



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 with original signatures must received via mail in order for us to process your application.
 - Copied or stamped signatures are not acceptable
- The 4-digit ZIP code extension is required on all addresses.
- Rendering providers are required to be enrolled.
- 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 enrollment.

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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
- Passport and Team Care Agreement
- CHIP Dental Agreement
- CHIP Agreement for Extended Mental Health Benefits for Children
- Mental Health Services Plan Addendum
- CSCT Services Contract
- Exhibits: Statement of Work and Payment Schedule
- 72-Hour Presumptive Eligibility Program Addendum
- Electronic Billing Agreement (EBA)
- Medicaid Provider Requirements



Reference Number

Montana IPHHS
 Immediate Access to Health Net Fund

Online Provider Enrollment Application - Before You Begin...

Your Reference Number is: 4E4B21BC2D
 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 emailing 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.

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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 30 days from the last date they were saved. Submitted applications will only be available for 30 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:

Medical Provider Relations:
 P.O. Box 4936,
 Helena, Montana 59604

Statements:
 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 used with a photocopied signature. On all other forms that require a signature, copied or scanned 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 helpdesk@dmhs.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 one 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.

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Provider Demographics

Online Provider Enrollment Application - Provider Demographics

Reference Number: 4E413A0585
 *denotes required field(s)

PROVIDER TYPE
 * Provider Type:

* Specialty:
 * Codes and Descriptions

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.npses.org before you may complete your enrollment.
 * National Provider Identifier (NPI):

PROVIDER NAME OR ORGANIZATION
 * Business Type:

* Title: Professional Title:
 * Last Name: First Name: M.I.:
 (Full name is required if you are an individual practitioner)
 * SSN: * DOB: / /

PHYSICAL OR PRACTICE ADDRESS / CONTACT INFORMATION
 * Address: (PO Boxes are not acceptable)
 Address Line 2: (PO Boxes are not acceptable)
 * City: * State: * Zip: -
 Country: (Only required for in-state provider)
 * Telephone Number: (Numbers only) Extension: (Numbers only)
 Administrative Fax: (Numbers only) Extension: (Numbers only)

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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



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Questions?

Provider Relations:
mtprhelpdesk@xerox.com
 1-800-624-3958
 PO Box 4936
 Helena, MT 59604

Provider Relations Field Reps:
 Aaron Hahm
Aaron.Hahm@xerox.com
 1-406-457-9598

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 1-406-457-9553

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