



Montana Provider Relations

Xerox State Healthcare, LLC
PO Box 4936
Helena, MT 59604

Telephone: 406.442.1837
Toll Free: 1.800.624.3958
Fax 406.442.4402
mtprhelpdesk@xerox.com

DATE

NAME
ADDRESS

CITY STATE ZIP

PROVIDER REVALIDATION REQUEST

Dear PROVIDER:

In order to comply with the Patient Protection and Affordable Care Act, Section 6401(a) and 42 CFR 455.414, Montana Healthcare Programs now requires all actively enrolled providers and suppliers to revalidate the enrollment information on file every three to five years, depending on provider type.

To complete this required revalidation, please review the attached documents which contain your current information. Validate all provider information presented for accuracy. Space is provided for any necessary changes. Please sign the document to certify all information is true and accurate, and return completed packet to Xerox Provider Relations.

The requested documentation must be returned by (insert due date). Failure to complete your revalidation in 30 days can lead to termination of your enrollment with Montana Healthcare Programs.

Please follow the instructions provided on the enclosure to minimize delays in processing. For convenience, responses will be accepted via fax or mail.

For more information on revalidation, application fees, and other screening requirements under the Patient Protection and Affordable Care Act, view the MLN Matters article found at <http://www.cms.gov/MLN MattersArticles/downloads/MM7350.pdf>.

If you have questions about this request, please contact Xerox Montana Provider Relations at 1-800-624-3958, option 6.

Thank you for your cooperation and continued participation in Montana Healthcare Programs.

Sincerely,

Xerox Montana Provider Relations

ENCL: Provider Revalidation Packet Instructions and Form

Montana Healthcare Programs

Provider Revalidation Packet



Date

Instructions

To complete this required revalidation for Montana Healthcare Programs, please review the enclosed document(s). Verify all provider information presented for accuracy, and then sign to acknowledge, and return to Xerox Provider Relations.

On the Revalidation Form, Column 2 displays current data on file. If updates to this data are necessary, cross out the incorrect information in Column 2 and legibly print the corrected information in Column 3, which is titled *Data to be changed*. Any information in Column 3 will be processed as an update to the provider file. Please include additional pages if sufficient room has not been provided on the form.

If the data displayed in Column 2 is correct, and no change is necessary, please mark Column 4.

Details

SSN/EIN: is for identification purposes of the enrolled provider. If provider is an individual, the SSN is required.

Tax Reporting Status: reflects how provider reports to IRS.

Ownership Disclosure: Ownership Type and Control Information pertains to the owner of the registered NPI number. At least one owner must be disclosed. Additional owners and managing employees must also be disclosed if they exist. Provide the name and address of each person/corporation with current ownership or current control interest in the provider or in any subcontractor in which the provider has direct or indirect ownership of five percent or more.

- An individual provider should be the owner of the NPI, and this section should reflect that individual.
- Organizations must disclose two levels of ownership. Both direct and indirect ownership must be reported. *Indirect ownership interest* means an ownership interest in an entity that has an ownership interest in the disclosing provider entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity (provider)
- Federal regulation requires that identifying information be disclosed on all Managing Employees and Agents.
- If necessary, please use this form to add all additional owner and manager information:
<http://medicaidprovider.mt.gov/Portals/68/docs/enrollment/ownershipcontrolinfoextrapages.pdf>

Miscellaneous Program Information: to gather data on participation and/or fees paid to Medicare or another state Medicaid.

If applicable, you will need to pay the application fee or provide verification that you have paid the fee to Medicare or another state Medicaid program in order to complete the revalidation process. For more information about the application fee, go to: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareApplicationFee.html>

The fee amount for 2016 is \$554.00. The fee should be sent to:

Surveillance Review Utilization Section
Revalidation
2401 Colonial Drive
PO Box 202953
Helena, MT 59620

Providers required to pay the fee:

The “moderate” level of categorical screening defined by CMS-6028-FC consists of the following provider and supplier types:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRSSs)
- Revalidating home health agencies (HHAs)
- Revalidating DMEPOS suppliers

Completion

When the data has been verified, please sign the document to certify all information is current and accurate.

The requested documentation must be returned to Xerox Montana Provider Relations by **{due by date}**. Failure to complete your revalidation will lead to termination of your enrollment with Montana Healthcare programs.

Return Methods for Requested Response: *Please follow these instructions to minimize delays in processing.*

FAX: Fax a copy of this completed packet and requested corrected documentation with cover sheet to **406-457-9566**.

MAIL: Mail a copy of this completed packet and requested corrected documentation to:

**Provider Relations
PO Box 4936
Helena MT 59604**

Please visit <https://medicaidprovider.mt.gov> for more information.

If you have questions about this request, please contact Xerox Montana Provider Relations at 1-800-624-3958, option 6.

Montana Healthcare Programs

Provider Revalidation Packet



Header Data: For internal purposes.

NPI/PID:
 Provider Type:
 CRN:

Provider Revalidation Form

Please review the following data for accuracy.

Data Element	Current Data	Data to be Changed	No Change
Demographics			(X)
Provider Name or Organization	<i>John Smith</i>		
Taxonomy *Primary as reflected on NPI Registry	1. 2. 3.		
SSN/EIN	<i>xxx-xx-1234</i>		
Physical Address *Include +4 digit extension code on Zip Code https://tools.usps.com/go/ZipLookupAction_input	<i>123 A Street City, ST Zip+4</i>		
Telephone Number	<i>406-123-4567</i>		
Fax Number	<i>406-123-4567</i>		
Email Address *Add up to 5 email addresses for contact purposes.	provider@server.com		

Montana Healthcare Programs

Provider Revalidation Packet



Header Data: For internal purposes.

NPI/PID:
 Provider Type:
 CRN:

Data Element	Current Data	Data to be Changed	No Change
Licensure			
*License numbers will not display the alpha character(s) at the beginning of the license number.			
State:	MT		
License Number:	1234		
Expiration Date:	12/31/2016		
DEA Number	12345678910		
NABP	12345678910		
Tax Reporting Data			
Tax Reporting Status	Organization or Individual		
Tax ID *Change of Tax ID requires re-enrollment	xx-xxx1234	A change to Tax ID requires Re-enrollment	
Medicare Program Participation			
Medicare Enrolled	Yes or No		
Application Fee Paid Date *If paid to CMS or another State			
Application Fee Paid To *If paid to CMS or another State	CMS or ST		

Montana Healthcare Programs

Provider Revalidation Packet



Header Data: For internal purposes.

NPI/PID:
 Provider Type:
 CRN:

Ownership Disclosure

Provide the name and address of each person/corporation with current ownership or current controlling interest in the provider or in any subcontractor in which the provider has direct or indirect ownership of five percent or more. Additional pages [can be downloaded from https://medicaidprovider.mt.gov](https://medicaidprovider.mt.gov). Select the Revalidation link, or navigate to the Forms Menu, then Enrollment Forms, and then Owner/Manager Additional Pages.

Owner Name:	SSN:	Date of Birth:	State of Birth:	Country of Birth:
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Physical Address:	Mailing Address: (if different)
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Is this person the spouse, parent, child, or sibling of a person with ownership or controlling interest? **YES** or **NO**
 If yes, what is the relationship? (Spouse, Parent, Child, etc.) _____

Owner Name:	SSN:	Date of Birth:	State of Birth:	Country of Birth:
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Physical Address:	Mailing Address: (if different)
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Is this person the spouse, parent, child, or sibling of a person with ownership or controlling interest? **YES** or **NO**
 If yes, what is the relationship? (Spouse, Parent, Child, etc.) _____

Managing Employee/Agent: Federal regulation requires that the following information be disclosed on all Managing Employees and Agents.

Owner Name:	SSN:	Date of Birth:	State of Birth:	Country of Birth:
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Physical Address:	Mailing Address: (if different)
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Is this person the spouse, parent, child, or sibling of a person with ownership or controlling interest? **YES** or **NO**
 If yes, what is the relationship? (Spouse, Parent, Child, etc.) _____



Header Data: For internal purposes.

NPI/PID:
Provider Type:
CRN:

Contact

Please provide the name and contact information for a designated individual in the event Xerox Provider Relations has a question regarding submitted information.

Contact Information for Revalidation	
Contact Name	
Contact Email	
Contact Phone	

Acknowledgement

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law. I understand and agree to comply with all disclosures, screening and enrollment requirements as required under 42 CFR 455 subparts B and E.

Printed Name of Individual Practitioner _____

Signature of Individual Practitioner _____

Date _____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative _____

Title/Position _____

Address _____

Telephone Number _____

Signature of Authorized Representative _____

Date _____