



Montana Healthcare Programs Provider Enrollment

Thank you for choosing to enroll as a Montana Healthcare Programs Provider. All applicable sections of the provider enrollment form must be completed to process your application. The 4-digit ZIP code extension is required on all addresses. **Incomplete applications will not be processed.**

All forms that require a signature must have an original or valid digital signature. Stamped or copied signatures are not accepted. A photocopy may be sent for the W-9. Signed material may be mailed, faxed, or securely emailed. Your application will not be processed until both application and supplemental information are received.

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

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

Or

Fax: (406) 442-4402 Attn: Enrollment
[Email: MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com) Subject:
Enrollment

Passport to Health reenrollment is *not* required.

Rendering providers are required to be enrolled and their NPI must be indicated on the claim in the appropriate field. 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 for the separate provider type. Individuals who will not be identified as the Pay-To on a claim may want to consider enrolling as Rendering Only, or Ordering, Referring, Prescribing (ORP). Montana Healthcare Programs encourages a Group/Rendering setup, where the Group/Clinic as the Pay-To on a claim, and the individual servicing provider as Rendering/Treating.

[If you have any questions regarding information required on the enrollment application, please contact Montana Provider Relations by calling \(800\) 624-3958 or \(406\) 442-1837 or sending an email to MTEnrollment@conduent.com.](#)

Applicants who wish to change information on a submitted application or change information for an existing provider must contact Montana Provider Relations directly and request changes in writing.

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 form is completed correctly. The following information must be read, signed, and dated as applicable.

All Medicaid-Only Providers

- _____ 1. Read, sign, and date 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. It must be signed by all who are required to sign.
- _____ 2. Complete, sign, and date the printed Disclosures, Screening and Enrollment Requirements.
- _____ 3. [Complete, sign, and date the printed W-9 form found at <https://www.irs.gov/forms-pubs/irs-section-508-compliant-pdf-forms>.](https://www.irs.gov/forms-pubs/irs-section-508-compliant-pdf-forms)
- _____ 4. Complete, sign, and date the printed Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement.
- _____ 5. Include a **photocopy of your current professional license** showing an effective and expiration date. If you are enrolling to bill for services already provided, also include a photocopy of your license covering that date of service.
- _____ 6. Include a **photocopy of your applicable board certification**.
- _____ 7. Read, sign, and date the printed Trading Partner Agreement to enable access to the Montana Access to Health web portal.
- _____ 8. Include a photocopy of the organization's W-9 if there is ownership or control interest of five percent or more in other organizations that bill for publicly funded healthcare programs.
- _____ 9. If you perform laboratory services, you must enclose a **photocopy of the current CLIA certification** for each of the rendering providers or practice locations reported on this application.
- _____ 10. Include your CMS Provider-Based Facility Designation (if applicable).
- _____ 11. 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 or CHIP program.
- _____ 12. Include a letter of termination if you are changing ownership or your tax ID. These changes require you to terminate your old provider number and apply for a new provider number. The termination letter needs to contain the following information: the provider number to be terminated, the termination date, and the effective date of the new provider number. The termination date of your previous number must be after any dates of service for which claims were billed utilizing that provider number. Changes for tax ID will only be made retroactive to the beginning of the current tax year.

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 Montana HMK/CHIP Providers (Dental Only)

In addition to the above Medicaid-only requirements:

- _____ 1. Read, sign, and date 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, sign, and date 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.

You do not need to read, sign, and date the Montana Healthcare Programs Provider Enrollment Agreement and Signature Page if you are enrolling to provide **only** HMK/CHIP services.

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 read, 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. Please identify if replacing team or adding to existing team roster.

You will be notified in writing upon approval/denial of your enrollment request. Please contact Montana Provider Relations if you have not received a status after thirty (30) working days of receipt at our office. Do not bill Montana Healthcare Programs for any services until you have received, in writing, notice of your approval and its effective date. Claims submitted prior to completion of provider enrollment will be denied.

If you are re-enrolling due to a change in tax reporting, please supply a clear effective date of the change. The provider is responsible for adjusting any claims submitted and paid prior to approval of the new enrollment.