

# Provider Enrollment Tutorial

Overview of Enrollment Process for Montana Medicaid  
April 2016

# Enrollment Guidelines

- Enrollment includes **Application** and receipt of **Supplemental Material**.
- Incomplete applications will not be processed.
- All applicable sections of the provider enrollment application must be completed
  - Requirements may vary depending on Provider Type, or response to questions
  - Required fields are noted in the application with a red asterisk \*
- Supplemental forms can be mailed, emailed, or fax. Just be mindful of sending sensitive information through unsecured means
- The 4-digit ZIP code extension is required on all addresses.
- Rendering, Ordering, Referring, and Prescribing providers are required to be enrolled, but can use Abbreviated form.
- Individual Providers only need to enroll one time, regardless of the number of locations in which they practice.
  - Exception: Participation in waiver programs requires separate enrollments.

# Supplemental Forms

- Enrollment Checklist
- Disclosures, Screening and Enrollment Requirements
- Enrollment Agreement and Signature Page
- License, CLIA, and Certification
- Trading Partner Agreement
- W-9 Form
- EFT/ERA Authorization Agreement
- Additional forms may be required based on Provider Type

# Indian Health Service/Tribal 638 Programs

Indian Health Service/Tribal 638 facilities, when State licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.

Physicians must meet Montana Medicaid 's State Plan requirements. Montana Medicaid does not require IHS physicians to hold a Montana physician license; however, they must meet the substantive licensure requirements. A current license from another state would satisfy this requirement.

Tribal programs enrolling as Provider Type 57 as eligible 638 services for the IHS all-inclusive reimbursement rate must provide a copy of the 638 agreement from IHS.

# National Provider Identifier Standard (NPI)

The Administration Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers.

The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

The NPI Enumerator may be contacted at the following:

- Customer Service: 800.465.3203
- [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)
- The NPI Enumerator team can assist with applying for an NPI, and maintaining NPI records in NPPES.
- The NPI Enumerator can answer many questions about the NPI and NPPES, they cannot supply advice on billing, subpart structuring, or legislation.

# How to Apply for an NPI

## Individual Providers:

As an Individual Provider, you may only have a single NPI, which will be associated with your unique, individual information. Once you login to NPPES, you will be able to complete your NPI application.

1. Create a Login through the Identity & Access Management System (I&A).
2. Login to NPPES with your I&A Username and password.
3. Complete the NPI application. Estimated time to complete the NPI application form is 20 minutes.

## Healthcare Provider Organizations:

Healthcare Organizations are currently required to have a separate Username and password for each NPI associated with the organization.

1. Create an NPPES ONLY Username and password for the NPI you are applying for.
2. Complete the NPI application. Estimated time to complete the NPI application form is 20 minutes.

If you have accessed NPPES before, your existing account information has not changed.

# The Application Layout

Title of Page

Montana Access to Health Web Portal

**Online Provider Enrollment Application - Provider Practice Information**

Section

**MOST CURRENT PROFESSIONAL LICENSE INFORMATION**

**Note:** Up to five (5) licenses can be added.

\* License Number:

[License/Certification Details](#)

\* State:

\* Effective Date:

  

Expiration Date:

  

Yellow Question

? Is the mailing address different from the physical address?

Yes  No

Expanded criteria

? Is the mailing address different from the physical address?

Yes  No

**MAILING ADDRESS**

\* Address:

(A PO Box is considered the mailing address and can be a PO Box. The mailing address is required if different from the physical address. Note: Business entities are included.)

(A PO Box is considered the mailing address and can be a PO Box. from the physical address.

Gray Tables

Add License Info

Update License Info

[Find ZIP+4 by Address](#)

No.	License Number	Effective Date	Expiration Date	
1	0281911	1999-03-01	2017-03-30	Delete

SAVE!

Save & Continue

Save & Exit

Back

Cancel

Clear Fields

# What you may need:

- NPES (National Plan and Provider Enumeration System), confirmation with NPI (National Provider ID)
- Photocopy Medical License including effective and expiration dates
- Photocopy of board certification including type and number if applicable
- Medicare certification.
- Current ownership information for the enrolling provider.
- Current copy of your completed, signed and dated W9.
- Previous Montana Healthcare Provider number/s.
- Completed and signed Montana Medicaid Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement.
- Signed letter from your Financial Institution verifying the routing number and account number (do not send voided checks or deposit slips).
- Signed Trading Partner Agreement if you wish to use any of the web portal services.
- Submitter number for the entity that will retrieve your 835 remittance advice.

Start at <http://medicaidprovider.mt.gov/>

http://medicaidprovider.mt.gov/

MONTANA.GOV  
OFFICIAL STATE WEBSITE

SERVICES AGENCIES LOGIN SEARCH

MONTANA DPHHS  
Healthy People. Healthy Communities.  
Department of Public Health & Human Services

Richard Opper, Director

About Us Meetings & Events Health Data & Statistics Contact Us A - Z Index

Children Families Seniors Health Medical Assistance

Montana Healthcare Programs Provider Information » Home

**Montana Healthcare Programs**

**Provider Enrollment**  
New or Existing  
Providers

**MATH Web Portal**  
Log in to  
Montana Access to  
Health

## Montana Healthcare Programs Provider Information

Welcome to the Montana Healthcare Programs Provider Information website. While there is a new look to the website, accessing the information remains the same. See the table below for a list of links you may find useful.

**If you are unable to locate a resource you need, please contact  
Provider Relations at 1.800.624.3958 or 406.442.1837.**

▾ [Announcements for All Providers](#)

# Provider Enrollment Menu

The screenshot shows the Montana Department of Public Health & Human Services (DPHHS) website. The header includes the DPHHS logo and the tagline "Healthy People. Healthy Communities." Below this is a green bar with the text "Montana Access to Health Web Portal". A navigation menu on the left lists several options: "Log In", "Web Registration", "Provider Enrollment", "Provider Information Website", "Electronic Billing", and "Provider Locator". The "Provider Enrollment" section is highlighted, and its content is as follows:

**Provider Enrollment**

This is the menu page for Provider Enrollment and Re-Enrollment in the Medicaid, Children's Health Insurance Plan (CHIP)-Dental Services Only, and Mental Health Services Plan (MHSP). Links to forms, enrollment, status of enrollment, and web portal registration are provided below.

- [Enroll or Re-Enroll as a Provider Online](#) Enroll or Re-Enroll as a Provider via the Web
- [Download Enrollment Forms](#) Link to a page which displays all enrollment forms
- [Check Status of your Enrollment](#) Check Status of your Enrollment
- [Web Portal Registration](#) Link to a page through which a new Web user can register for Web Portal Access

At the bottom of the page, there is a call to action: "Click here to check your [browser compatibility](#)."

# Enrollment Options

**MONTANA**  
**DPHHS**  
*Healthy People. Healthy Communities.*  
Department of Public Health & Human Services

Montana Access to Health Web Portal

- Log In
- Web Registration
- Provider Enrollment**
- Provider Information Website
- Electronic Billing
- Provider Locator

### Provider Enrollment Options

#### Create a New Application

Please enter your e-mail address and click **Create**.

E-mail Address:

Confirm E-mail Address:

#### Enroll Using Copy

If you have already completed the enrollment process, you may copy a previously completed enrollment application for use as a new enrollment application. Enter your E-mail address and Reference # and click **Enroll Using Copy** to get a copy of an enrollment application you've previously completed as a new enrollment application.

\* E-mail Address:

\* Reference #:

#### Recall Your Existing Application

To recall an application that you have partially completed or submitted, enter both your e-mail address and the reference number and click **Recall**.

E-mail Address:

Reference #:

#### Forgotten Your Reference Number

If you have forgotten your reference number, enter your e-mail address below and click **Submit**. The address you submit will be validated against the one on file for you, and your reference number will be sent to that address.

E-mail Address:

# Reference Number



Montana Access to Health Web Portal

## Online Provider Enrollment Application - Before You Begin...



**Your Reference Number is: 4E4B21BC20**

You will need your reference number to return to this website at a later time and complete or check the status of your application (once it has been submitted).

To facilitate the enrollment process, the following is a list of tips and information to have available. The information below may not be applicable based on your provider type and options selected.

Beginning **October 1, 2007**, submit claims with your NPI or new Provider Id.

### Tips:

- Print this page!
- Use the navigation buttons at the bottom of each page. DO NOT use the browser back/forward buttons.
- When enrolling more than one provider, you can use the copy function. This functionality may be found on the Provider Enrollment Notice Page.
- Physical address cannot contain a P.O.Box. There is a place to enter the correspondence address later on in the application process.

Note: You will see additional instructions on the following pages.

Continue

Back

Cancel

# Additional Instructions

- Complete all sections of the application
- A list of PDFs will appear for you to print, sign and return
- Signatures: Original/Wet signatures are required
- Contact Provider Relations 800-624-3958
- Changes: Contact Provider Relations
- Save & Exit
- PDF Files

## Online Enrollment Application Instructions:

Complete all sections of the online application unless otherwise indicated.

**Note:** Incomplete but saved applications will only be available for 90 days from the last date they were saved. Submitted applications will only be available for 60 days from the date it was submitted.

After submitting your application online, a list of PDFs will appear for you to print, sign and return (along with any additional required documents) to Provider Relations:

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

## Signatures:

Original signatures are required on all forms that require a signature, except for the W-9 and direct deposit forms. For the W-9 and direct deposit forms, photocopies may be sent with a photocopied signature. On all other forms that require a signature, copied or stamped signatures are not accepted.

## Contact the Provider Relations Office:

You may contact Provider Relations by calling 1-800-624-3958 or 406-442-1837 or sending an e-mail to [mtprhelpdesk@xerox.com](mailto:mtprhelpdesk@xerox.com) with any questions concerning this application.

## Changes to Submitted Applications or to Existing Provider Information:

Applicants who wish to change information on a submitted application or for an existing provider must contact Provider Relations directly at 1-800-624-3958 or 406-442-1837.

## Saving an Application for Recall at a Later Time:

If at any time while completing this application, you would like to save your information and finish at a later time, click the **Save & Exit** button at the bottom of the page. The next time you visit the online application, enter your e-mail address and the reference number in the 'Recall Your Existing Application' section to retrieve your saved application.

## Use of PDF Files:

The Provider Enrollment application, signature page and other documents available for downloading from this website are saved in the Adobe PDF file format. To view PDF files, you will need the Adobe Acrobat Reader installed on your computer. If you wish to download this program, click on the Adobe Reader icon below:



# Provider Demographics

Montana Access to Health Web Portal

## Online Provider Enrollment Application - Provider Demographics

Reference Number: 544F3157F5

\* denotes required field(s)

### PROVIDER TYPE

\* Provider Type: Indian Health Service (IHS) ▼

Taxonomy  
\* Codes and Descriptions: 261QP2300X - Ambulatory Health Care Facilities - Clinic/Center - Primary Care ▼

+ Additional Taxonomy Codes

### National Provider Identification (NPI)

Enter your 10 digit NPI number. If you are a healthcare provider, this is required. If you are a healthcare provider and do not have an NPI, you must obtain one from [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov) before you may complete your enrollment.

\* National Provider Identifier (NPI): 1234567890

### PROVIDER NAME OR ORGANIZATION

\* Enrollment Type: Organization ▼

\* Organization: Organization Name

\* EIN: Tax ID

### PHYSICAL OR PRACTICE ADDRESS / CONTACT INFORMATION

\* Address: 123 Wood Lane (PO Boxes are not acceptable)

Address Line 2: (PO Boxes are not acceptable)

\* City: Helena \* State: MT ▼ \* Zip: 59601 - \* 0023

[Zip + 4 lookup](#)

County: Lewis & Clark ▼ (Only required for in-state provider)

\* Telephone Number: 4064497693 x (Numbers only) Extension: (Numbers only)

Administrative Fax: (Numbers only) Extension: (Numbers only)

# Demographics Continued

County:  (Only required for in-state provider)

\* Telephone Number:  (Numbers only) Extension:  (Numbers only)

Administrative Fax:  (Numbers only) Extension:  (Numbers only)

Yes  No

**CONTACT E-MAIL ADDRESSES**

**Note:** Up to five contact e-mail addresses can be added.

\* E-mail Type:  \* E-mail Address:

No.	E-mail Type	E-mail Address	
1	BUSINESS	Dr.Test@web.com	<a href="#">Delete</a>

# Errors

## Online Provider Enrollment Application - Provider Demographics

Correct the following errors and continue:

- NPI Number is not valid.
- At least one E-mail Address is required.

Reference Number: 4E411A00B5

\* denotes required field(s)

# Provider Practice Information



Healthy People. Healthy Communities.  
Department of Public Health & Human Services

Montana Access to Health Web Portal

### Online Provider Enrollment Application - Provider Practice Information

Reference Number: 4E4B21BC20

\* denotes required field(s)

**MOST CURRENT PROFESSIONAL LICENSE INFORMATION**

**Note:** Up to five (5) licenses can be added.

\* License Number:  [License/Certification Details](#) \* State:

\* Effective Date:  mm  dd  ccyy      Expiration Date:  mm  dd  ccyy

**Note:** An Expiration Date is only required for out-of-state License.

\*Have you had any actions or sanctions against your license within this State?  Yes  No

Reason for action or sanction:

No.	License Number	Effective Date	Expiration Date	
1	0281911	1999-03-01	2017-03-30	<a href="#">Delete</a>

? Are you Board Certified?  Yes  No

# Provider Practice Information

**OWNERSHIP TYPE**

Enter your type of ownership

\* Ownership Type:

- Other
- Individual
- Partnership
- Corporation
- Hospital Based
- HMO
- Group

Montana Medicaid only CMS. Have you been designated as a 'Provider Based Facility'?  Yes  No

**Note:** Include your CMS ID number with your enrollment paperwork.

**TAX REPORTING STATUS**

\* Reporting Status:  Individual  Organization

**TAX REPORTING STATUS**

\* Reporting Status:  Individual  Organization

**INDIVIDUAL FILING INFORMATION**

Enter the Name and Social Security Number of the individual for which this application is being filed. The name must match the name on file with the IRS exactly. This is the entity to which payments will be made when the enrolling provider is the billing provider on the claim.

\* Last Name:

\* Social Security #:

The U.S. State:

Gender:

**TAX REPORTING STATUS**

\* Reporting Status:  Individual  Organization

**BUSINESS FILING INFORMATION**

Enter the Name and Federal Employer Identification Number (FEIN) or Employer Identification Number (EIN) of the business for which this application is being filed. The name must match the name on file with the IRS exactly. This is the entity to which payments will be made when the enrolling provider is the **billing** provider on the claim.

\* Organization Name:  \* FEIN/EIN:

Complete for each person:

- with direct or indirect ownership
- and/or controlling interest
- Managing employee or agent

Up to 24 online app  
Download and submit additional

#### OWNERSHIP/CONTROL INFORMATION

This section must be completed for each person who has a direct or indirect ownership and/or controlling interest in the entity and/or provider specified in this enrollment application. This section must also be completed for each managing employee or agent of the enrolling entity and/or provider.

*Ownership interest* means the possession of equity in the capital, the stock, or the profits of the disclosing entity (provider). 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).

A person with an ownership or control interest means a person or corporation that (a) has an ownership interest totaling 5% or more in a disclosing entity (provider); (b) has an indirect ownership interest equal to 5% or more in a disclosing entity (provider); (c) has a combination of direct and indirect ownership interests equal to 5% or more disclosing entity (provider); (d) owns an interest of 5% or more in any mortgage, deed of trust note or other obligation secured by the disclosing entity (provider) if that interest equals at least 5% of the value of the property or assets of the disclosing entity (provider); (e) is an officer or director of a disclosing entity (provider); that is organized as a corporation; or (f) is a partner in a disclosing entity (provider); that is organized as a partnership.

(a) *Indirect ownership interest.* The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) *Person with an ownership or control interest.* In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. An agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

[Click here for Instructions](#)

**Note:** At least one person must be, and up to 24 persons can be, added. If you need additional fields, please download and print them at <http://medicaidprovider.hhs.mt.gov/providerpages/enrollment.shtml> and attach additional pages to the paper enrollment package when they are completed.

\* Ownership:  \*Owner  Agent  Managing Employee  Subcontractor

\* Last Name:  \* First Name:  MI:

\* Date of Birth:  mm  dd  cyy  \* Social Security #:

\* Country of Birth:

\* State of Birth:  (Only required if Country of Birth is US)

\* Physical Address:  (A PO Box is considered the mailing address and can be a PO Box. The mailing address is required if different from the physical address. Note: Business entities are included.)

Physical Address Line 2:  (A PO Box is considered the mailing address and can be a PO Box. The mailing address is required if different from the physical address. Note: Business entities are included.)

\* City:  \* State:  \* Zip:  -

# Ownership/Control

print them at <http://medicaidprovider.hhs.mt.gov/providerpages/enrollment.shtml> and attach additional pages to the paper enrollment package when they are completed.

\* Ownership:  \*Owner  Agent  Managing Employee  Subcontractor

\* Last Name:  \* First Name:  MI:

\* Date of Birth:    \* Social Security #:

\* Country of Birth:

\* State of Birth:  (Only required if Country of Birth is US)

\* Physical Address:  (A PO Box is considered the mailing address and can be a PO Box. The mailing address is required if different from the physical address. Note: Business entities are included.)

Physical Address Line 2:  (A PO Box is considered the mailing address and can be a PO Box. The mailing address is required if different from the physical address. Note: Business entities are included.)

\* City:  \* State:  \* Zip:  - \*

[Find ZIP+4 by Address](#)

\* County:  (Only required for in-state Business)

? Is the mailing address different from the physical address?  Yes  No

\* Telephone Number:  (Numbers only) Extension:  (Numbers only)

MT Provider #:  (Enter the owner's or managing employee's most recent provider number, if applicable.)

? Are you the spouse, parent, child or sibling of a person with ownership or control interest?  Yes  No

## NAME AND RELATIONSHIP

\* Name:  \* Relationship:

? Have you ever been sanctioned, debarred, suspended, excluded or convicted of a criminal offense related to Medicare/Medicaid or any other State or Federal program?  Yes  No

Add Person

Update Person

No.	Last Name	First Name	Date of Birth	Country of Birth
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# Provider Practice Information

No.	Last Name	First Name	Date of Birth	Country of Birth	
<u>1</u>	Smith	John	01-01-1978	US	<a href="#">Delete</a>

**?** Do you have ownership or control interest of 5% or more in another organization that participates in publicly funded programs?  Yes  No

**?** **ORGANIZATION OWNERSHIP INFORMATION**

**Note** **?** Is your organization a subsidiary company or joint venture?  Yes  No

**?** **SUBSIDIARY or JOINT VENTURE BUSINESS INFORMATION**

**Note:** Up to four organizations can be added.

\* Legal Business Name:  \* Employer ID:

**?** Have you previously billed Montana Medicaid, Healthy Montana Kids (HMK)/CHIP or MHSP?  Yes  No

**?** **PREVIOUS PROVIDER NUMBER(S)**

**Note:** In cases of re-enrollment it is critical that you provide accurate information so we may set up your new enrollment consistently with your previous enrollment. Up to four provider numbers can be added. Please enter all that apply to the

**?** Have you changed or ever used another Tax ID number?  Yes  No

**?** **PREVIOUS TAX ID**

**Note:** Up to four tax IDs can be added.

\* Tax ID #:

Begin Date: mm dd cyy    End Date: mm dd cyy

No.	Tax ID	Begin Date	End Date
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# Provider Practice Information Continued

**Online Provider Enrollment Application - Provider Practice Information Continued**

Reference Number: 4E4B21BC20

\* denotes required field(s)

? Have you already provided services to a Montana Medicaid, Healthy Montana Kids (HMK)/CHIP or MHSP client?  Yes  No

**CLIENT DEMOGRAPHICS**

Number of Clients Currently Being Seen:  (Montana Medicaid clients only)

Gender of Clients:

**DEA NUMBER**

If you have a DEA number you must enter this number and it may be required to enroll for some provider types.

DEA Number:

? Do you bill laboratory services?  Yes  No

**FISCAL YEAR END MONTH**

\* Month End:

? Are you enrolled in the Medicare program?  Yes  No

# Payment and Remittance Advice

## PAYMENT AND REMITTANCE ADVICE (RA) INFORMATION

Payments will be made via Electronic Funds Transfer (EFT) unless extenuating circumstances exist. If you feel you have extenuating circumstances that prohibit you from receiving payment via EFT, include a signed letter explaining why paper checks are required to request a waiver.

\* Payment, Schedule, and RA Options:

**Note:** An Electronic Statement of Remittance (ESOR) is an electronic image of remittance advice.

Requesting a Waiver for Paper Check:

**Note:** Signed explanation required to be submitted with paperwork.

\* Bank Routing Number:

\* Account Number

\* Indicate whether the account referenced above is a checking or savings account:  Checking  Savings

? Do you wish to receive an electronic remittance advice in the HIPAA standard ANSI 835 transaction format?  Yes  No

## ELECTRONIC TRANSACTION INFORMATION

\* Enter the Submitter ID of the entity you want your 835 delivered to. This is the submitter ID of your clearing house, billing agent, or yourself if you conduct these transactions yourself.

# Passport to Health

\* Enter the submitter ID of the entity you want your CDS delivered to. This is the submitter ID of your clearing house, billing agent, or yourself if you conduct these transactions yourself.

? Do you already have a PASSPORT Number? [What is PASSPORT?](#)  Yes  No

? Do you want to be a PASSPORT Provider?  Yes  No

**PASSPORT INFORMATION**

Will you enroll as:  Solo Provider  Group Provider [PASSPORT Contract](#)

**PATIENT DEMOGRAPHICS**

\* Client Age Range:  All Ages  
 Only Under Age:   
 Only Over Age:

\* Client Gender:

Enter any language(s) other than English you have available for interpretation.

Language:

**+ Additional Languages Available For Interpretation**

? Is your 24 hour access telephone number different from your practice number?  Yes  No

**Note:** PASSPORT providers must provide 24 hour client emergency care direction using one of the following: an answering service, call forwarding, provider on-call coverage or an answering machine message.

# Contact Information

**CONTACT INFORMATION FOR ENROLLMENT**

Provide contact information in case there are questions regarding this Enrollment Application.

\* Contact Name:

\* Contact Phone:  (Numbers only) Extension:  (Numbers only)

## Provider Relations:

[mtprhelpdesk@xerox.com](mailto:mtprhelpdesk@xerox.com)

1-800-624-3958  
1-406-422-1837

PO Box 4936  
Helena, MT 59604

# Electronic Submission Complete

The screenshot shows a web application interface with a sidebar on the left containing navigation links like 'help', 'Mc', 'C', 'Y', 'P', 'Y', 'C', 'The prov listed in applicab', and 'Mailing I'. The main content area is divided into three steps:

**Step 2**  
**Verify your Package is Complete**  
Review the checklist included on the first page of your Application Supplement.

**Step 3**  
**Mail Your Application Materials**  
Once you've reviewed and completed all additional forms and assembled any required documentation, mail these documents - to:  
**Montana Provider Relations**  
**P.O. Box 4936**  
**Helena, Montana 59604**

**Step 4**  
**Print A Copy For Your Records**  
Click below to view a copy of the information that was submitted in your application. This copy is for your records only and should not be sent.  
[Submitted Application](#)  
Once you have printed your Application Supplement, click 'Exit' to exit this form and return to the Provider Enrollment Page. You may access your application to print additional copies for 60 days after submitting it.

# After Application Submission

- When Provider Relations receives your application and supplemental materials, and verify it is complete, processing can begin.
- Provider Relations screen every piece and verify against multiple federal databases.
- After screening is complete, an application may need to be sent to appropriate officers at DPHHS for final approval
- Once application is approved, you will receive a welcome letter in the mail with your Montana Healthcare Provider ID and an effective date. Do not bill for services until you have received written approval and an effective date



# Use your resources before beginning

## Resources:

DPHHS Provider Web Page

<http://medicaidprovider.mt.gov/>

Montana Access to Health Web Portal

<https://mtaccesstohealth.acs-shc.com/mt/general/home.do>

Xerox Montana Provider Relations

1-800-624-3958, or [mtprhelpdesk@xerox.com](mailto:mtprhelpdesk@xerox.com)

1-406-442-1837

Enrollment Tutorial: Can pause and follow along.

<http://www.brainshark.com/acs-inc/vu?pi=zJfzmqrqgdzGpHrz0>

# Questions?

Provider Relations:

[mtprhelpdesk@xerox.com](mailto:mtprhelpdesk@xerox.com)

1-800-624-3958

1-406-422-1837

P.O. Box 4936  
Helena, MT 59604



Ready For Real Business