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 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**

- 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.

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

Section

Yellow Question

Expanded criteria

Gray Tables

SAVE!
What you may need:

- NPPES (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/
Provider Enrollment Menu

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
- Download Enrollment Forms
- Check Status of your Enrollment
- Web Portal Registration

Click here to check your browser compatibility.
Enrollment Options

1. **Create a New Application**
   - Please enter your e-mail address and click Create.
   - E-mail Address: [Input Field]
   - Confirm E-mail Address: [Input Field]
   - Create

2. **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: [Input Field]
   - Reference #: [Input Field]
   - Enroll Using Copy

3. **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: [Input Field]
   - Reference #: [Input Field]
   - Recall

4. **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: [Input Field]
   - Submit
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.
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 miphelpdesk@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

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: 261QP2308X - Ambulatory Health Care Facilities - Clinic/Clinic - Primary Care

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 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

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

* Telephone Number: 4064497693 * (Numbers only) Extension: (Numbers only)
Administrative Fax: (Numbers only) Extension: (Numbers only)
Demographics Continued

<table>
<thead>
<tr>
<th>Count:</th>
<th>Lewis &amp; Clark</th>
<th>(Only required for in-state provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone:</td>
<td>406497683</td>
<td>(Numbers only) Extension: (Numbers only)</td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
<td>(Numbers only) Extension: (Numbers only)</td>
</tr>
</tbody>
</table>

Do you want to direct your provider correspondence to a different address?
- Yes
- No

**CORRESPONDENCE ADDRESS**
- Address:
- Address Line 2:
- City:
- State: MT
- Zip:

**CONTACT E-MAIL ADDRESSES**
- Note: Up to five contact e-mail addresses can be added.
- E-mail Type:
- E-mail Address:

Add Contact E-mail Address
Update Contact E-mail Address

<table>
<thead>
<tr>
<th>No.</th>
<th>E-mail Type</th>
<th>E-mail Address</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BUSINESS</td>
<td><a href="mailto:Dr.Test@web.com">Dr.Test@web.com</a></td>
<td></td>
</tr>
</tbody>
</table>
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)
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:

The U.S. Department of Human Services, Office of Civil Rights is requesting the following information be completed for statistical purposes only. This information is optional and is not required for Montana Medicaid.

Gender:  ☐  Race:  ☐
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

* Ownership:  ● Owner  ○ Agent  ○ Managing Employee  ○ Subcontractor

* Last Name:  Smith
* First Name:  John
* MI:  

* Date of Birth:  01  01  1978
* Social Security #:  555129874

* Country of Birth:  UNITED STATES

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

* Physical Address:  123 Main Street

Physical Address Line 2:

* City:  Anywhere
* State:  MT  
* Zip:  59487  -  6547

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

Find ZIP+4 by Address

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

* Telephone Number:  4054567893  (Numbers only)

MT Provider #:  

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
## Provider Practice Information

<table>
<thead>
<tr>
<th>No.</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Country of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Smith</td>
<td>John</td>
<td>01-01-1978</td>
<td>US</td>
</tr>
</tbody>
</table>

### ORGANIZATION OWNERSHIP INFORMATION

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

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

### SUBSIDIARY or JOINT VENTURE BUSINESS INFORMATION

- **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:**
- **End Date:**

### ADD TAX ID / UPDATE TAX ID

<table>
<thead>
<tr>
<th>No.</th>
<th>Tax ID</th>
<th>Begin Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
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?

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?

FISCAL YEAR END MONTH
* Month End: ___

Are you enrolled in the Medicare program?

April 27, 2016
**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: **Weekly EFT Payment with ESOR**

**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

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Do you wish to receive an electronic remittance advice in the HIPAA standard ANSI 835 transaction format?

☒ Yes  ☐ No

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**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.
Do you already have a PASSPORT Number?  What is PASSPORT?

Do you want to be a PASSPORT Provider?

PASSPORT INFORMATION
Will you enroll as:
- Solo Provider
- Group Provider

PATIENT DEMOGRAPHICS
- All Ages
- Client Age Range:
  - 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?

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

Provider Relations:

mtprhelpdesk@xerox.com  1-800-624-3958  PO Box 4936
1-406-422-1837  Helena, MT 59604
Electronic Submission Complete

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
1-406-442-1837

Enrollment Tutorial: Can pause and follow along.
http://www.brainshark.com/acs-inc/vu?pi=zJfzmqrGdZGpHrz0
Questions?

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mtprhelpdesk@xerox.com

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