

# Revalidation Guide



DEPARTMENT OF  
**PUBLIC HEALTH &  
HUMAN SERVICES**

# What is revalidation

- To comply with the Patient Protection and Affordable Care Act, Section 6401(a) and 42 CFR 424.515, Montana Healthcare Programs requires all actively enrolled providers and suppliers to revalidate their enrollment information every five years.



# Documentation Before you begin a Revalidation

- License
- DEA
- CLIA
- EFT form
- Insurance
- W9 with Legal Entity Address

# Provider Portal Log In

The screenshot shows the top navigation bar of the Montana DPHHS website. On the left is the logo for the Department of Public Health & Human Services. To the right are icons for 'Home' and 'Contact us'. Below the navigation bar are two tabs: 'Provider' (which is selected and has a mouse cursor) and 'State Agent'. The main content area features a large photograph of two people sitting on a rocky shore next to a green canoe on a lake. Below the photo is a row of six menu items, each with an icon: 'Getting started' (rocket), 'FAQs' (question mark), 'Find a provider' (person with location pin), 'Announcements' (megaphone), 'DPHHS Website' (computer monitor), and 'DocDNA' (notepad and pencil).

Log into the MPATH Provider Services Portal to access enrollment workbench and begin a revalidation

This screenshot shows the 'Provider' section of the website. At the top left is the Montana DPHHS logo. To its right is the text 'DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES'. Below this is a white box containing the heading 'Provider' in orange, followed by the question 'How can we help you?'. A blue button with the text 'Login and Registration' is positioned below the question, with a mouse cursor hovering over it. To the right of this box is a vertical photograph showing a person's shoulder and part of a white lab coat.

# Provider Portal Log In

## Sign In With Your Optum GovID

Optum GovID or email address

MPATHPROD@mt.gov

Password

.....

SIGN IN

Additional options:

[Create Optum GovID](#)

[Manage your Optum GovID](#)

[What is Optum GovID?](#) 

[Forgot Optum GovID](#) | [Forgot Password](#)

As a security enhancement, we are removing Security questions as an account recovery and authentication method. Users will have the option to use other available methods.

Warning! This system contains U.S Government information. By using this information system, you are consenting to system monitoring for law enforcement and other purposes. Unauthorized or improper use of, or access to, this computer system may subject you to state and federal criminal prosecution and penalties as well as civil penalties. At any time, the government may intercept, search, and seize any communication or data transiting or stored on this information system.

If you'd like assistance, contact [MTPRHelpdesk@conduent.com](mailto:MTPRHelpdesk@conduent.com)

Enter your Optum GovID or registered email and Password. For security a passcode will be emailed to your registered email address.

## Sign In: Access Code

We've sent you an email to **mpa\*\*\*\*od@getnada.com**. Type the code from the message here to verify your identity and sign in. You can bypass this step in the future by checking the box.

Access Code \*

.....

Still waiting for your access code? [Resend Email](#)

Check your email for a message from Optum GovID(noreply@optumgovid.com). If you don't see it, check your junk or spam folders. You may need to resend the message or add our address to your list of approved senders.

**Skip this step in the future when signing in because this device is personal or private.**

NEXT

[Cancel](#)

If you'd like assistance, contact [MTPRHelpdesk@conduent.com](mailto:MTPRHelpdesk@conduent.com)



DEPARTMENT OF  
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# Provider Portal Log In

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Account Settings Log Out

Member search ?

Find everything you need to know about a member in just one search!

Search By Member ID  
 Search By Member Name  
 Search By Member SSN

Member ID:\*

Service Date:\*

MM/DD/YYYY

Go

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment**
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

Hello, MPATHP PROD Last login: 9/14/2024

Provider Resources Forms FAQs

The Provider portal offers many features. For revalidation click on the Provider Enrollment tile on the left menu.

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment**
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

# Enrollment workbench search

HI MPATH PROD

Enrollment Workbench

User Guide

Show Legend

Show Filter Select "Search By" NPI/Atypical ID Search Criteria 1003362864 Search Clear

Actions	Type	Enrollment Status	Submission Date	Confirmation #	Tax ID	NPI/Atypical ID	Provider Name	Last Accessed By	Last Accessed Date
	Update	Enrolled	05-19-2024	71492147	100336285	1003362864	MPATH NORTHWEST...	PROD MPATHP	10-02-2024
	Update	Enrolled	05-19-2024	71492054	100336285	1003362864	MPATH NORTHWEST...	Last First	05-19-2024
	Update	Enrolled	05-19-2024	71491923	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	05-19-2024
	Update	Enrolled	05-19-2024	71491488	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	05-19-2024
	Update	Denied	05-18-2024	71252055	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	05-18-2024
	Update	Denied	03-14-2024	71206494	100336285	1003362864	MPATH NORTHWEST...	SMA Config Milan	03-22-2024
	Update	Enrolled	01-24-2024	70546586	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	05-19-2024
	Update	Enrolled	11-01-2023	70343533	100336285	1003362864	MPATH NORTHWEST...	PROD MPATHP	12-04-2023
	Update	Denied	10-13-2023	70259025	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	10-23-2023

Use the Select "Search By" to search by NPI. Enter the 10 digit NPI in the Search Criteria text box and click search. The result will return the NPI with a history of all activities completed specific to that NPI.

# Checking for Revalidation

Actions	Type	Enrollment Status
<input checked="" type="radio"/> ▶ 🔍 ✎ 🗑️ ✓ 👍	Update	Enrolled
<input type="radio"/> ▶ 🔍 ✎ 🗑️ ✓ 👍	Update	Enrolled

Select the radio button on the top line or current enrolled line.

- Update
- Revalidate**
- Disenrollment
- Manage Affiliations
- FEIN Management
- Compendium History

Enrollment Units for Revalidation		
0001668862	Update	Enrolled
0001748279	Update	Enrolled
	Update	Enrolled

Hover over the revalidation tile on the left menu. If the tile highlights and revalidation Enrollment Units display your file is ready for revalidation.



# Creating a Revalidation

The screenshot shows a software interface with a left-hand menu and a main content area. The menu items are: Update, Revalidate (highlighted with a mouse cursor), Disenrollment, Manage Affiliations, FEIN Management, and a partially visible 'Compliance History'. The main content area shows a table with columns for 'Update' and 'Enrollment Units for Revalidation'. The table contains two rows of data with values '0001668862' and '0001748279'. A pop-up window titled 'Enrollment Units for Revalidation' is overlaid on the table, showing the same two rows of data. The 'Update' column in the table is grayed out.

Click the revalidation tile on the left menu. The pop out Enrollment Units are grayed out and informational only.

The screenshot shows a software interface with a left-hand menu and an 'Actions' panel. The menu items are: Update, Revalidate (highlighted with a mouse cursor), Disenrollment, and Manage Affiliations. The 'Actions' panel on the right contains three rows of icons: a play button, a magnifying glass, a trash can, a checkmark, and a thumbs up icon.



# Creating a Revalidation on workbench

Show Filter Select "Search By" NPI/Atypical ID Search Criteria 1003362864 Search Clear

Actions	Type	Enrollment Status	Submission Date	Confirmation #	Tax ID	NPI/Atypical ID	Provider Name	Last Accessed By	Last Accessed Date
	Update	Enrolled	05-19-2024	71491488	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	05-19-2024
	Update	Denied	05-18-2024	71252055	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	05-18-2024
	Update	Denied	03-14-2024	71206494	100336285	1003362864	MPATH NORTHWEST...	SMA Config Milan	03-22-2024
	Update	Enrolled	01-24-2024	70546586	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	05-19-2024
	Update	Enrolled	11-01-2023	70343533	100336285	1003362864	MPATH NORTHWEST...	PROD MPATHP	12-04-2023
	Update	Denied	10-13-2023	70259025	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	10-23-2023
	Update	Enrolled	08-24-2023	69552088	100336285	1003362864	MPATH NORTHWEST...	Juvik Denise	11-01-2023
	Re-Enrollment	Enrolled	04-16-2023	69536012	100336285	1003362864	MPATH NORTHWEST...	Agumamidi Avinash	08-10-2023
	Disenrollment	Disenrolled	04-16-2023	69536003	100336286	1003362864	MPATH NORTHWEST...	Agumamidi Avinash	08-10-2023
	Enrollment	Enrolled	12-09-2021	100166188	100336286	1003362864	MPATH NORTHWEST...	Agganwal Vinay	05-31-2023
	Revalidate	InProgress		73066883	100336285	1003362864	MPATH NORTHWEST...	PROD MPATHP	10-02-2024

The Revalidation line will appear at the bottom of the workbench. Click the blue pencil icon to begin the revalidation process.

	Enrollment	Enrolled	12-09-2021	100166188	100336286	1003362864	NORTHWEST...	Vinay	05-31-2023
	Revalidate	InProgress		73066883	100336285	1003362864	MPATH NORTHWEST...	PROD MPATHP	10-02-2024

Edit

Items per page 50 1 - 14 of 14

# Navigating sections of Revalidation



MPATH NORTHW...  
NPI#:1003362864  
Provider ID#:100152324

<b>Provider Information</b>	<input type="radio"/>
Credentials	<input type="radio"/>
Financial Information	<input type="radio"/>
Physical Location	<input type="radio"/>
Enrollment Units	<input type="radio"/>
Final Submission	<input type="radio"/>
Summary	
Demographic Maintenance	

▶ My Menu

The left tiles will appear red at the beginning of the revalidation. As each section is completed these tiles will change to green.

Within each tile there are another set of tabs that are red across the top of the page. These will change to green when each tab is complete.

<b>Practice Information</b> <input type="radio"/>	Legal Name & Address <input type="radio"/>	Ownership <input type="radio"/>	Disclosure Information <input type="radio"/>
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## Practice Information

Required fields are marked with an asterisk (\*).




# Revalidation Attestation



Great Falls, MT 59403

I have reviewed the information on this screen as presented \* 

Great Falls, MT 59403

I have reviewed the information on this screen as presented \* 

Type of Provider: \*  

Type of Provider	Effective Date	Terminate Date	Actions
Ambulatory Health Care Facilities	04/02/2023		 

Save and Exit

Cancel

Previous

Save and Continue

Revalidation is a process of reviewing and updating information on your enrollment. Each page of the enrollment during revalidation will have a checkbox to attest to the statement "I have reviewed the information on this screen as presented. Click Save and Continue to proceed to the next section.



# Provider Information Tile

Practice Information ○ Legal Name & Address ○ Ownership ○ Disclosure Information ○

## Practice Information

Required fields are marked with an asterisk (\*).

Welcome to the Montana Department of Health and Human Services Provider Enrollment Portal. Please enter all required information in each section, the application will not allow a user to submit an application with missing required fields or documentation.

Please select your provider type by selecting the "Add" button next to Type of Provider field. When selected, the Type of Provider pop-up will display, select the provider type from the drop-down and enter the effective date.



Help

The first tab to complete will be the Practice information. This is where you will validate the provider taxonomy, state and/or waiver programs. Updates can be made by selecting the Add button and navigating the popup screen.

## Type of Provider: Add ⓘ

Type of Provider	Effective Date	Terminate Date	Actions
Ambulatory Health Care Facilities	04/02/2023		

## Specialties: Add ⓘ

Type of Provider	Specialty	Taxonomy	Primary	Effective Date	Terminate Date	Actions
Ambulatory Health Care Facilities	Clinic/Center, Federally Qualified Health Center (FQHC)	261QF0400X	<input checked="" type="radio"/>	04/02/2023		

Do you have Subparts of the organization sharing this NPI, which are a different Provider Type than the Primary one selected? \* ⓘ

Yes  No

## State Programs: Add ⓘ

Program Name	Requested Date	Effective Date	Terminate Date	Actions
Montana Medicaid (HMK Plus)	04/02/2023	04/02/2023		

## Waiver Programs: Add ⓘ





Program Name	Requested Date	Effective Date	Terminate Date	Actions
No program found.				

Save and Exit Cancel Previous Save and Continue



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# Provider Information Tile


Practice Information  Legal Name & Address  Ownership  Disclosure Information 


## Legal Name & Address

Required fields are marked with an asterisk (\*).

Please enter in your Legal Name and Address information, this information would be the same information on your W9. Each address in the enrollment United States Postal Service information. To complete, enter the address information and select the "Validate Address" button and confirm the information. Provider/Organizational descriptive information by selecting and entering in the required values in each section. Enter in the Billing Address information. If the address is the same as the Legal Address or Billing Address, select the checkbox to pre-populate the address information into this section. Each address information allowing the user to select from a previously entered address. In order to update your Legal Entity email, please navigate to the FEIN Management workbench.


I have reviewed the information on this screen as presented \* 


Legal Entity Name: \* 

FEIN: \* 

MPATH NORTHWEST COMMUNITY HEALTH CA

10-0336285

Type of Business Entity: \* 

Business Entity Profit Status: \* 

Corporation

Private Non-Profit

Legal name and address tab also contains the billing (physical address) and mailing sections.



# Provider Information Tile

Practice Information ✓ Legal Name & Address ✓ **Ownership** ✓ Disclosure Information ○

## Ownership ? Help

Individual Providers - Please indicate if you have ever been sanction, excluded, or convicted. Select the Yes indicator and enter in the details in the "Conviction Details" section, Please include the data of offense, outcome, and state in which action has been taken.

Organizational Providers - Federal and State regulations requires users to disclose ownership information. The collected data will be used to identify the organizational structure and to check if the disclosed individuals have been sanctioned, excluded, or convicted. If the disclosed individual has been sanctioned, excluded, or convicted, please provide details in the Comment box in the Ownership pop-up. Use the top ? to access User Documentation to help navigate each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.

I have reviewed the information on this screen as presented \* ⓘ

Federal Medicaid regulations (42 CFR 455.100 - .106) require that all Medicaid providers must attest and disclose identifying information for each person and organizations having direct or indirect ownership interests or control interest equal to or more than 5% or more value of the disclosing entity. I attest: \* ⓘ

Yes means there ARE person(s) or organization entity(s) that have 5% or more direct and/or indirect ownership. **Please Note:** Agents, Officers, Board Members, Directors and at least one managing employee must also be reported if applicable.

No means there are NO person(s) or organization entity(s) that have 5% or more direct and/or indirect ownership. **Please Note:** If No, **at least one managing employee must be reported** (on the disclosure tab).

Save and Exit Cancel Previous **Save and Continue**

If "yes" is selected each individual or business owner must be listed in the ownership section. If "no" is selected at least one managing employee must be listed on the next tab.

# Provider Information Tile

- Practice Information ✓
- Legal Name & Address ✓
- Ownership ✓
- Disclosure Information ○

## Disclosure Information



Required fields are marked with an asterisk (\*).

In this section please enter the disclosure information applicable to your organization. The information collected is required based up federal requirements outlined in 42 CFR Subpart B - Disclosure of Information by Providers and Fiscal Agents and 42 CFR Subpart E - Provider Screening and Enrollment.

I have reviewed the information on this screen as presented \* ⓘ

### Agents, Officers, Directors, and Board Members Add ⓘ

List ALL agents, officers, directors who have expressed or implied authority to act on behalf of the provider entity.

First Name	M.I.	Last Name	Date of Birth	Address	Action
No Records Found					

### Managing Employees \* Add ⓘ

List ALL managing employees who have expressed or implied authority to act on behalf of the provider entity.

First Name	M.I.	Last Name	Date of Birth	Address	Action
Hayes		Fredrick	01/01/1980	123 Main Street	

List all Agents, Officers, Director, Board Members and Managing Employees.





# Provider Information Tile

Practice Information ✓

Legal Name & Address ✓

Ownership ✓

Disclosure Information ✓

## Authorized Official Attestation:

By checking the box below, I attest that I have searched and continue to search on a monthly basis the (OIG) Office of Inspector General List of Excluded Individuals/Entities prior to enrolling in any State or Federal program, before hiring new employee and employing contractors. I attest the provider, all owners, managers, employees and contractors are not excluded from participation in Medicare, Medicaid, CHIP or other federal health care programs and agree to immediately notify any exclusion information to the State Medicaid Agency.

I Attest \* ⓘ

Save and Exit

Cancel

Previous

Save and Continue

Navigate through the additional questions on the disclosures page, read the Attestation and click I Attest. Then click save and continue. Note the tabs across the top should all appear green.



# Credentials Tile

### Add Licenses

Required fields are marked with an asterisk (\*).

Provider Type: \* ?  
Ambulatory Health Care Facilities

Specialty: \* ?  
Clinic/Center, Federally Qualified Health Center (FQHC) - 261QF0400X

License#: \* ? State: \* ?  
 Select One  
(Format: Universal)

Issuing Party Identifier: \* ?  
Select One

Effective Date: \* ? Expiration Date: \* ?  
MM/DD/YYYY MM/DD/YYYY

Save

Please enter the exact License number located on your certificate, including special characters.

I have reviewed the information on this screen as presented \* ?

Licenses: \* ?

Add ?

License #	Specialty	State	Effective Date	Expiration Date	Issuing Party Identifier	Other (Mail or Fax)	Actions
1212 *	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	04/01/2023	12/31/2023	Other	<input type="checkbox"/>	  
5465165 *	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	11/01/2023	11/30/2023	Other	<input type="checkbox"/>	  





Review the licensure on file. Add a new license for an expired line. Click Add and follow the prompts in the popup.

If the license is close to expiration the date can be extended by clicking the pencil icon.



# Credentials Tile

1514 \*      Clinic/Center; Federally Qualified Health Center (FQHC)      MT      12/01/2023      12/31/2025      Federation of State Medical Boards

**Upload**

**License** **Browse**

**loading documents:**

Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)

- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

Attachment	Document Type	Upload Date	Remove
No documents found.			

**Open** **Cancel** **Close**

Upload a current copy of the license by clicking the blue upload icon. Click browse, navigate to the license and click open.

# Credentials Tile

Document Type: License Browse

**Rules for uploading documents:**

- Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)
- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

File successfully uploaded

Attachment	Document Type	Upload Date	Remove
LICENSE 4.docx	License	10/02/2024	

Close

## Licensing, Certifications & Accreditations ✓

Please enter the exact License number located on your certificate, including special characters.

I have reviewed the information on this screen as presented

Licenses: \*

Add

License #	Specialty	State	Effective Date	Expiration Date	Issuing Party Identifier	Other (Mail or Fax)	Actions
1212 *	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	04/01/2023	12/31/2023	Other	<input type="checkbox"/>	
5465165 *	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	11/01/2023	11/30/2023	Other	<input type="checkbox"/>	
1514 *	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	12/01/2023	12/31/2025	Federation of State Medical Boards	<input type="checkbox"/>	

When the file is successfully uploaded click close on the upload pop up. Navigate through the rest of the page and click save and continue.

# Financial Information Tile

### Add Insurance Company ✕

Required fields are marked with an asterisk (\*).

Insurance Company: \*

Agent Name:

Contact Number:

I have reviewed the information on this screen as presented \* i

Manage Insurance Companies:

i

Add Insurance Company

Insurance information will be added on the insurance tab. Click Add to add the insurance company.

# Financial Information Tile

**Add Manage Policies** ✕

Required fields are marked with an asterisk (\*).

Policy Type: \* ⓘ

Policy Number: \* ⓘ

Policy Coverage Limit (\$): ⓘ

Per Claim/Aggregate Amount (\$): ⓘ

Effective Date: \* ⓘ  ⓘ




Manage Policies ⓘ

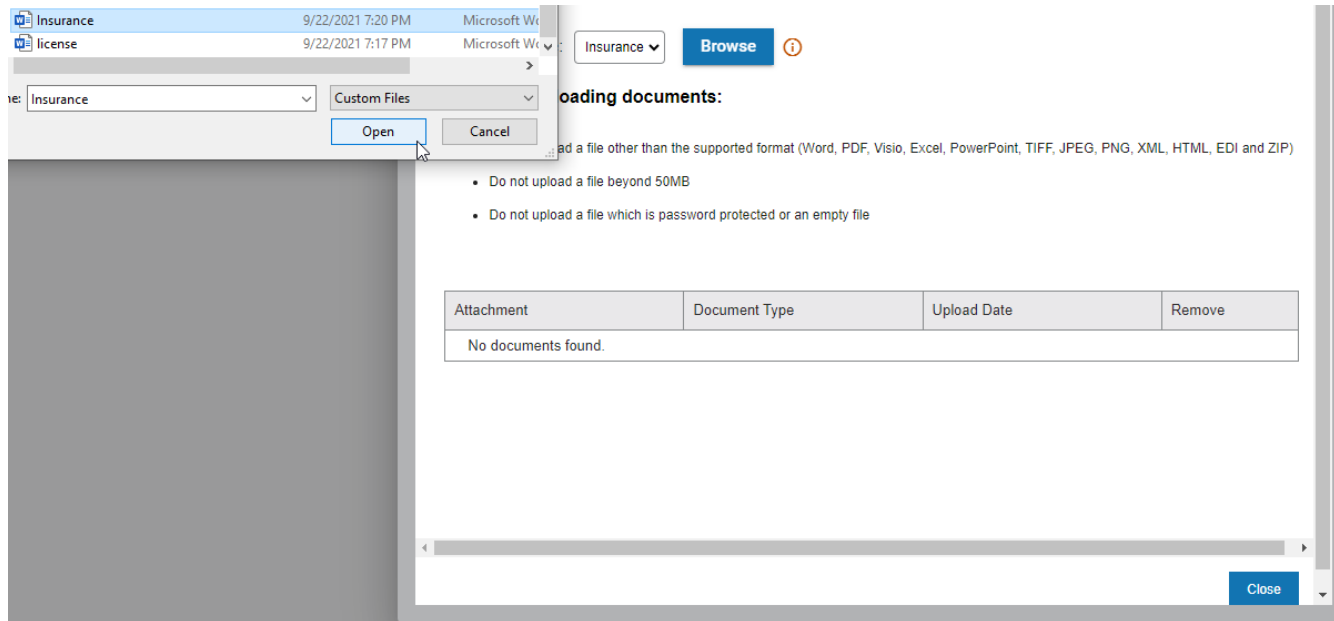
Policy Type	Policy Number ↑	Policy Coverage Limit	Per Claim/Aggregate Amount	Effective Date	Expiration Date	Other (Mail or Fax)	Actions
No Records Found							

Once the Insurance Information is added click Add next to Manage Policies. This popup will allow you to enter the details of the policy.



# Financial Information Tile

Policy Type	Policy Number ↑	Policy Coverage Limit	Per Claim/Aggregate Amount	Effective Date	Expiration Date	Other (Mail or Fax)	Actions
General Liability	1078845124	\$1,000,000.00	\$25,000.00	2024-01-01	2024-12-31	<input type="checkbox"/>	   Upload



Insurance 9/22/2021 7:20 PM Microsoft Word

license 9/22/2021 7:17 PM Microsoft Word

Insurance

Custom Files

Open Cancel

loading documents:

Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)

- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

Attachment	Document Type	Upload Date	Remove
No documents found.			

Close

Upload a current copy of the insurance policy by clicking the blue upload icon. Click browse, navigate to the document and click open.



When the file is successfully uploaded click close on the upload pop up.




# Financial Information Tile

I have reviewed the information on this screen as presented \* ⓘ

Manage Insurance Companies: **Add** ⓘ

Insurance Company	Agent Name	Contact Number	Actions
State Farm	Jake	(406)444-4444	 

Manage Policies ⓘ State Farm **Add** ⓘ

Policy Type	Policy Number ↑	Policy Coverage Limit	Per Claim/Aggregate Amount	Effective Date	Expiration Date	Other (Mail or Fax)	Actions
General Liability	1078845124	\$1,000,000.00	\$25,000.00	2024-01-01	2024-12-31	<input type="checkbox"/>	  

Insurance information will appear on this tab. Click save and continue.





# Financial Information Tile

I have reviewed the information on this screen as presented \*

Please complete this form below for Electronic Funds Transfer reimbursement.

As part of a quarterly regulation update CMS-00281FC Final Rule), The Centers for Medicare & Medicaid Services (CMS) has requiring the use of Electronic Funds Transfers (EFT) for all providers.

Type of Account: \*

Checking  Savings

Financial Institution Routing Number: \*

123456789

Re-enter Financial Institution Routing Number: \*

123456789

Account Number: \*

\*\*\*\*\*

Re-enter Account Number: \*

\*\*\*\*\*

Account Holder Name: \*

Hayes River

Financial Institution Name: \*

Valley Bank

Address Line 1: \*

8 Last Chance

Address Line 2:

Supporting Documents:

Rules for uploading documents:

- Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)
- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

Document Name	Document Type	File Name	Upload Date	Uploaded By	Other (Mail or Fax)	Actions
EFT/ERA Authorization...	EFT/ERA Authorization ...				<input type="checkbox"/>	

Upload Signed Documents

Save and Exit

Cancel

Previous

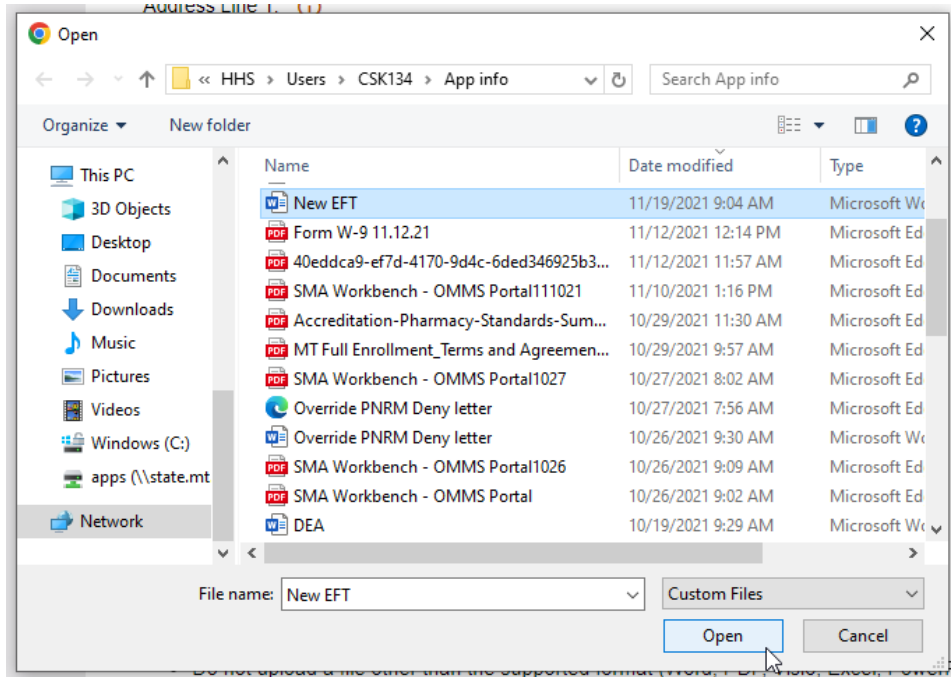
Save and Continue

Review banking information on file and validate the address information.

An EFT is required for revalidation. The EFT routing and account number must match exactly to the information on the screen and be signed within a year of revalidation submission date.



# Financial Information Tile



Insurance  Banking

Supporting Documents: ⓘ

Rules for uploading documents:

- Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)
- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

Document Name	Document Type	File Name	Upload Date	Uploaded By	Other (Mail or Fax)	Actions
<a href="#">EFT/ERA Authorization ...</a>	EFT/ERA Authorization ...	<a href="#">New EFT.docx</a>	10/02/2024 19...	MPATHPROD	<input type="checkbox"/>	

Save and Exit Cancel Previous Save and Continue

Upload a current EFT form by clicking the blue upload icon. Click browse, navigate to the document and click open. When the file is successfully uploaded click close on the upload pop up.

# Physical Location Tile

## Physical Location

Users have the ability to enter multiple physical locations within a single enrollment application submission. After entering in all of the required information, the application will generate an additional physical location. Each physical location is identified by using the National Provider Identifier (NPI) or Atypical Provider Identifier (API). For example the first physical location number would be ex. 1234567891-001 and the additional locations would be -002, -003, etc. The information collected will be used in the provider directory. The information disclosed will help the member population determine where to receive care and provider characteristics. Use the information in each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.







Physical locations are where the provider has a servicing location. There can be one or multiples.

Each location will appear with a red progress status. To review and update each location click on the pencil icon.

## Location

Add \* 

Manage Affiliations 


ID	Address	City	State	County	Action	Progress
002	102 J STREET	HELENA	MT	Park		
003	123 Main St	Helena	MT	Lewis and Clark		
005	7 J Street	Helena	MT	Lewis and Clark		



# Physical Location Tile

## Location

**Add** \* ⓘ **Manage Affiliations** ⓘ

ID	Address	City	State	County	Action	Progress
002	102 J STREET	HELENA	MT	Park		○
003	123 Main St	Helena	MT	Lewis and Clark	<b>Edit</b>	○

- Address** ○
- Hours ○
- Languages ○
- Medicare/Medicaid ○
- Services Provided ○
- Drug Program ○

To review and update each location click on the pencil icon. This will open the location and tabs will appear across the top with a red status. Each tab will need to be reviewed and/or updated.

# Physical Location Tile

## Address

Required fields are marked with an asterisk (\*).

Users have the ability to enter multiple physical locations within a single enrollment application submission. After entering in all of the required information the user can select the "Add" button and the application will generate an additional physical location. Each physical location is identified by using the National Provider Identifier (NPI) or Atypical Provider Number plus a three digit extension. For example the first physical location number would be ex. 1234567891-001 and the additional locations would be -002, -003, etc. The information collected in each physical location will be included in the provider directory. The information disclosed will help the member population determine where to receive care and provider characteristics. Use the top ? to access User Documentation and help navigate each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.

I have reviewed the information on this screen as presented \* (i)

Location# (i)

Service Location Name: \* (i)

Physical Practice Location Address: \* (i)

Address Line 1: \* (i)

Address Line 2: (i)

City: \* (i)  State: \* (i)  Zip Code: \* (i)  County: \* (i)  Terminate Date: (i)

Phone Number: \* (i)  Ext: (i)  Fax Number: (i)  Ext: (i)



Help

### Questions:

- 1) Do you have the SAMHSA accreditation? \* (i)
  - Yes
  - No
- 2) Do you have a DEA License? \* (i)
  - Yes
  - No
- 3) Are you a CMS designated facility? \* (i)
  - Yes
  - No
- 4) Do you provide laboratory services at this location? \* (i)
  - Yes
  - No
- 5) Are you physically located in the State of Montana? \* (i)
  - Yes
  - No

### Specialties (i)

	Type of Provider	Specialty	Taxonomy	Terminate Date
<input checked="" type="checkbox"/>	Ambulatory Health Care Facilities	Clinic/Center, Federally Qualified Health Center (FQHC)	261QF0400X	MM/DD/YYYY

### Programs (i)

	Program Name	Care Management ID	Required Team Name	Terminate Date
<input checked="" type="checkbox"/>	Montana Medicaid (HMK Plus)			MM/DD/YYYY

### Supporting Documents:

Document Name	Document Type	Other (Mail or Fax)	Actions
Location Business License	Location Business License	<input type="checkbox"/>	(i)

Cancel Previous Save and Continue Save



DEPARTMENT OF  
PUBLIC HEALTH &  
HUMAN SERVICES

# Physical Location Tile

## Hours



Please enter the Hours of Operation for each Physical Location. Complete each day of the week with the appropriate information which will display in the member search of the provider directory. To enter office hours, first indicate for each day of the week if the physical location is closed or open 24 hours by selecting the checkbox. When the closed checkbox is selected, the portal will grey out the Opening and Closing time hours field for that day of the week. If Open 24 hours is selected the portal will prefill the Opening and Closing time data fields applying the 24 hours for that day of the week. To enter specific hours of operation, the user will select from the drop-down under the Opening Time option and select the time the physical location opens. Next, if the physical location has a break (ex. the office closes for lunch, etc.) indicate the Break Start Time by selecting the appropriate Break Start time. Next, enter the time when the Break Ends indicating when the physical location is re-opened after the break. Finally, enter the Closing time when the physical location is closed for the day. Complete each day of the week and select Save at the bottom of the screen. If this physical location does not have a break through the course of the day enter only the Opening time and Closing time and leave the Break start time and Break end time blank. Use the top ? to access User Documentation to help navigate each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.

I have reviewed the information on this screen as presented \*

Office Hours:

Monday \*

Closed

Open 24 hours

Opening time:

Select

Break start time:

Select

Break end time:

Closing time:

Cancel

Previous


Save and Continue


Save





# Physical Location Tile


Address 

Hours 

Languages 

Medicare/Medicaid 

Services Provided 


Drug Program 


## Languages



Help

Please select the languages this physical location services. Please select all that apply. This information will be included in the Provider Directory which will help members select a provider and location that supports their language. Use the top? to access User Documentation to help navigate each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.

I have reviewed the information on this screen as presented \* 

Please select spoken languages supported at this location: \* 

- English
- Spanish
- French
- Arabic
- German
- Hmong
- Mandarin
- Other

Cancel

Previous

Save and Continue

Save



DEPARTMENT OF  
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HUMAN SERVICES

# Physical Location Tile

Address  Hours  Languages  Medicare/Medicaid  Services Provided  Drug Program

## Medicare/Medicaid



Required fields are marked with an asterisk (\*).

Please indicate your participation with Medicare or another state's Medicaid or Children's Health Insurance Program. This information is used to validate screening has been completed by CMS or another state's Medicaid/CHIP agency. Please only include current status, not historical information. If applicable, enter your Medicare status, Medicare ID (NPI number or Provider ID used for Medicare billing), Enrollment date, and if an application was collected by CMS. Enter the same information for any other Medicaid/CHIP Agencies including proof of application fees collected by other states. Use the top ? to access User Documentation to help navigate each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.

I have reviewed the information on this screen as presented \*

Have you ever been enrolled in Medicare? \*

Yes  No

Have you ever been enrolled in Medicaid/CHIP in another state? \*

Yes  No

### Medicaid Details

Add

Medicaid Status	Medicaid ID	Enrollment Date	Inactive Date	State	Actions
No Records Found					





# Physical Location Tile

Address  Hours  Languages  Medicare/Medicaid  Services Provided  Drug Program

## Services Provided

Please select all values that apply (e.g., all services provided, languages, etc)

I have reviewed the information on this screen as presented \* [i](#)

1. Are you accepting new patients? \* [i](#)  
 Yes  No
2. Does this location accept family members of existing patients? \* [i](#)  
 Yes  No
3. Do you accept siblings of established patients? \* [i](#)  
 Yes  No
4. Are oral interpretation services available? [i](#)  
 Yes  No
5. Is Braille supported? [i](#)  
 Yes  No
6. Is sign language supported? [i](#)  
 Yes  No
7. 24 Hour Office Phone [i](#)    
Phone Number Ext
8. Are you enrolling as an Indian Health Services (IHS) provider? [i](#)  
 Yes  No
9. Are you enrolling as a Tribal Health Services (THS) provider? [i](#)  
 Yes  No
10. Are you enrolling as a Physician Group Clinic? [i](#)

13. Are you enrolling as a Psychiatric Residential Treatment Facility? [i](#)  
 Yes  No
14.  Services - Family Practice [i](#)
15.  Services - General Practice [i](#)
16.  Services - Internal Medicine [i](#)
17.  Services - Obstetrics [i](#)
18.  Services - Other [i](#)
19.  Services - Gynecology [i](#)
20.  Services - Pediatrics [i](#)
21.  Special Needs Accommodations - Blind/Visually Impaired [i](#)
22.  Special Needs Accommodations - Deaf/Hearing Impaired [i](#)
23.  Special Needs Accommodations - Physically Handicapped [i](#)
24.  Special Needs Accommodations - Behaviorally Disruptive [i](#)
25. What gender does this facility accommodate? \* [i](#)
26. Does this location have an Age Restriction? \* [i](#)  
 Yes  No
27. Age served - Minimum Age Served (format: 1234567890) \* [i](#)
28. Age served - Maximum Age Served (format: 1234567890) \* [i](#)



DEPARTMENT OF  
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HUMAN SERVICES

# Physical Location Tile

Address ✓ Hours ✓ Languages ✓ Medicare/Medicaid ✓ Services Provided ✓ Drug Program ○

## Drug Program

The Drug Program is provided to qualifying Hospitals (Facilities, Groups, Individuals), DPHHS and Indian Health providers that participate in the 340B Drug Program and/or dispense 340B stock to Montana DPHHS members.

I have reviewed the information on this screen as presented \* ⓘ

1. Do you participate in the 340B program? ⓘ

Yes  No

2. Do you dispense your 340B stock to Montana DPHHS Members? ⓘ

Yes  No



# Physical Location Tile

The process will need to be completed for each location. Once all sections of the location are complete the progress bar will appear green with a checkmark.

## Location

Add ⓘ Manage Affiliations ⓘ

ID	Address	City	State	County	Action	Progress
002	102 J STREET	HELENA	MT	Park		
003	123 Main St	Helena	MT	Lewis and Clark		
005	7 J Street	Helena	MT	Lewis and Clark		

### Physical Location

Users have the ability to enter multiple physical locations within a single enrollment application submission. After entering in all of the required information the user can select the "Add" button and the application will generate an additional physical location. Each physical location is identified by using the National Provider Identifier (NPI) or Atypical Provider Number plus a three digit extension. For example the first physical location number would be ex. 1234567891-001 and the additional locations would be -002, -003, etc. The information collected in each physical location will be utilized in the provider directory. The information disclosed will help the member population determine where to receive care and provider characteristics. Use the top ? to access User Documentation to help navigate each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.

Save and Exit Cancel Previous **Save and Continue**

## Location

Add ⓘ Manage Affiliations ⓘ

ID	Address	City	State	County	Action	Progress
002	102 J STREET	HELENA	MT	Park		
003	123 Main St	Helena	MT	Lewis and Clark		
005	7 J Street	Helena	MT	Lewis and Clark		

Save and Exit Cancel Previous **Save and Continue**



# Enrollment Units Tile

User Guide

## Enrollment Units



Enrollment Units are components/sections of the application that are created to capture additional information. Items that make up an enrollment unit are, additional physical locations, particular state programs, or a combinations of location and program. within the enrollment unit additional information is confirmed or captured. The enrollment application will create each enrollment unit automatically and information from previous sections will populate within the Enrollment Unit. This workbench will display all enrollment units for this enrollment application, please complete each as applicable.

Show Filter Select "Search By" Select One Search Criteria Search Clear

Enrollment Unit	Program	Specialty	Service Location Name	Team Name	Team Number	Effective Date	Terminate Date	System Status	Actions
0001668862	◦ Montana Medicaid (HMK Plus)	◦ Clinic/Center; Federally Qualified Health Center (FQHC)	Clinic West			04/02/2023		Pending	
0001748279	◦ Montana Medicaid (HMK Plus)	◦ Clinic/Center; Federally Qualified Health Center (FQHC)	New location Armory			05/18/2024		Pending	

Items per page 50 1 - 2 of 2

Save and Exit Cancel Previous Save and Continue

Enrollment Units (EU) are unique numbers that identify the type of provider service when billing/paying claims. These EUs contain information specific to the provider services. Click the pencil icon to review the information at the Enrollment Unit (EU).



# Enrollment Units Tile

I have reviewed the information on this screen as presented \* ⓘ

## Licenses ⓘ

Licenses Available:  ⓘ

License #	Specialty	State	Effective Date	Expiration Date	Issuing Party Identifier	Primary	Action
1212	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	04/01/2023	12/31/2023	Other	<input type="radio"/>	
5465165	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	11/01/2023	11/30/2023	Other	<input type="radio"/>	
1514	Clinic/Center, Federally Qualified Health Center (FQHC)	MT	12/01/2023	12/31/2025	Federation of State Medical Boards	<input checked="" type="radio"/>	

## Certifications ⓘ

Certifications Available:  ⓘ

Certification #	Specialty	State	Effective Date	Expiration Date	Issuing Party Identifier	Primary	Action
No Certifications found							

## Accreditations ⓘ

Accreditations Available:  ⓘ

Accreditation #	Specialty	State	Effective Date	Expiration Date	Accreditation Organization	Primary	Action
No Accreditations found							

Validate the license is current at the Enrollment Unit level. Click the Primary radio button next to the current active license.



# Enrollment Units Tile

Licensing, Certifications & Accreditations  **Address**  Communications  Managing Employees

Please see below for the Address information specific to this Enrollment Unit. [Help](#)

Required fields are marked with an asterisk (\*).

I have reviewed the information on this screen as presented \* ⓘ

Type	Address Line 1	Address Line 2	City	State	Zip Code
Billing*	Select				
Mailing*	Select				
Remittance*	Select				
Other	Select				

Licensing, Certifications & Accreditations  **Address**  Communications  Managing Employees

Please see below for the Address information specific to this Enrollment Unit. [Help](#)

Required fields are marked with an asterisk (\*).

I have reviewed the information on this screen as presented \* ⓘ

Type	Address Line 1	Address Line 2	City	State	Zip Code
Billing*	9 J STREET		HELENA	MT	56906-7906
Mailing*	8 J STREET		HELENA	MT	56787-6788
Remittance*	8 J STREET		HELENA	MT	56787-6788
Other	Select				

Cancel Previous Save and Continue Save

Validate or update the billing (physical address), mailing and remittance addresses at the Enrollment Unit level. Note: billing address cannot be a PO Box.

# Enrollment Units Tile

Licensing, Certifications & Accreditations ✓ Address ✓ **Communications** ○ Managing Employees ○

Please see below for the Contact information specific to this Enrollment Unit. ? Help



Show Filter Select "Search By" Select One Search Criteria Search Search Clear

Required fields are marked with an asterisk (\*).

I have reviewed the information on this screen as presented \* ⓘ

Available Contacts: \* ⓘ

Select

Primary	First Name ↑	Last Name	Phone Number	Email	Contact Type	Actions
<input checked="" type="radio"/>	JOHN	LEE	(987)984-6541	UAT0316@getnada.com	Office Manager	 

Items per page 50 1 - 1 of 1 < >


Cancel Previous Save and Continue Save

Validate or update the contact information. This will be used for questions about the revalidation or updates.

# Enrollment Units Tile

Licensing, Certifications & Accreditations Address Communications **Managing Employees**

**Managing Employees**

Please see below for the Managing Employee information specific to this Enrollment Unit.  **Help**

Required fields are marked with an asterisk (\*).

I have reviewed the information on this screen as presented

Managing Employee: \*

Select

First Name	M.I.	Last Name	Date of Birth	Address	Effective Date	Terminate Date	Action
Hayes		Fredrick	01/01/1980	123 Main Street	04/02/2023	MM/DD/YYYY	


**Note:** Removing a Managing Employee on this page only removes the employee from this enrollment unit.

Managing employees are selected by using the drop down. This information was entered earlier in the revalidation. If a managing employee was not required or entered no information will appear in the drop down.





# Enrollment Units Tile

**Enrollment Units** User Guide

 Help

Enrollment Units are components/sections of the application that are created to capture additional information. Items that make up an enrollment unit are, additional physical locations, particular state programs, or a combinations of location and program. within the enrollment unit additional information is confirmed or captured. The enrollment application will create each enrollment unit automatically and information from previous sections will populate within the Enrollment Unit. This workbench will display all enrollment units for this enrollment application, please complete each as applicable.


Show Filter Select "Search By" Select One Search Criteria Search - + Search Clear

Enrollment Unit	Program	Specialty	Service Location Name	Team Name	Team Number	Effective Date	Terminate Date	System Status	Actions
0001668862	Montana Medicaid (HMK Plus)	Clinic/Center, Federally Qualified Health Center (FQHC)	Clinic West			04/02/2023		Complete	
0001748279	Montana Medicaid (HMK Plus)	Clinic/Center, Federally Qualified Health Center (FQHC)	New location Armory			05/18/2024		Pending	

Items per page 50 1 - 2 of 2 < > >>



Save and Exit Cancel Previous Save and Continue

**Enrollment Units** User Guide

 Help

Enrollment Units are components/sections of the application that are created to capture additional information. Items that make up an enrollment unit are, additional physical locations, particular state programs, or a combinations of location and program. within the enrollment unit additional information is confirmed or captured. The enrollment application will create each enrollment unit automatically and information from previous sections will populate within the Enrollment Unit. This workbench will display all enrollment units for this enrollment application, please complete each as applicable.

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Enrollment Unit	Program	Specialty	Service Location Name	Team Name	Team Number	Effective Date	Terminate Date	System Status	Actions
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Items per page 50 1 - 2 of 2 < > >>

Save and Exit Cancel Previous Save and Continue

The process will need to be completed for each location. Once all sections of the location are complete the Systems status will state complete.

# Final Submission Tile

Provider Name: ⓘ

NPI: ⓘ

Please click the hyper link shown below to review, download, and print the most recent Terms & Agreement form. The document must be printed signed, scanned/imaged and uploaded using the upload Terms & Agreement button before the application can be submitted for final review

### Rules for uploading documents:

- Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)
- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

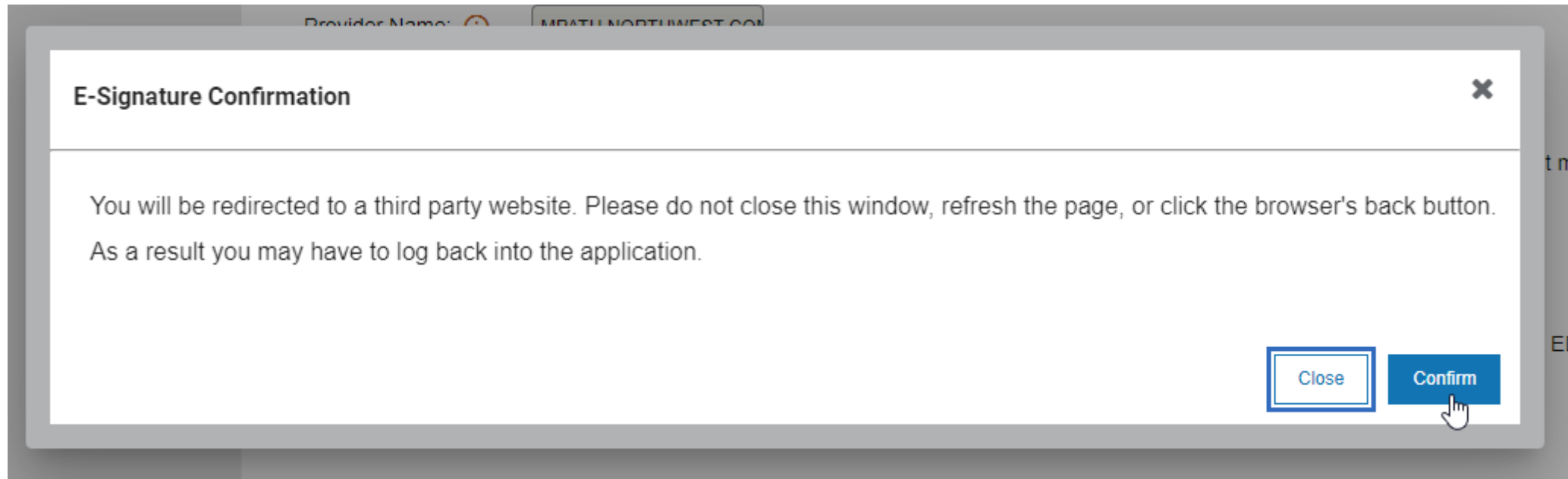
Document Name	Document Type	E-Sign The Document	File Name	Upload Date	Uploaded By	Other (Mail or Fax)
<a href="#">MTDisclosuresScreenin...</a>	DisclosuresScreeningEn...	<input type="checkbox"/> E-Sign				<input type="checkbox"/>
<a href="#">MTDPHHSTermsandAgr...</a>	MTDPHHSTermsandAgr...	<input type="checkbox"/> E-Sign				<input type="checkbox"/>

Revalidation requires new signed Montana Terms and Agreement and Disclosure, Screening and Enrollment Requirements documents. The documents are available for download by clicking the blue download button.

Electronic signature is available by clicking E-Sign.



# Final Submission Tile



# Final Submission Tile

## Disclosures, Screening and Enrollment Requirements

**Title 42—Public Health**  
**Part 455—Program Integrity: Medicaid**  
**Subpart B—Disclosure of Information by Providers and Fiscal Agents**  
**Source: 44 FR 41644, July 17, 1979, unless otherwise noted.**

### 455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding—(a) Disclosure by providers and fiscal agents of ownership and control information; and (b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

### 455.101 Definitions.

*Agent* means any person who has been delegated the authority to obligate or act on behalf of a provider.

*Disclosing entity* means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

*Other disclosing entity* means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes: (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

*Fiscal agent* means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

*Group of practitioners* means two or more health care practitioners who practice their profession at a common

By clicking continue, I acknowledge that I have read and agree to the Adobe [Terms of Use](#). See our [Privacy Policy](#) for details on our privacy practices.

Continue

## Disclosures, Screening and Enrollment Requirements

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*Fiscal agent* means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

*Group of practitioners* means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

↑ ↓ 1 / 7 ⌂ ⊕ ⊖



# Final Submission Tile

Printed Name of Individual Practitioner \_\_\_\_\_

Signature of Individual Practitioner \_\_\_\_\_ Date \_\_\_\_\_

**Or for facilities and non-practitioner organizations:**

Printed Name of Authorized Representative Maisy HB Marshall

Title/Position Admin

Address 9 J Street Helena, MT 59601 Telephone Number

Signature of Authorized Representative  Date Oct 2, 2024



**Attach the Montana Provider Services Mail Cover Sheet and mail to:**

Department of Public Health and Human Services  
 Montana Healthcare Programs Provider Services  
 P.O. Box 89  
 Great Falls, MT 59403

To change the Signature of Authorized Representative.  
 Highlight the current name and begin typing.  
 Once both documents are signed click save and continue.

**Rules for uploading documents:**

- Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)
- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

Document Name	Document Type	E-Sign The Document	File Name	Upload Date	Uploaded By	Other (Mail or Fax)	Actions
 MTDisclosuresScreenin...	DisclosuresScreeningEn...	<input type="button" value="E-Sign"/>	E-Signed Document	10/02/2024 ...		<input type="checkbox"/>	
 MTDPHHSTermsandAgr...	MTDPHSTermsandAgr...	<input type="button" value="E-Sign"/>	E-Signed Document	10/02/2024 ...		<input type="checkbox"/>	

By signing, I agree to this document, the [Consumer Disclosure](#) and to utilize electronic signatures.  
 Sender requests you be redirected to omms-mt.optum.com after signing.

W-9



Provider Enrollment W-9

Please complete the following sections. Use the ? symbol for additional help or the (i) for field level help

I have reviewed the information on this screen as presented \*

Click this link to download the most recent version of the Federal [W-9 Form](#).

This is required for all billing providers. Name and Tax ID must be exactly as reported to the IRS. The Signer of the W9 must be listed in the Managing/Directing section of the enrollment application.

Please complete and attach the completed document with your application.

Supporting Documents:

Document Name	Document Type	Other (Mail or Fax)	Actions
W9 *	W-9	<input type="checkbox"/>	

A W-9 with a legal entity and signed within a year revalidation submission date is required.



# Final Submission Tile

W-9

**Adding documents:**

- Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)
- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

Document Type: W-9

**Rules for uploading documents:**

- Do not upload a file other than the supported format (Word, PDF, Visio, Excel, PowerPoint, TIFF, JPEG, PNG, XML, HTML, EDI and ZIP)
- Do not upload a file beyond 50MB
- Do not upload a file which is password protected or an empty file

File successfully uploaded

Attachment	Document Type	Upload Date	Remove
W9.docx	W-9	10/02/2024	

Close

Upload a current W-9 form by clicking the blue upload icon. Click browse, navigate to the document and click open.

When the file is successfully uploaded click close on the upload pop up.



# Summary Tile

The screenshot shows a web application interface for 'HI MPATHP PROD'. On the left is a navigation menu with a user profile for 'MPATH NORTHW...' (NPI# 1003362864, Provider ID# 100152324). The menu items are: Provider Information, Credentials, Financial Information, Physical Location, Enrollment Units, Final Submission, Summary (highlighted with a red border), and Demographic Maintenance. Below the menu is a 'My Menu' section. The main content area is titled 'Summary' and contains the text: 'This page allows you to review all information completed on the application. Each heading in gray below matches a page name in the enrollment application.' Below this text is a 'Review Your Enrollment' section with a 'Show All' (selected) and 'Show Missing' radio button. Underneath is a 'Provider Information' section with four items, each with a green checkmark and an 'Edit' button: Practice Information, Legal Name & Address, Ownership, and Disclosure Information. Below this are several gray expandable sections: Credentials, Financial Information, Physical Location, Enrollment Units, Final Submission, and Enrollment Documents. At the bottom of the page are three buttons: 'Cancel', 'Previous', and 'Submit'.

Summary is the final step of the revalidation process. If any information is missing the tiles on the left will appear red. You can navigate direct back to the section by clicking the tile and reviewing the missing information.

Once the review is complete click the Submit button at the bottom right corner of the revalidation.



# Enrollment Workbench

## Thank you confirmation

Your provider enrollment application was submitted and sent to your SMA.

Continue

Click submit. A Thank you confirmation page will appear, click continue.

On the Enrollment workbench the top line will display Revalidation Submitted.

## Enrollment Workbench

User Guide

Show Legend

Show Filter

Select "Search By"

NPI/Atypical ID

Search Criteria 1003362864

Search

Clear

Actions	Type	Enrollment Status	Submission Date	Confirmation #	Tax ID	NPI/Atypical ID	Provider Name	Last Accessed By	Last Accessed Date
	Revalidate	Submitted	10-04-2024	73066883	100336285	1003362864	MPATH NORTHWEST...	PROD MPATHP	10-04-2024



# Provider Relations Contact Information

- Provider Relations Call Center:
  - (800) 624-3958
  - Monday through Friday 8am to 5pm MST
- General, Claims, TPL, and EDI questions:  
[MTPRHelpdesk@conduent.com](mailto:MTPRHelpdesk@conduent.com)
- Enrollment Questions and documents:
  - [MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com)
  - Note: the Conduent emails cannot accept secured emails.



**Thank you for the care and  
support of Montana  
Healthcare Programs  
members that you provide.**



DEPARTMENT OF  
**PUBLIC HEALTH &  
HUMAN SERVICES**