



**Hewlett Packard
Enterprise**

RI Medicaid Revalidation – Tips and Reminders

Hewlett Packard Enterprise

October, 2015

PR0092 V1.0 10.1.15



Agenda

- How to begin
- Access your information
- Verifying your information for revalidation
- Important reminders
- Disclosures
- Signature page

Begin Revalidation Process

Home

Wednesday 09/02/2015 11:47 AM EST

Do NOT login
with your User
ID.

Click here for
Provider
Enrollment

Login ?

*User ID

Log In

[Forgot User ID?](#)
[Register Now](#)
[Where do I enter my password?](#)

Protect Your Privacy!
Always log off and close all of your browser windows

Would you like to enroll as a Provider?

[Provider Enrollment](#)

Would you like to enroll as a Trading Partner?

[Click here to Enroll](#)

What can you do in the RI Medicaid Health Care Portal

Through this secure and easy to use internet portal:

- Healthcare providers and Billing Agents can **enroll as a Trading Partner** with RI Medicaid.
- Trading Partners can access eligibility, claim status, file exchange and other Interactive Web Services including the Electronic Health Record (EHR) Incentive Program - **MAPIR** - utilizing their Trading Partner ID as their User ID.



[Provider Enrollment User Guide](#)

[Trading Partner Enrollment User Guide](#)

[Trading Partner Agreement](#)

[Website Requirements](#)

[Rhode Island Medicaid Providers](#)

Access Your Information

Select
Resume
Enrollment

[Home](#) > Provider Enrollment

Wednesday 09/02/2015 11:46

Provider Enrollment

[Enrollment Application](#)

Initiate a new provider enrollment application.

[Resume Enrollment](#)

Resume an existing enrollment application that has not been submitted.

[Enrollment Status](#)

Check the current status of an enrollment application.

Customer Links

[National Plan & Provider Numeration System](#)

Apply or Verify your National Provider Identifier (NPI).

[Trading Partner Enrollment](#)

Enroll as a Trading Partner in the Healthcare Portal.



Enter your Tracking Number

Provider Enrollment: Resume Enrollment ?

Enter your assigned Tracking Number (including the hyphens), Tax ID and Password in order to resume an existing provider enrollment application. For further questions, please contact Provider enrollment at (401) 784-8100 ☎ for local and long distance calls or (800) 964-6211 ☎ for in-state toll calls.

* Indicates a required field.

*Tracking Number	<input type="text"/>
*Tax ID	<input type="text"/>
*Password	<input type="text"/>

Submit

Cancel

The tracking number and password were sent in two separate letters. Enter tracking number exactly as typed, including dashes.
Then enter Tax ID and Password that was sent to you by mail.
This is not your Healthcare Portal password.

Verify Information

Verify or complete the information on each screen. You cannot advance to the next screen without completing the current one. You can go back by using the menu on the left.

The following pages in this guide highlight some of the more common “errors” made.



Provider Name

Provider Legal Name	
The provider legal name and information is provided once for each enrollment. Ownership Information is required.	
*Provider Legal Name	<input type="text"/>
*Ownership	<input type="text" value="v"/>
Business Name	<input type="text"/>

You must enter the LEGAL name for your facility. Then select the type of ownership from the drop down. If another business name is used, enter in the Business Name field.

Electronic Funds Transfer

Bank and Bank Account Information

*ABA Routing Number

*Account Number

*Account Type

*EFT Start Date

EFT End Date

After verifying your banking information, you **MUST** change the EFT start date to today's date. If you save your application and complete later, you must change again. Select the date from the calendar (see image at right)

*Account Type

*EFT Start Date

September, 2015

Su	Mo	Tu	We	Th	Fr	Sa
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	1	2	3
4	5	6	7	8	9	10

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Today: September 2, 2015

W-9

Form **W-9**
Rev. December 2011
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)
Ronald Green

Business name (disregarded entity name, if different from above)
Blue Y Dryclean

Check appropriate box for federal tax classification:
 Individual proprietor C Corporation S Corporation Partnership Trust/estate
 Limited liability company. Enter the tax classification (S-C corporation, S-B corporation, Partnership) Exempt payee
 Other (see instructions)

Address (number, street, and apt. or suite no.)
155 Flower Lane
City, state, and ZIP code
Oakman, AL 36000

Requester's name and address (optional)
J Builders
123 Maple Avenue
Oakman, AL 36000

Law account numbers (see instructions)

Part 1 Taxpayer Identification Number (TIN)
Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part 1 instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see how to get a TIN on page 3.
Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Enter security number
1 2 3 - 4 5 - 6 7 8 9

Employer identification number
1 - - - - -

ALL providers must upload a new W-9 at the end of the revalidation process.

Medicare Number /CLIA

*NPI	<input type="text"/>	
License #	<input type="text"/>	Expiration Date ⓘ <input type="text"/> 
Medicare #	<input type="text"/>	
DEA #	<input type="text"/>	
CLIA #	<input type="text"/>	
Supplemental NPI	<input type="text"/>	
Supplemental Taxonomy	<input type="text"/>	

If also a Medicare provider, enter the number and upload a copy of your Medicare letter

Hospitals – enter CLIA# and upload your certificate.

Disclosures

IMPORTANT

Disclosures must be completed all at once. If you save your revalidation application, all prior work will be saved EXCEPT disclosures. These must be completed when you are ready to submit.



The image shows a document titled "Rhode Island Medicaid Disclosure Questions" from the Executive Office of Health & Human Services, State of Rhode Island. The document is tilted and features the Hewlett Packard Enterprise logo in the bottom right corner. A grey box highlights the following text:

ALL PROVIDERS
1. Programs – Please check all other programs that you want to participate in, in addition to Medicaid:

- Behavioral Health, Developmental Disabilities, and Hospitals CNOM
- Community Medication Assistance Program (CMAP)
- Dept. of Corrections

Disclosure Question #4

4. *Is there an Owner/Administrator, Agent of the Provider, Managing Employee or Officer for the Corporation?

Yes No

*a. Name:

*b. Title:

*c. Legal entity or home address:

*d. Social Security Number or Employer Identification Number

*e. Date of Birth 

Question 4 asks for the owner/administrator's name, title, and **home address**.

Also, the **Social Security** number of the owner must be listed.

Disclosure Question #10

Question #10 asks if you have more than one individual to disclose for question 4, 5, 6, 7, and/or 9. If the answer is yes, complete the Additional Federally Required Disclosures form, found on the Agreement page, following the disclosures.

The form is titled "Ownership and Control" and is divided into several sections. The top section, labeled "Ownership and Control", contains a table with columns A through F. Column A is "Provider Name", B is "List the name and address of each person with an ownership or control interest in the disclosing entity and has direct or indirect ownership of 5 percent or more.", C is "List any persons who has an ownership or control interest in another disclosing entity.", D is "Provider NPI/ Service Location", E is "Disclosing Entity", and F is blank. Below this, there are two identical sections for disclosing ownership and control interests. Each section has a table with columns for Name & Title, Legal Entity or Home Address, Relationship, EIN/SSN, Subcontractor? Y/N, and Ownership percentage amount. The table has 4 rows for each section.

Signing your Application

Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Agreement and Addendum have been read.

Read and Print: [Provider Agreement](#)

Read and Print: [Provider Addendum I Glossary](#)

Read and Print: [Exclusion Letter](#)

You will be submitting the Provider Enrollment application electronically. By submitting this application, you acknowledge that you have read and agree to the policies of the Provider Agreement and Provider Addendum I Glossary for all Programs to which you are applying. Therefore, your signature indicates that you have legal authority to submit this application and understand that your electronic signature is binding to the same extent as your written signature.

***I accept** I understand that my electronic signature is equivalent to written signature. The electronic signature should be my legal name (first and last name).

***Your Signature**

Title

Agreement Date 09/02/2015

Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Agreement and Addendum have been read.

Read and Print: [Provider Agreement](#) ✓

Read and Print: [Provider Addendum I Glossary](#) ✓

Read and Print: [Exclusion Letter](#) ✓

You will be submitting the Provider Enrollment application electronically. By submitting this application, you acknowledge that you have read and agree to the policies of the Provider Agreement and Provider Addendum I Glossary for all Programs to which you are applying. Therefore, your signature indicates that you have legal authority to submit this application and understand that your electronic signature is binding to the same extent as your written signature.

***I accept** I understand that my electronic signature is equivalent to written signature. The electronic signature should be my legal name (first and last name).

***Your Signature**

Title

Agreement Date 09/02/2015

You are unable to sign your document until you open each of the document links in blue: Provider Agreement, Provider Addendum and Exclusion Letter. Once you open each, the "I accept" box can be checked and the signature section will open.

Agreements

Read and Print: [Provider Agreement](#)

Read and Print: [Provider Addendum / Glossary](#)

Read and Print: [Exclusion Letter](#)

It is not necessary to sign and fax these documents. Signing the application electronically also signs these three documents.

Completing Application

You will be submitting the Provider Enrollment application electronically. By submitting this application, you acknowledge that you have read and agree to the policies of the Provider Agreement and Provider Addendum I Glossary for all Programs to which you are applying. Therefore, your signature indicates that you have legal authority to submit this application and understand that your electronic signature is binding to the same extent as your written signature.

*I accept I understand that my electronic signature is equivalent to written signature and my electronic signature should be my legal name (first and last name)

*Your Signature

Title

Agreement Date 12/01/2011

[Submit](#) [Finish Later](#) [Cancel](#)



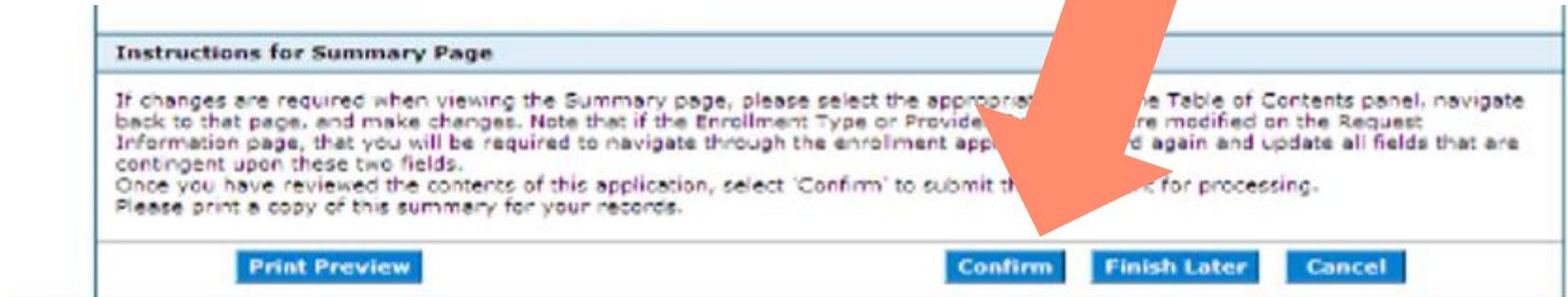
After checking the “I Accept” box and entering your name and title, you have three choices:
Submit....Finish Later.....Cancel

- Submit – Brings you to your Summary Page. **You must confirm** the information on the Summary to complete revalidation process
- Finish Later – Saves the information excluding Disclosure information
- Cancel – Erases all entered information

Summary Page

Your summary page appears for you to review all information.

However, your revalidation application WILL NOT be submitted for processing until you click the confirm button.



Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate item in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider are modified on the Request Information page, that you will be required to navigate through the enrollment application and again and update all fields that are contingent upon these two fields. Once you have reviewed the contents of this application, select 'Confirm' to submit the application for processing. Please print a copy of this summary for your records.

[Print Preview](#) [Confirm](#) [Finish Later](#) [Cancel](#)

Time Out!

For security purposes, your session will time out after 30 minutes. If it will take more than 30 minutes for you to complete, save your work, exit, and enter the process again.

Remember: Your disclosure question responses **WILL NOT** be saved, so you need to allow time to complete these in their entirety and submit, or your responses will be lost.



Questions?

Please contact our Customer Service Help Desk at

- (401) 784-8100 for local and long distance calls
- (800) 964-6211 for in-state toll calls.



Thank you



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