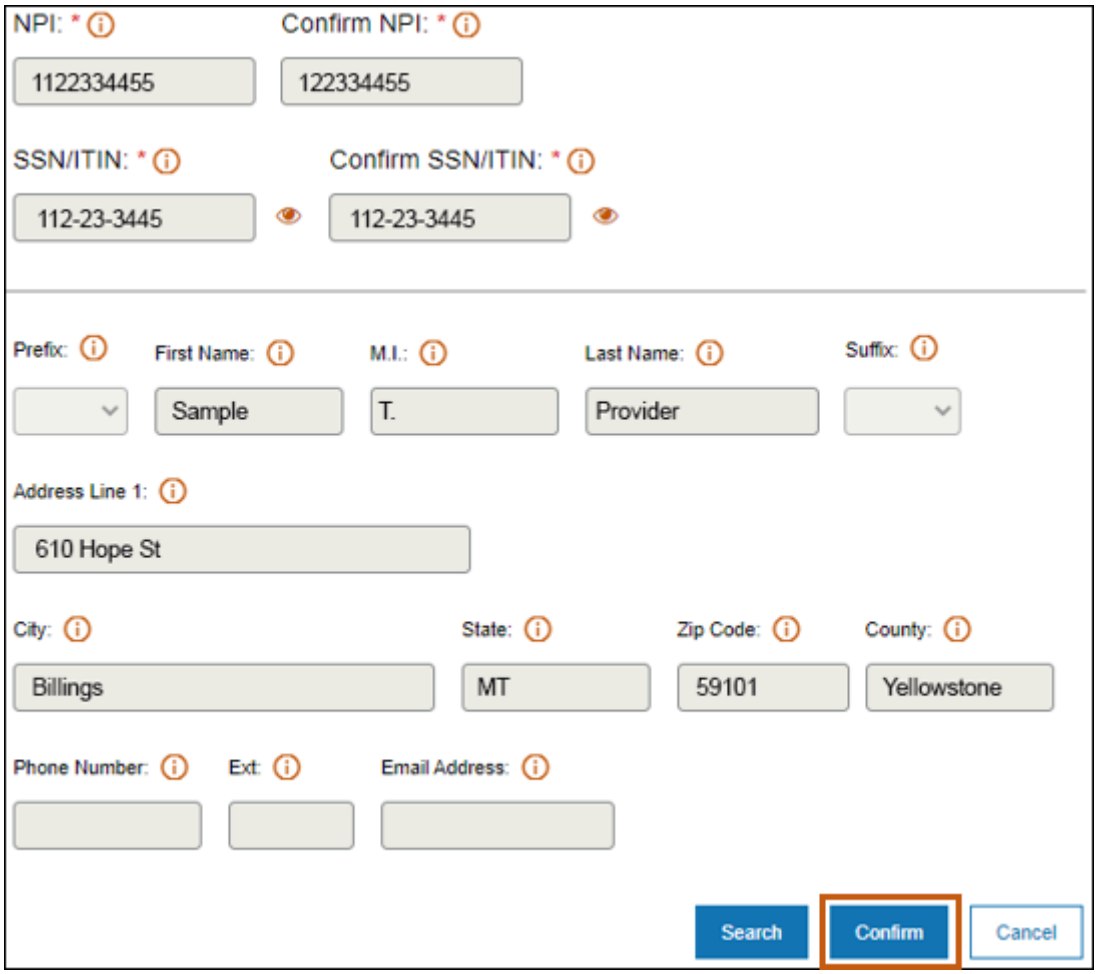


Figure 2-15: Data Pre-Populates

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.

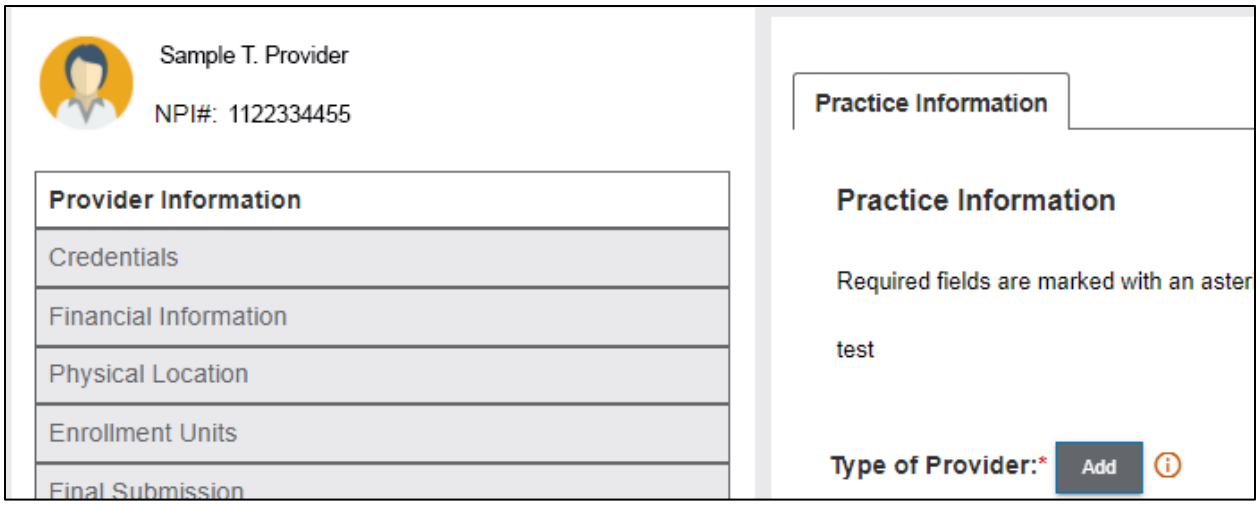


Figure 2-16: Provider Information Page Redirect

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.

Table 3-1: Application Page Name and Provider Type

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)

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.

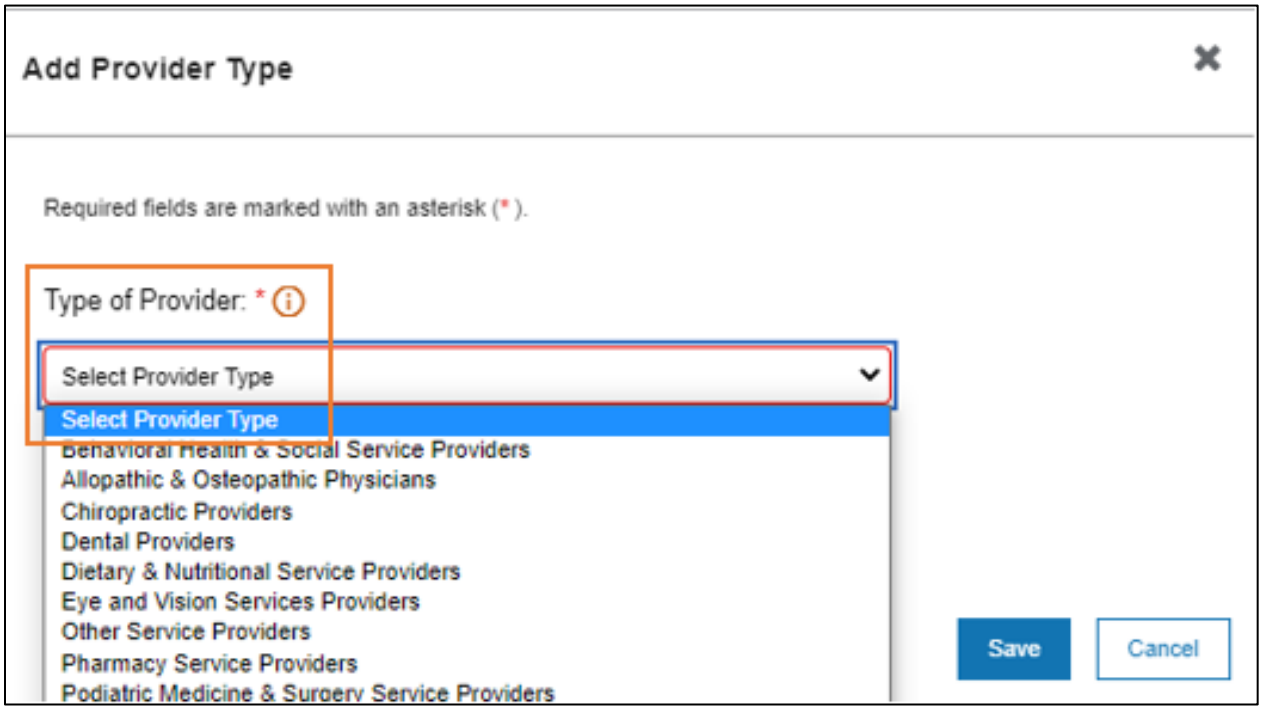


Figure 3-1: Select Type of Provider

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

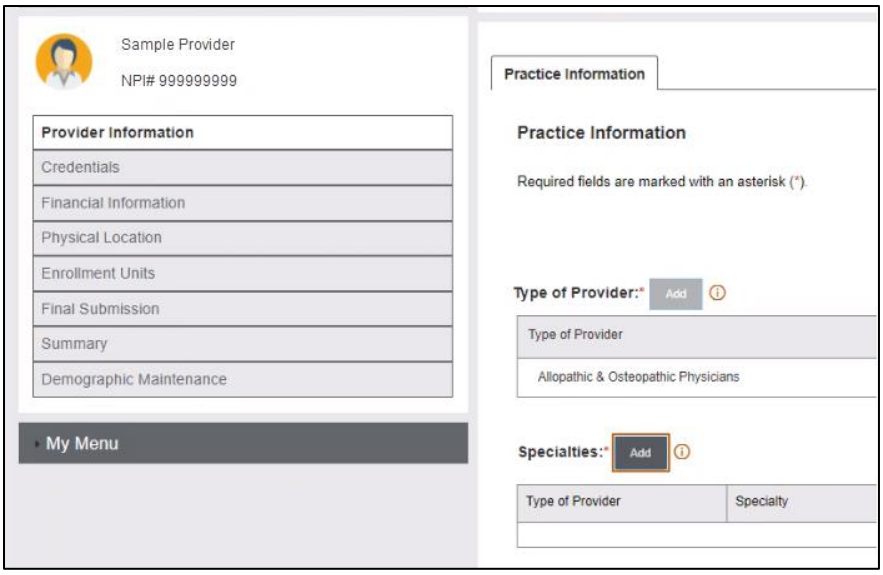


Figure 3-2: Add Specialties

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.

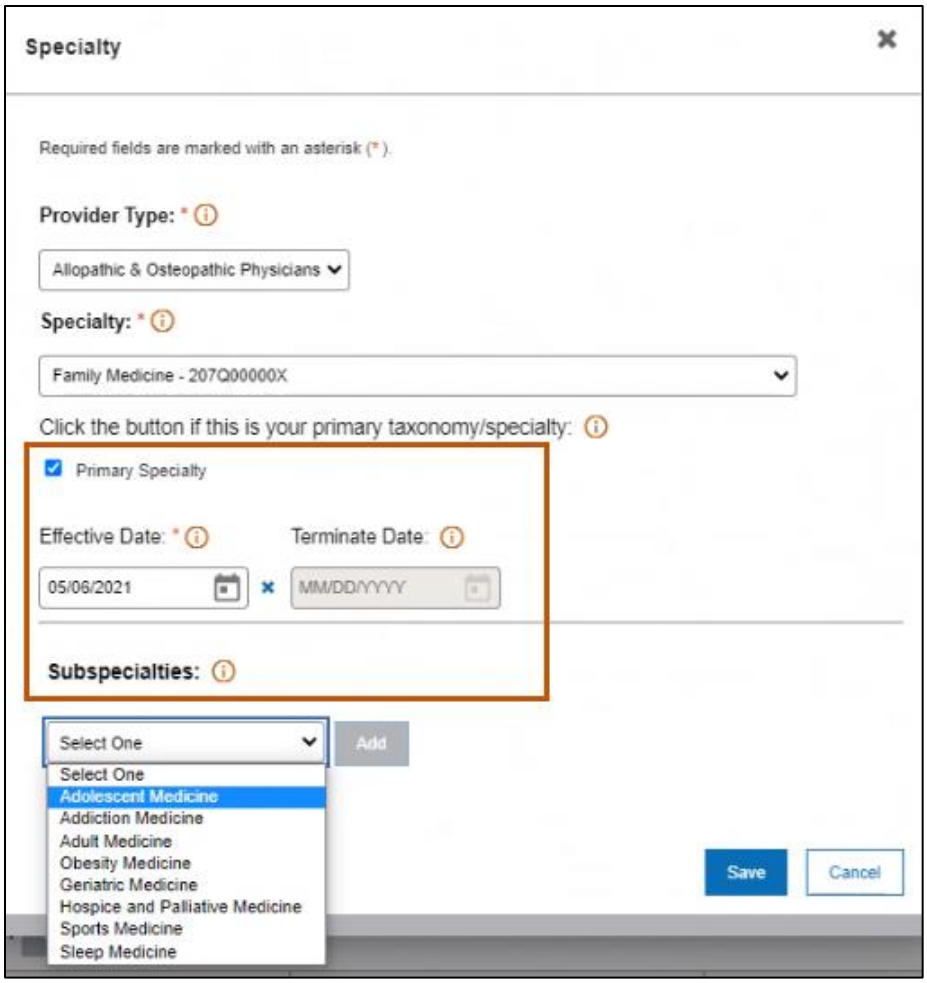


Figure 3-3: Add Specialties

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.

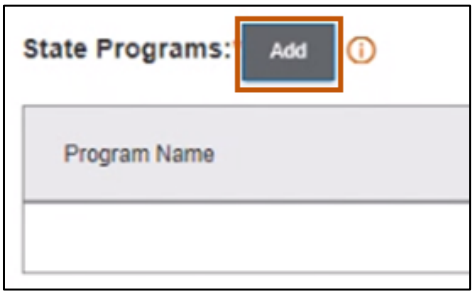


Figure 3-4: Add Button

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

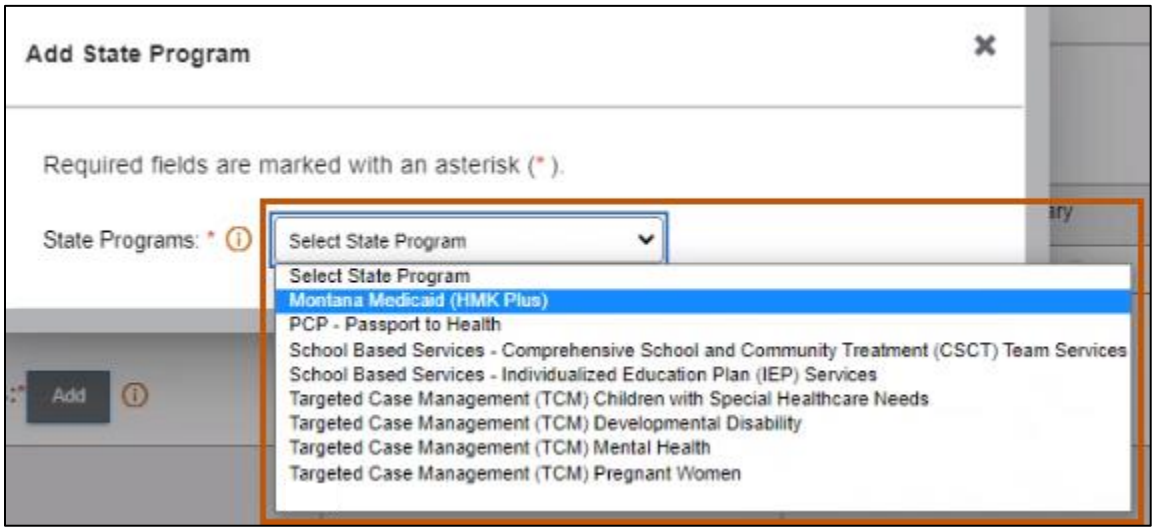


Figure 3-5: Select State Program

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

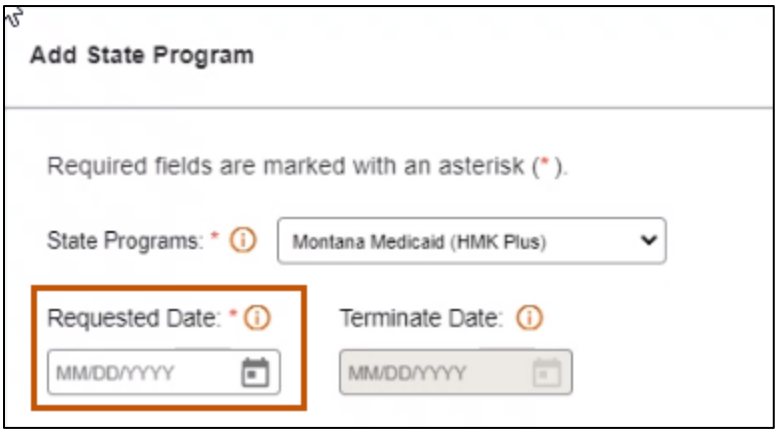


Figure 3-6: Requested Date for State Program

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**.

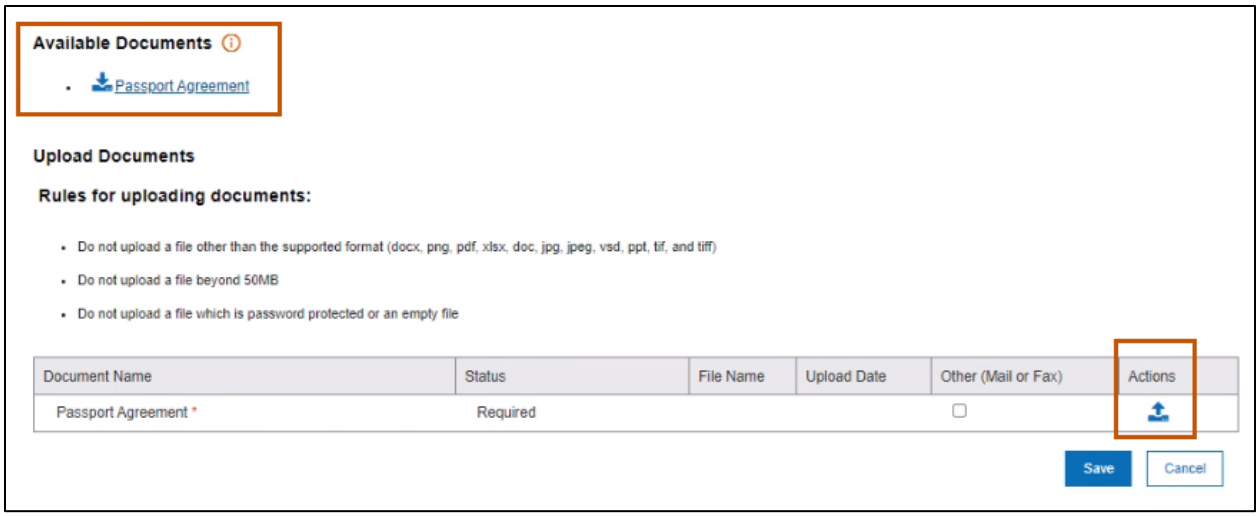


Figure 3-7: Upload Documents

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.

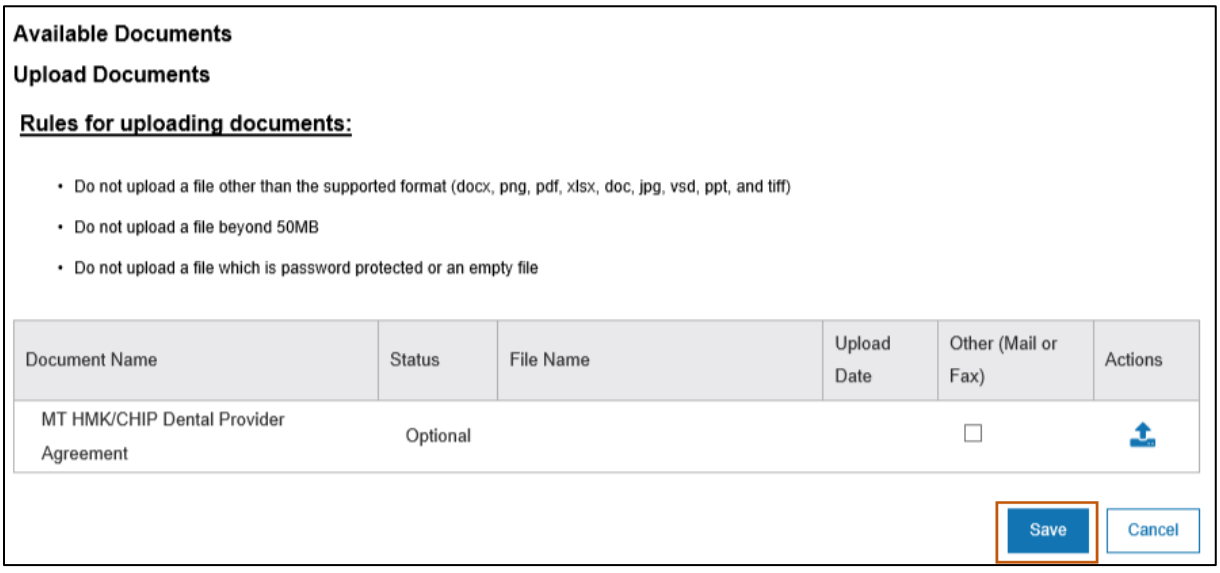


Figure 3-8: Save Button

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.

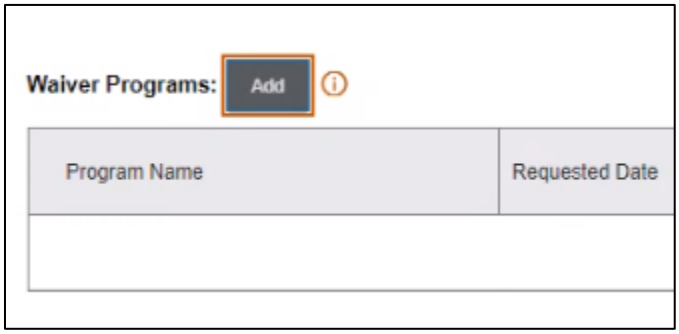


Figure 3-9: Add Waiver Program

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

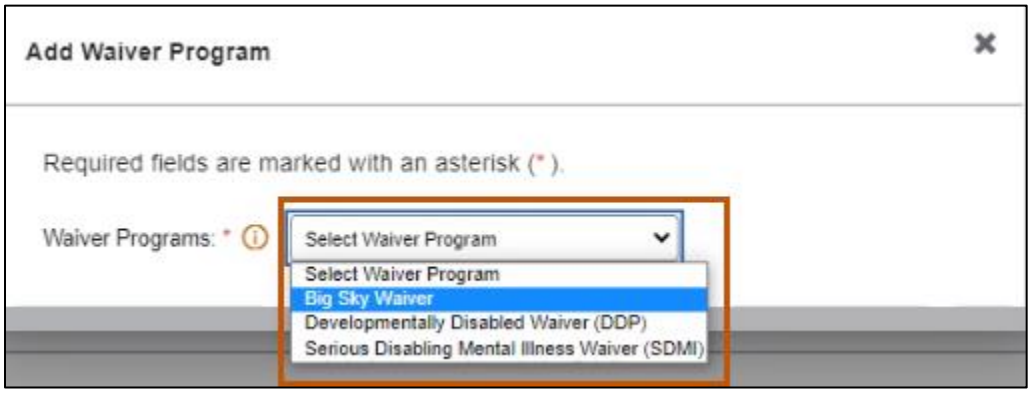


Figure 3-10: Select a Waiver Program

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

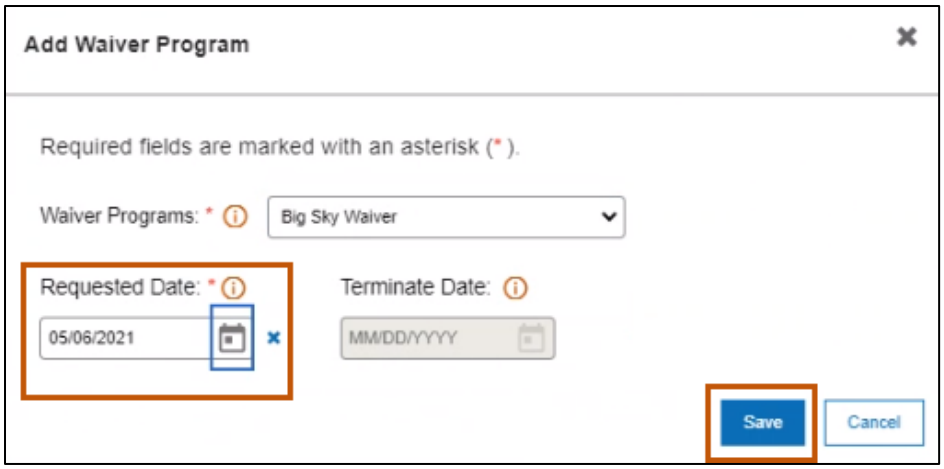


Figure 3-11: Choose a Requested Date

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.

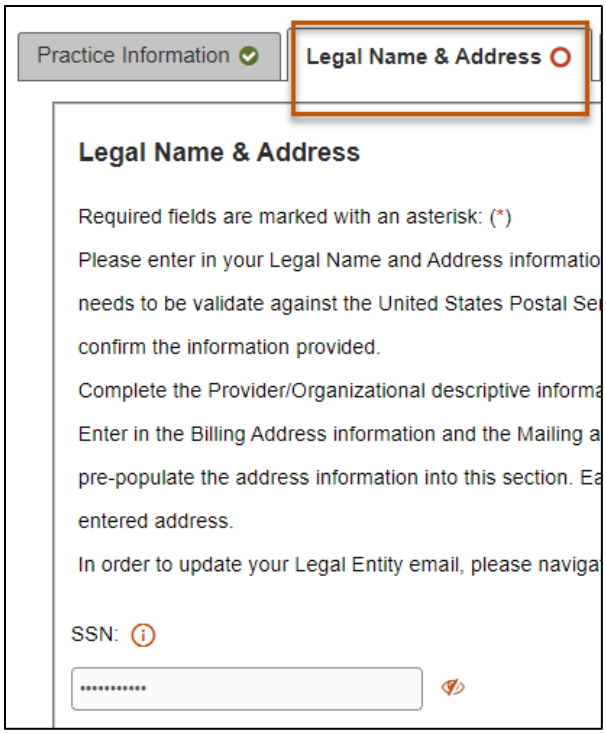


Figure 3-12: Legal Name and Address Tab

2. The SSN or FEIN field will auto-populate as read-only from the pre-enrollment screen.

3. 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

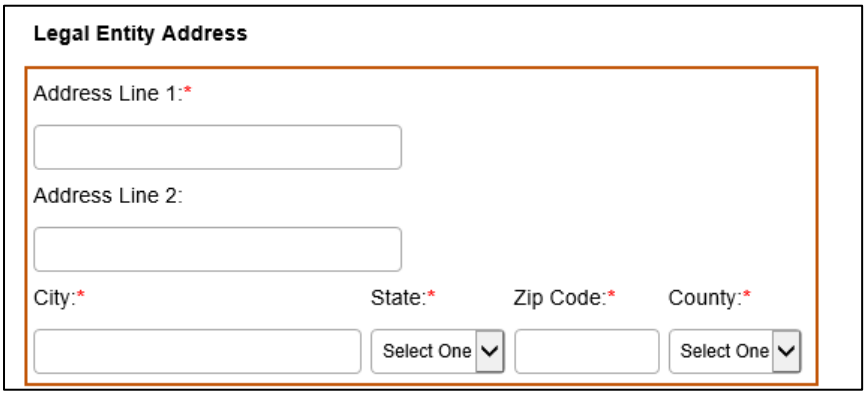


Figure 3-13: Address Fields

4. 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.

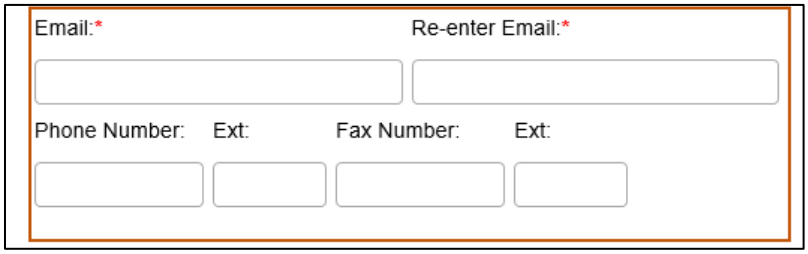


Figure 3-14: Email Address, Phone and Fax Number Tab

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.

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.

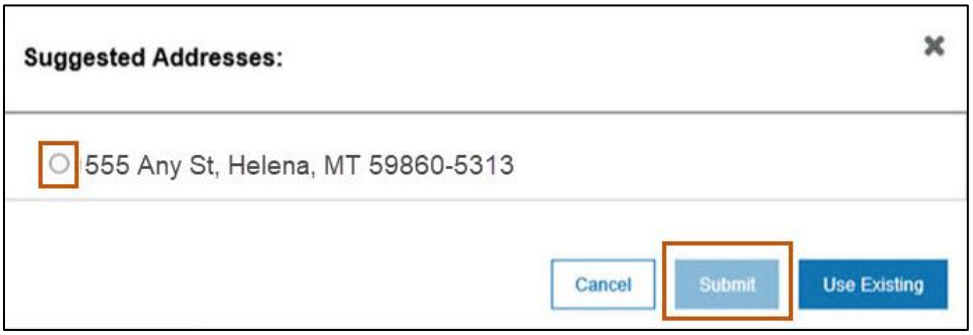


Figure 3-16: Legal Address Validation Suggestion

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

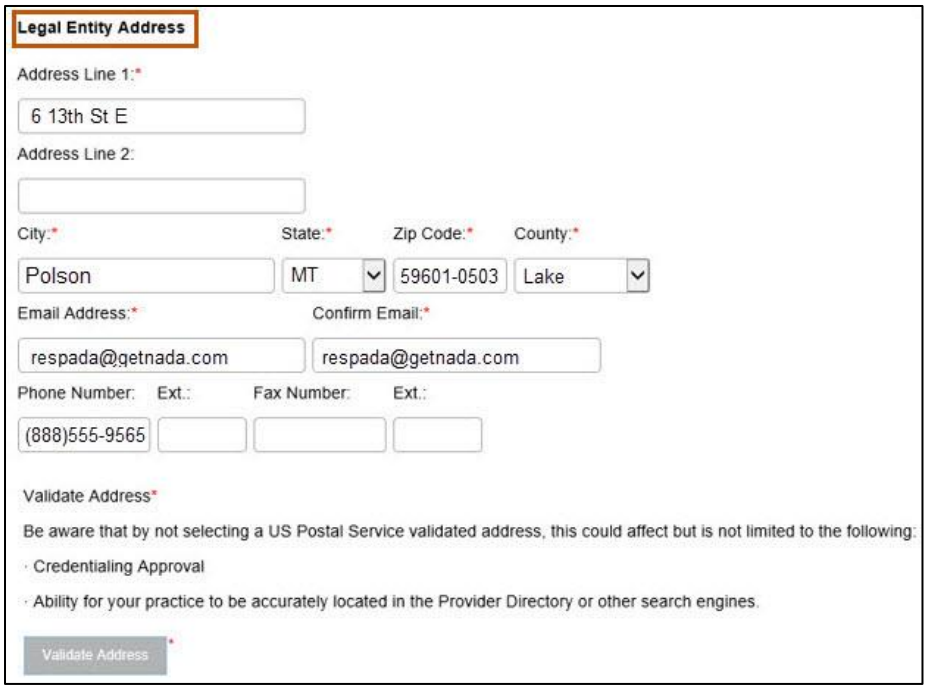


Figure 3-17: Legal Entity Address Section

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

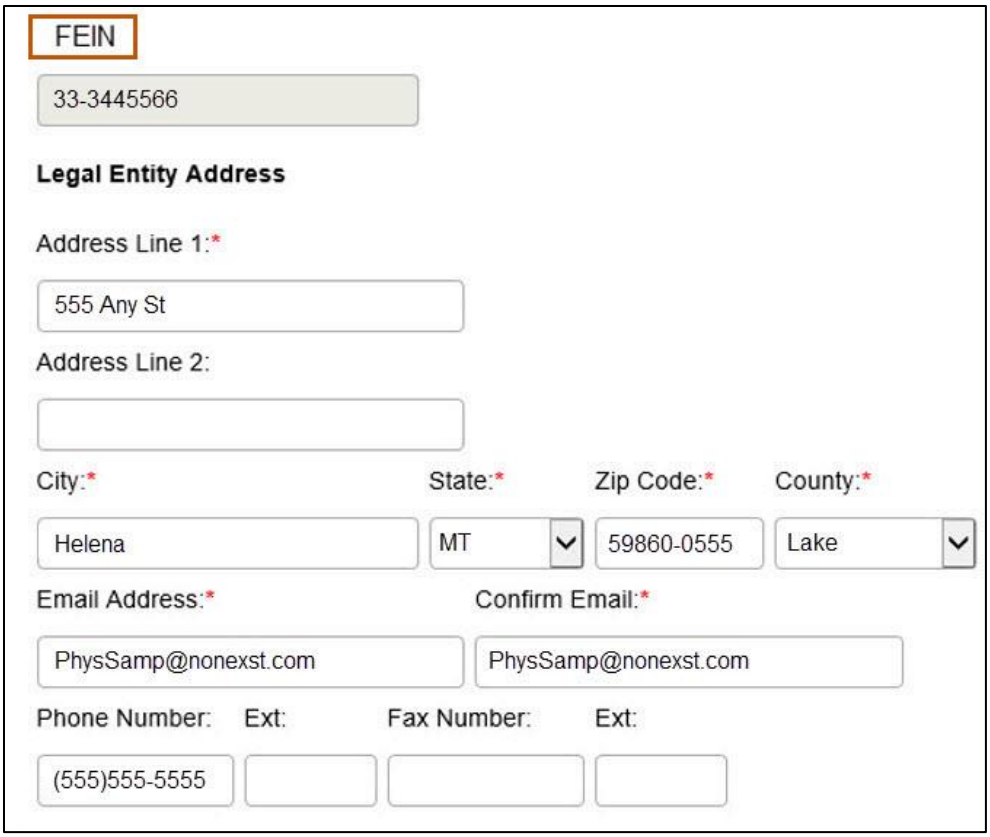


Figure 3-18: Example Sole Proprietor Enrolling with FEIN

3.1.2.1. Individual Provider Information

1. 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.

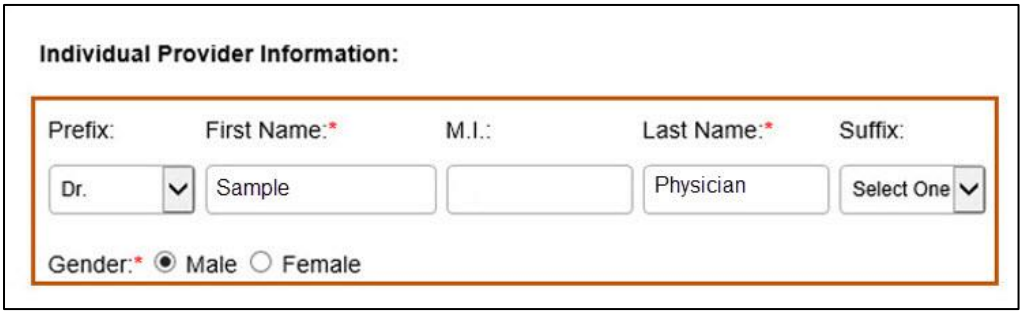


Figure 3-19: Individual Provider Information

   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.

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 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.

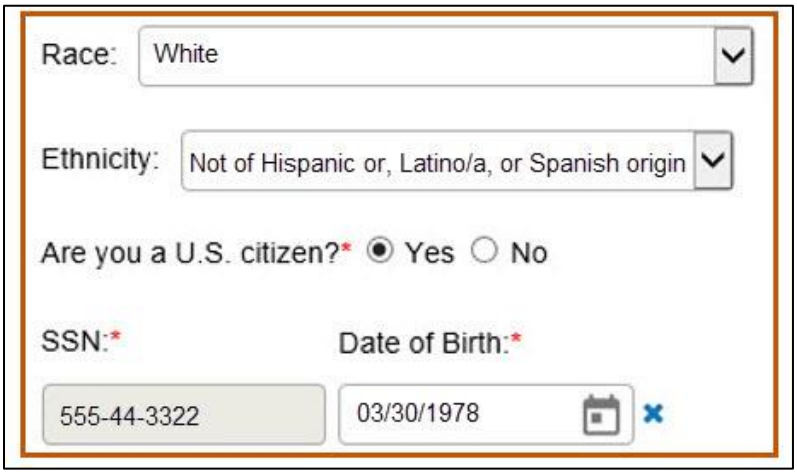


Figure 3-20: Ethnicity, Citizenship, SSN and Date of Birth

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.

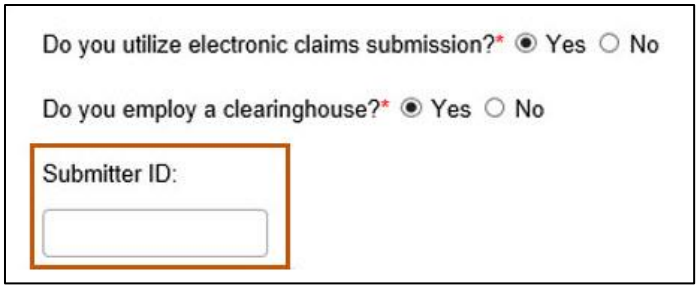


Figure 3-21: Legal Entity Address Section

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.

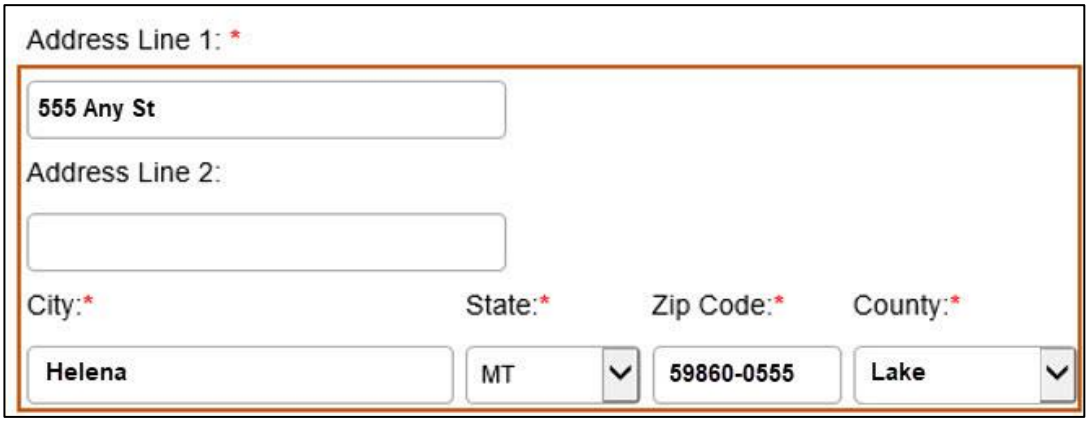


Figure 3-22: Provider Billing Information

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

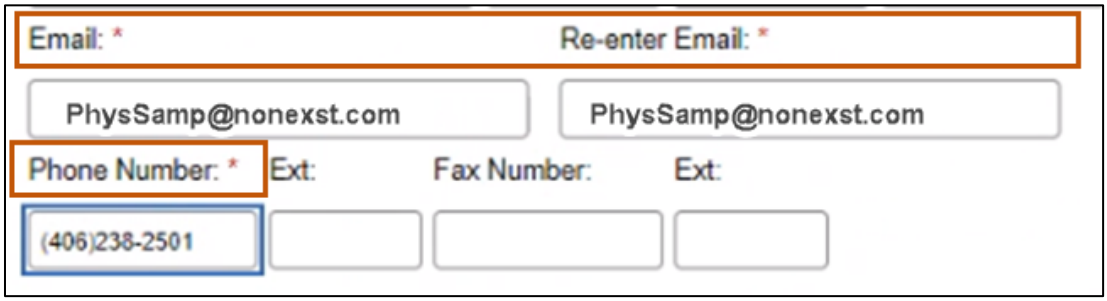


Figure 3-23: Email and Phone Number

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.

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.

Figure 3-25: Legal Address Validation Suggestion

3.1.2.3. Mailing Address

All enrolling providers must complete this section.

1. 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.

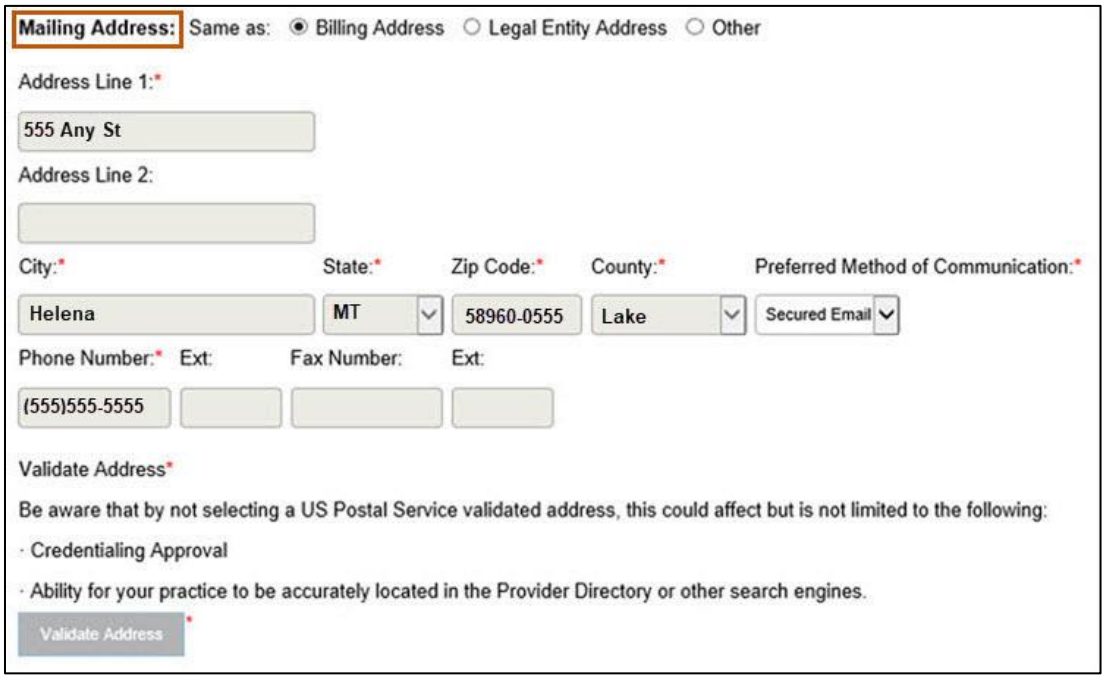


Figure 3-26: Mailing Address

4. 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.

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.

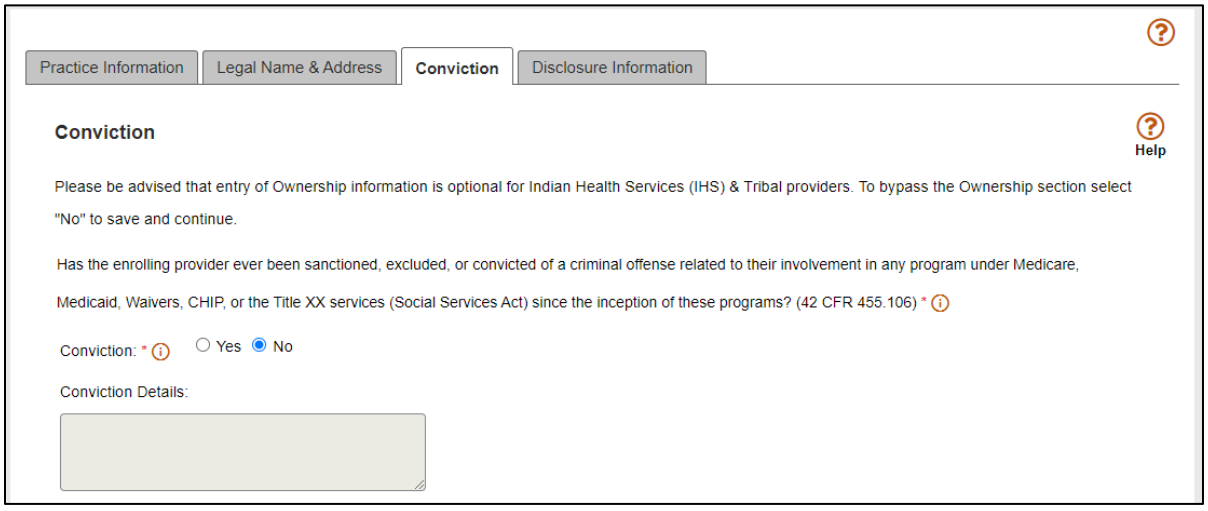


Figure 3-28: Ownership – Conviction Question

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.

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.

1. 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.

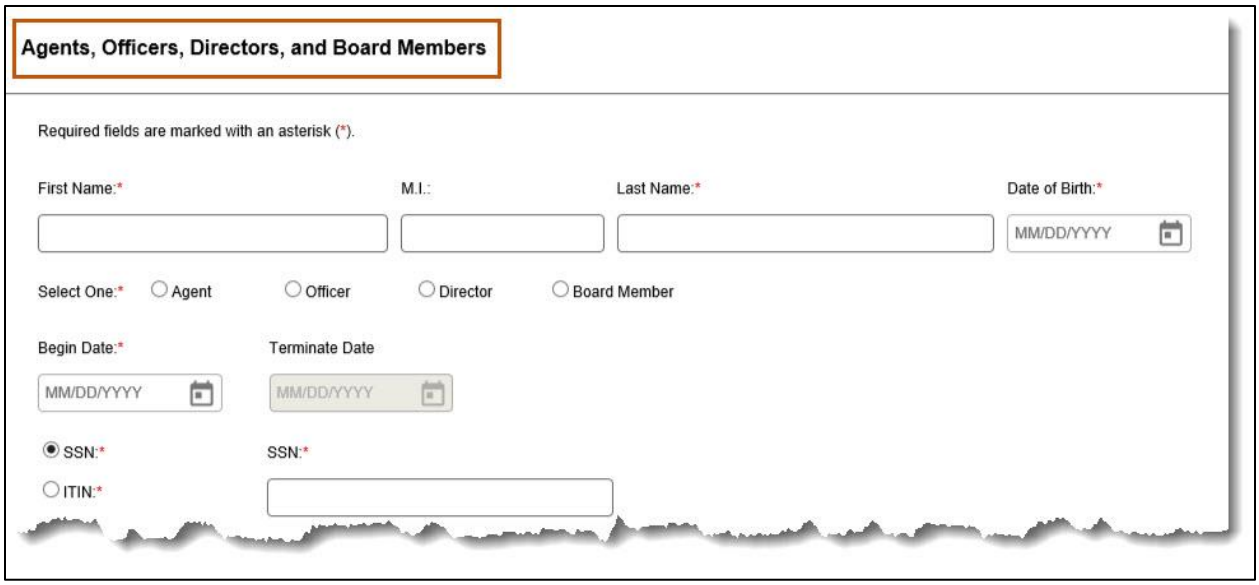


Figure 3-30: Agents, Officers, Directors, and Board Members Name

Table 3-2: Disclosure Information Role Definitions

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.

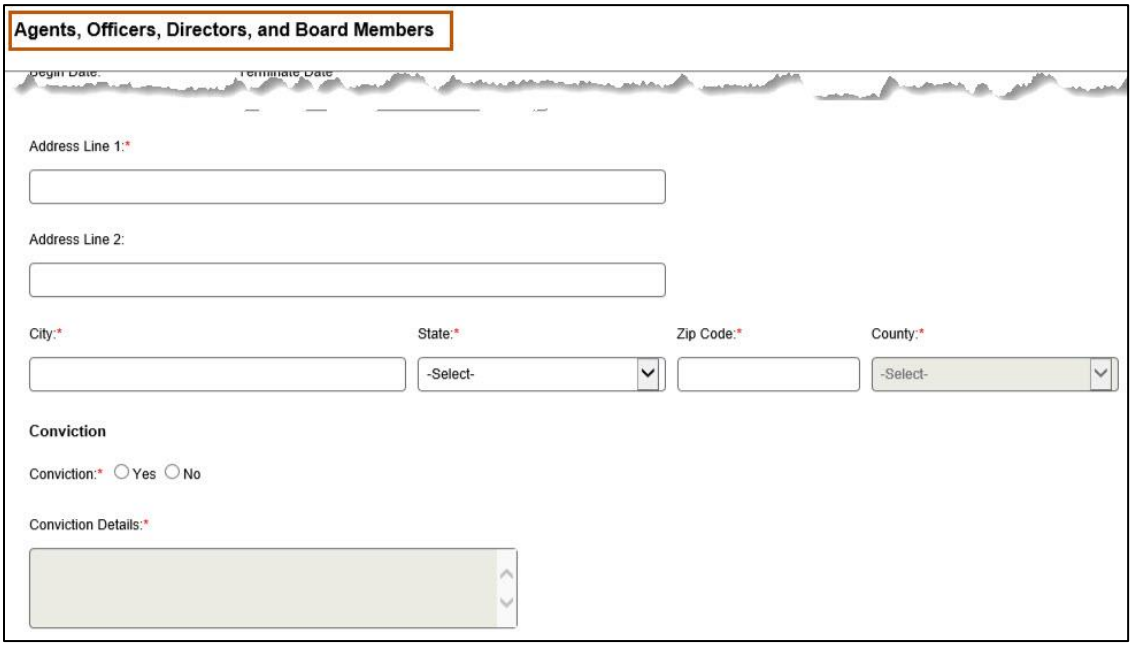


Figure 3-31: Agents, Officers, Directors, and Board Members Additional Information

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.

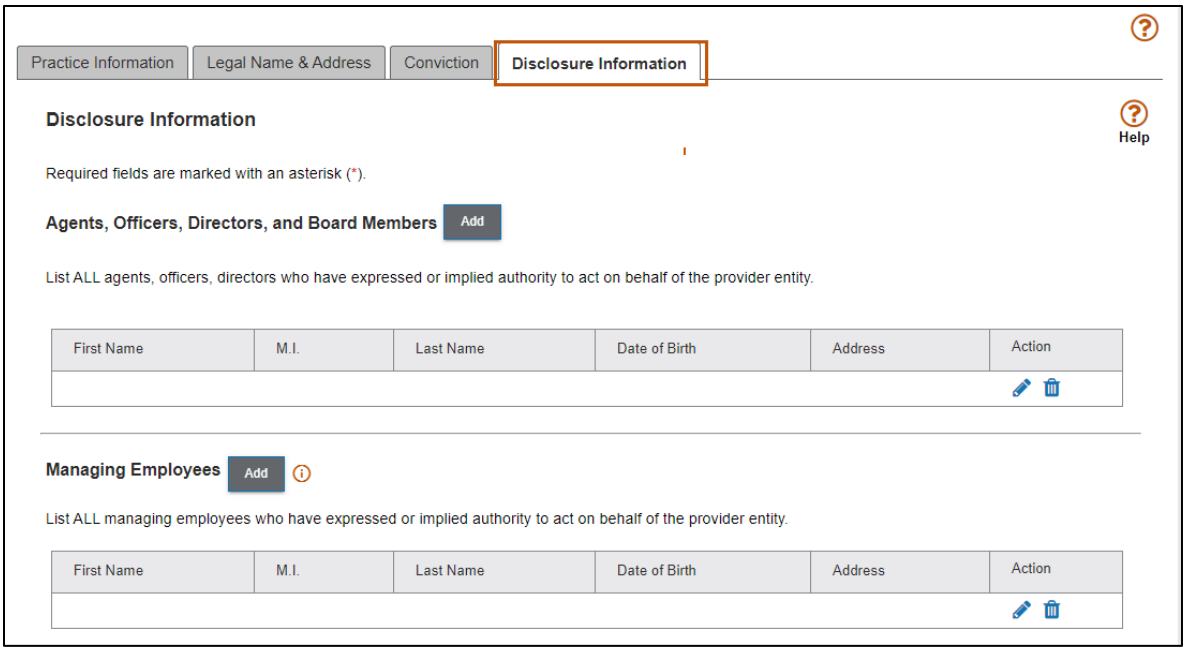


Figure 3-33: Managing Employees

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.

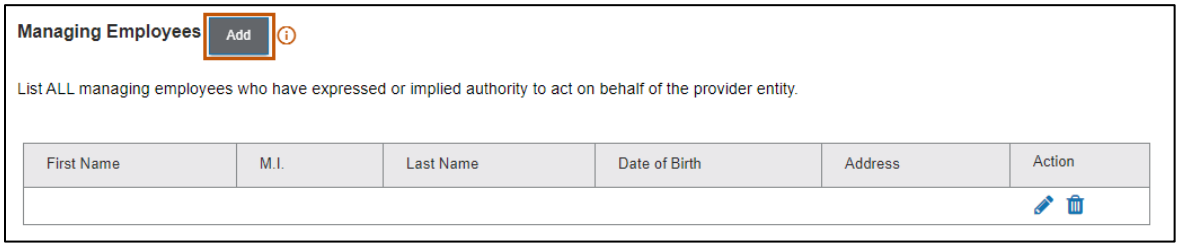


Figure 3-34: Add Managing Employees

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

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.

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

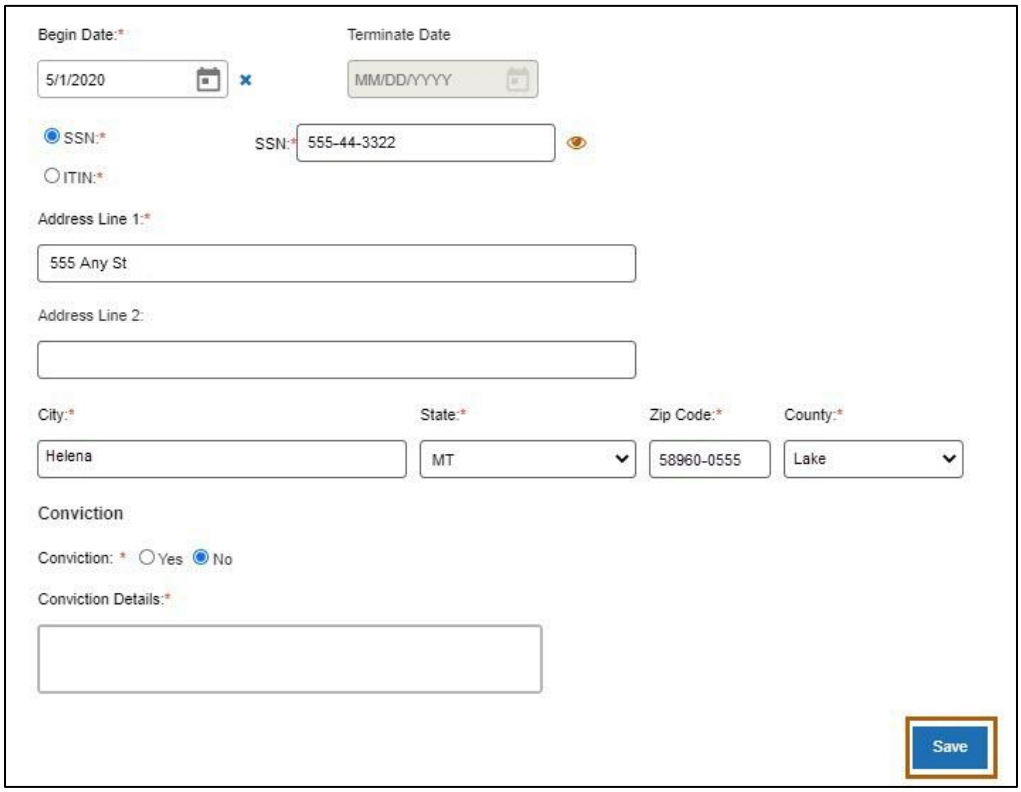


Figure 3-36: Managing Employees Details - continued

7. Click **Save.**

3.1.4.3. Managing Relationship

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

1. 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.

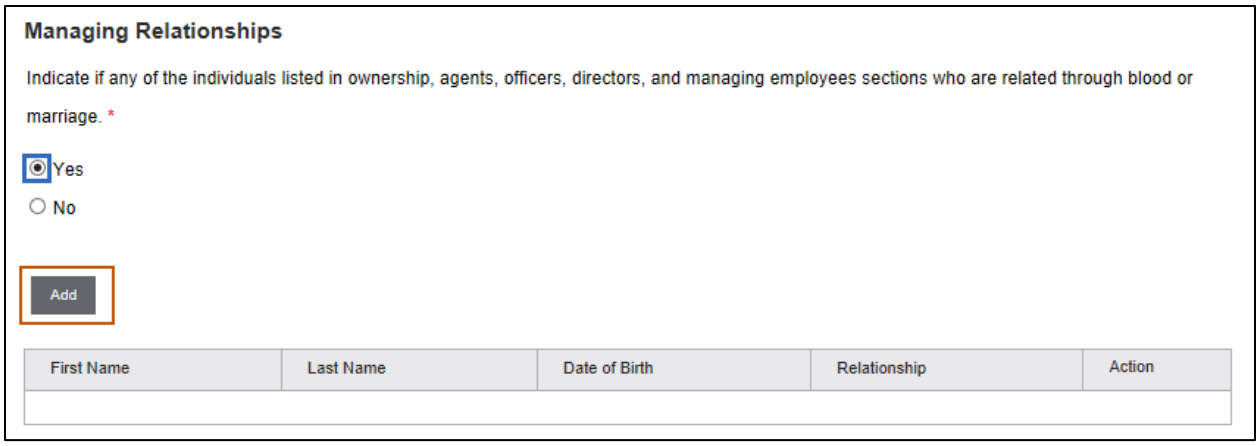


Figure 3-37: Add Managing Relationship

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.

2. 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.

Figure 3-38: Managing Relationship Search

3. 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.

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.

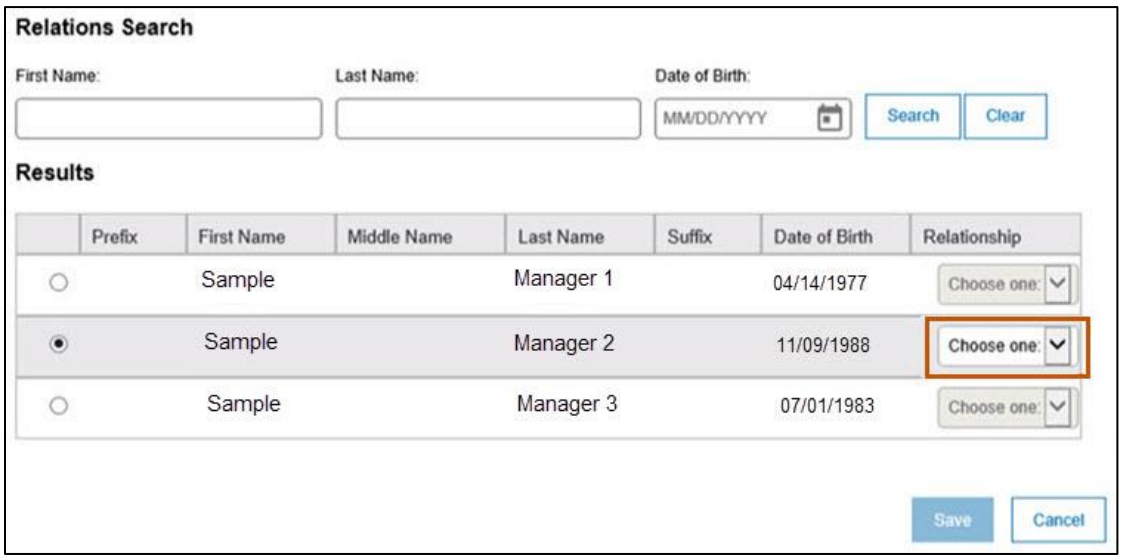


Figure 3-40: Relationship Drop-down Selection

3.1.4.4. Sub-Contractor

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

1. 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.

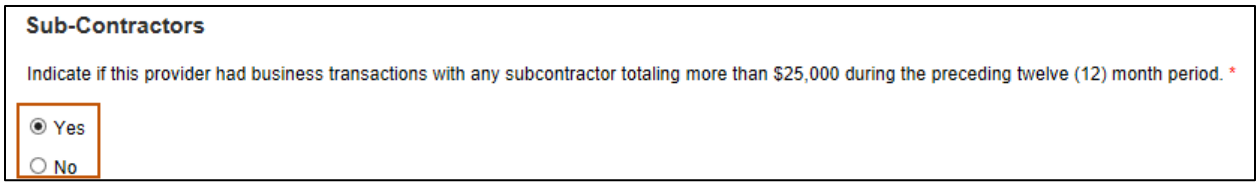


Figure 3-41: Add Sub-Contractor Question

2. 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**.

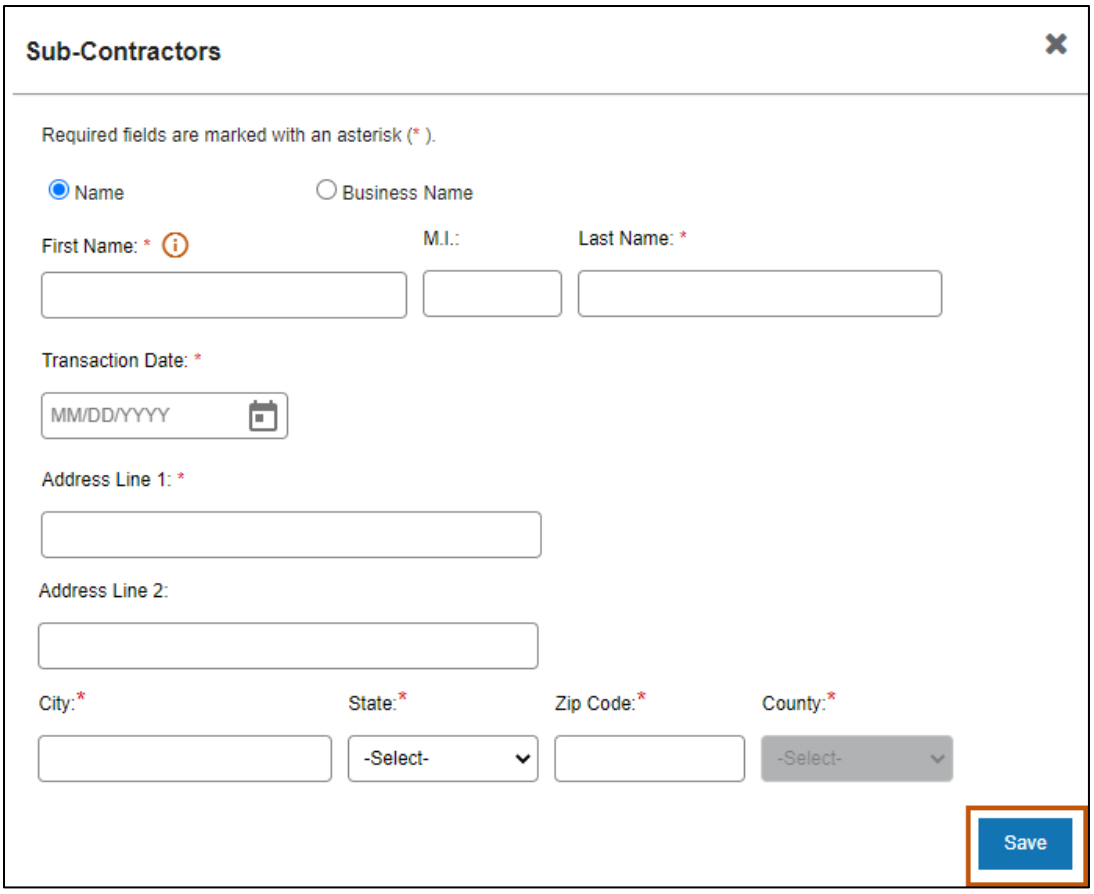


Figure 3-42: Sub-Contractors Screen

3.1.4.5. Business Transactions

The steps below describe how to add Business Transactions.

1. 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.

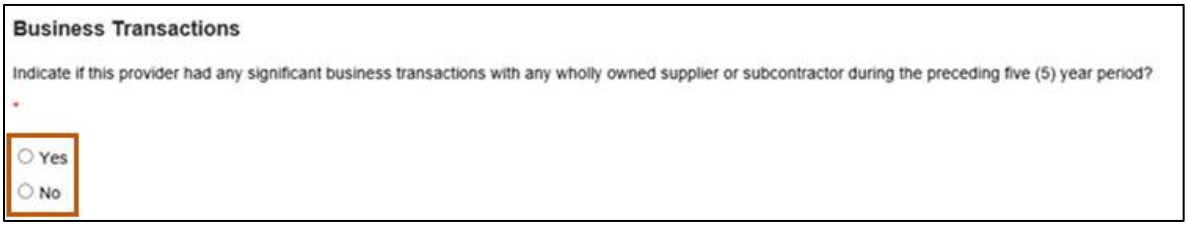


Figure 3-43: Business Transactions Question

2. 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.
3. 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**.

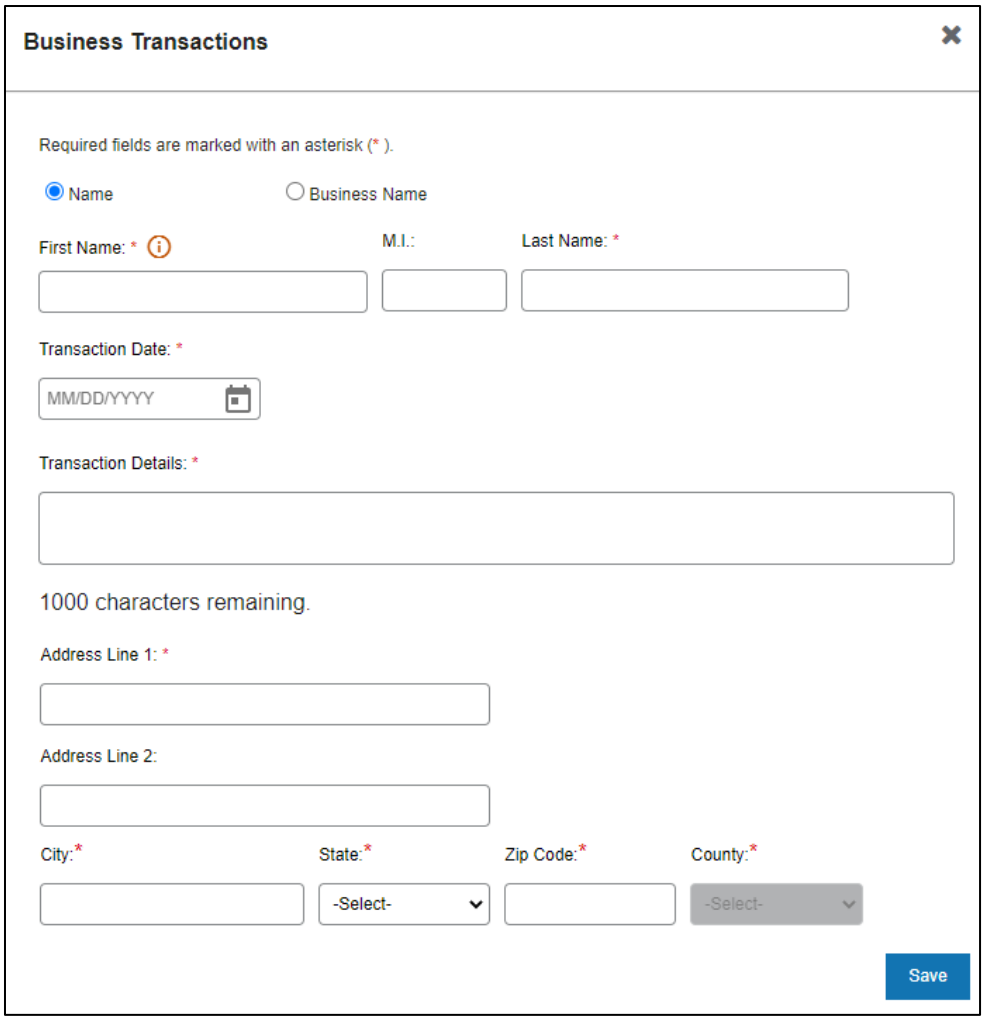


Figure 3-44: Business Transactions Screen

3.1.4.6. Controlling Interest

The steps below describe how to add the Controlling Interest.

1. 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.

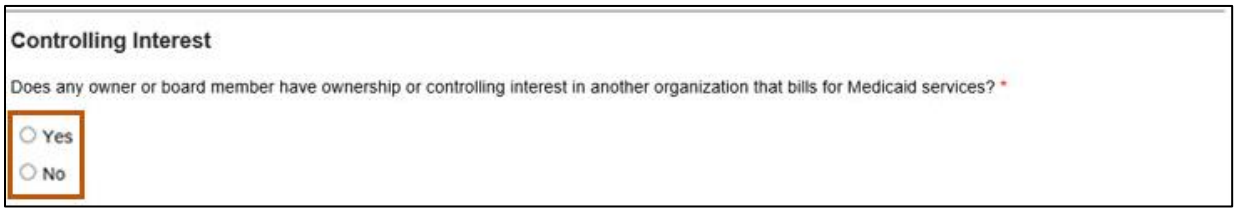


Figure 3-45: Controlling Interest Question

2. 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**.

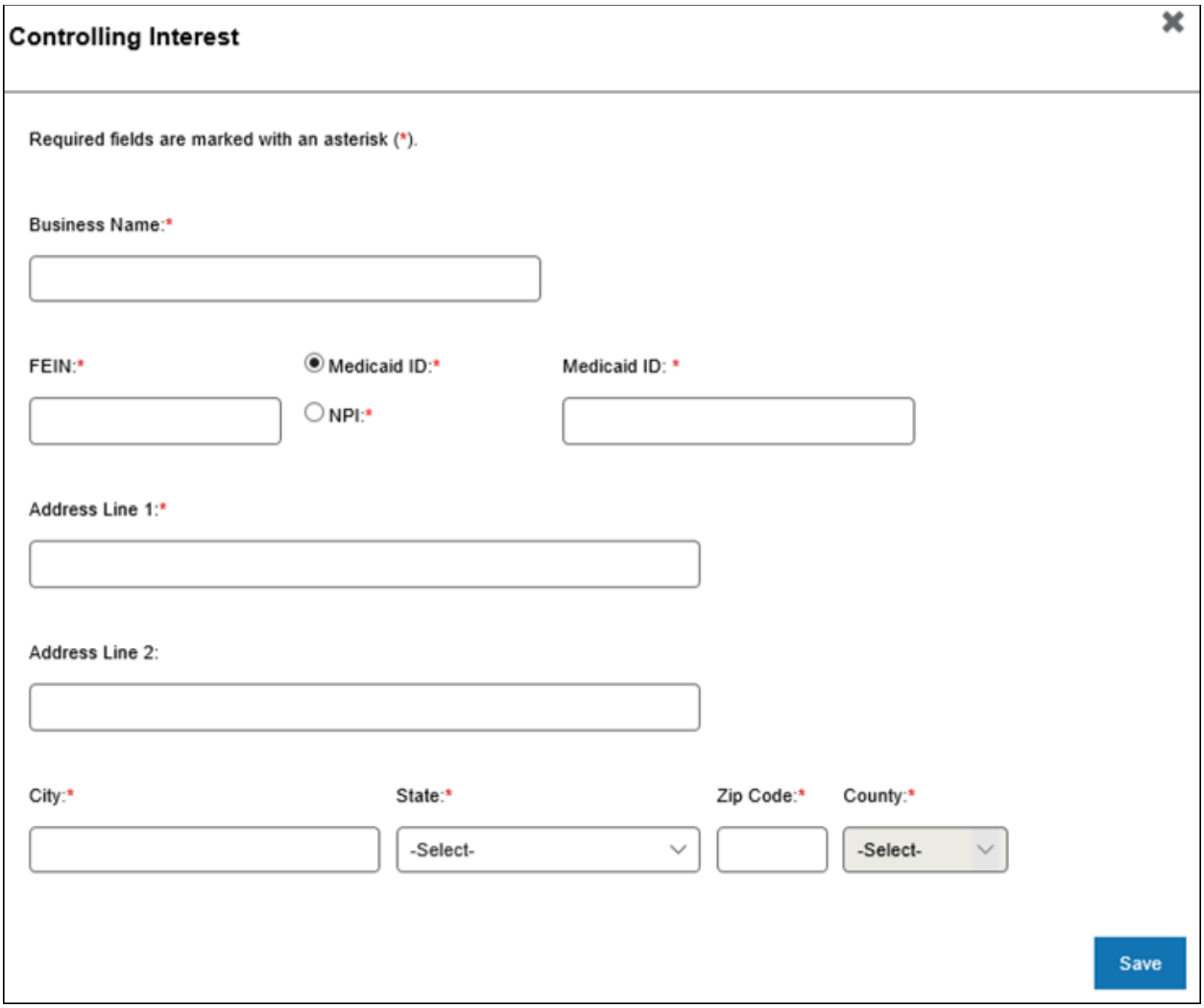


Figure 3-46: Controlling Interest Screen

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?

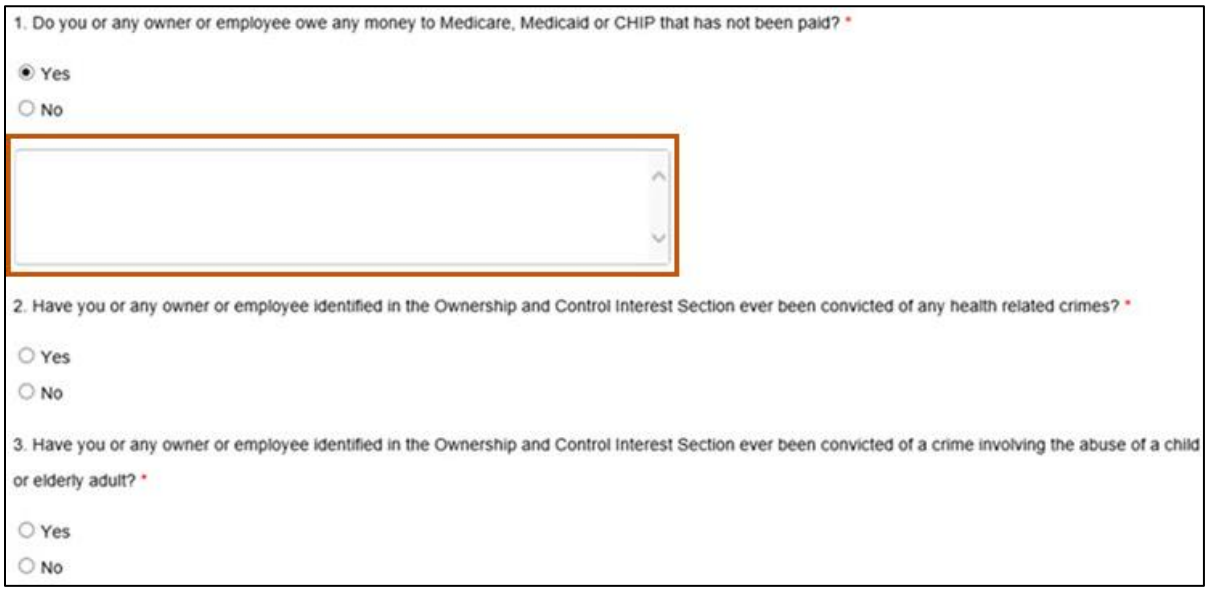


Figure 3-47: Enrollment Attestation Questions

2. 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.

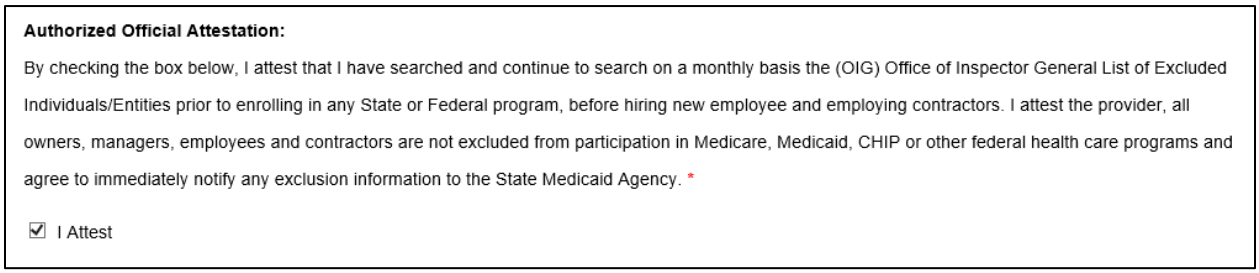


Figure 3-48: Authorized Official Attestation

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

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.

1. 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.

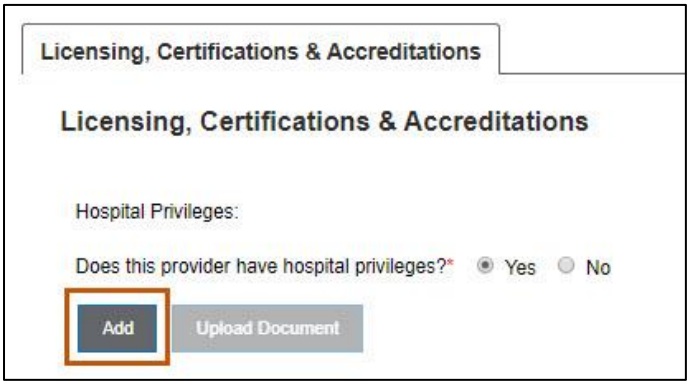


Figure 3-51: Add Hospital Privileges

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.

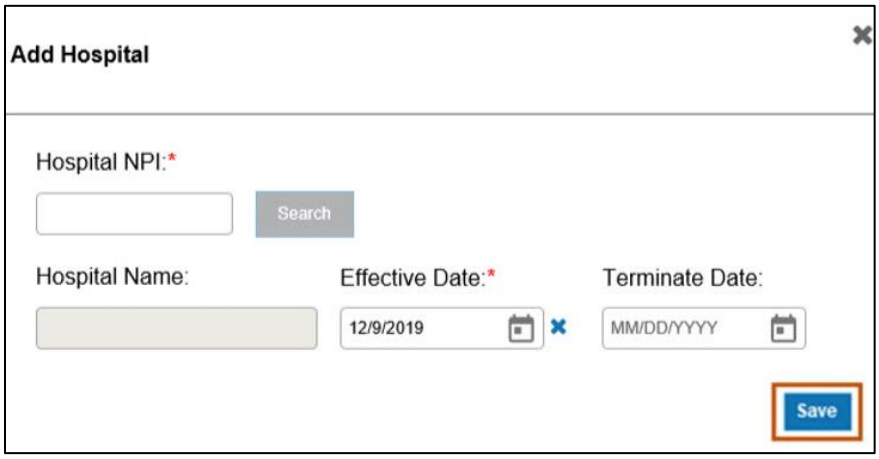


Figure 3-52: Add Hospital

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

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.

Figure 3-54: Document Type Selection

b. Click **Browse**.

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

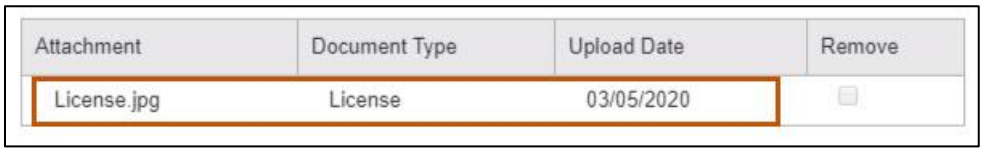


Figure 3-55: Upload Details

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.

2. 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.

3. If any answer to questions 1 through 3 is yes, select the Yes radio button. Refer to Figure 3-56.

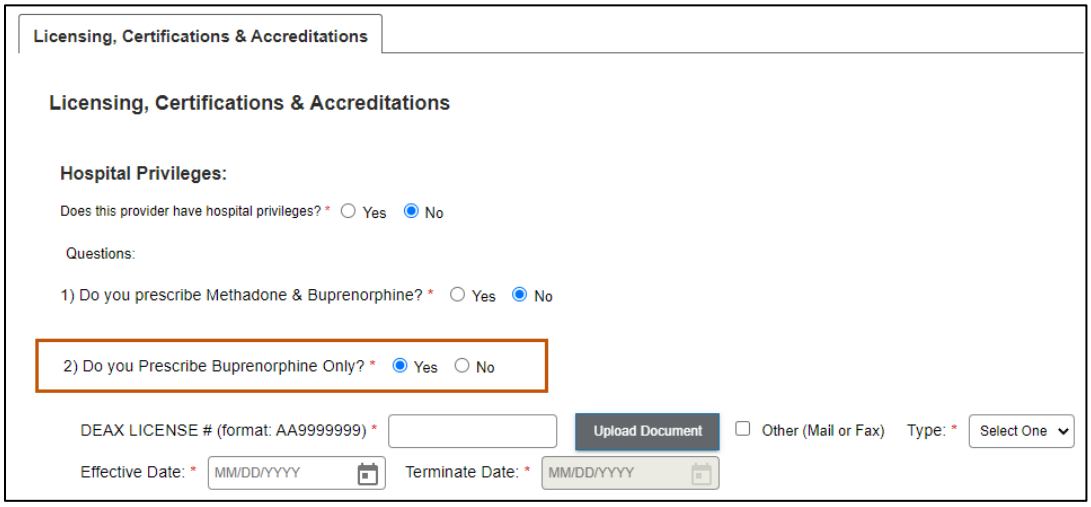


Figure 3-56: DEA License Information

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**.

Figure 3-57: Upload Document

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

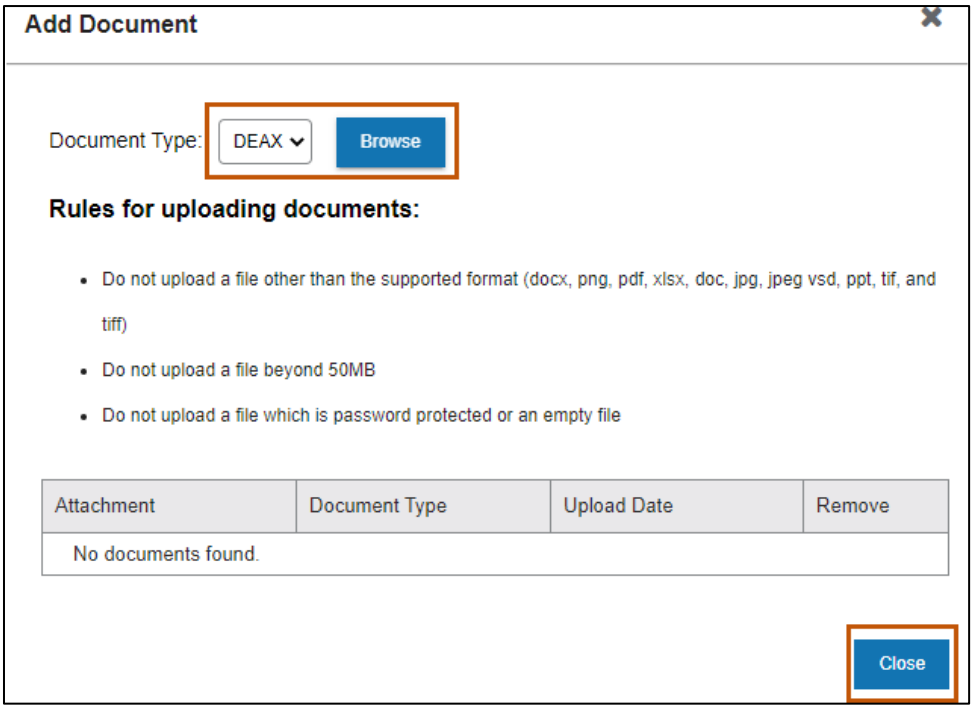


Figure 3-58: Add Document Box

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.

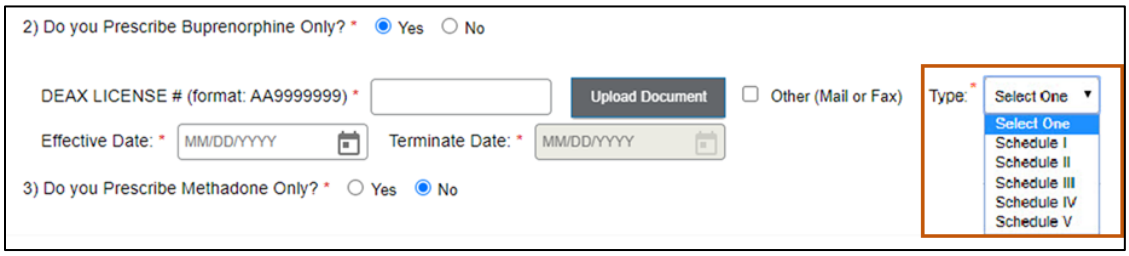


Figure 3-59: Required Fields for DEA

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.

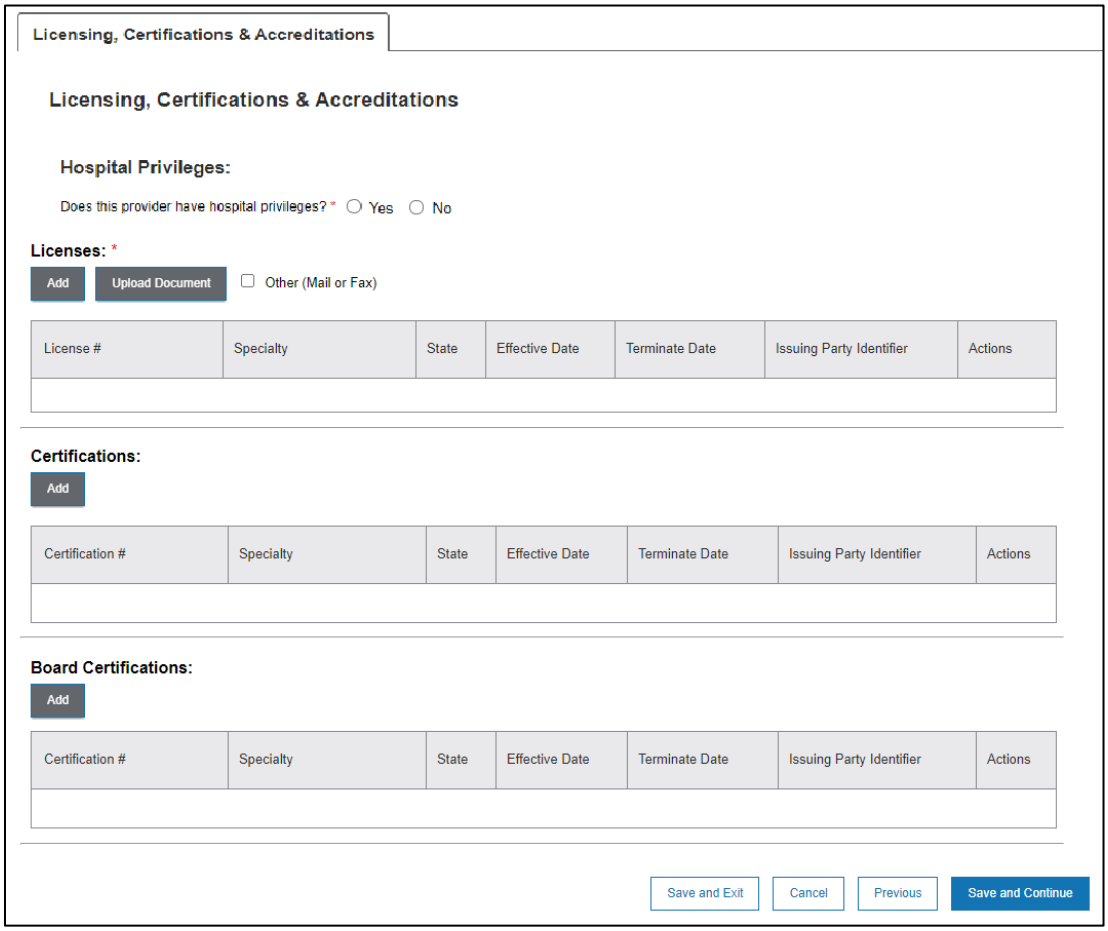


Figure 3-60: Licenses and Certifications Workbench

3. 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.

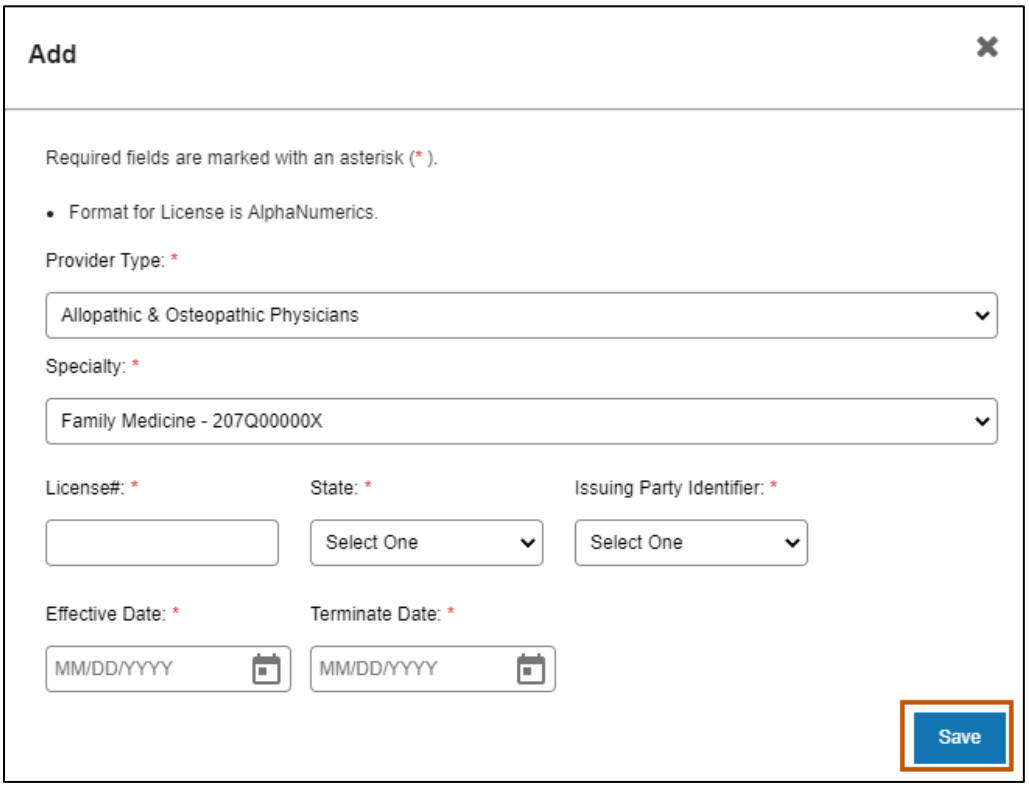


Figure 3-61: Add Licenses

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.

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.

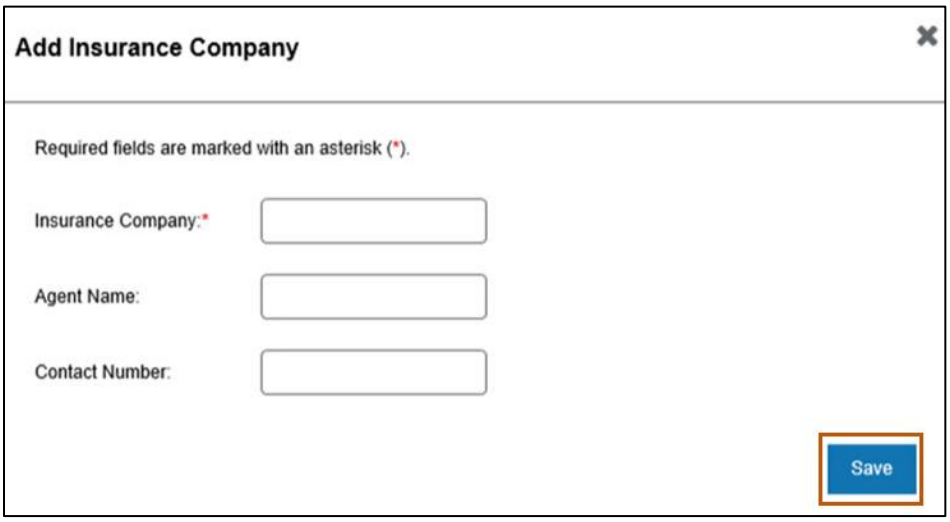


Figure 3-63: Add Insurance Company Screen

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

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**.

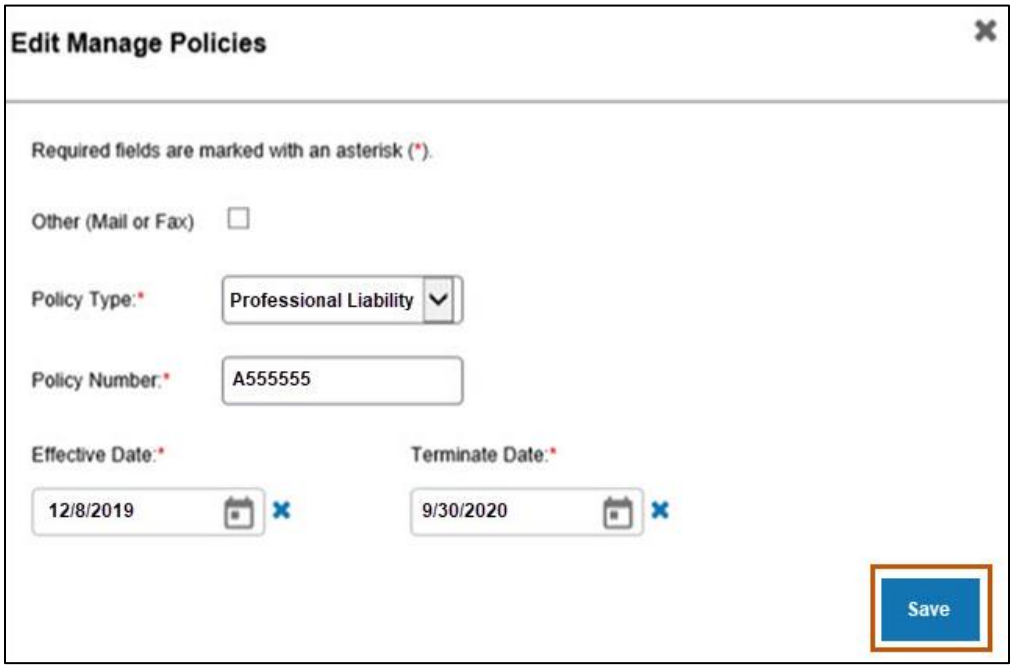


Figure 3-65: Add Insurance Company Screen

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.

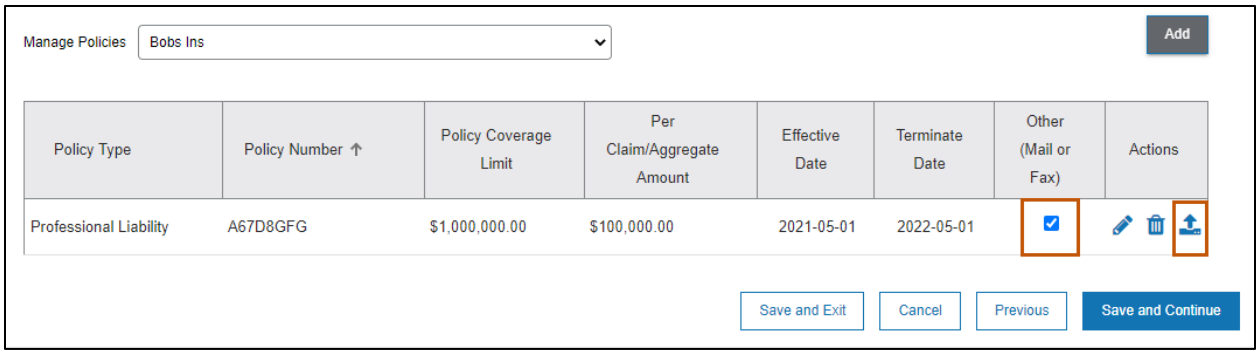


Figure 3-66: Upload or Mail/Fax Information

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

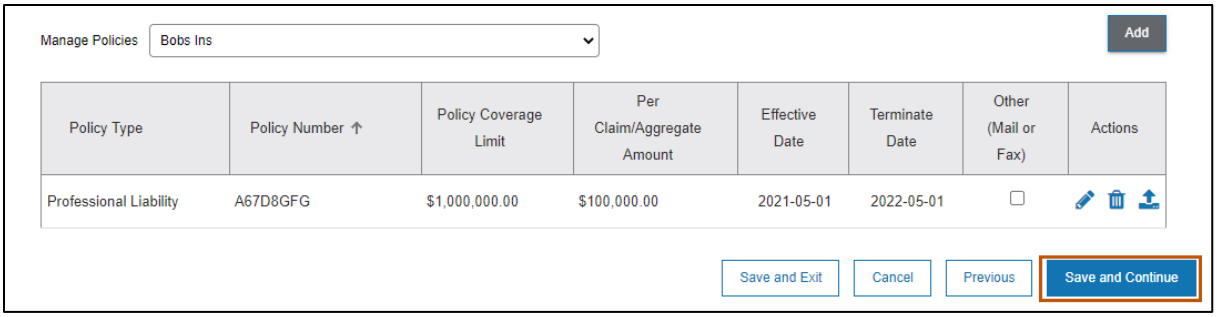


Figure 3-67: Manage Insurance Policy Screen

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.

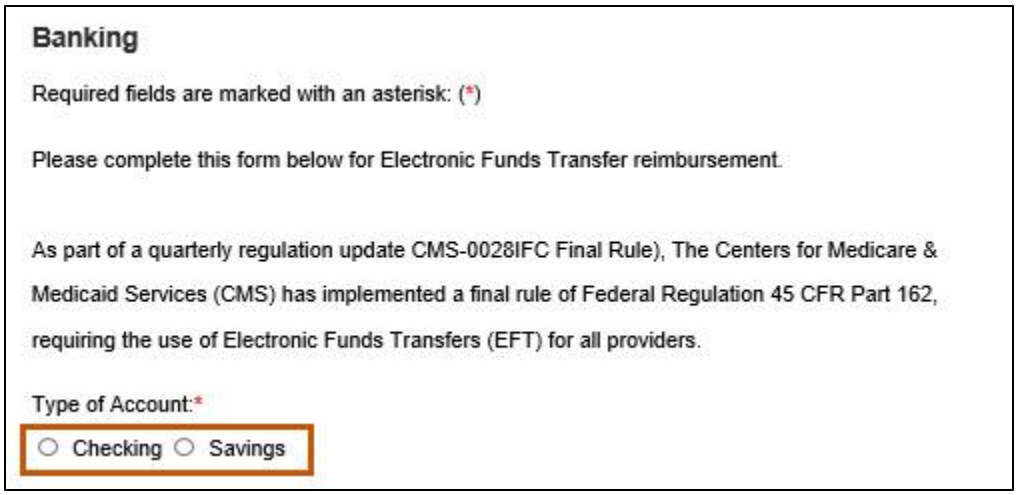


Figure 3-68: Banking Information

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.

l. Enter the Fax Number and Ext (if applicable) in the fields provided.

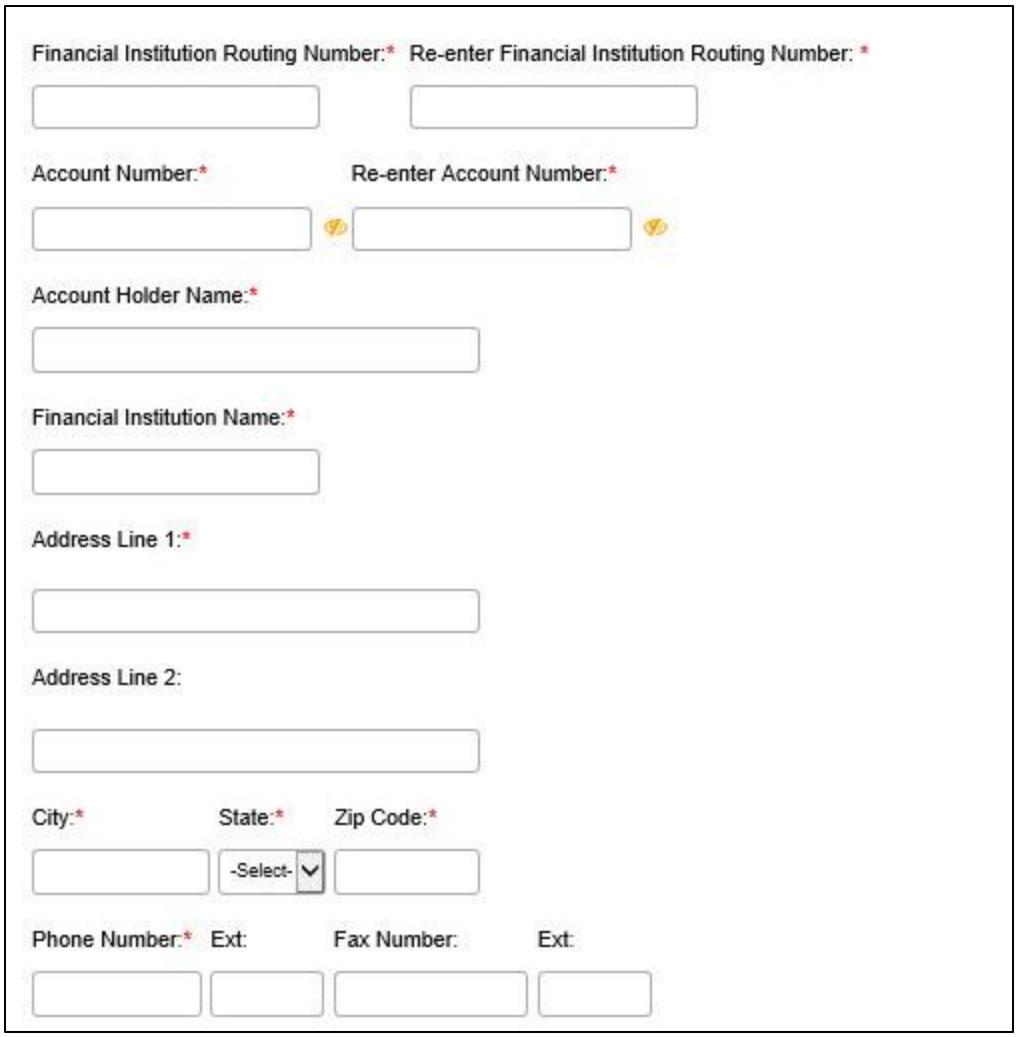


Figure 3-69: Additional Banking Information

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

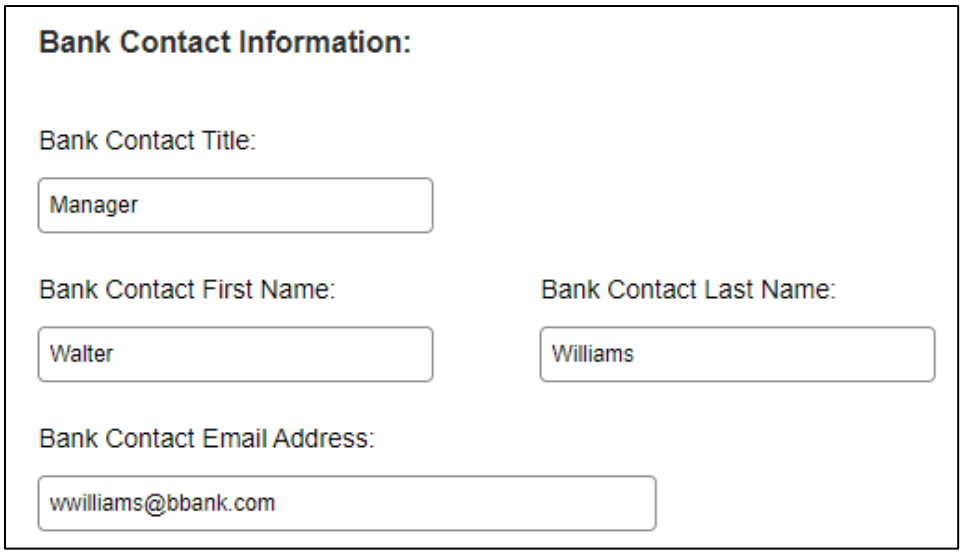


Figure 3-70: Bank Contact Information

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.

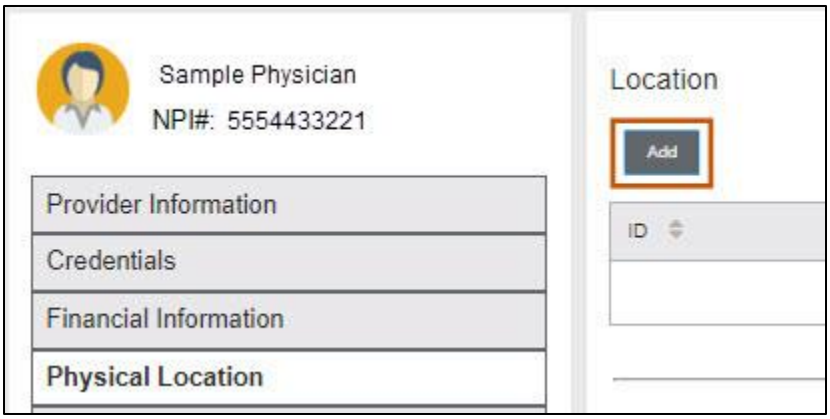


Figure 3-72: Add Physical Location

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.

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.

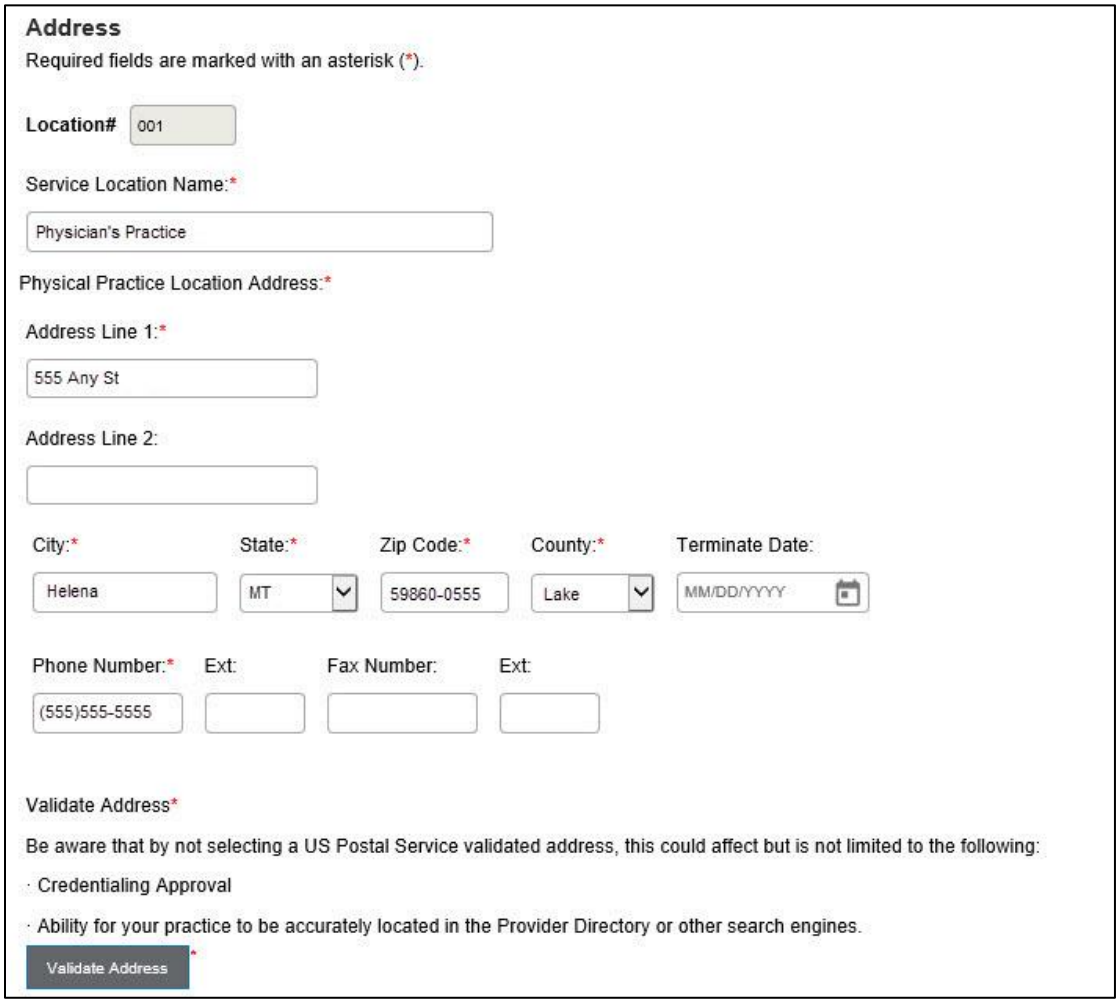


Figure 3-74: Validate Address

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.

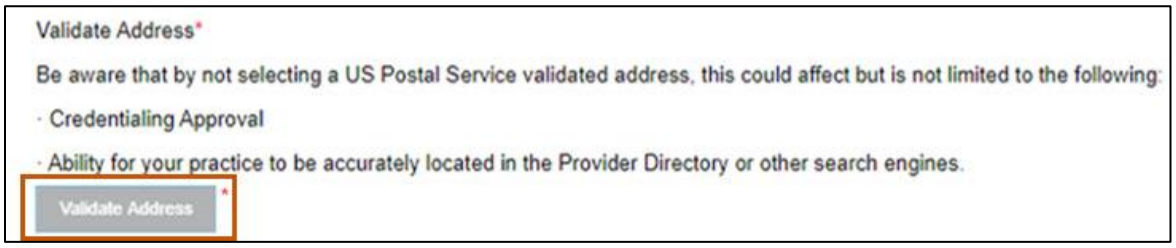


Figure 3-75: Address Previously Validated

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**.

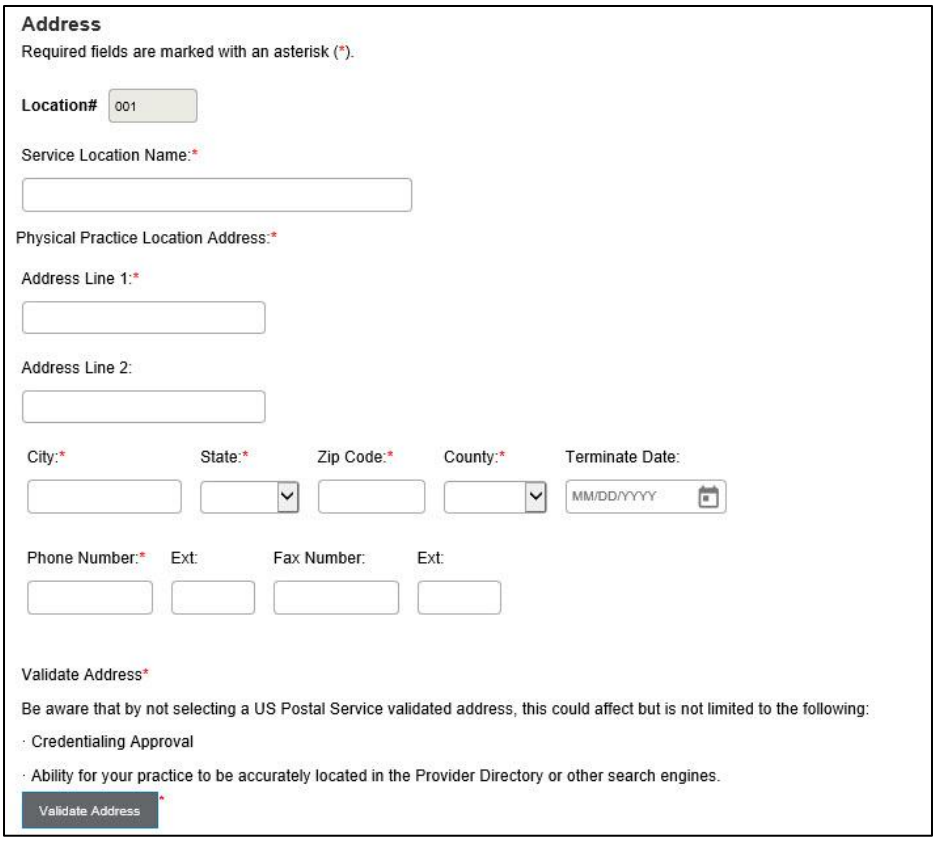


Figure 3-76: Address Information

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.

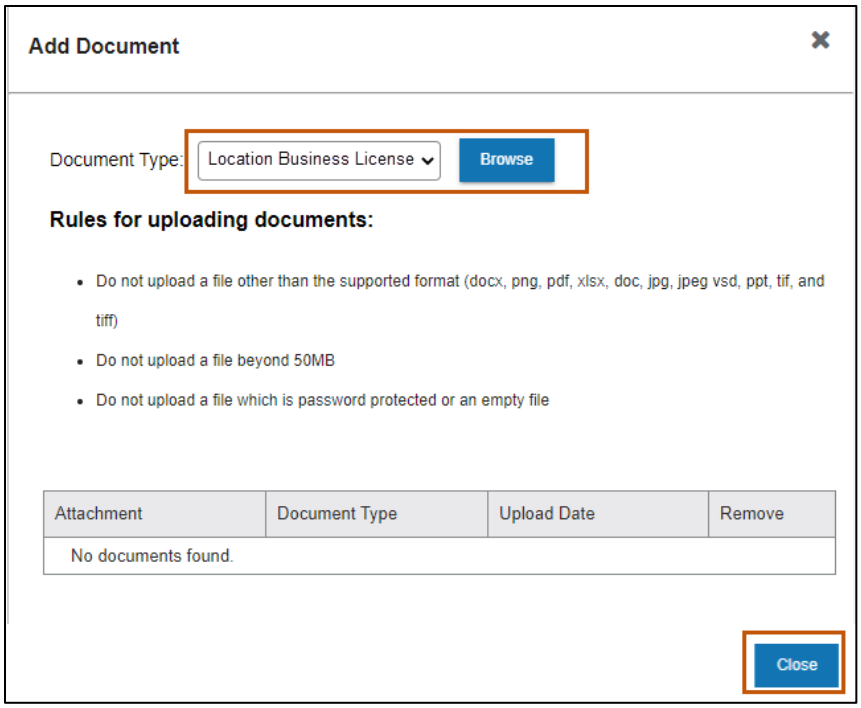


Figure 3-77: Add Location Business License Screen

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

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

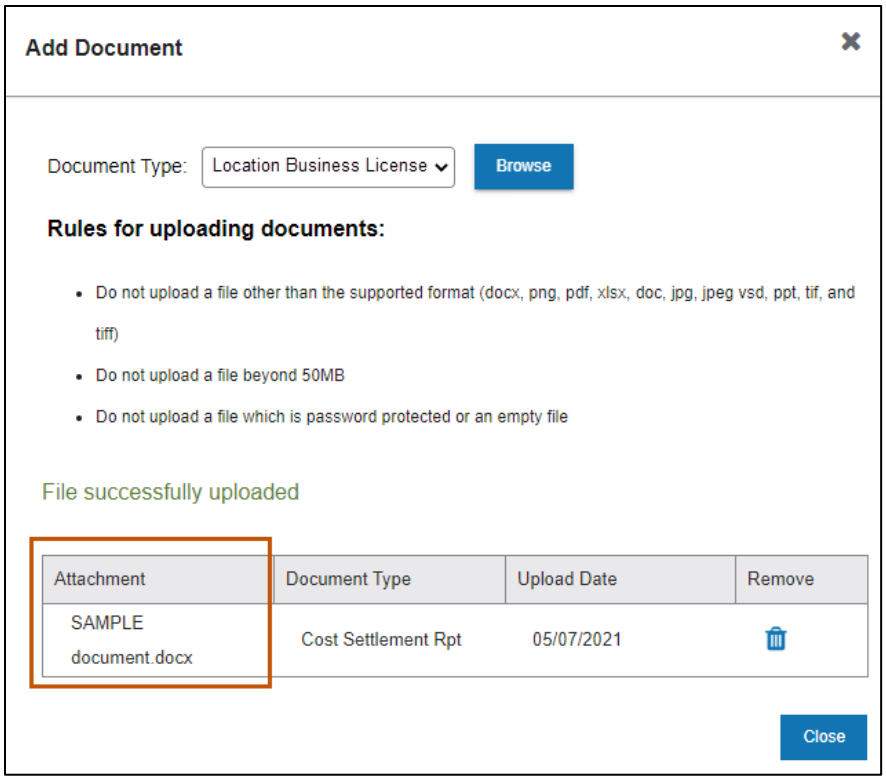


Figure 3-78: Add License

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.

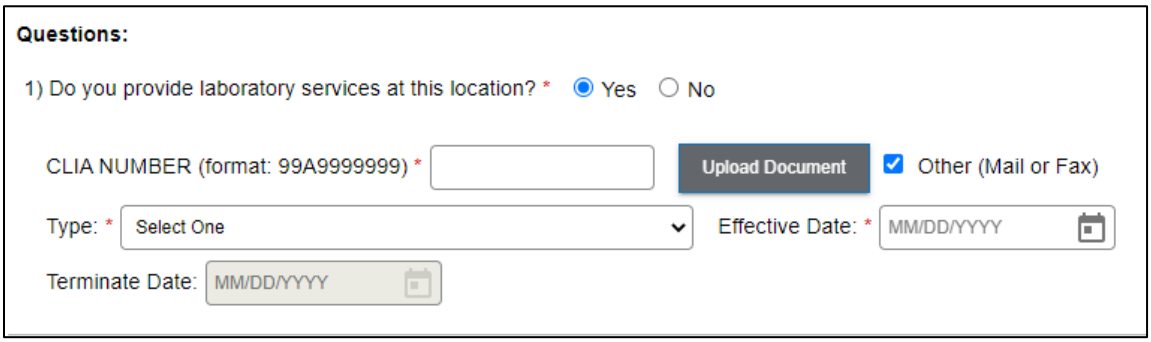


Figure 3-79: CLIA Information

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.

Figure 3-80: Specialties at the Physical Location

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

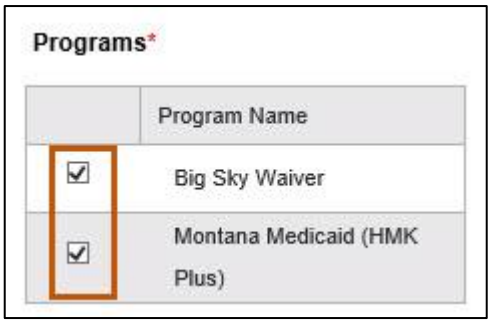


Figure 3-81: Programs at the Physical Location

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.

4. 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.

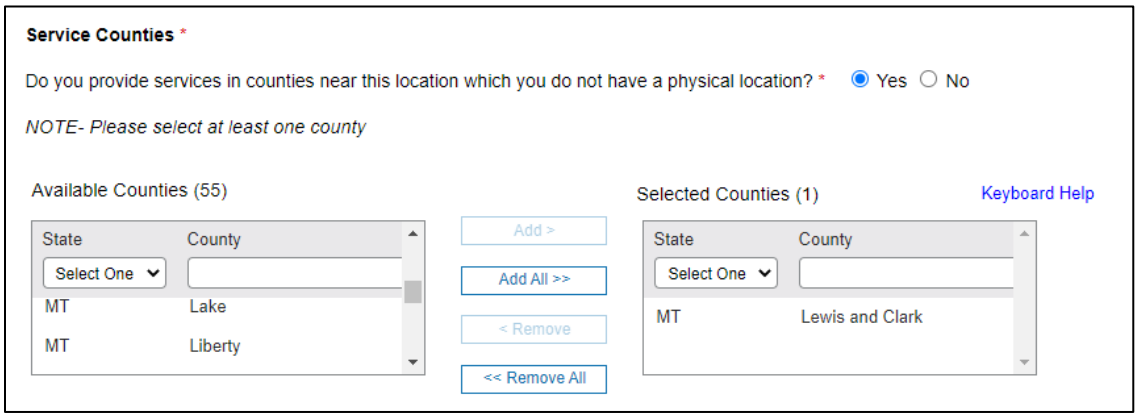


Figure 3-82: Service Counties

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'

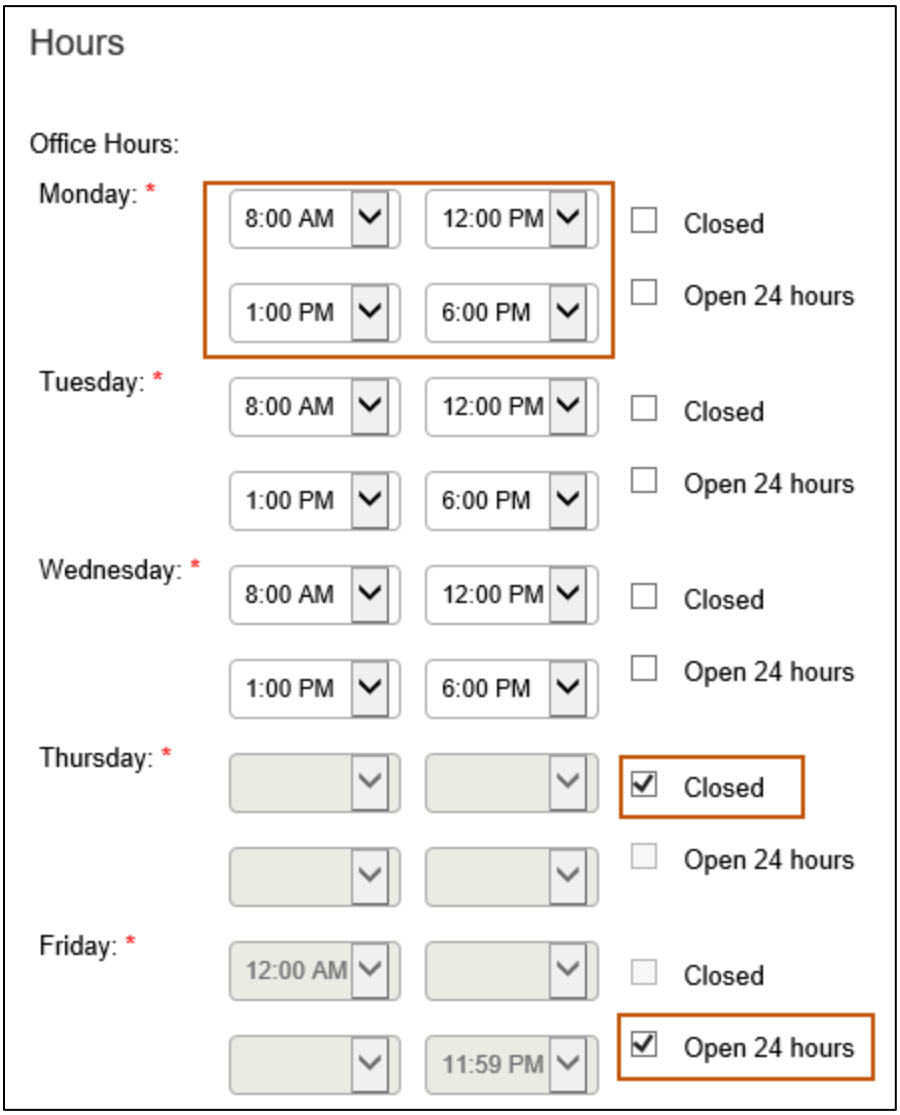


Figure 3-83: Practice Hours

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.

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 (*).

1. 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.

   b. 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.

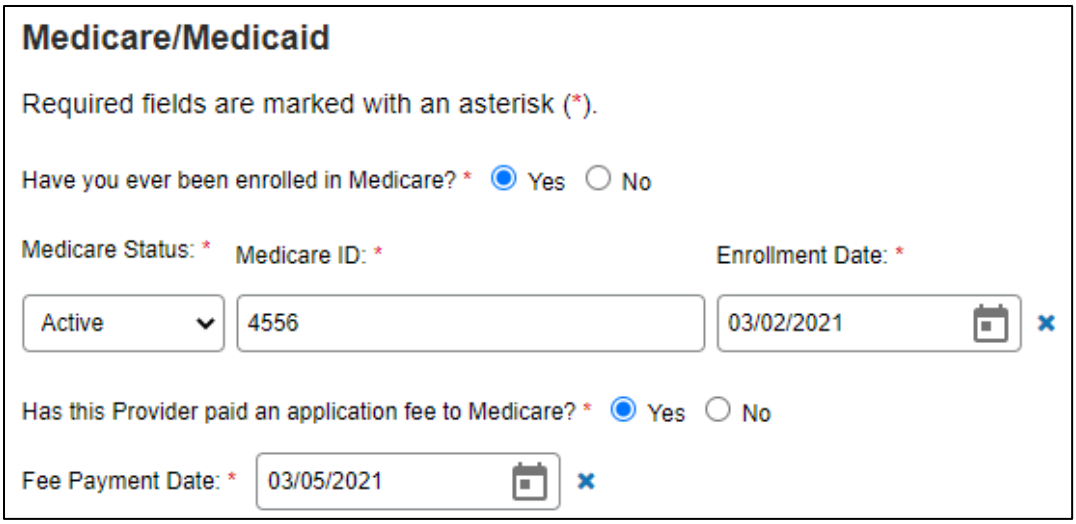


Figure 3-85: Medicare/Medicaid Questions

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.

2. 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.

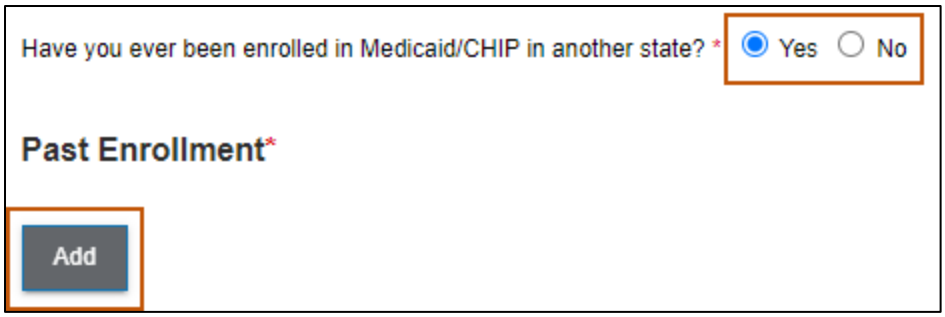


Figure 3-86: Medicaid/CHIP Enrollment in Another State

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.**

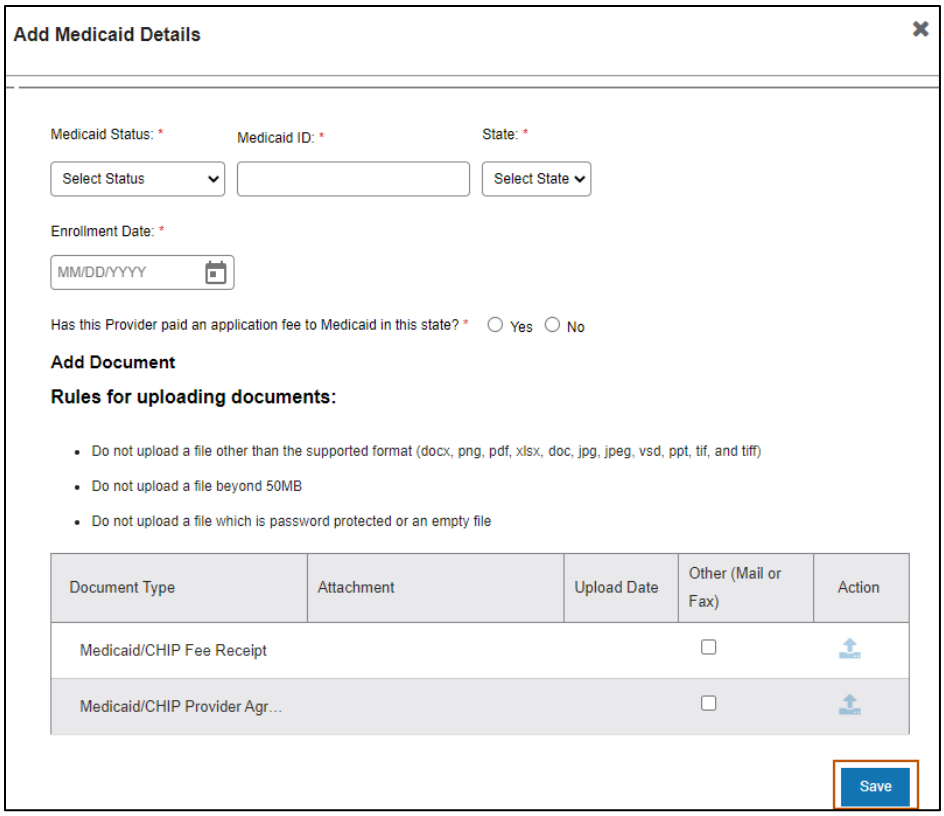


Figure 3-87: Add Medicaid Details

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.

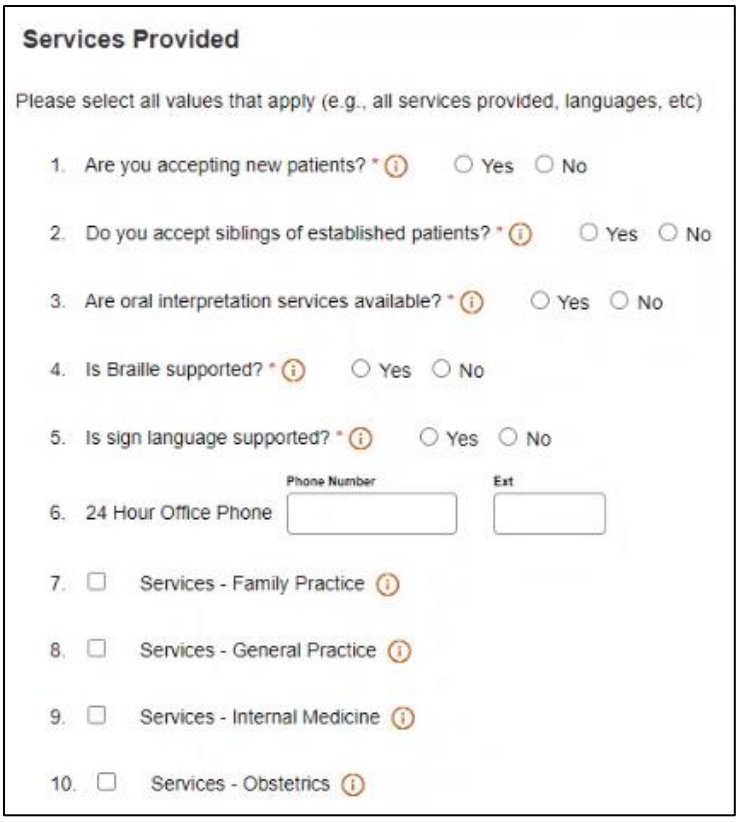


Figure 3-88: Services Provided

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.

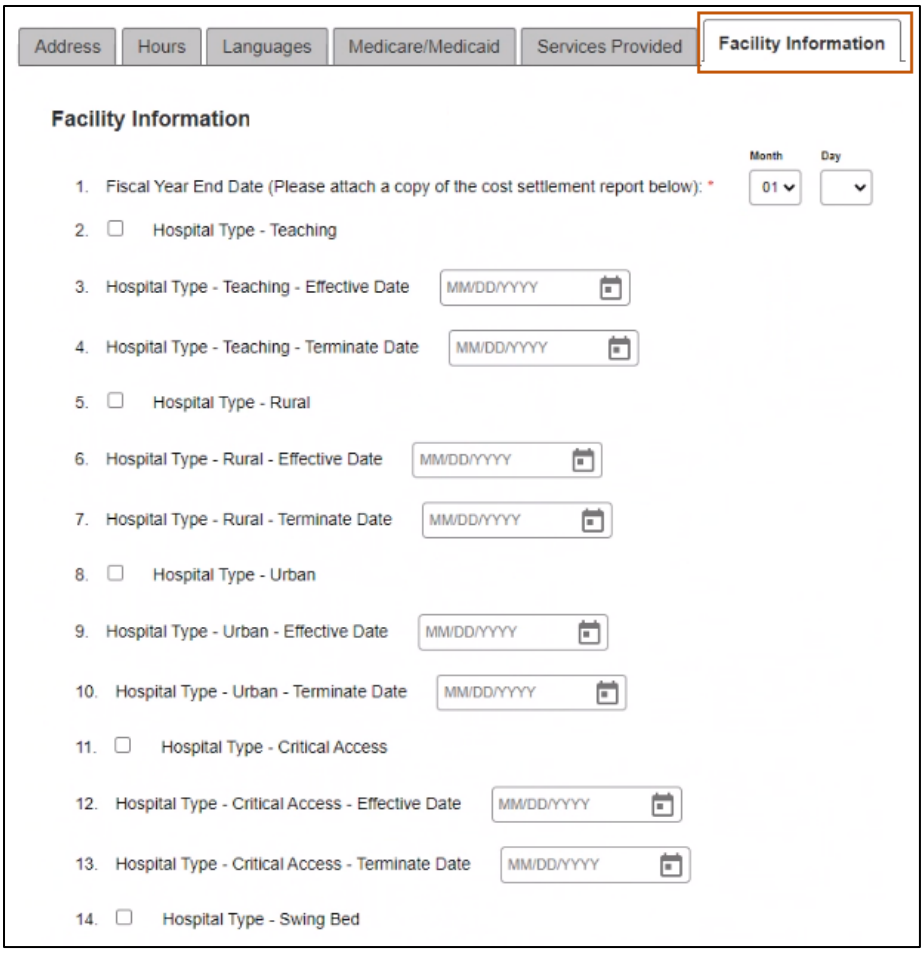


Figure 3-89: Custom Facility Information Tab

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.

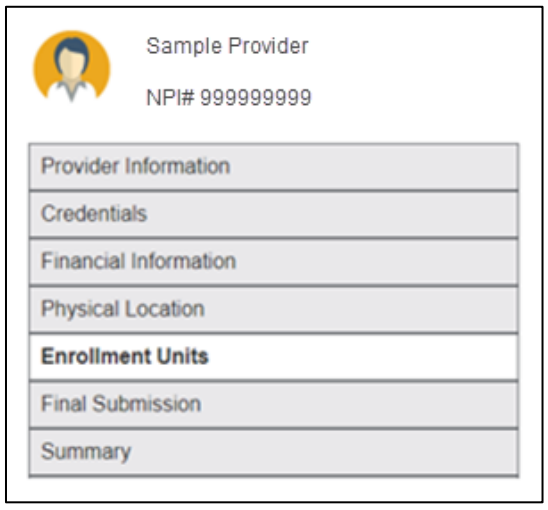


Figure 3-90: Enrollment Units

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

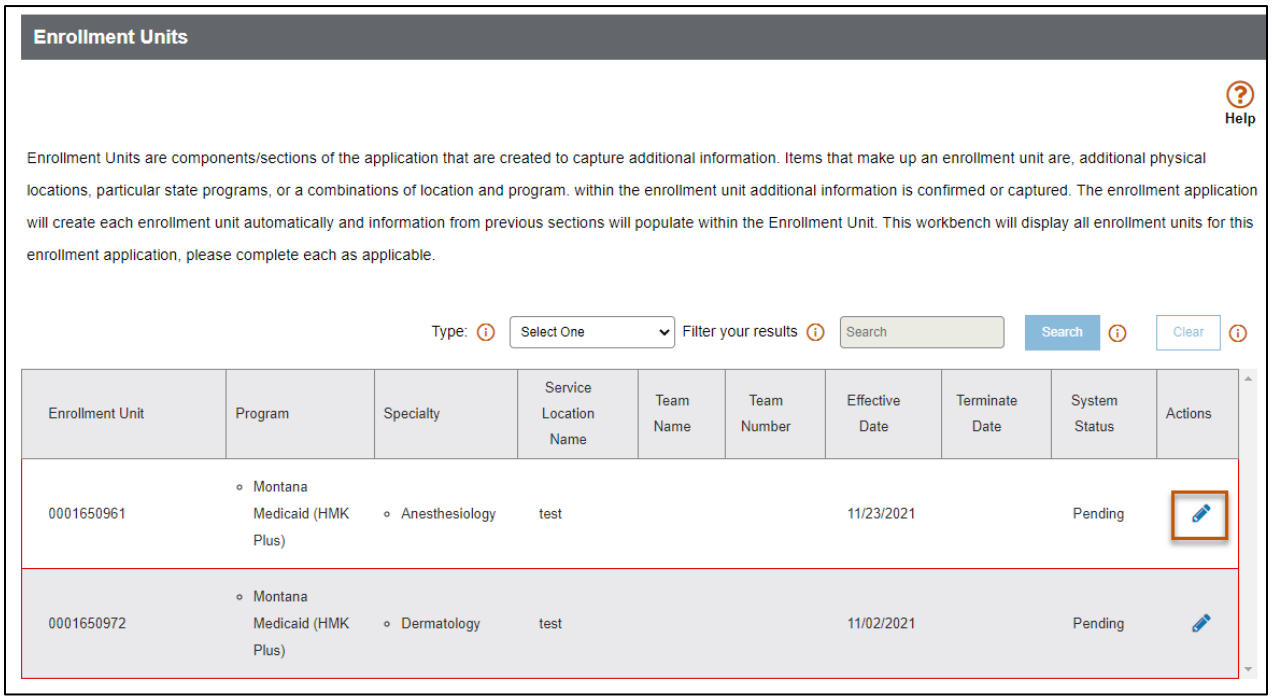


Figure 3-91: Enrollment Units - Edit

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

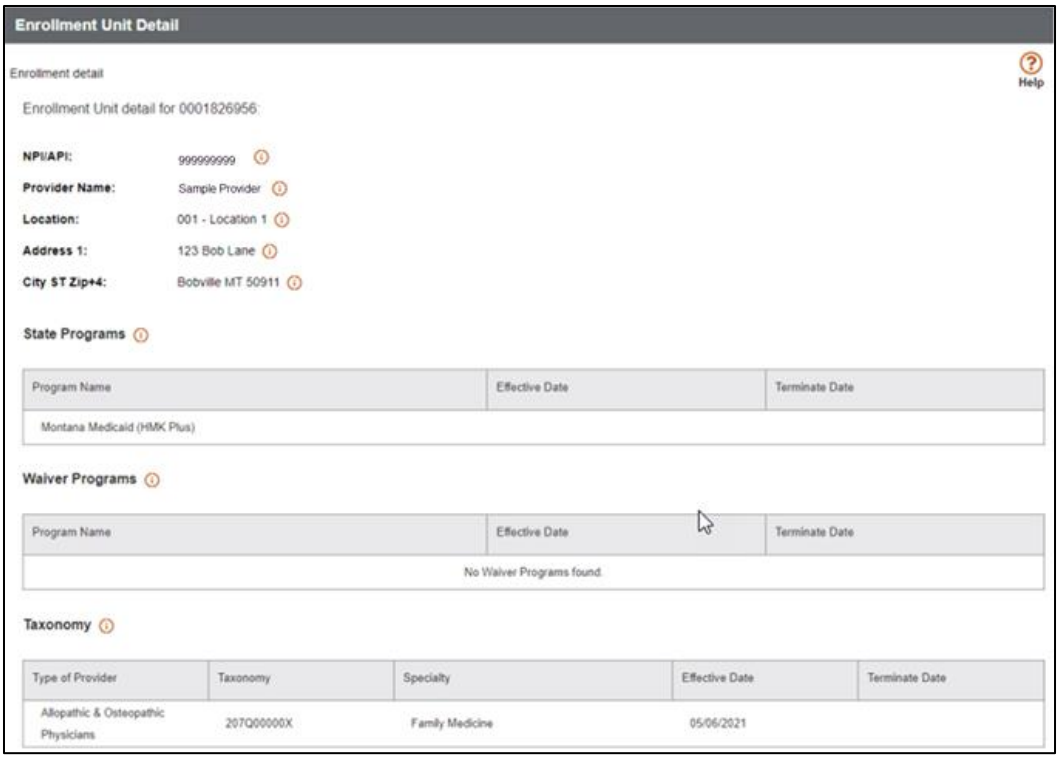


Figure 3-92: Enrollment Unit Detail

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.

Figure 3-93: Licensing, Certifications & Accreditations Tab

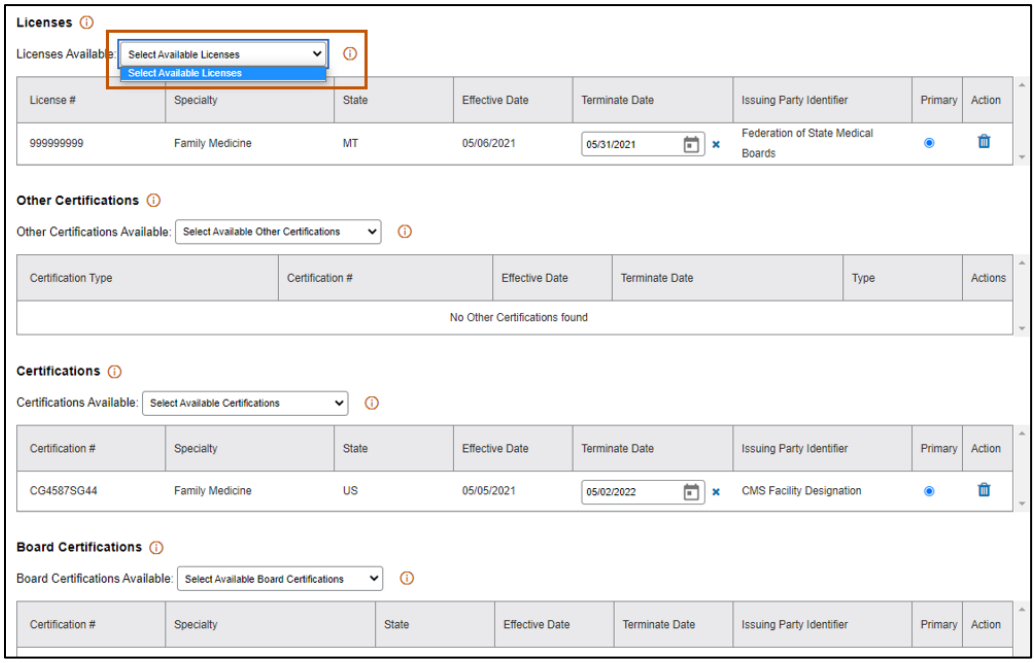


Figure 3-94: Select License Information

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.

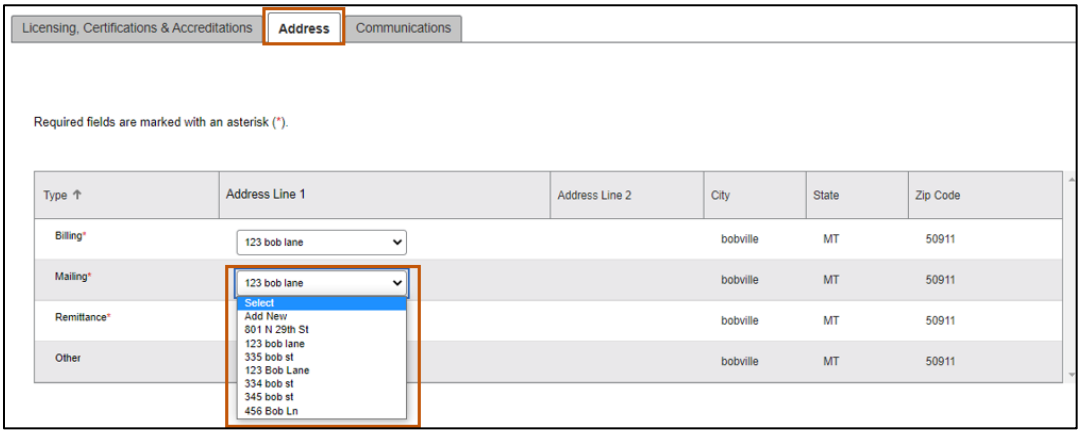


Figure 3-95: Select Addresses

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

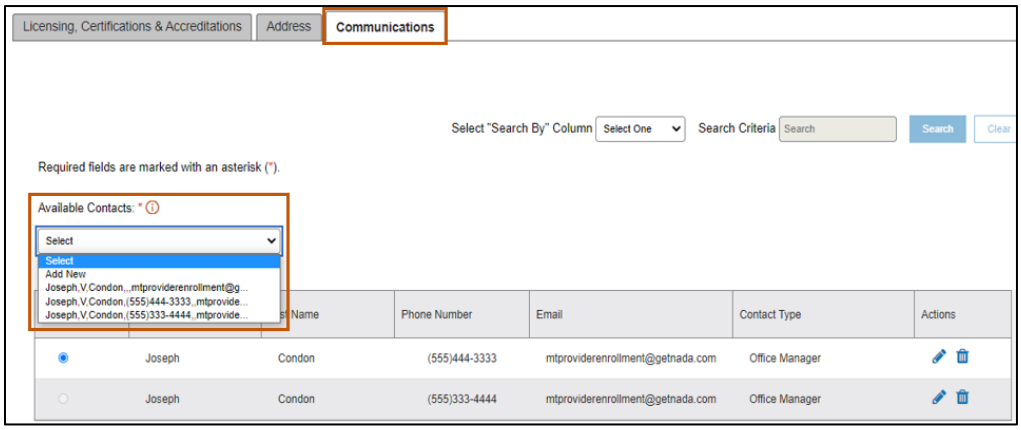


Figure 3-96: Select Contact Information

6. 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.

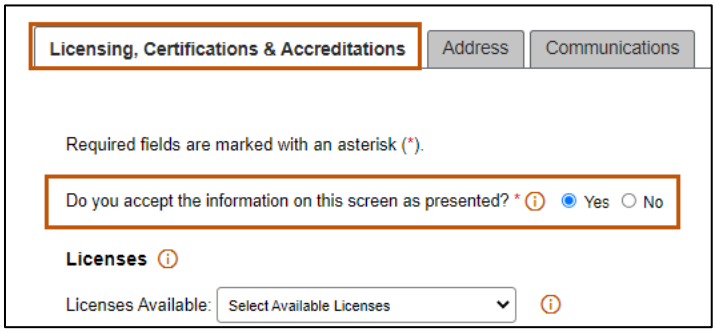


Figure 3-97: Answer the Attestation Question

Figure 3-98: Save Button

7. 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.

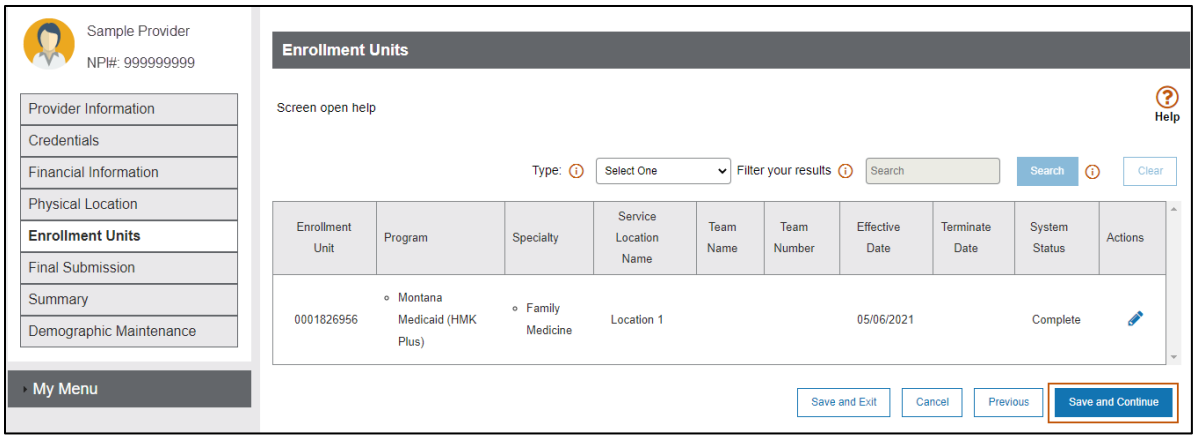


Figure 3-99: Save and Continue

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.

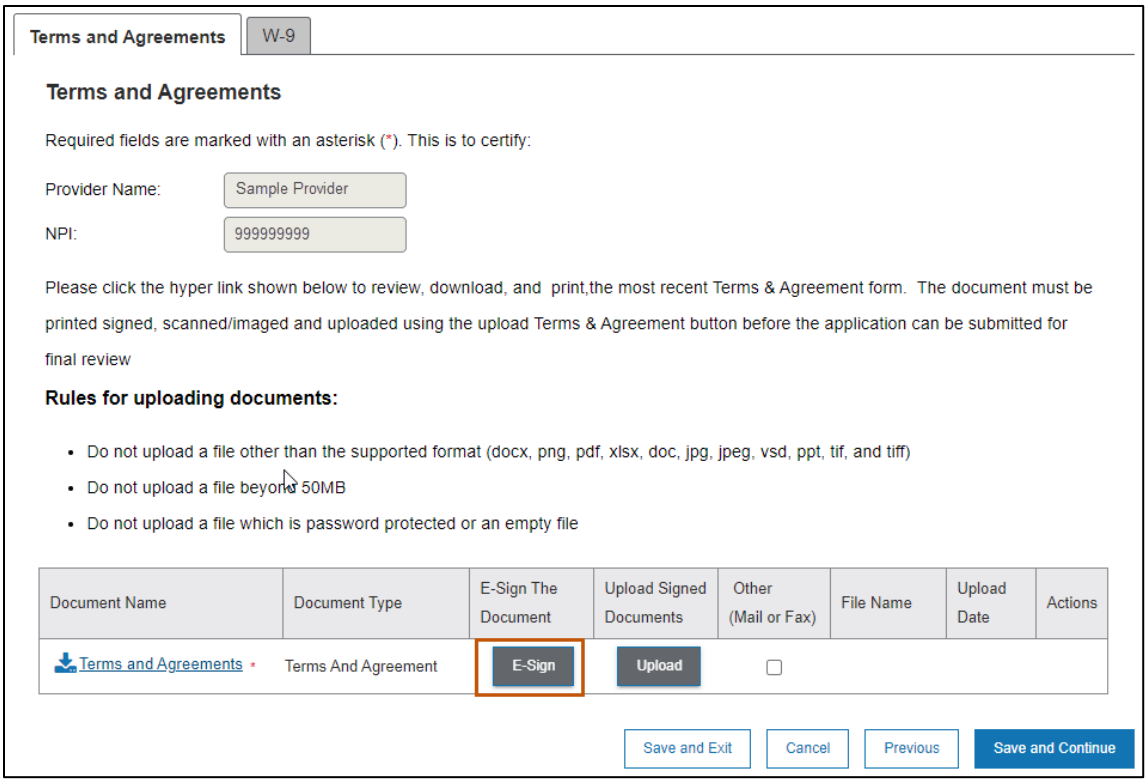


Figure 3-100: Terms and Agreements

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.

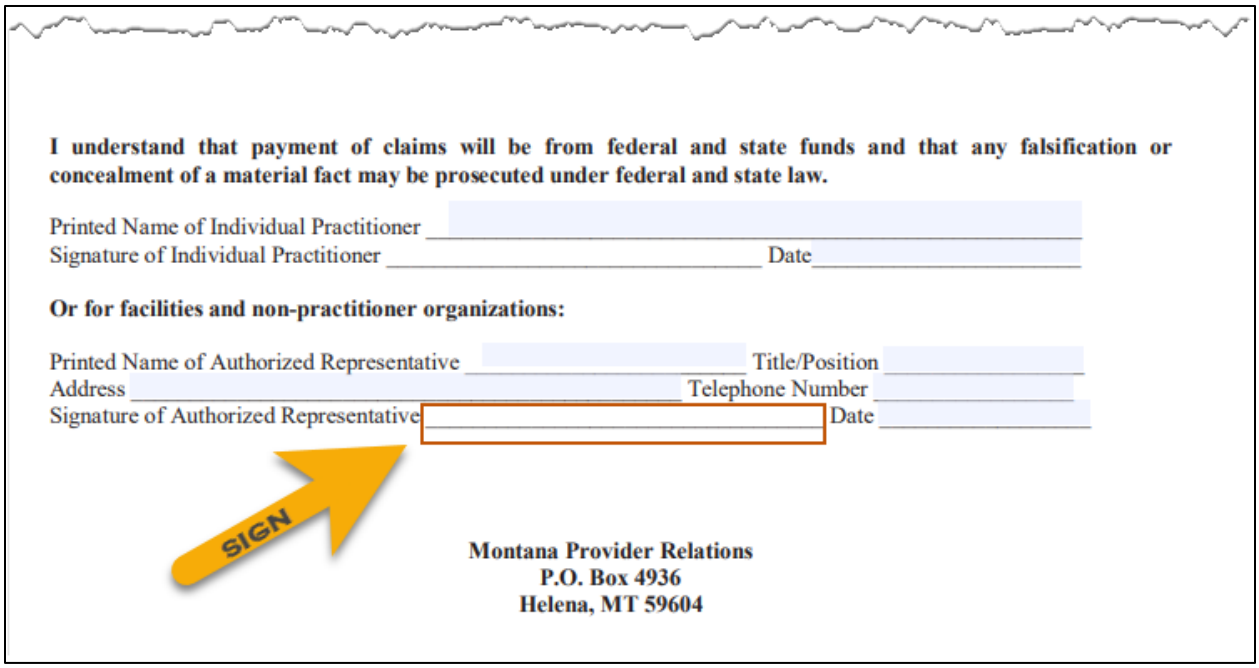


Figure 3-101: Terms and Agreements

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.

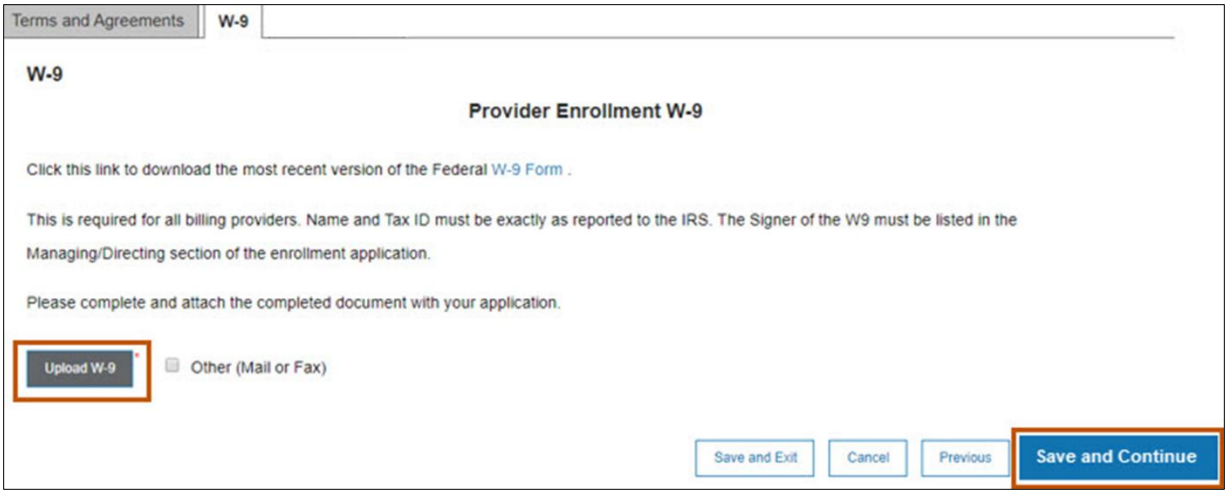


Figure 3-102: W-9 Tab

a. Click **Browse** in the Add Document window.

b. Navigate to the document on the computer's desktop or folder location. Double-click on the file name to select it. The document displays and uploads into the record. Refer to Figure 3-102.

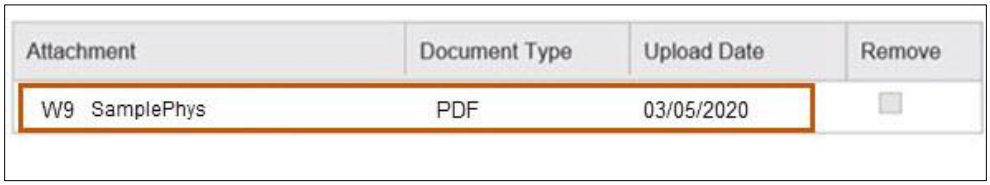


Figure 3-103: Upload Details

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.

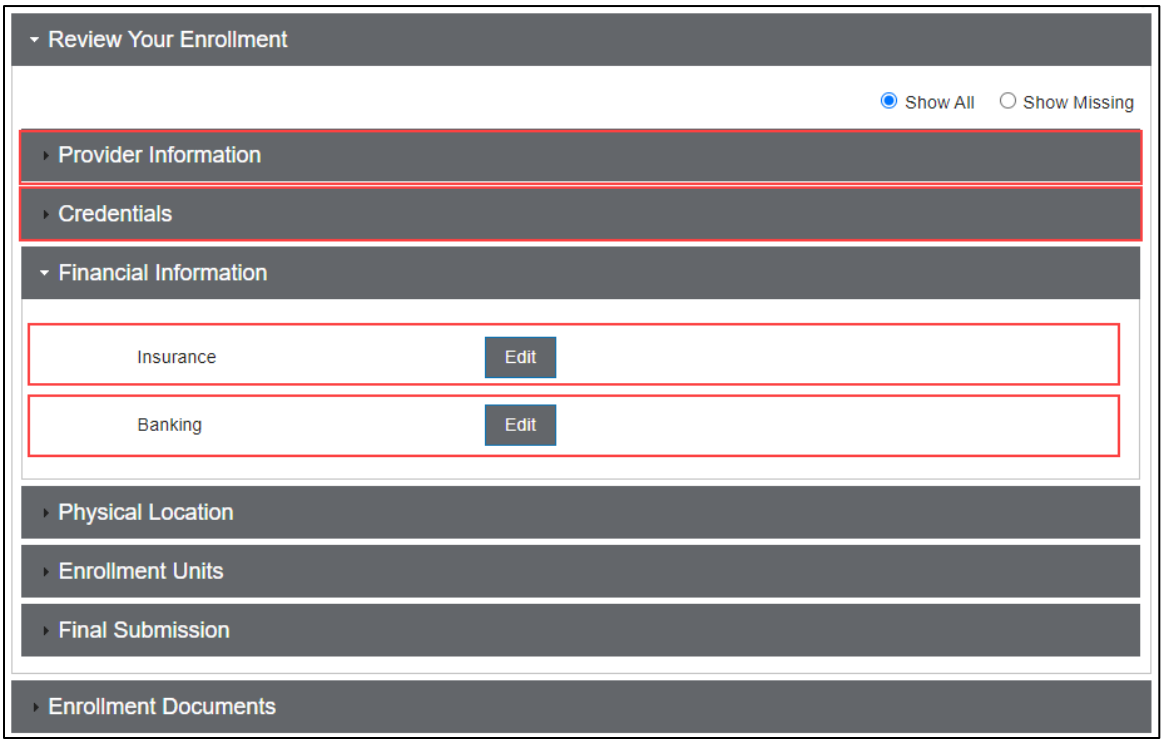


Figure 3-104: Sample of Incomplete Application – Enrollment Summary

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.

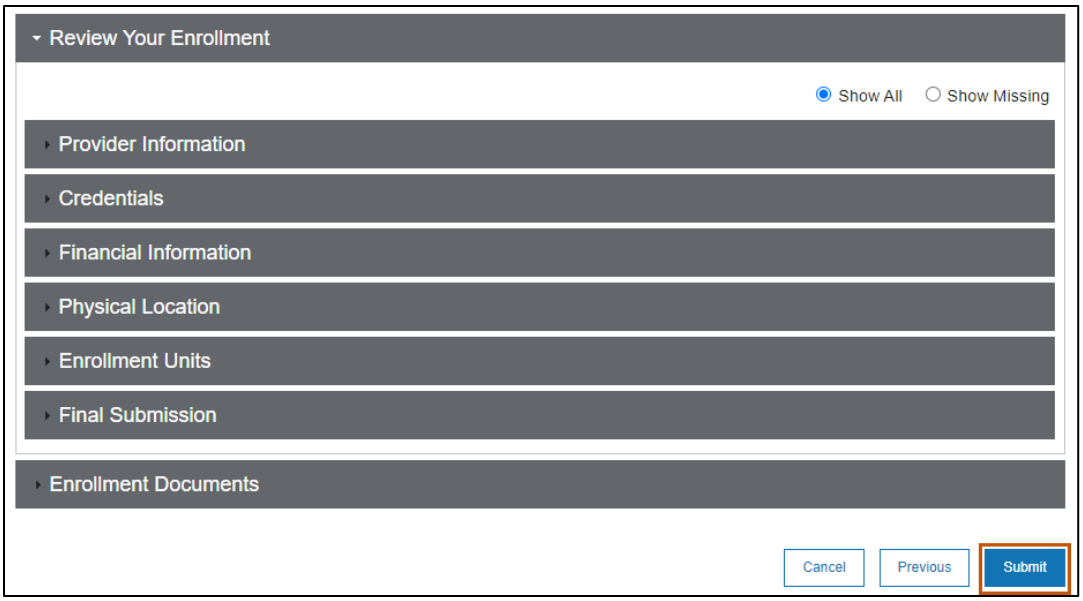


Figure 3-105: Sample of a Complete Application – Enrollment Summary

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.

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

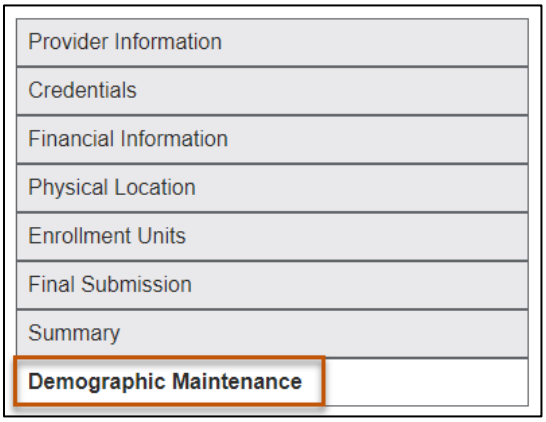


Figure 3-106: Select Demographic Maintenance

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

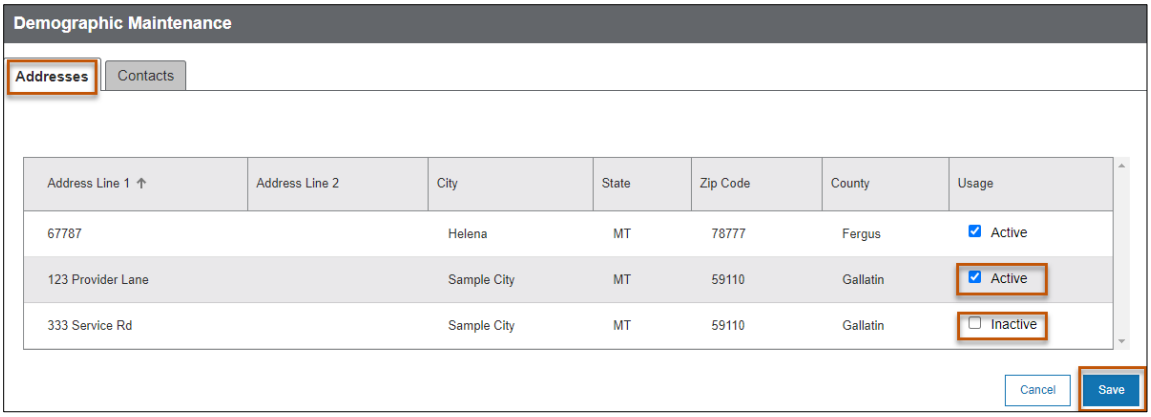


Figure 3-107: Addresses in Demographic Maintenance

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

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.

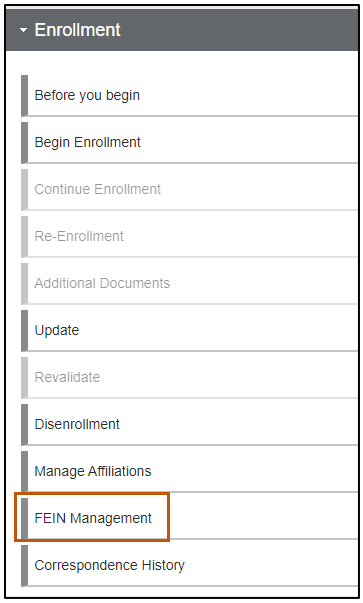


Figure 3-109: FEIN Management

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.

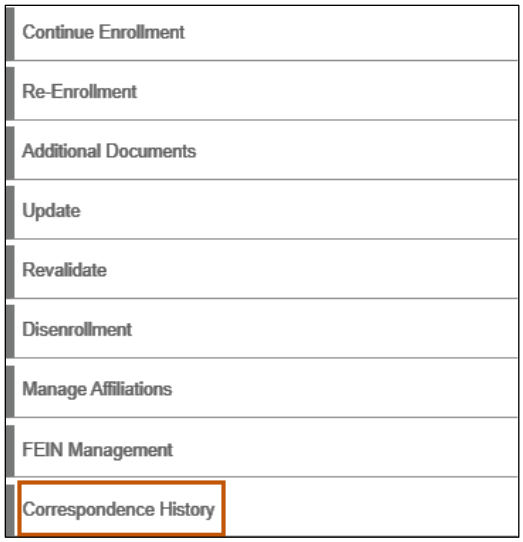


Figure 3-110: Select Correspondence History

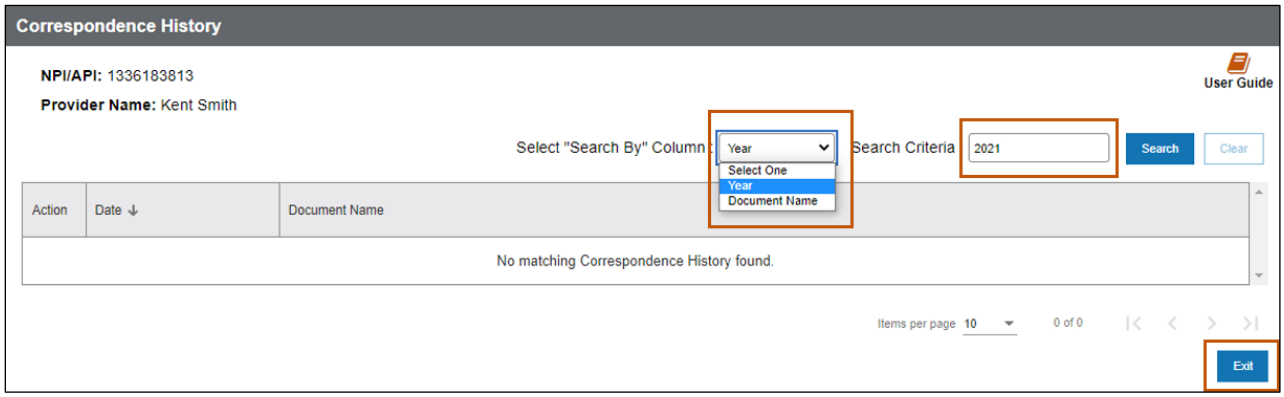


Figure 3-111: Correspondence History Page

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.

1. Select **Provider Information** from the navigation menu and click the Legal Name & Address tab.
2. 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.

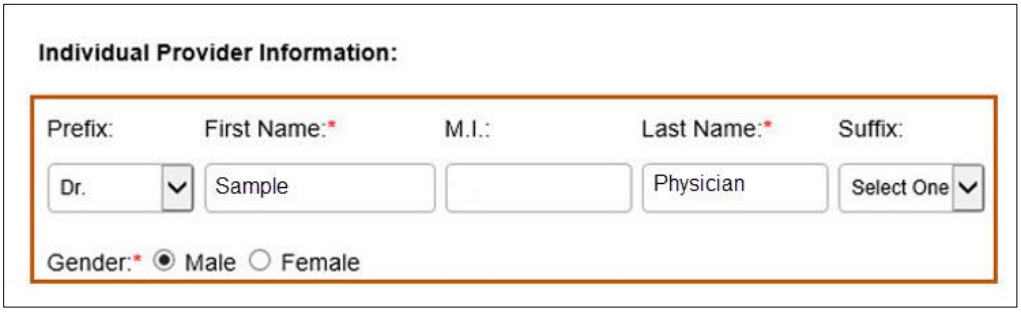


Figure 3-112: Individual Provider Information

3. 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.

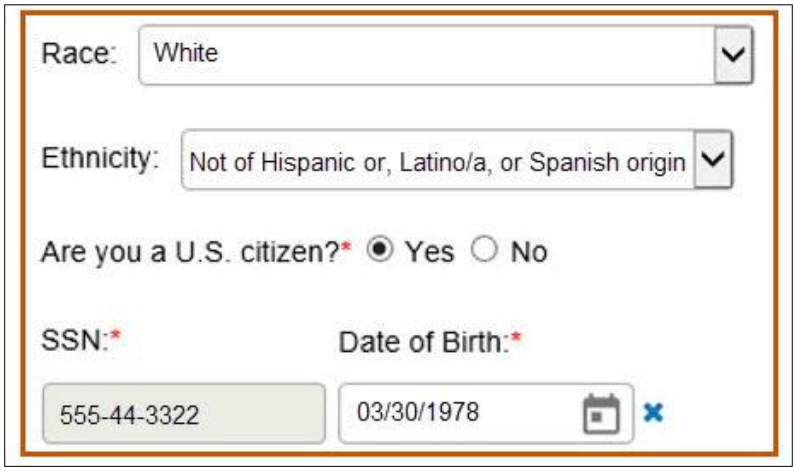


Figure 3-113: Ethnicity, Citizenship, SSN and Date of Birth

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.

1. 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**.

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.

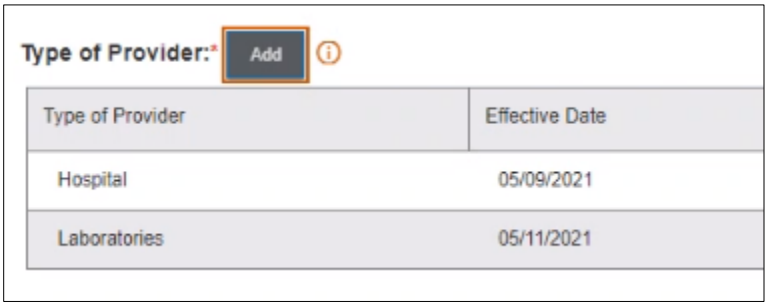


Figure 4-2: Organizational Type Grid

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

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.

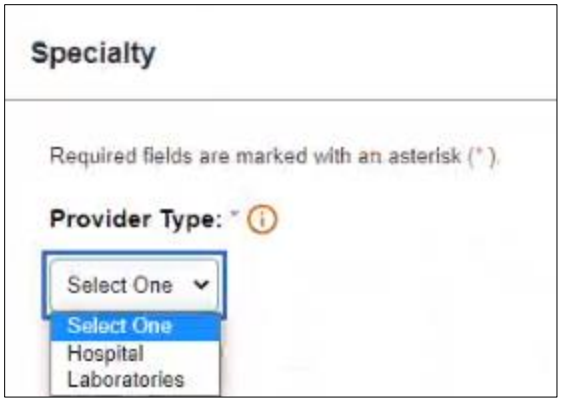


Figure 4-4: Select a Provider Type from the List

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.

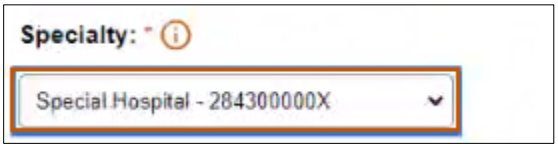


Figure 4-5: Specialty Drop-Down Box

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

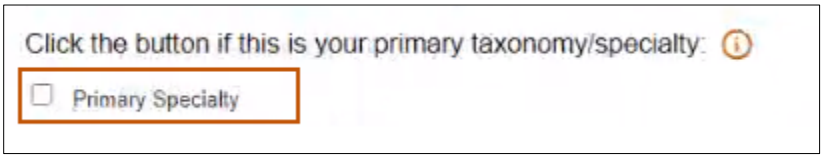


Figure 4-6: Primary Specialty Checkbox

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

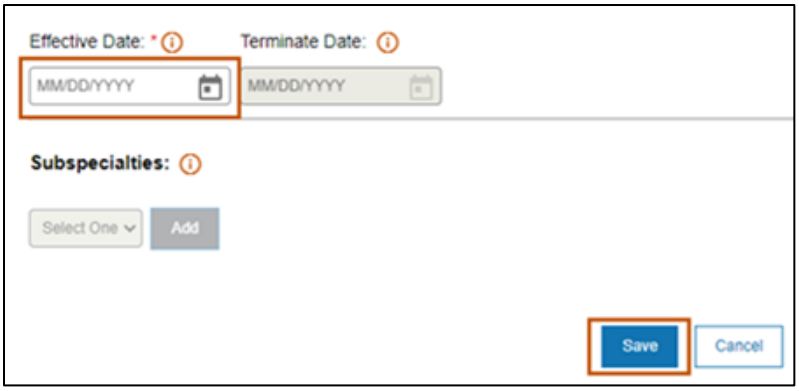


Figure 4-7: Effective Date

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.

9. 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.

   b. Select No if the provider does not have a subpart. Proceed to Section 4.2: Organizational Providers Legal Name and Address.

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 Section 3.1.1: 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.

1. 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.

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.

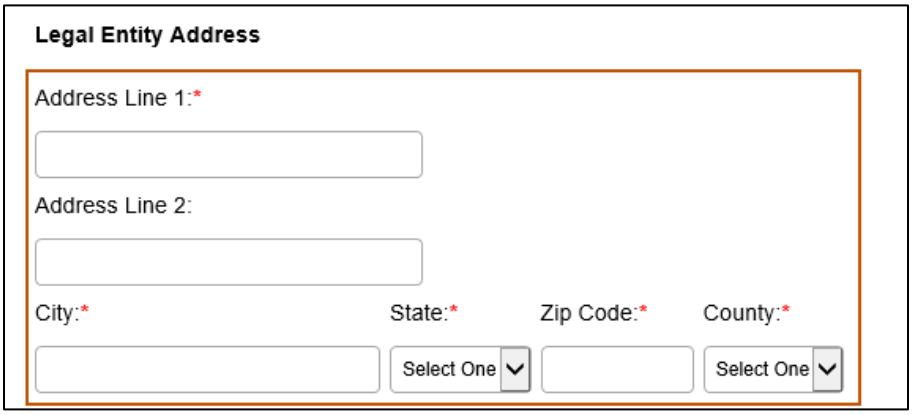


Figure 4-10: Legal Entity Address Fields

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.

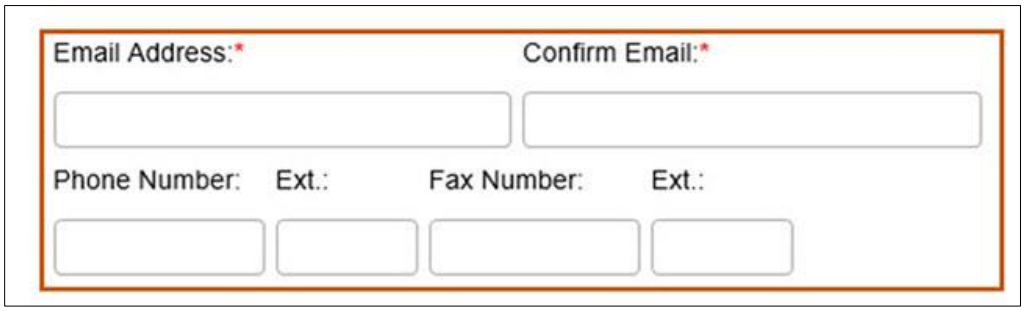


Figure 4-11: Email Address and Phone/Fax Numbers

8. 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.

Figure 4-13: Legal Address Validation Suggestion

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

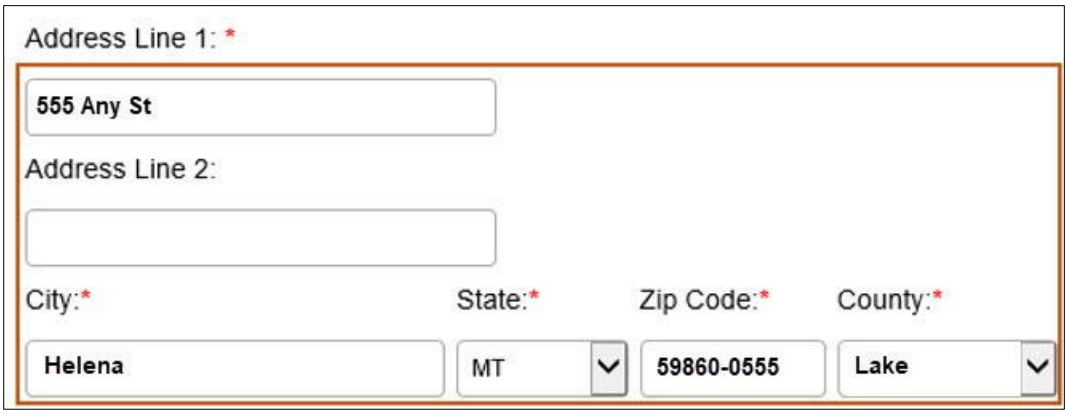


Figure 4-14: Legal Entity Address Section

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.

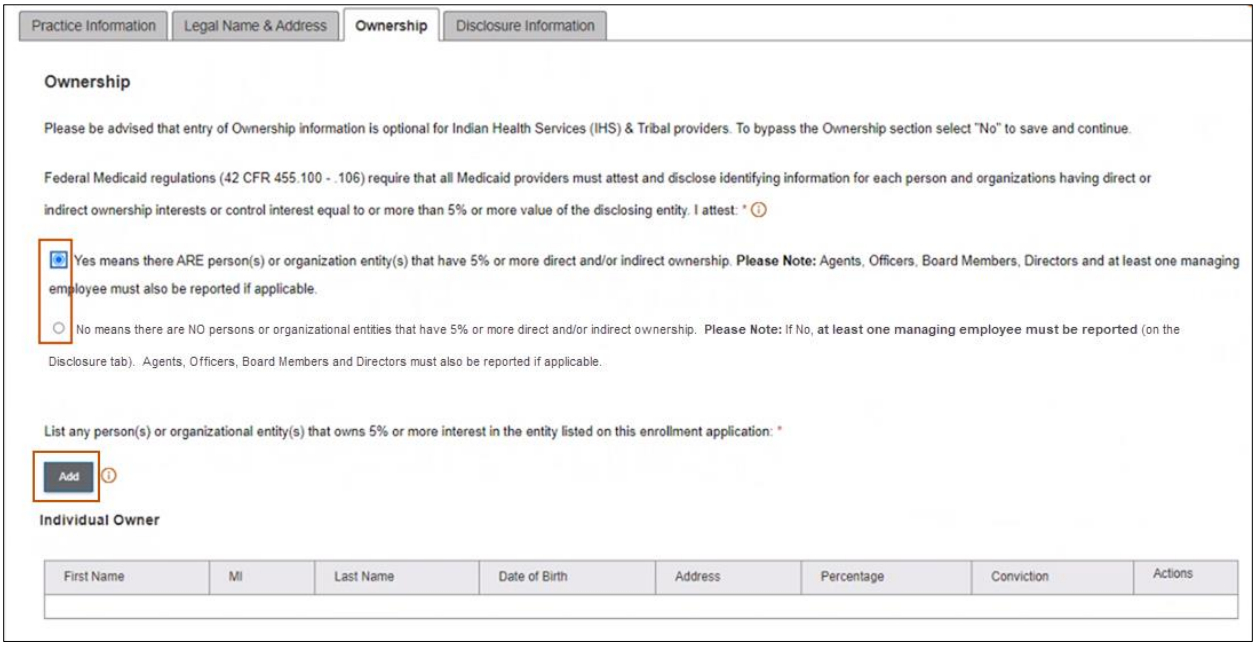


Figure 4-15: Ownership Attestation

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

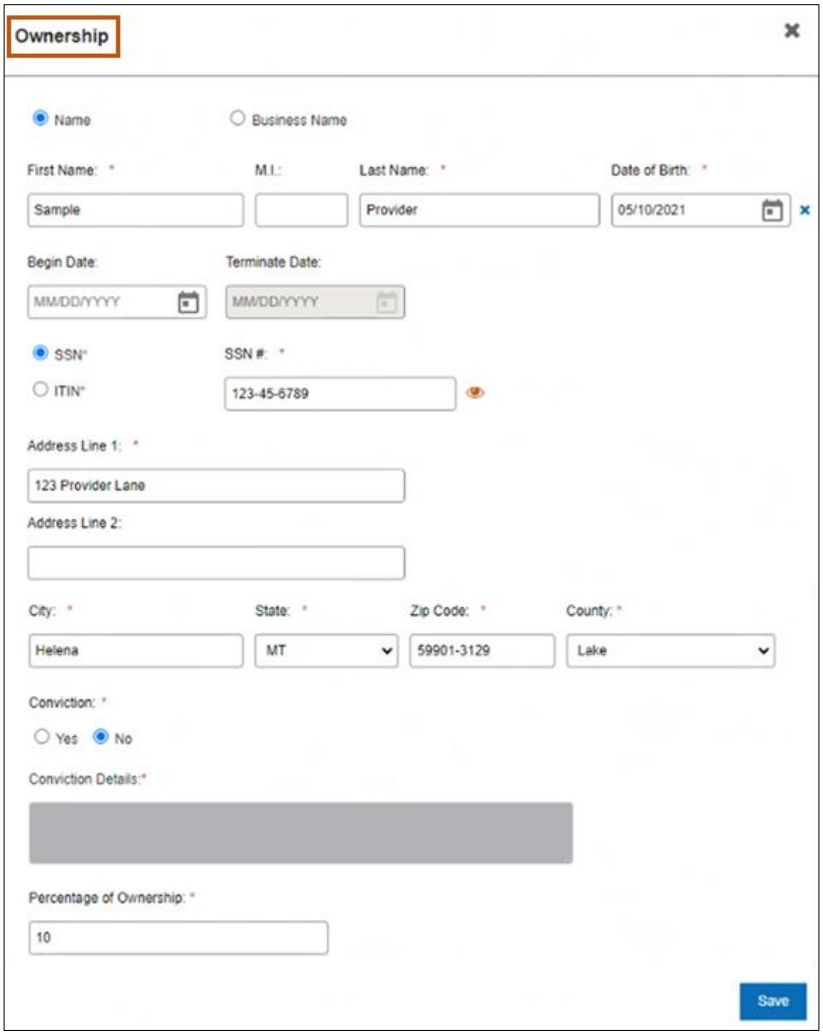


Figure 4-16: Ownership Details

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.**

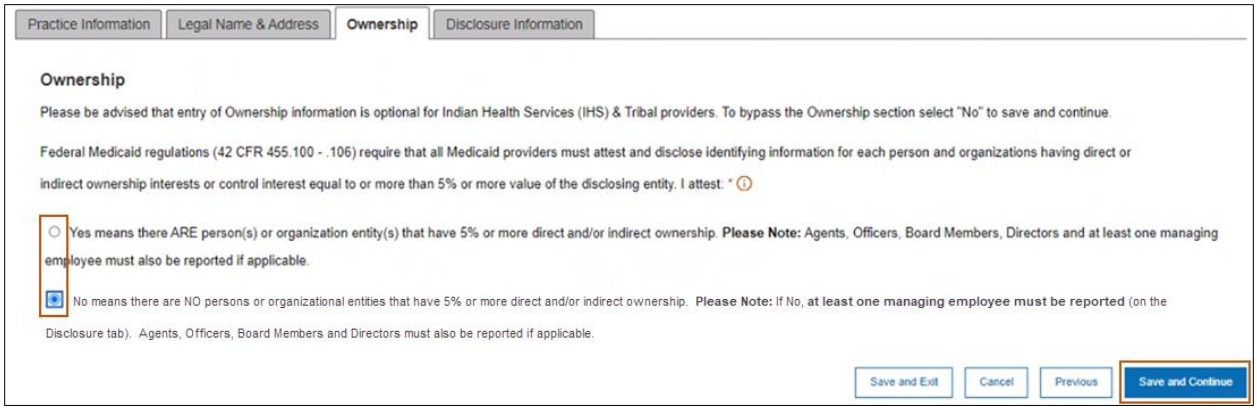


Figure 4-17: No Ownership

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:

1. 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.

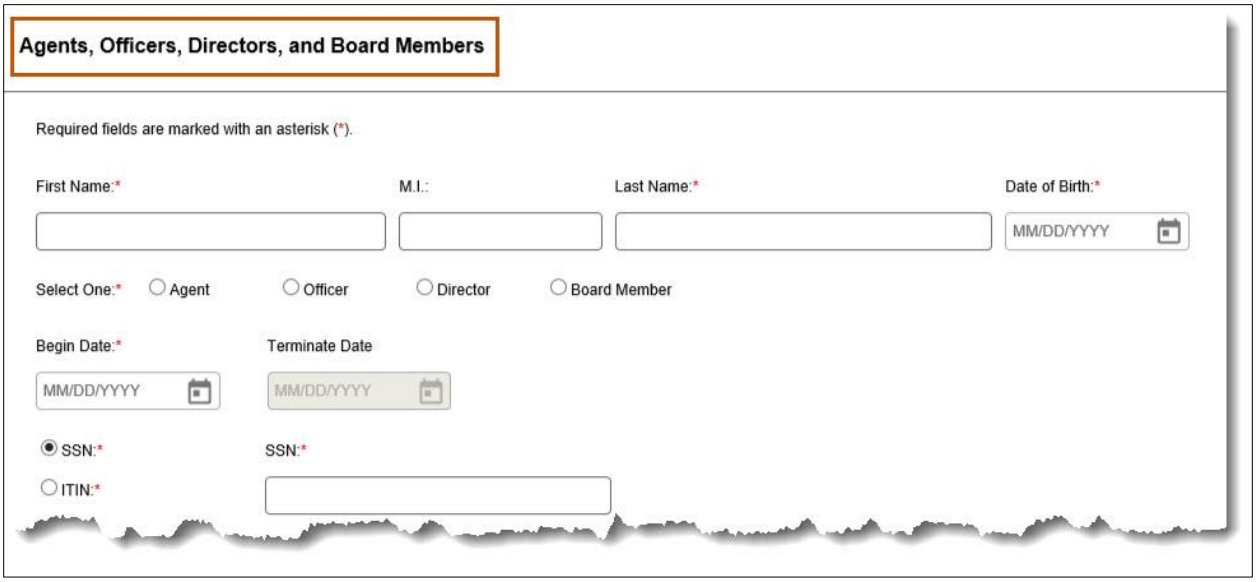


Figure 4-19: Agents, Officers, Directors, and Board Members Name

Table 4-1: Disclosure Information Role Definitions

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.

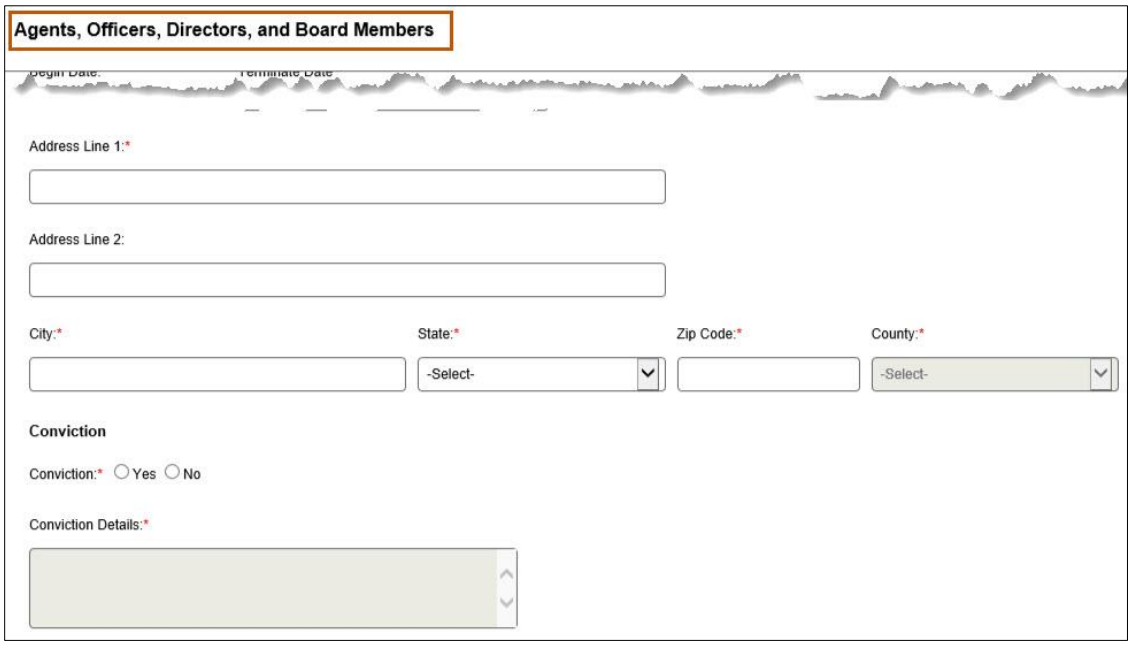


Figure 4-20: Agents, Officers, Directors, and Board Members Additional Information

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.

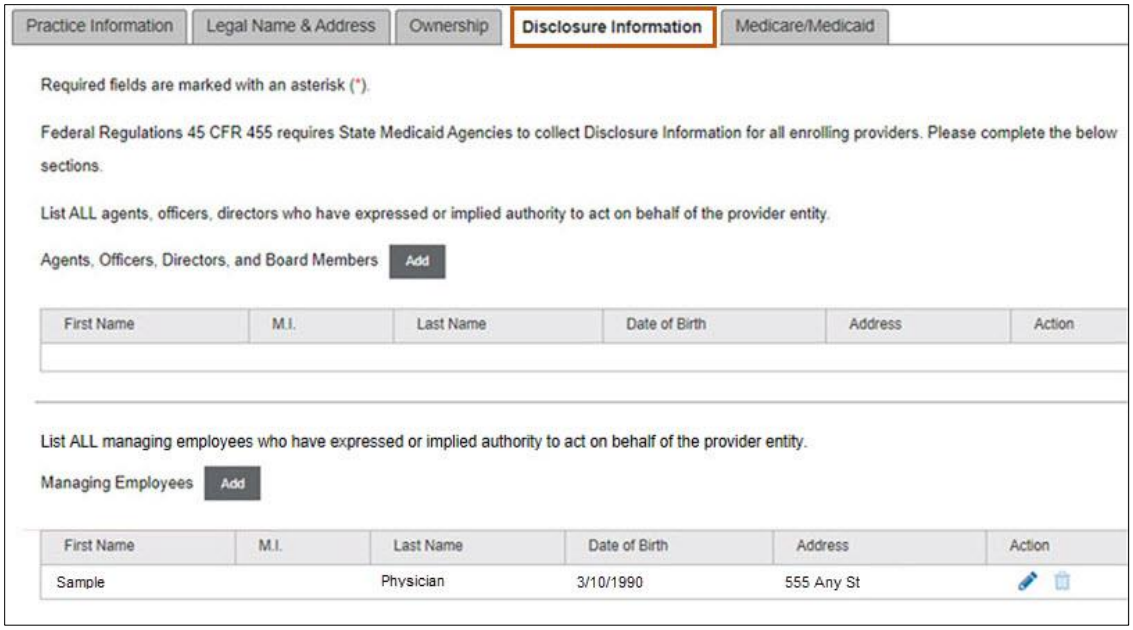


Figure 4-22: Managing Employees

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.

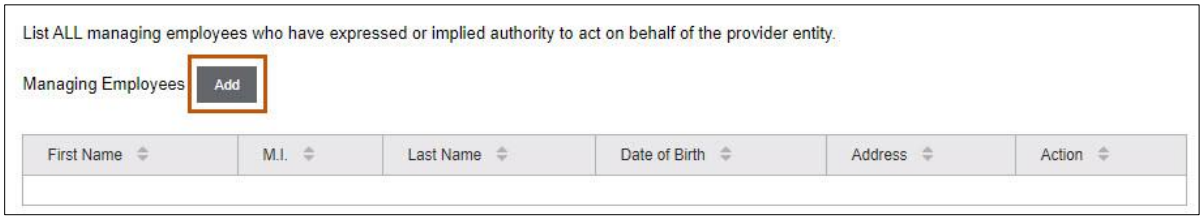


Figure 4-23: Add Managing Employees

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.

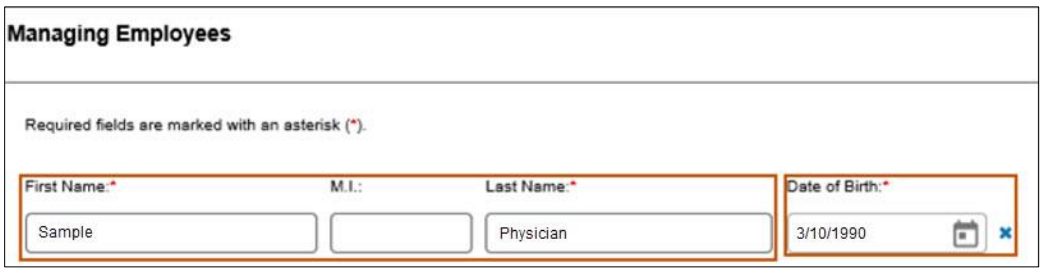


Figure 4-24: Managing Employee Details

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.

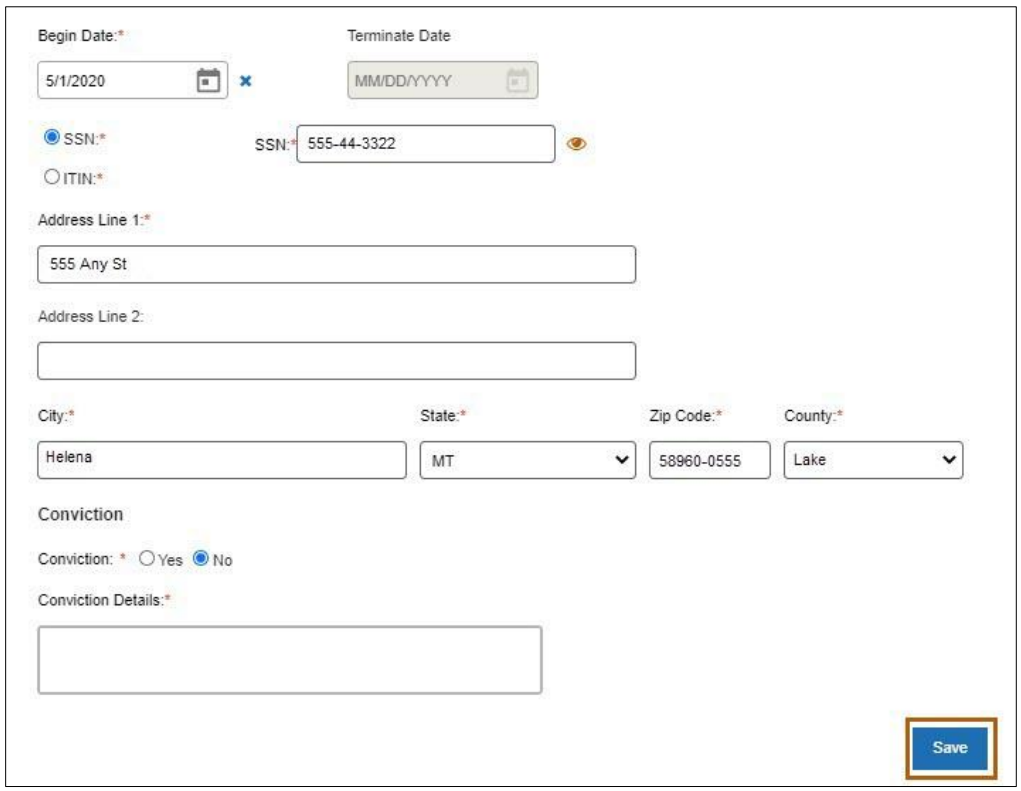


Figure 4-25: Managing Employees Details - continued

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.

1. 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.

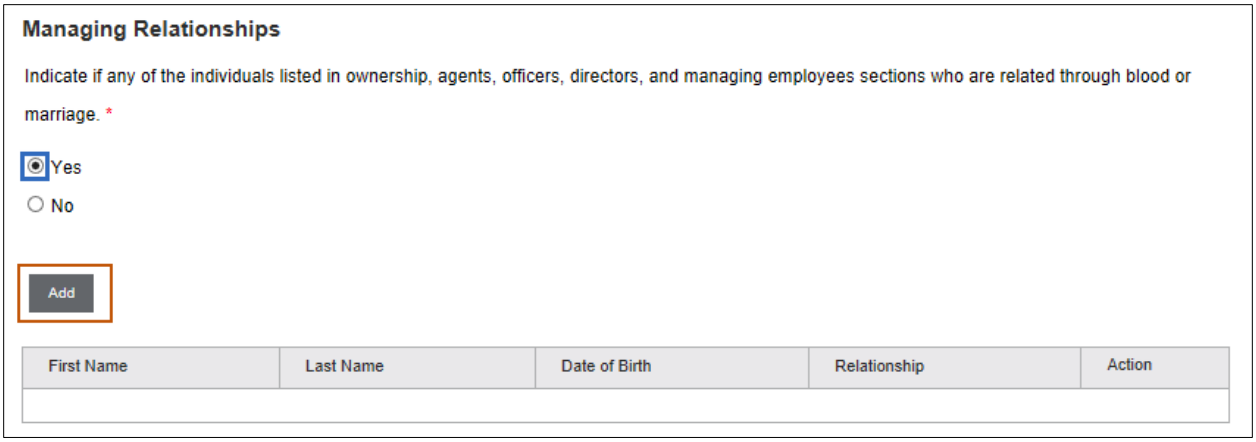


Figure 4-26: Add Managing Relationship

2. 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.

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.

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.

5. Select the corresponding relationship type from the Relationship list. Refer to Figure 4-29.

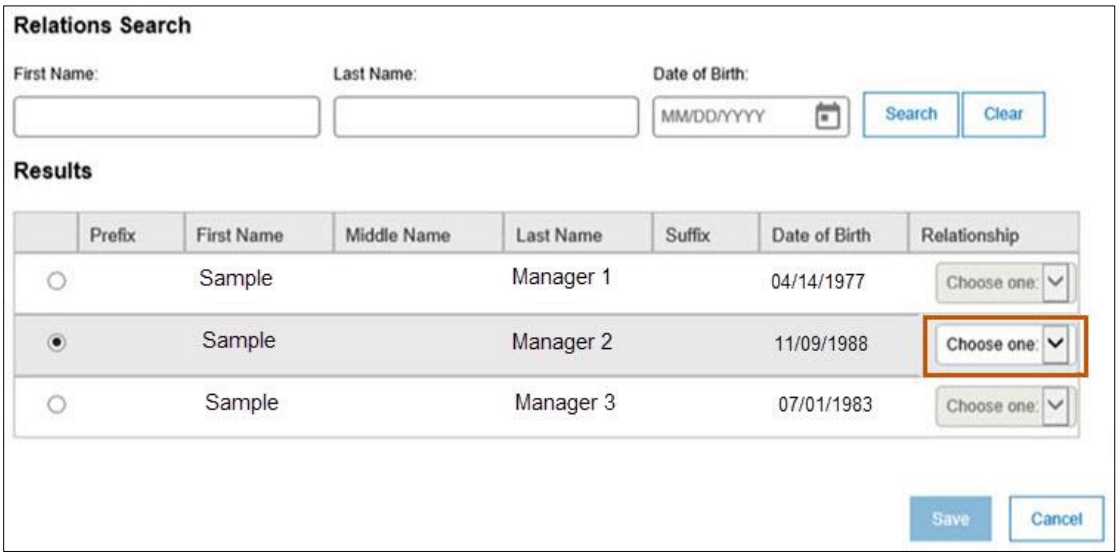


Figure 4-29: Relationship Drop-down Selection

4.4.4. Sub-Contractor

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

1. 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.

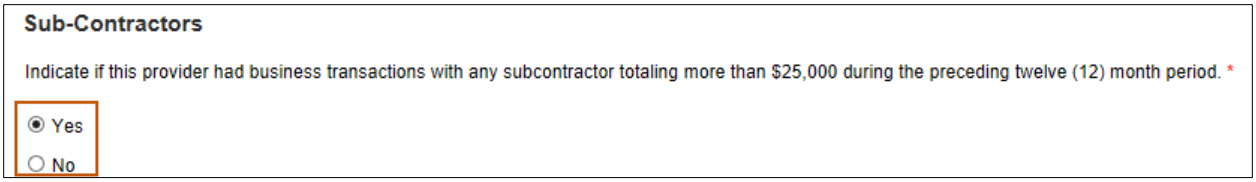


Figure 4-30: Add Sub-Contractor Question

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.

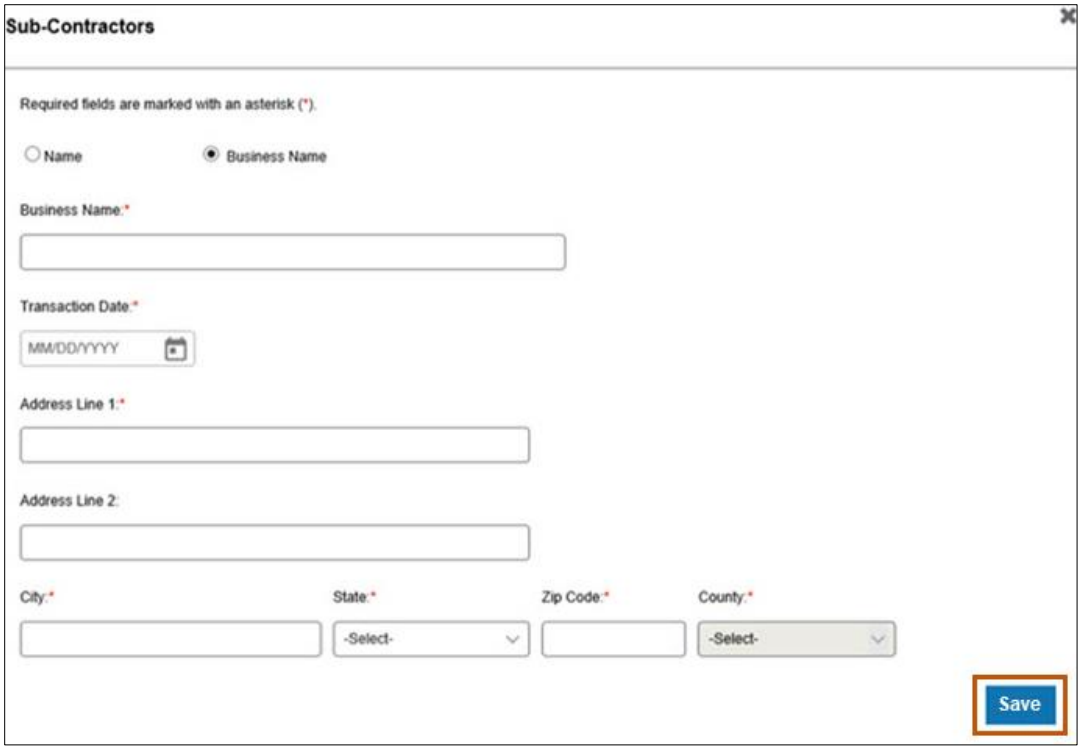


Figure 4-31: Sub-Contractors Screen

   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**.

3. 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.

1. 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.

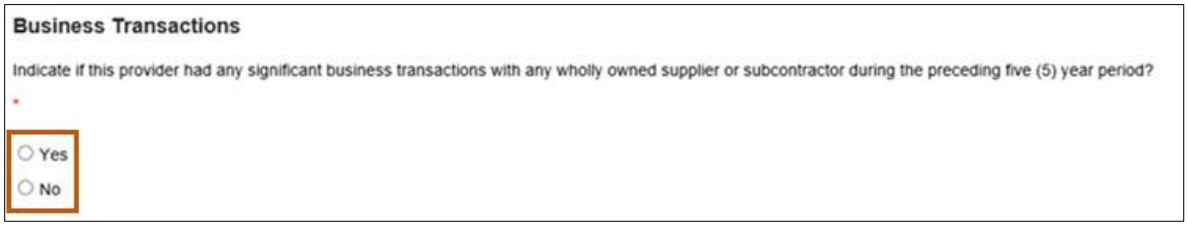


Figure 4-32: Business Transactions Question

2. 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.

3. 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.

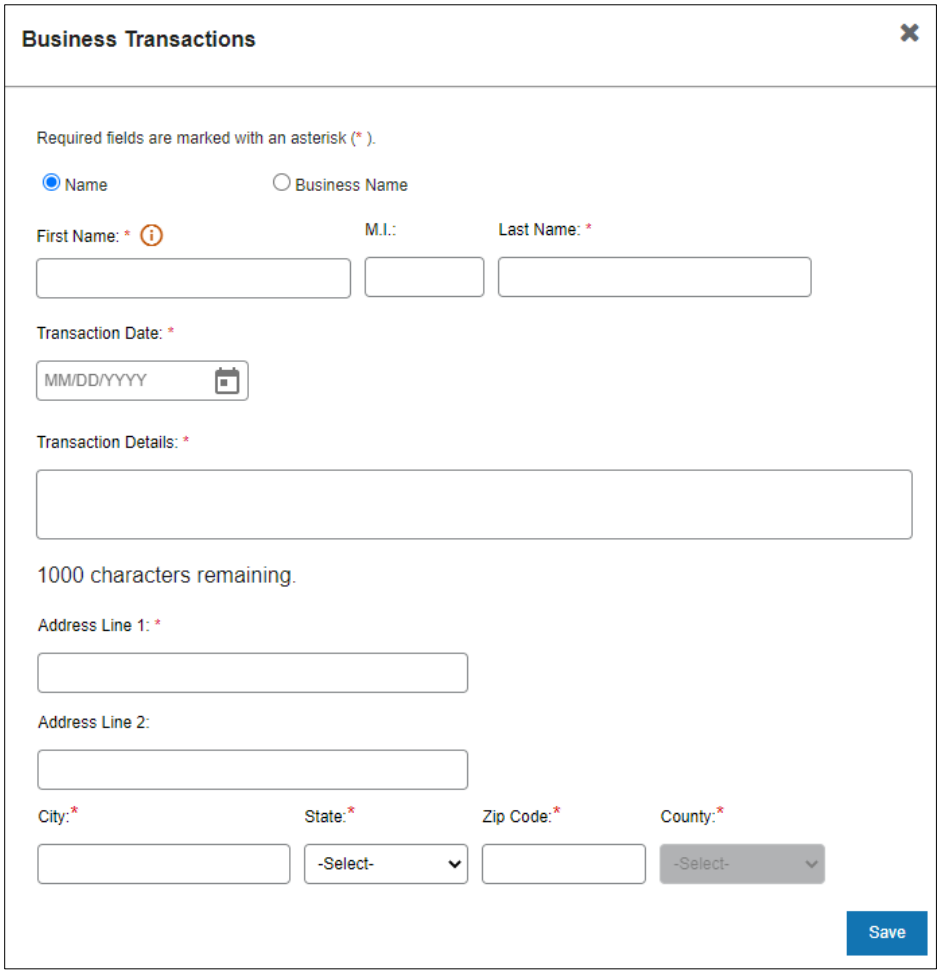


Figure 4-33: Business Transactions Screen

   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.

1. 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.

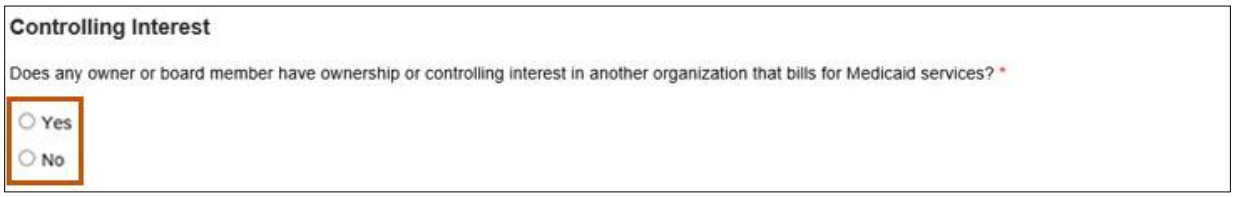


Figure 4-34: Controlling Interest Question

2. 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.

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 4-35.

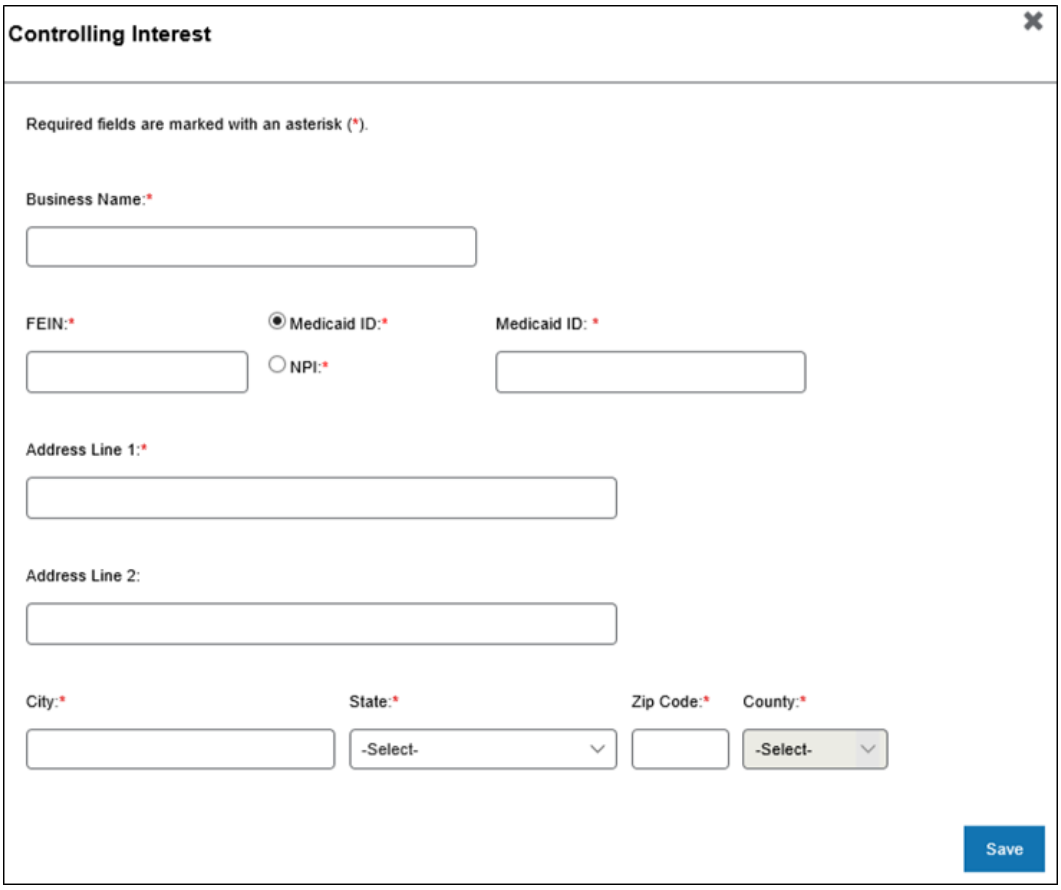


Figure 4-35: Controlling Interest Screen

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.

1. If selecting No to all questions**,** proceed to Section 4.4.8 Authorized Official Attestation.
2. 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?

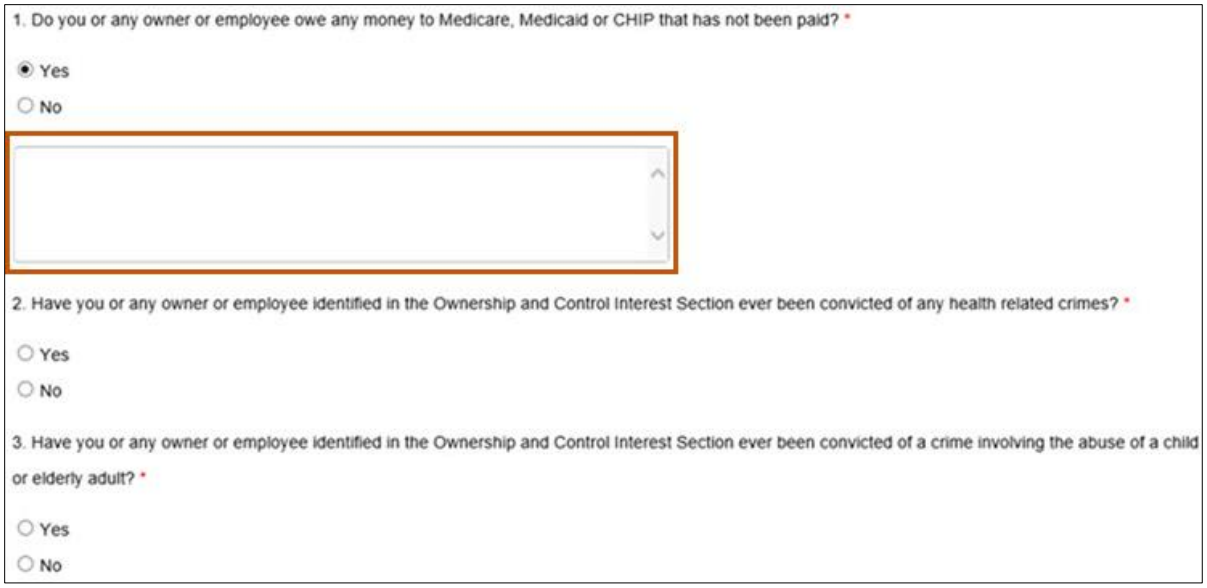


Figure 4-36: Enrollment Attestation Questions

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.

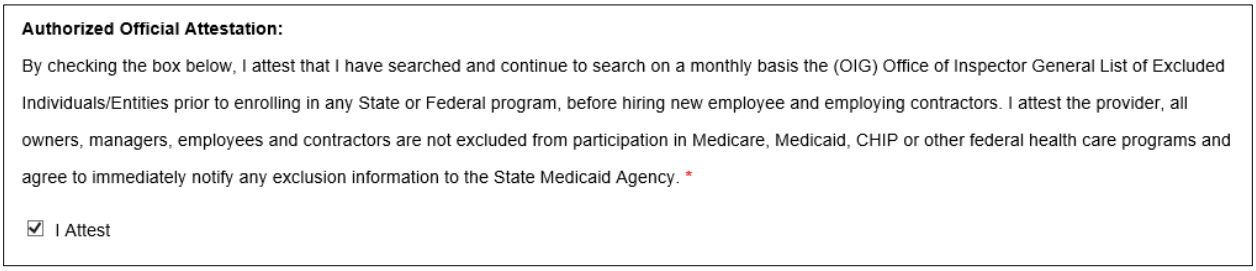


Figure 4-37: Authorized Official Attestation

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.

1. Select No if the location does not provide laboratory services and proceed to Section 4.7.2: Provider Type, Specialties & Programs.
2. Select **Yes** if the location provides laboratory services and complete the steps below. Refer to Figure 4-39.

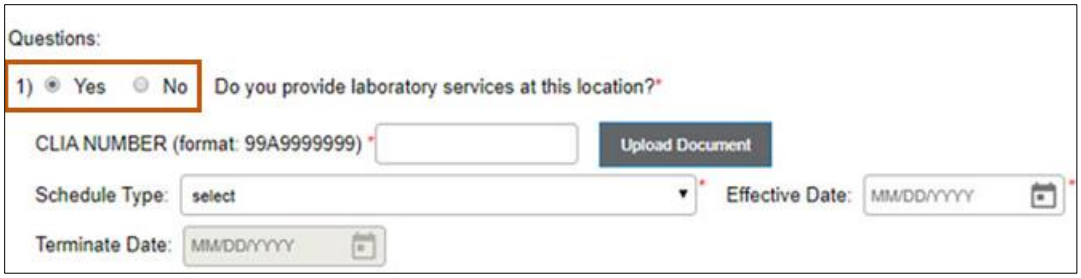


Figure 4-39: Laboratory Service at the Physical Location

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.

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.

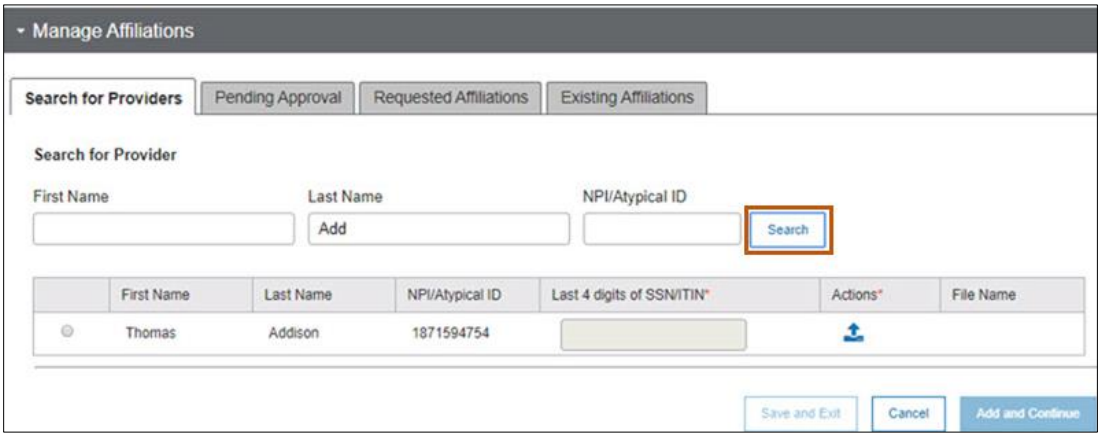


Figure 4-41: Searching for a Rendering Provider

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

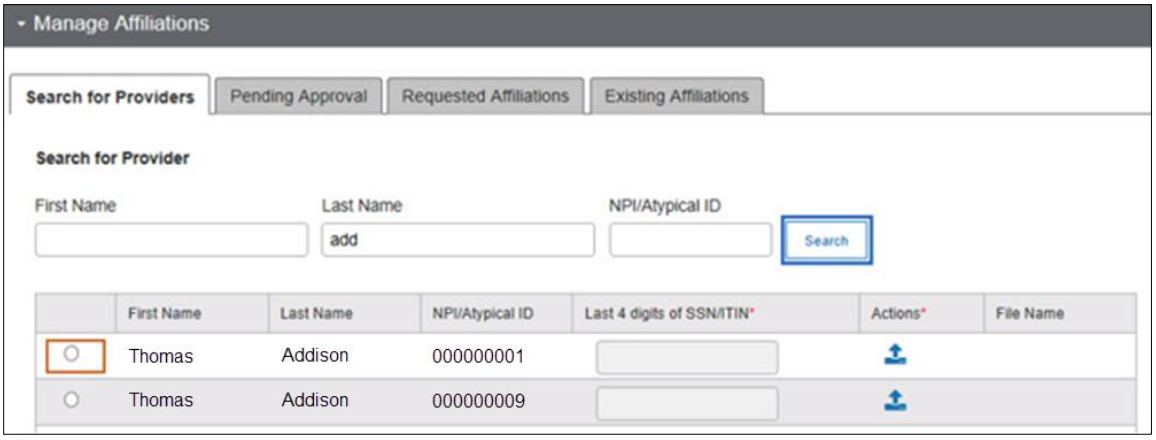


Figure 4-42: Provider Radio Button

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

Figure 4-43: Last Four Digits of Provider SSN

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

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.

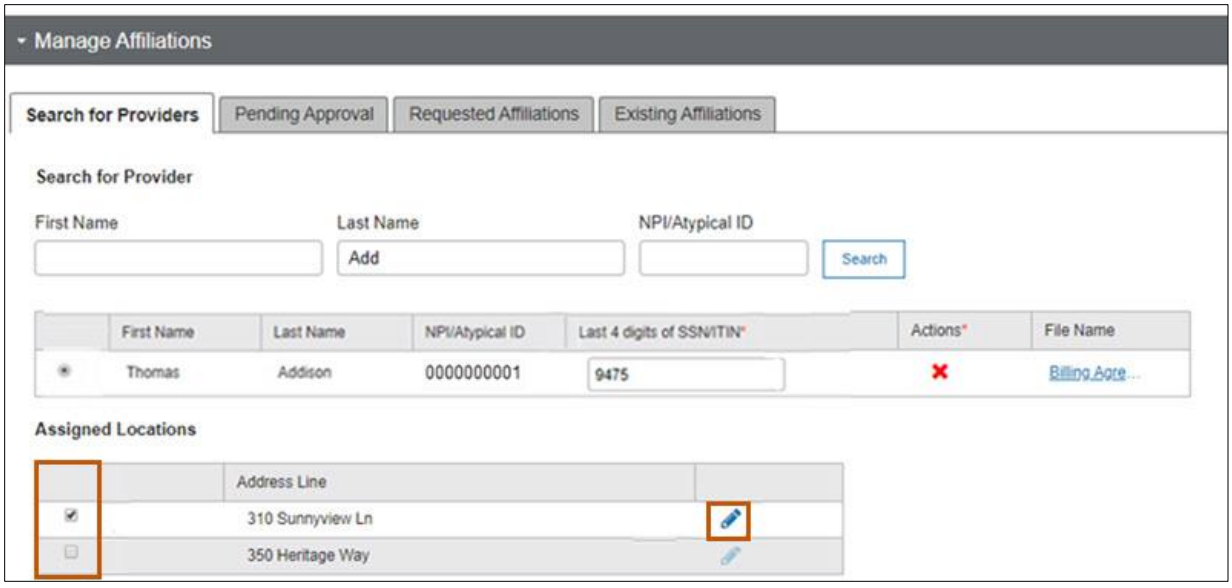


Figure 4-45: Assign Addresses where the Rendering Provider Performs Services

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

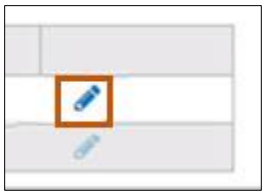


Figure 4-46: Pencil Icon

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.

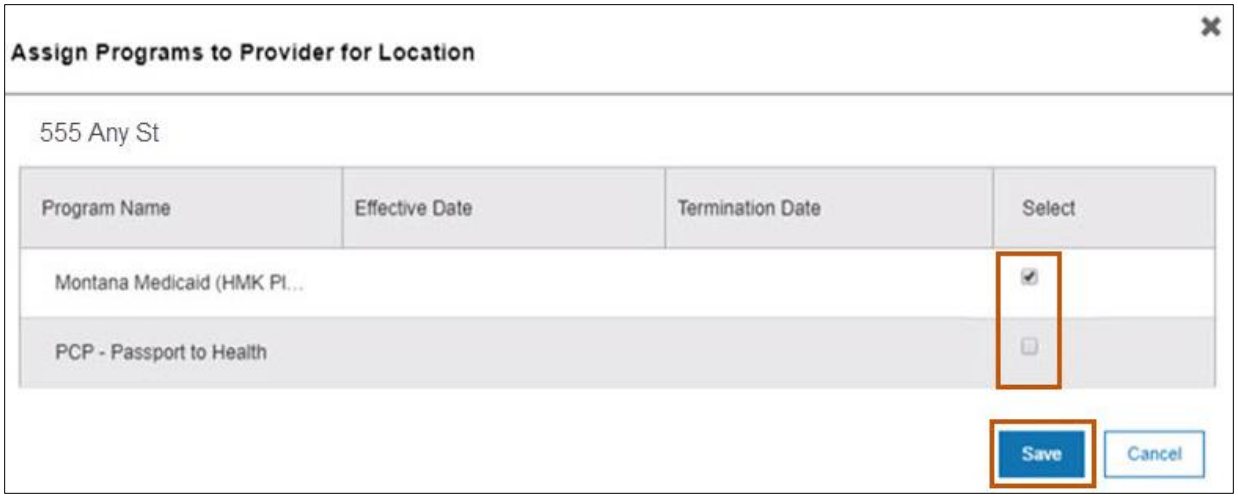


Figure 4-47: Assign Programs to the Address the Rendering Provider Performs Services

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

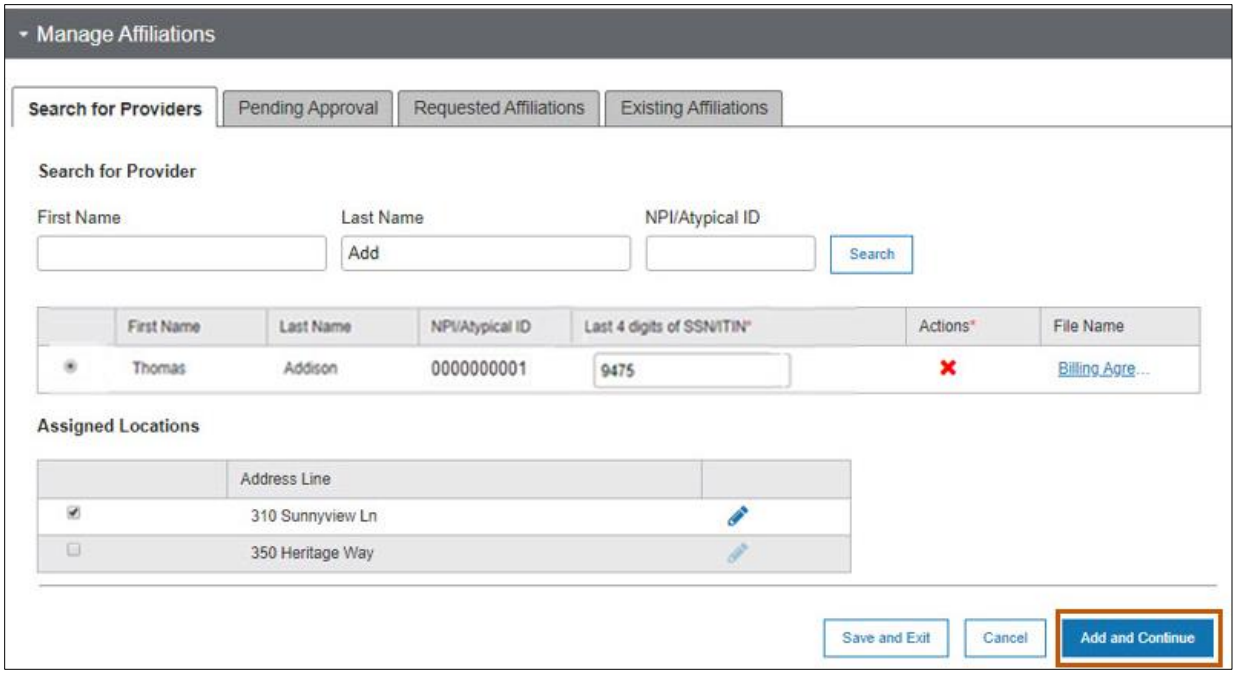


Figure 4-48: Saving the Rendering Provider Affiliation

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.

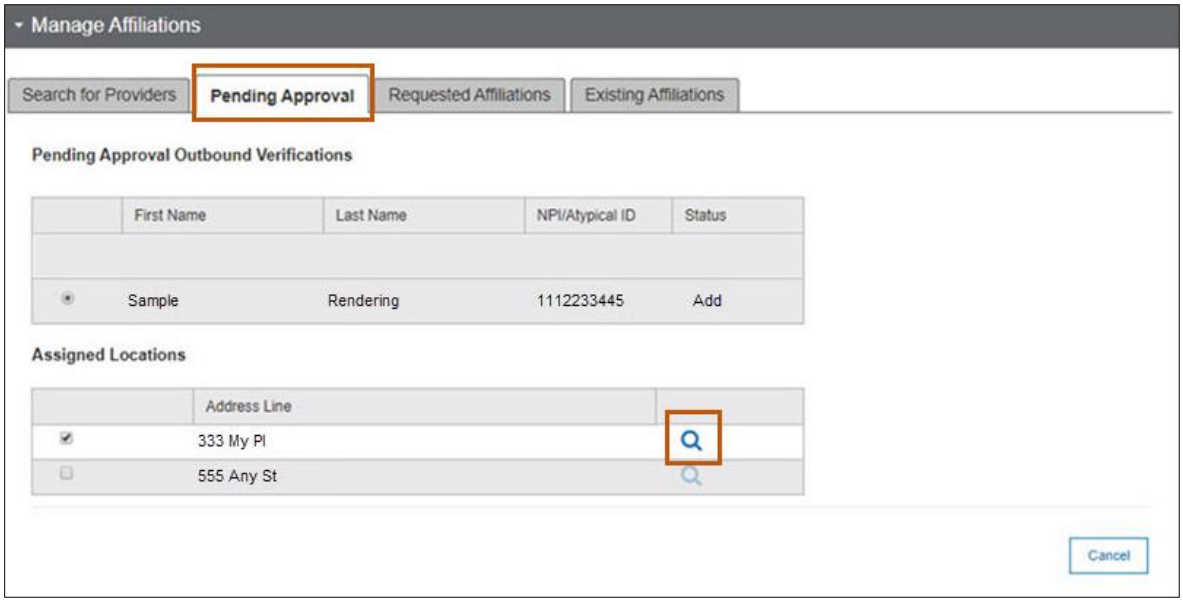


Figure 4-49: Pending Approval Tab

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.

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

Figure 4-52: Fee Collection Tab

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

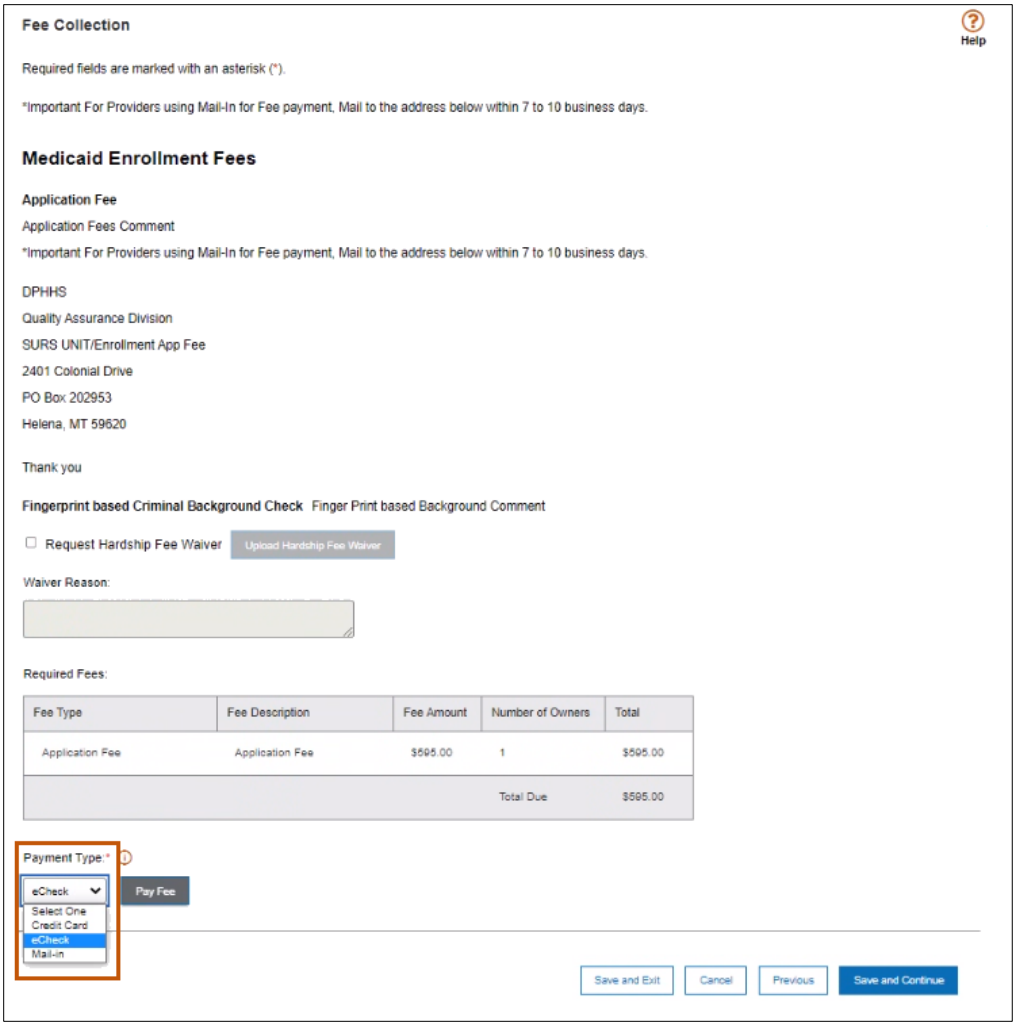


Figure 4-53: Fee Collection Screen

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

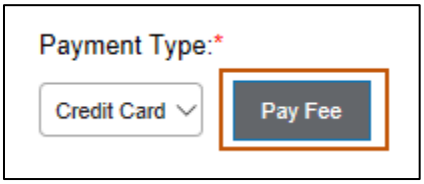


Figure 4-54: Pay Fee Button

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.

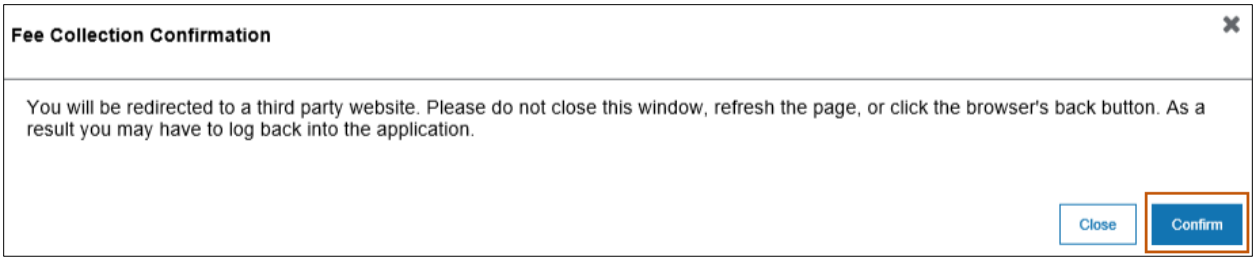


Figure 4-55: Fee Collection Confirmation

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

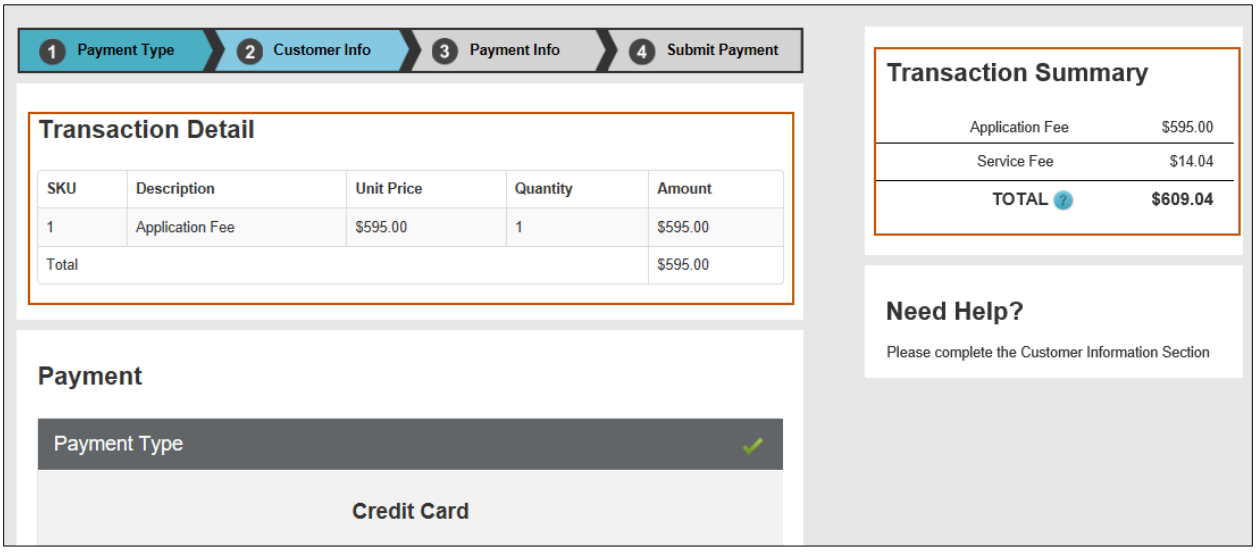


Figure 4-56: Transaction Detail and Transaction Summary

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

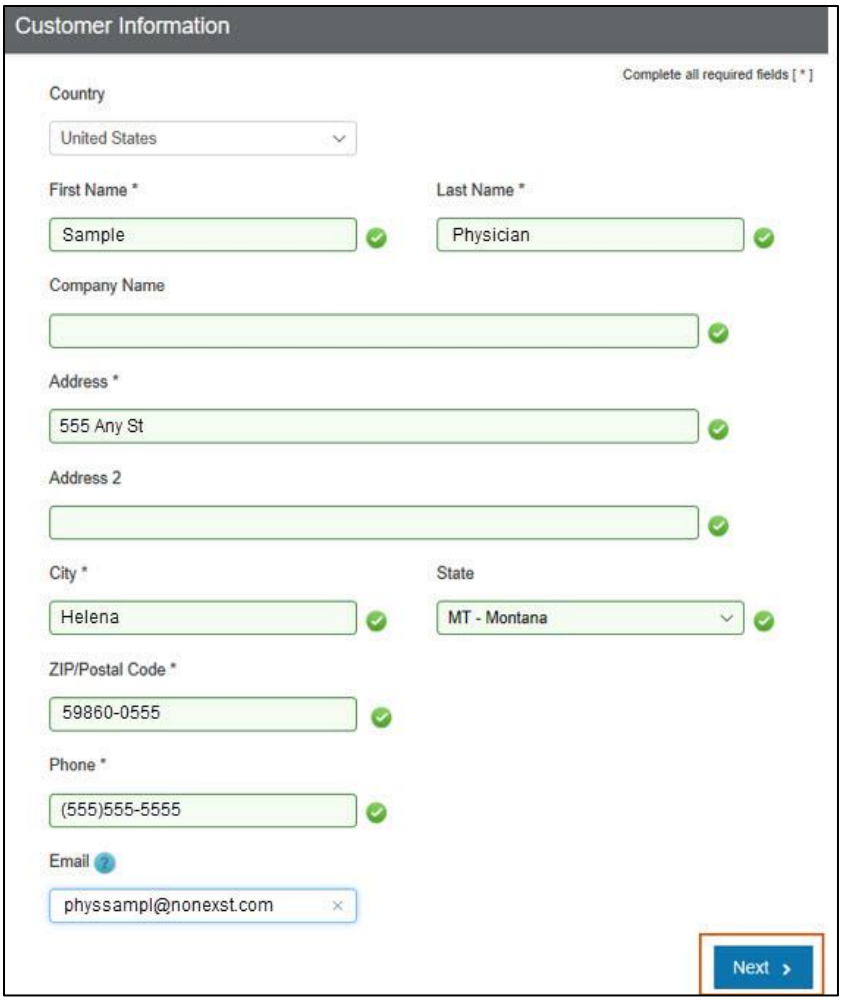


Figure 4-57: Customer Information

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.

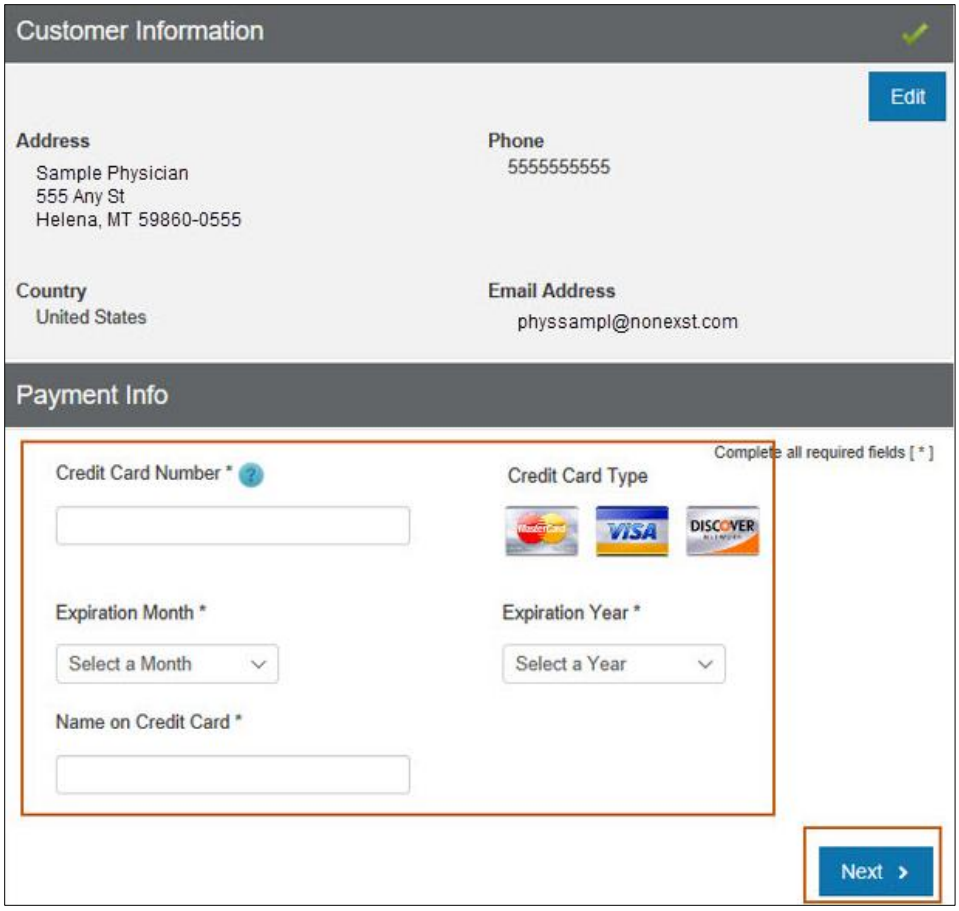


Figure 4-58: Payment Information

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.

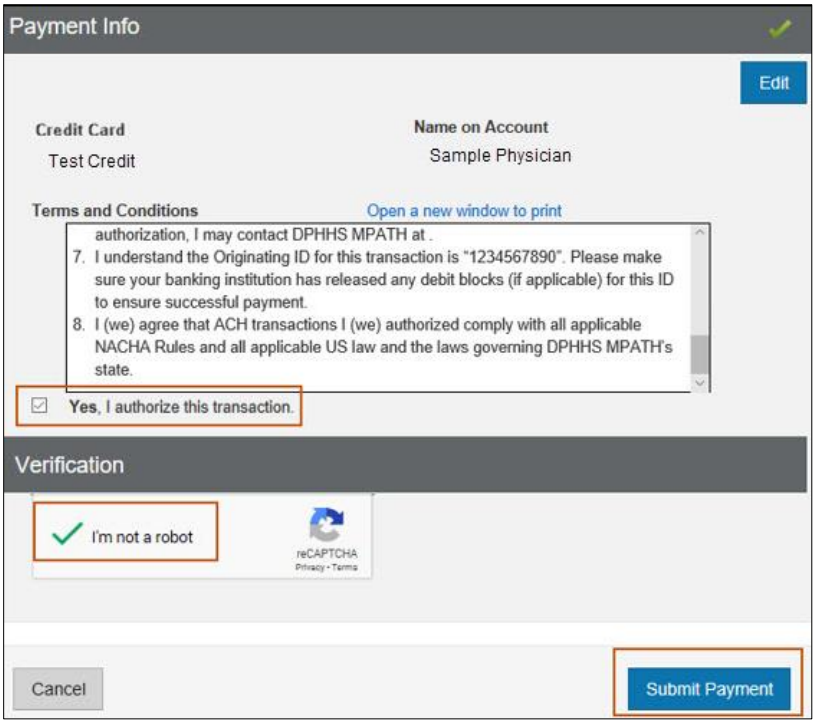


Figure 4-59: Terms and Conditions and Submit Payment

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

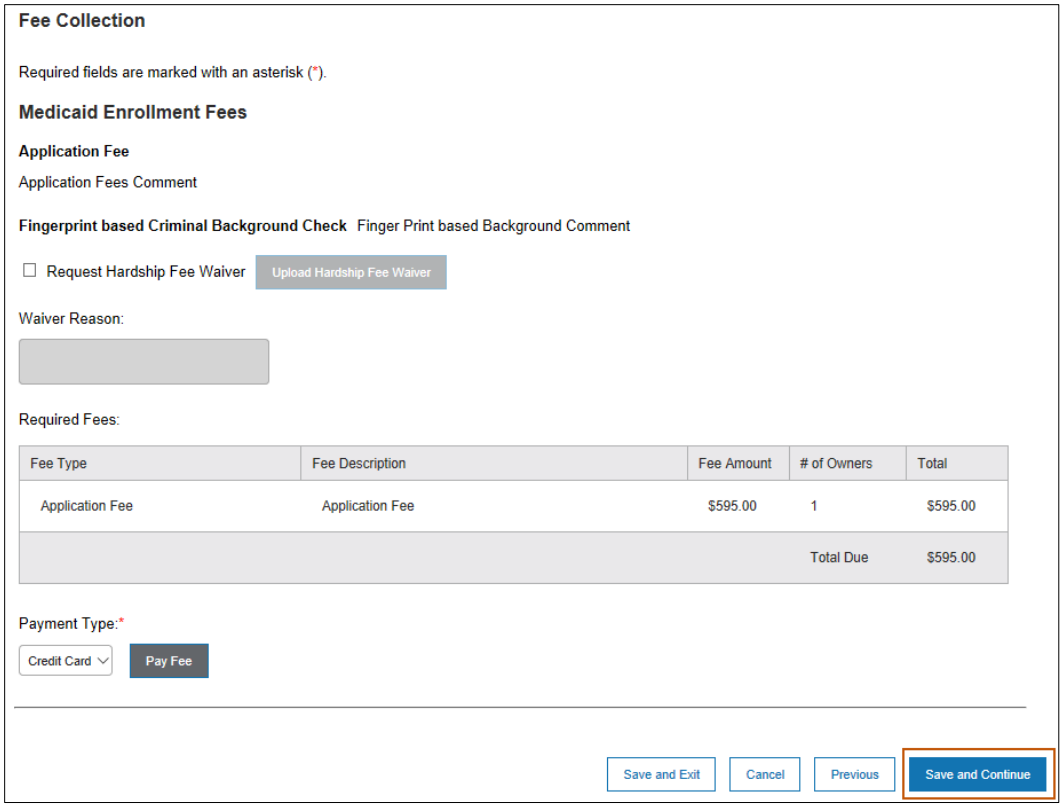


Figure 4-60: Save and Continue on Fee Collection Screen

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

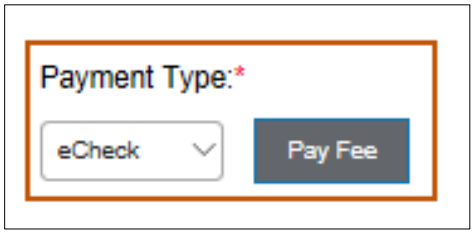


Figure 4-61: eCheck and Pay Fee Button

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.

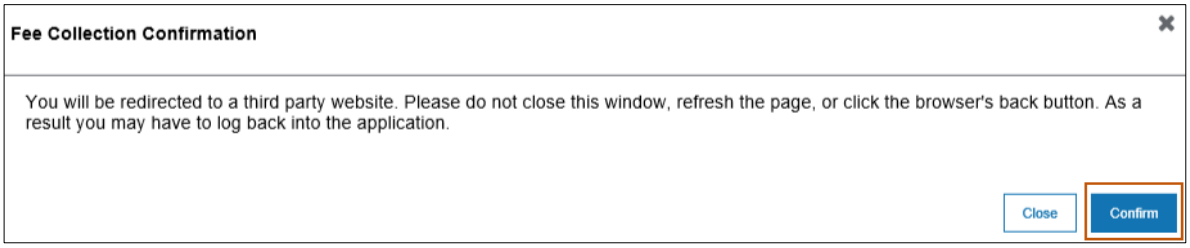


Figure 4-62: Fee Collection Confirmation

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.

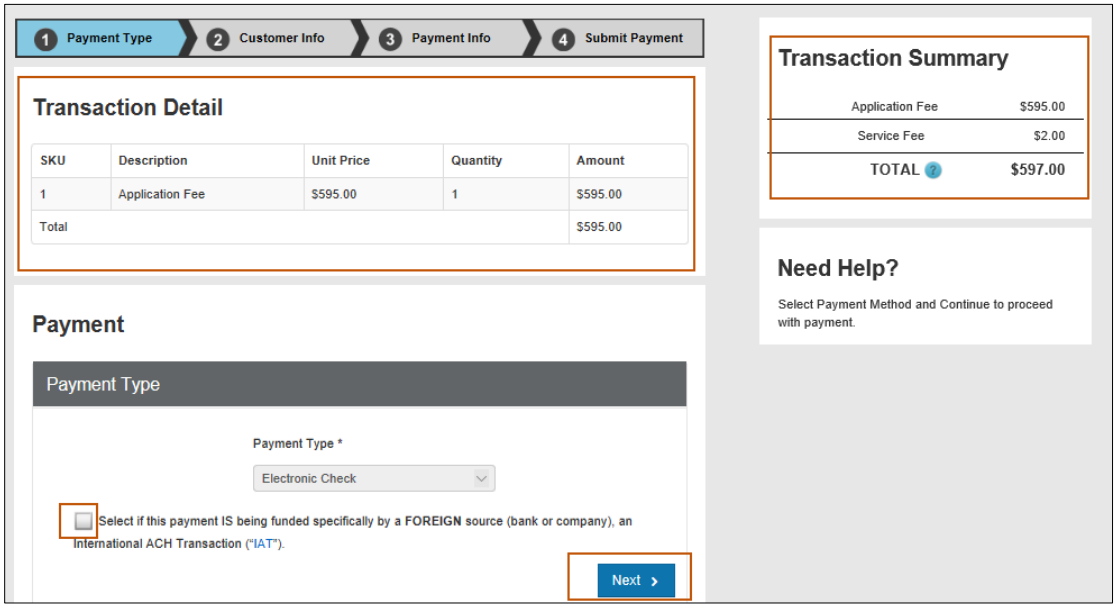


Figure 4-63: Transaction Detail and Summary

l. 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.

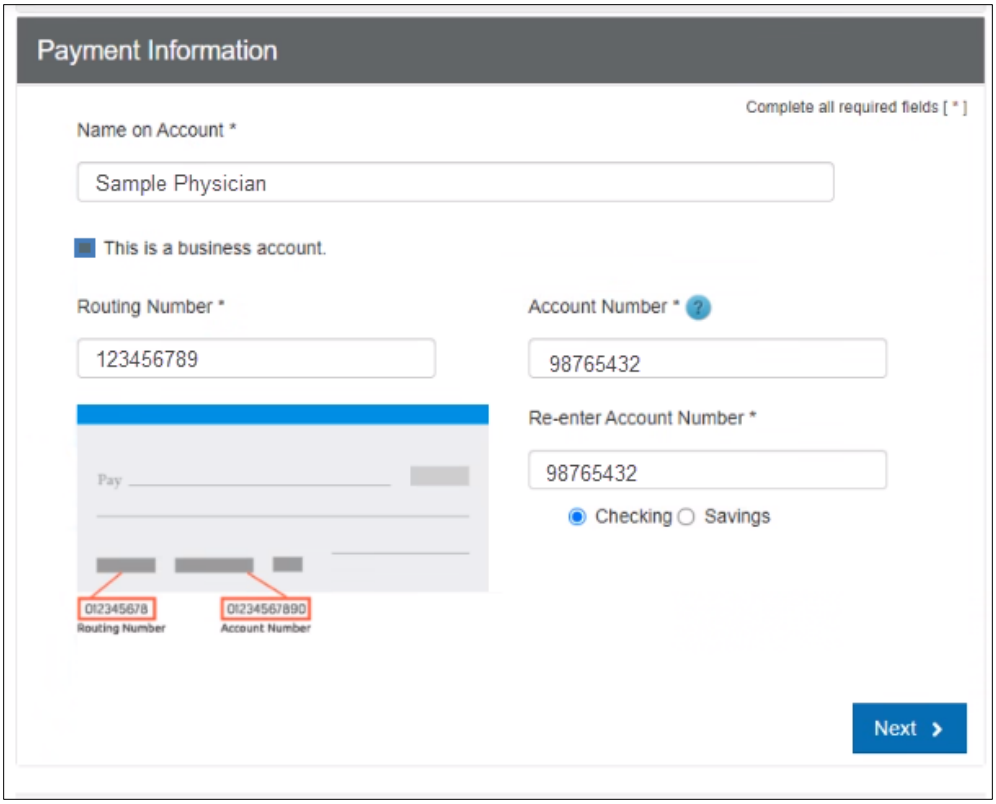


Figure 4-64: Payment Info Screen

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.

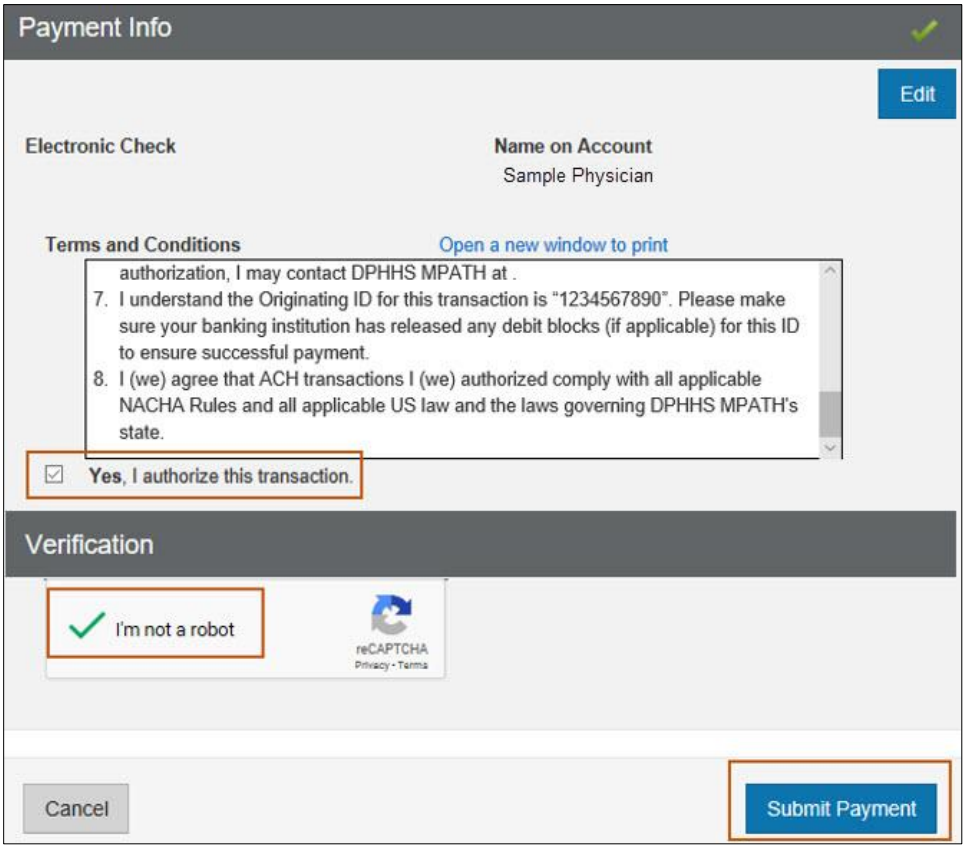


Figure 4-65: Terms and Conditions and Submit Payment

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

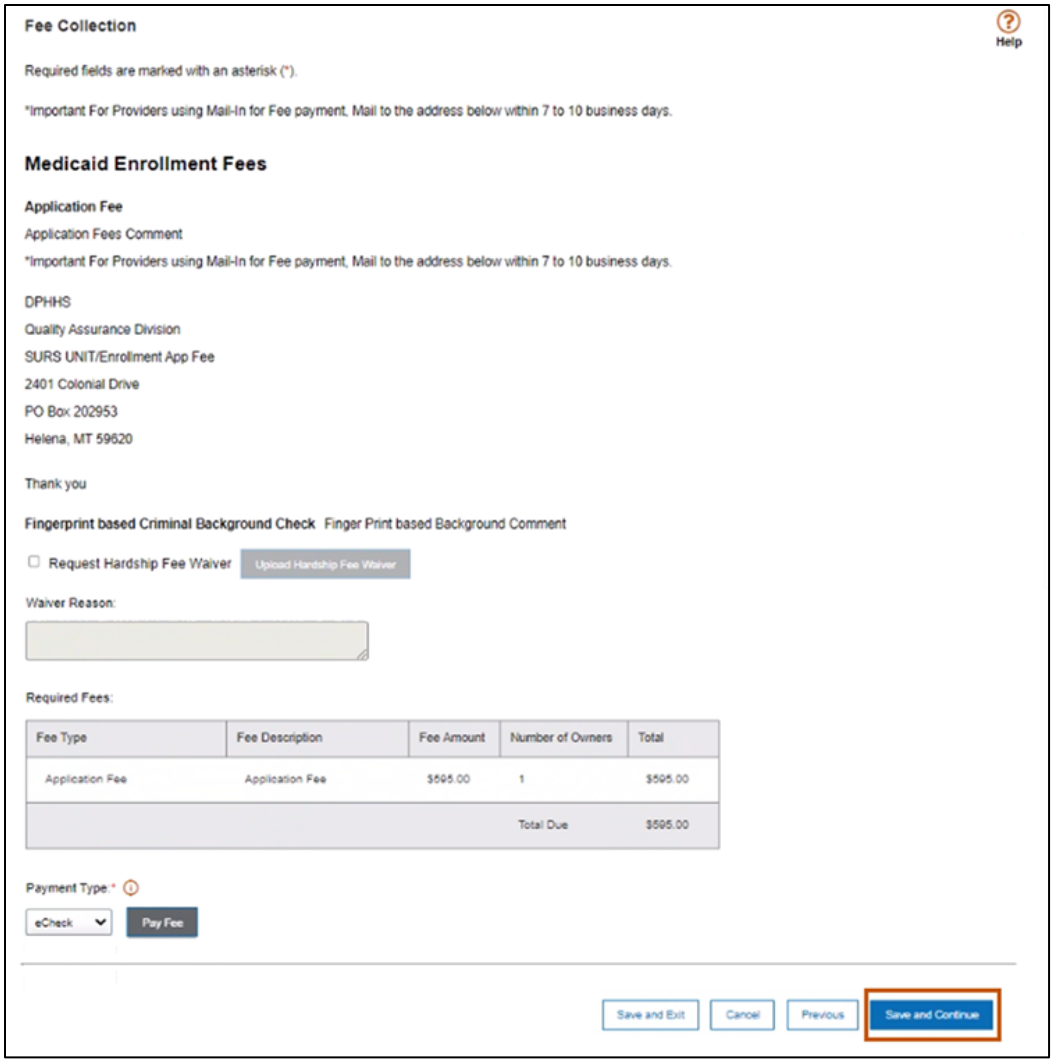


Figure 4-66: Save and Continue on Fee Collection Screen

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.

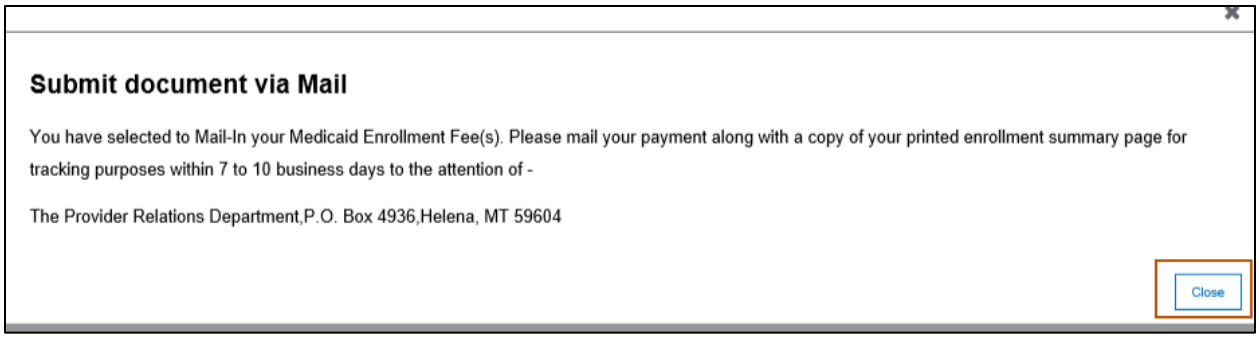


Figure 4-67: Submit Document via Mail

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

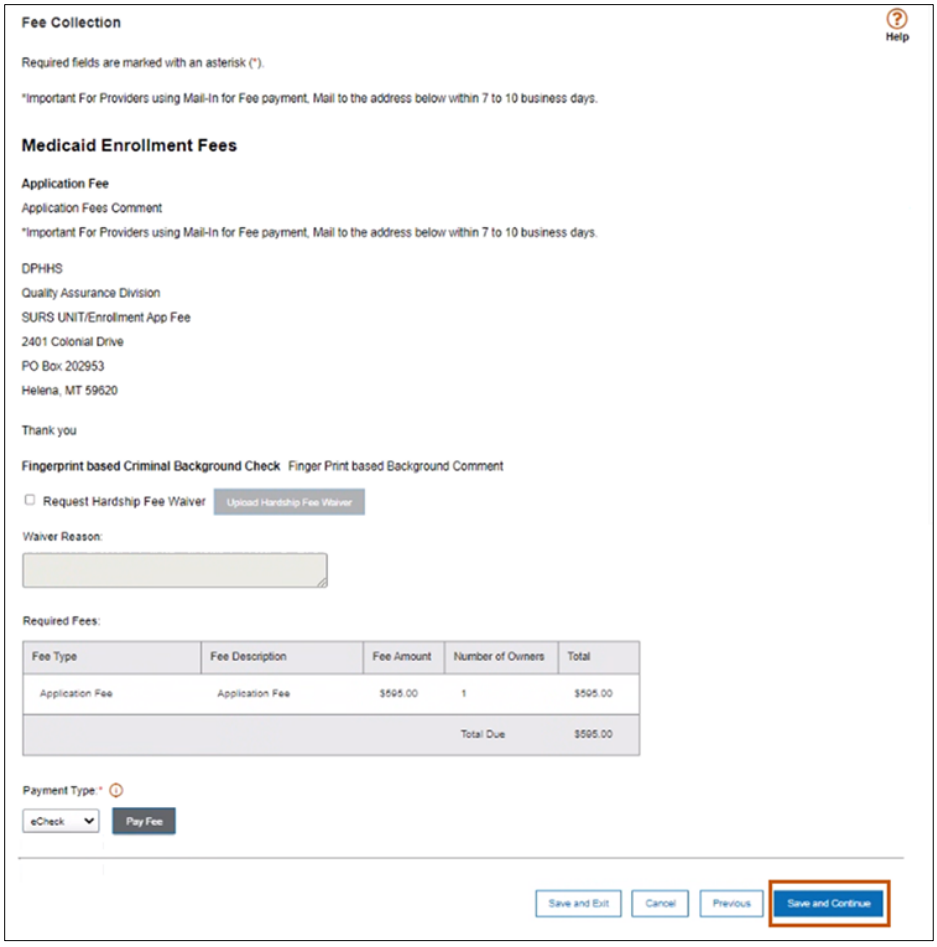


Figure 4-68: Save and Continue on the Fee Collection Screen

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® 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.

Table 5-1: DPHHS User Roles

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.

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

Table 5-2: Provider User Roles

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.

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

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

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

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.

Appendix Figure 1: Navigation Buttons

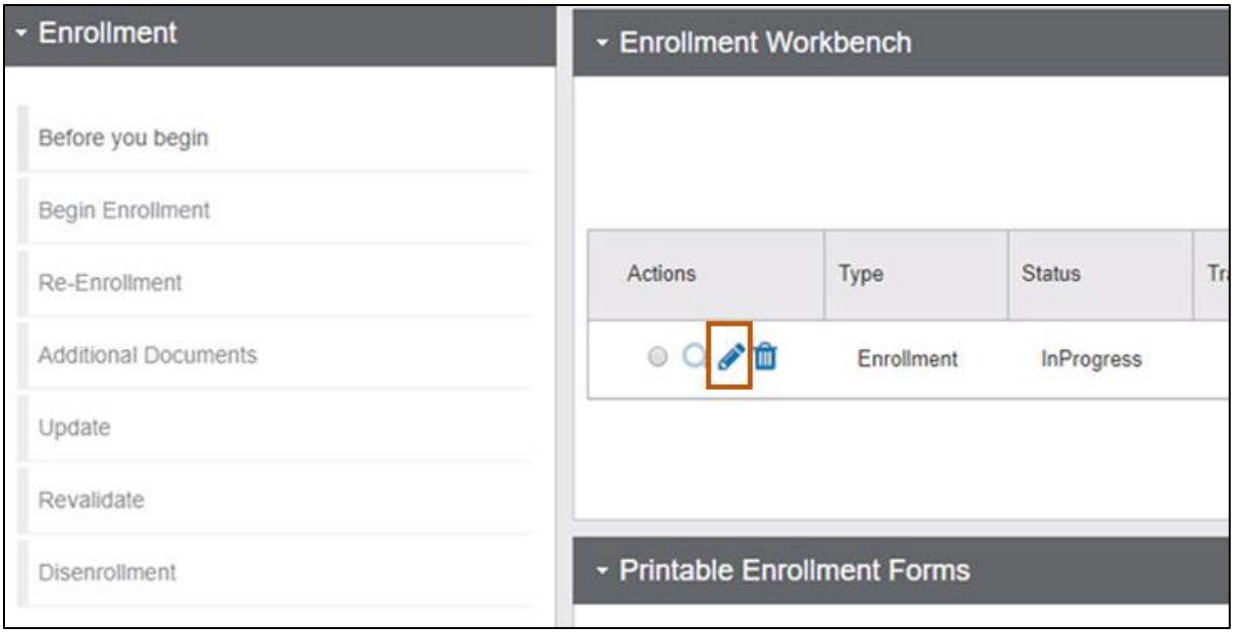
To stop the application process any time during enrollment, click **Save and Exit**. Any progress completed is saved and available for when the provider logs back into the portal. Refer to Appendix Figure 2.

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:

1. 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.



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;
	If 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.
		If 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
	If 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
		If 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
	If 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.
	If 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.
	If 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.
		If 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
	If 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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