

Montana Health Care Programs Enrollment

Thank you for choosing to enroll as a Montana Medicaid, CHIP Dental or Extended Mental Health and/or MHSP provider. All applicable sections of the provider enrollment form must be completed in order for us to process your application. The 4-digit ZIP code extension is required on all addresses. **Incomplete applications will not be processed.**

Complete all sections of this application unless otherwise indicated. Original signatures are required. Copied or stamped signatures are not acceptable.

Sign and return this application along with any additional required documents to:

Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Your application will not be processed until this information is received via mail.

Passport reenrollment is *not* required.

Clinics and groups may now enroll in Montana Health Care Programs. Rendering providers are required to be enrolled and indicated on the claim. Individuals must only enroll one time, regardless of the number of locations in which they practice, with the exception of enrolling to provide waiver services. Participation in the waiver program requires separate enrollment.

If you have any questions regarding information required on the enrollment application, you may contact Provider Relations by calling 1-800-624-3958 or 406-442-1837 or sending an e-mail to mtprhelpdesk@xerox.com. Applicants who wish to change information on a submitted application or for an existing provider must contact Provider Relations directly.

Montana Health Care Programs (Medicaid, HMK *Plus*/Children's Medicaid, HMK/CHIP) and MHSP Enrollment Checklist

For your convenience, we are providing a checklist to ensure that your provider enrollment form is completed correctly. The following information must be reviewed, signed, and dated as applicable.

All Medicaid-Only Providers

- _____ 1. Read and sign the Montana Medicaid Provider Enrollment 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. It must be signed by all who are required to sign.
- _____ 2. Complete, sign and date the printed W-9.
- _____ 3. Complete and sign the Montana Medicaid Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement.
- _____ 4. Letter from your Financial Institution verifying the routing number and account number (do not send voided checks or deposit slips).
- _____ 5. Attach a photocopy of your current license showing an effective and expiration date. If you are enrolling to bill for services already provided, also enclose a photocopy of your license covering that date of service.
- _____ 6. Attach a photocopy of your applicable board certification.
- _____ 7. Attach a photocopy of your National Provider Identifier (NPI) designation letter or e-mail from the National Plan and Provider Enumeration System (NPPES)
- _____ 8. Sign the printed Trading Partner Agreement to enable access to the Montana Access to Health web portal.
- _____ 9. Include a copy of the organization's form IRS-P575 or, if not available, the W-9 (if ownership or control interest of 5 percent or more in other organizations that bill for publicly funded health care programs).
- _____ 10. If you perform laboratory services, you must enclose a copy of the current CLIA certification for each of the practice locations reported on this application.
- _____ 11. Include your CMS Provider-Based Facility Designation (if applicable).
- _____ 12. Check here if you have paid an application fee and/or enrolled in Medicare, Healthy Montana Kids (HMK) and/or another State's Medicaid or CHIP Program. Provide your receipt from Medicare, HMK or another State's Medicaid Plan or CHIP Program.

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 NABP number, you must indicate an effective date after the termination date for the previous provider.

Medicaid and CHIP Providers (Dental or Extended Mental Health Only)

In addition to the above Medicaid-only requirements:

- _____ 1. Read and sign the CHIP Dental Provider Enrollment 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. Read and sign the CHIP Extended Mental Health Benefit Enrollment Signature Page. If the application is for an individual, the individual who will provide the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign.

CHIP Dental Providers

In addition to the above Medicaid-only requirements:

- _____ 1. Read and sign the CHIP Provider Enrollment 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.

You do not need to read and sign the Montana Medicaid Provider Enrollment Signature Page.

MHSP Providers

In addition to the above Medicaid-only requirements:

- _____ 1. Read and sign the Mental Health Services Plan Provider Enrollment Addendum.

School-Based Services Providers

In addition to the above Medicaid-only requirements:

- _____ 1. If the school is enrolling for a CSCT provider number, the Comprehensive School and Community Treatment Contract must be signed and dated by both the school and the mental health center the school is contracting with. The contract language included in this package is boilerplate and may be changed per the needs of the school and the mental health center.