RI Medicaid Provider Enrollment for Home Stabilization

DXC Technology

May, 2020

Agenda

- Getting Started
- Completing an Application for Enrollment
- Disclosure Questions
- Agreement Screen
- Signing your Application
- Uploading Required Documents and Submitting Application
- Pausing an Application to complete later
- Resuming an Application
- Checking your Application Status

Getting Started

- Provider enrollment for the RI Medicaid Program is completed electronically through the Enrollment Portal, in the Healthcare Portal.
- Detailed instructions for completing the electronic application are accessible on the homepage of the Healthcare Portal.
- These slides cover the basics of completing the electronic application.

Begin Enrollment Process

https://www.riproviderportal.org

Click here for Provider Enrollment

More information found in User Guide

Home

Wednesday 09/02/2015 11:47 AM EST

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

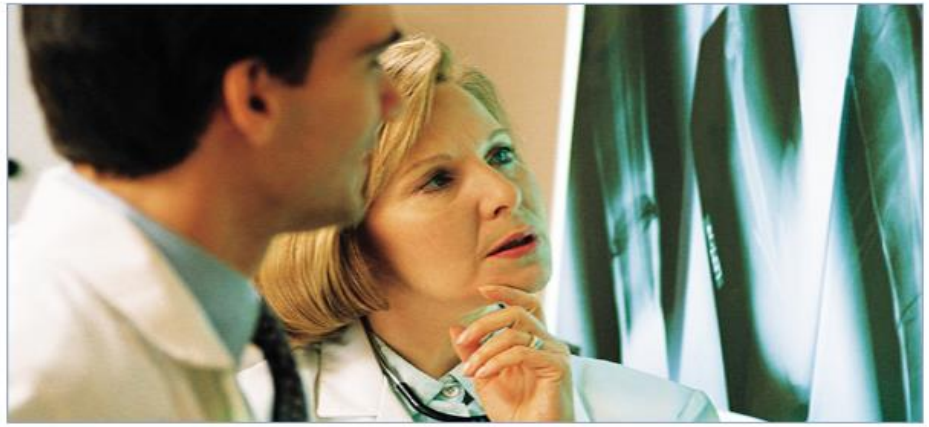
Would you like to enroll as a Trading Partner?

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 the Application

Select Enrollment Application

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.

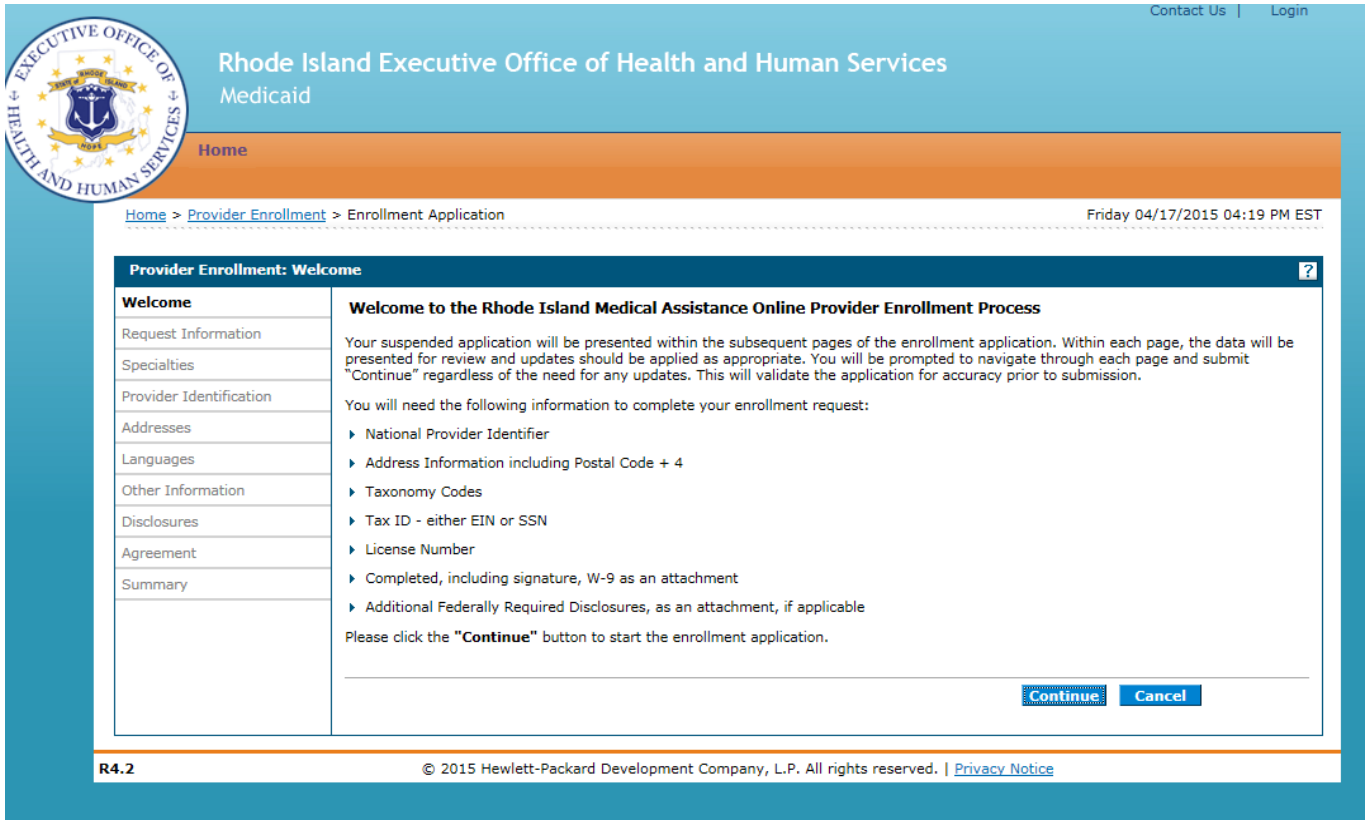
Customer Links

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.

Welcome Screen

This screen is the starting point. On each of the following screens, you must complete the required information. You cannot advance to the next screen without completing the current one. You can go back by using the menu on the left. Review the list of items you will need to complete the process.

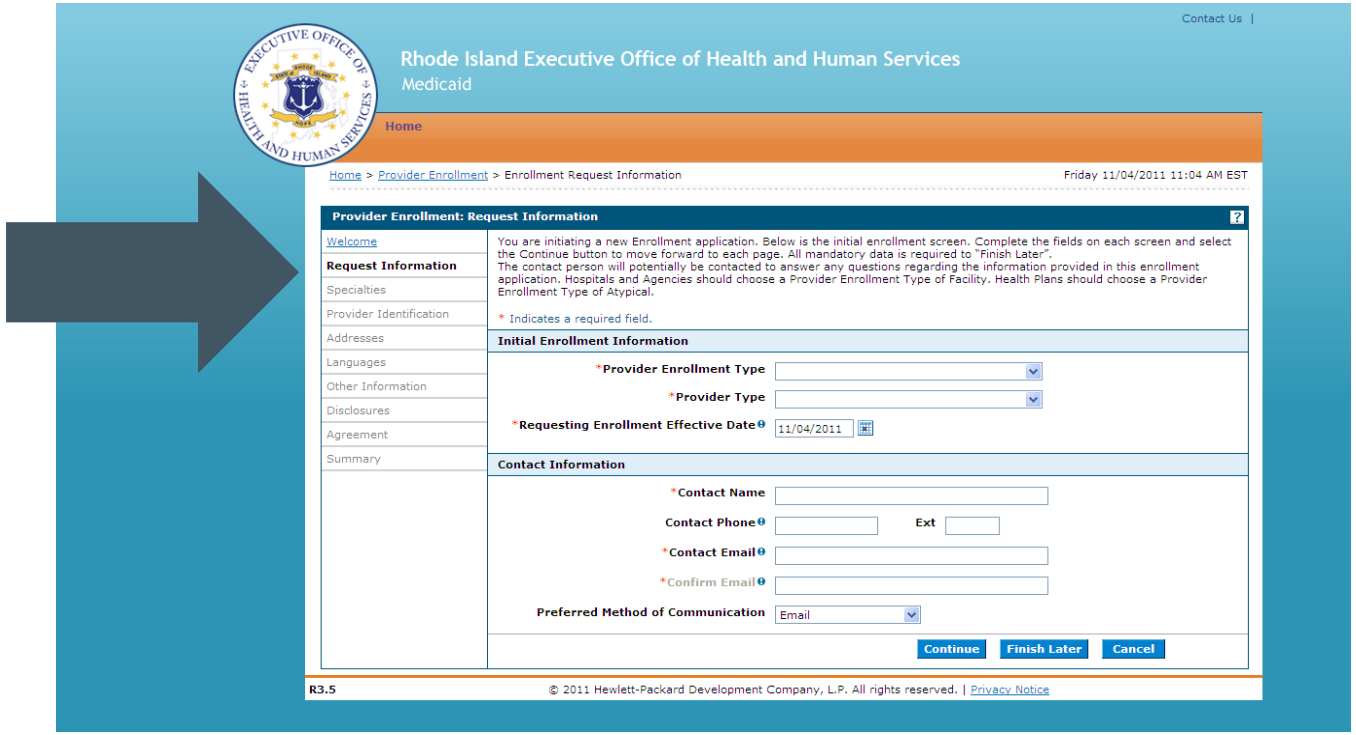


Provider Enrollment – Request Information Screen

- **Provider Enrollment Type** – Select the type of enrollment as Facility
- **Provider Type** – Select provider type 107 (Home Stabilization) from the list.
- **Requesting Enrollment Effective Date**
  – March 1, 2020

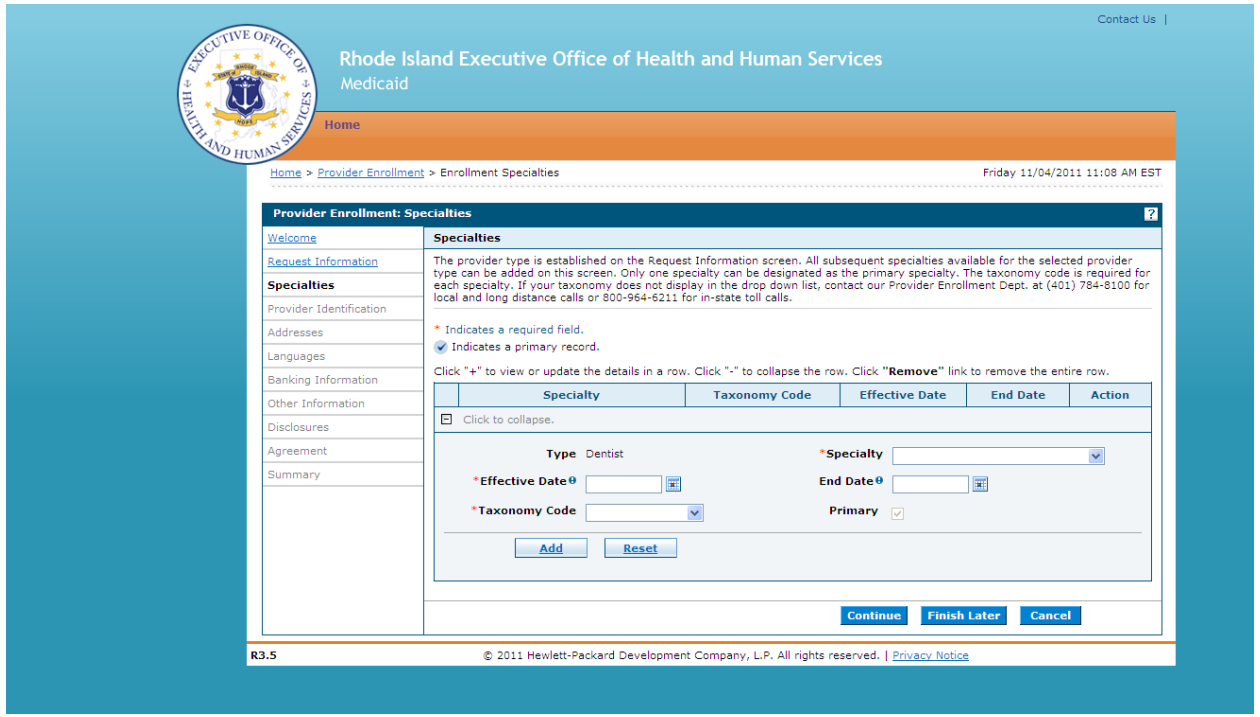
- **Contact information** should be completed with the primary contact information for the provider.

- Select Continue or Finish Later.



Enrollment Specialties

- **Specialty** – Select specialty 075 Case Management.
- **Effective Date** – March 1, 2020
- **End Date** – leave blank
- **Taxonomy Code** – Enter the taxonomy from your NPI letter, either 251B00000X or 251K00000X
- **Primary** – Select the checkbox if this specialty is the primary specialty.
- Click **Add** to add the specialty.
- Select continue or finish later to move to next screen.



Provider Identification – Legal Name

Home > Provider Enrollment > Enrollment Provider Identification

Friday 03/18/2016 08:49 AM EST

Provider Enrollment: Provider Identification

- Welcome
- Request Information
- Specialties
- **Provider Identification**
- Addresses
- Languages
- Banking Information
- Other Information
- Disclosures
- Agreement
- Summary

* Indicates a required field.

Provider Legal Name

The provider legal name and information is provided once for each enrollment. Ownership Information is required.

*Provider Legal Name

*Ownership

Business Name

Provider Identification Numbers

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

*Tax ID

*Tax ID Type EIN SSN

*Effective Date

End Date

*Fiscal End Date

*NPI

License #

Expiration Date

Medicare #

DEA #

CLIA #

Supplemental NPI

Supplemental Taxonomy

Continue Finish Later Cancel

- Enter the provider's **legal name** information.
- **Ownership** – Select the type of ownership as Corporation, Trust/Estate, or Government/Nonprofit Corporation, Individual, Legal Services Corporation, Medical Services Corporation, or Partnership.
- **Business Name** – Enter the business name.

Provider Identification – ID Numbers

Home > Provider Enrollment > Enrollment Provider Identification Friday 03/18/2016 08:49 AM EST

Provider Enrollment: Provider Identification

- Welcome
- Request Information
- Specialties
- **Provider Identification**
- Addresses
- Languages
- Banking Information
- Other Information
- Disclosures
- Agreement
- Summary

* Indicates a required field.

Provider Legal Name

The provider legal name and information is provided once for each enrollment. Ownership Information is required.

*Provider Legal Name
*Ownership
Business Name

Provider Identification Numbers

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

*Tax ID *Tax ID Type EIN SSN
*Effective Date End Date *Fiscal End Date

*NPI
License # Expiration Date
Medicare #
DEA #
CLIA #
Supplemental NPI
Supplemental Taxonomy

Continue Finish Later Cancel

- **Tax ID** – Enter the provider's tax ID. If the tax ID is the provider's Social Security Number, enter the 9-digit number without the dashes (-).
- **Tax ID Type** – Select the tax ID type as Employer Identification Number (EIN) or Social Security Number (SSN).
- **Effective Date** – Enter or select the effective start date for the tax ID.
- **End Date** – Enter or select the end date for the tax ID.
- **Fiscal End Date** – Enter the first letter of the month or select the month the fiscal year ends.
- **NPI** – Enter the provider's National Provider Identifier (NPI) number.
- **License** # - Enter the provider's license number.
- **Expiration Date** – Enter or select the date the license expires.
- **Medicare** # - Enter the provider's Medicare number.
- **DEA** # , **CLIA #, Supplemental NPI, and Supplemental Taxonomy** – Leave blank

W-9

Form **W-9**

Request for Taxpayer Identification Number and Certification

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

Ronald Green

Blue Y Drywall

Individual/sole proprietor | C Corporation | S Corporation | Partnership | Trust/estate

Exempt payee

Other (see instructions)

Print or type

See Specific Instructions on page 2.

416 Flower Lane

Oaktown, AL 00000

Requester's name and address (optional)

Z Builders

123 Maple Avenue

Oaktown, AL 00000

List account number(s) here (optional)

Part I **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 I 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.

Social security number: 1 2 3 – 0 0 – 4 7 8 9

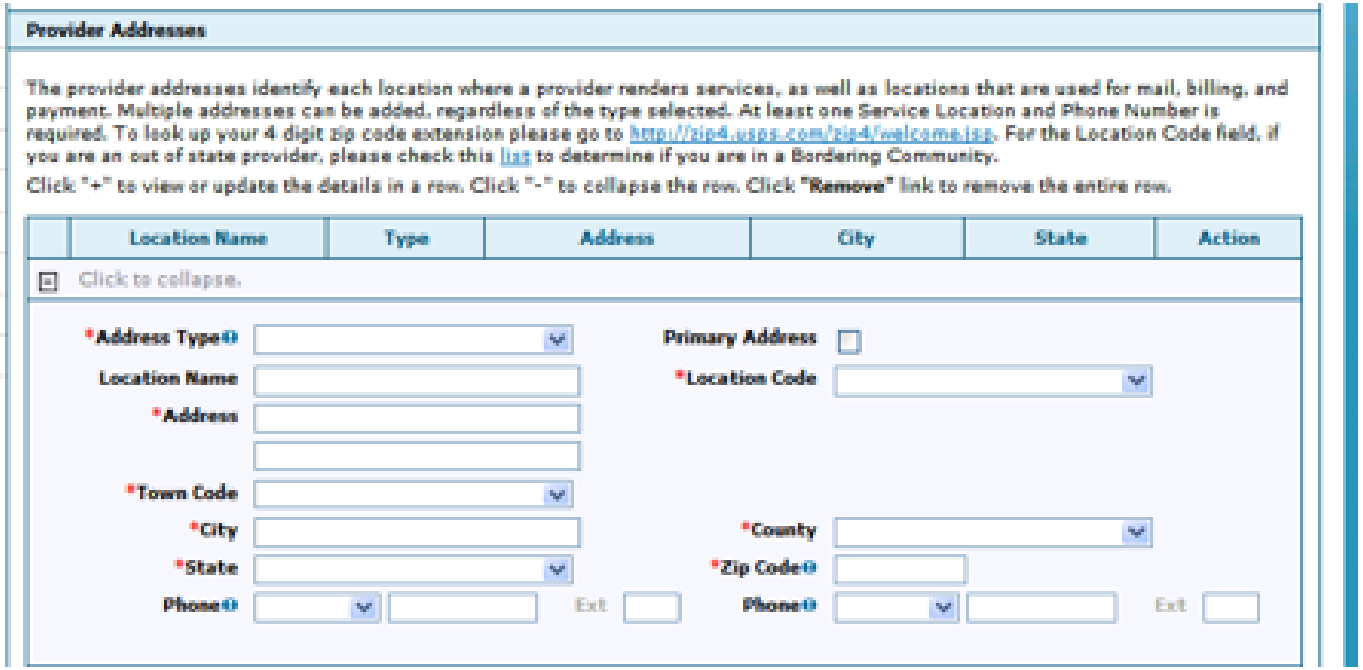
Employer identification number: –

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

The business name entered on the W-9 must match the provider's legal name.

Addresses

- **Address Type** – Select the provider's address type as Billing Service, Mail To, Pay To, or Service Location.
- **Primary Address** – Select the checkbox if this is the provider's primary address.
  - Service Location must be checked as the primary address.
- **Location Name** – Enter the address' location name.
- **Location Code** – Select the address' location code as In State, Border, or Out of State.
- **Address** – Enter the address.
- **Town Code** – Select the address' town code.
- **City** – Enter the city name.
- **County** – Select the county.
- **State** – Select the state where the address is located.
- **Zip Code** – Enter the address' zip code.
- **Phone and Ext** – Select the phone number type as Phone, Fax, TeleTypewriter, or Telephone Device for Deaf; enter the phone number, and extension. Mandatory

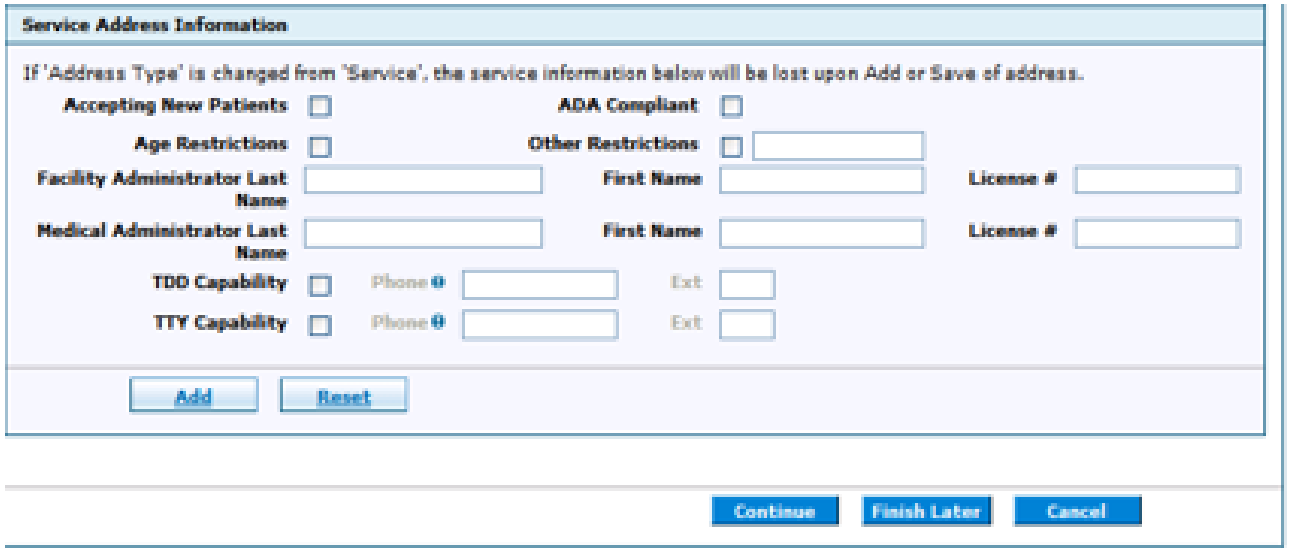


Service Addresses

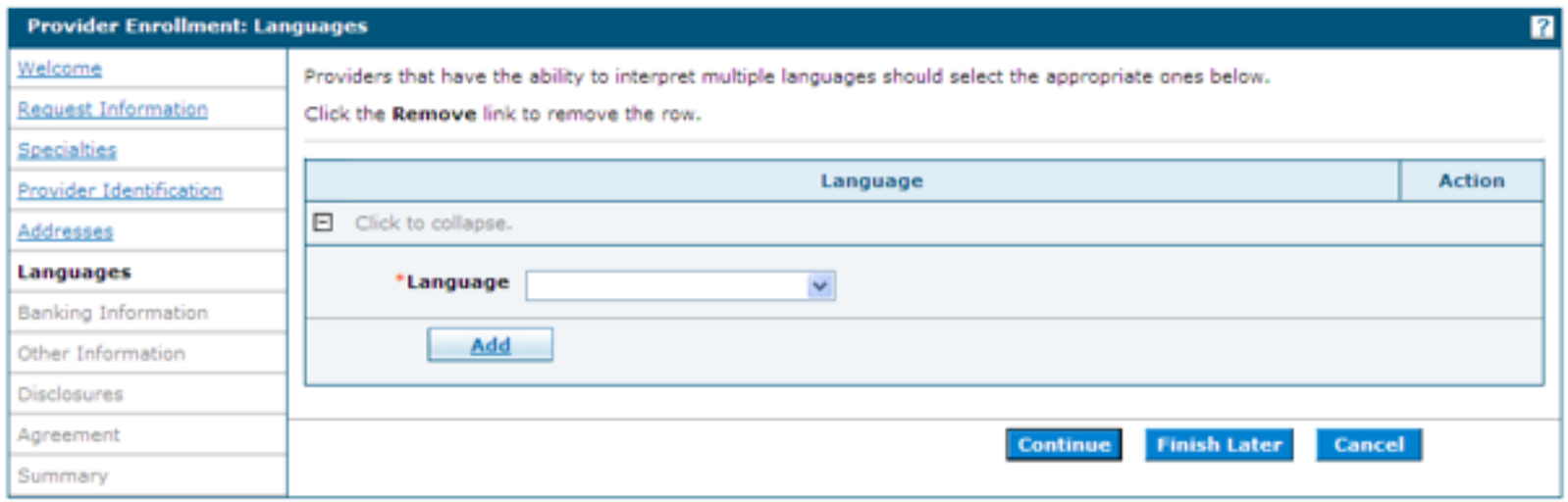
If the address selected was a Service Location, enter the service address information:

- **Accepting New Patients** – Select the checkbox if this service address is accepting new patients.
- **ADA Compliant** – Select the checkbox if this service address complies with the Americans with Disabilities Act (ADA).
- **Age Restrictions** – Select the checkbox if this service address has patient age restrictions.
- **Other Restrictions** – Select the checkbox if this service address has other restrictions and enter the restriction.
- **Facility Administrator Last Name, First Name, and License #** - Enter the facility administrator's last name, first name, and license number.
- **Medical Administrator Last Name, First Name, and License #** - Enter the medical administrator's last name, first name, and license number.
- **TDD Capability, Phone, and Ext** – Select the checkbox if the service address has telecommunication devices for the deaf (TDD), and enter the TDD's phone number and extension.
- **TTY Capability, Phone, and Ext** – Select the checkbox if the service address has a teletypewriter (TTY), and enter the TTY's phone number and extension.
- Click **Add** to add the address.

If you have more addresses to add, click + to add another service address.

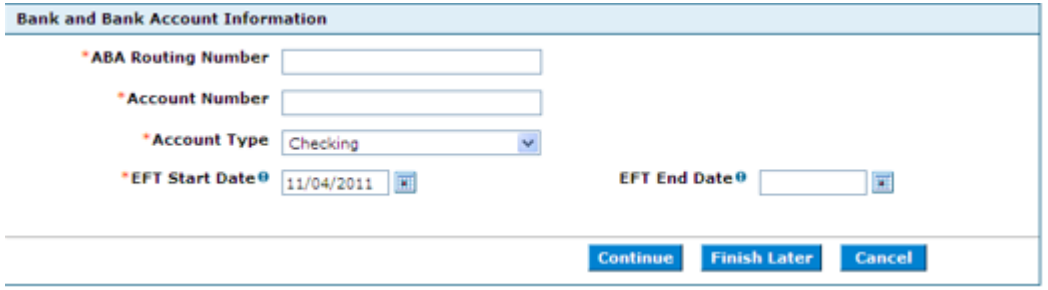


Languages



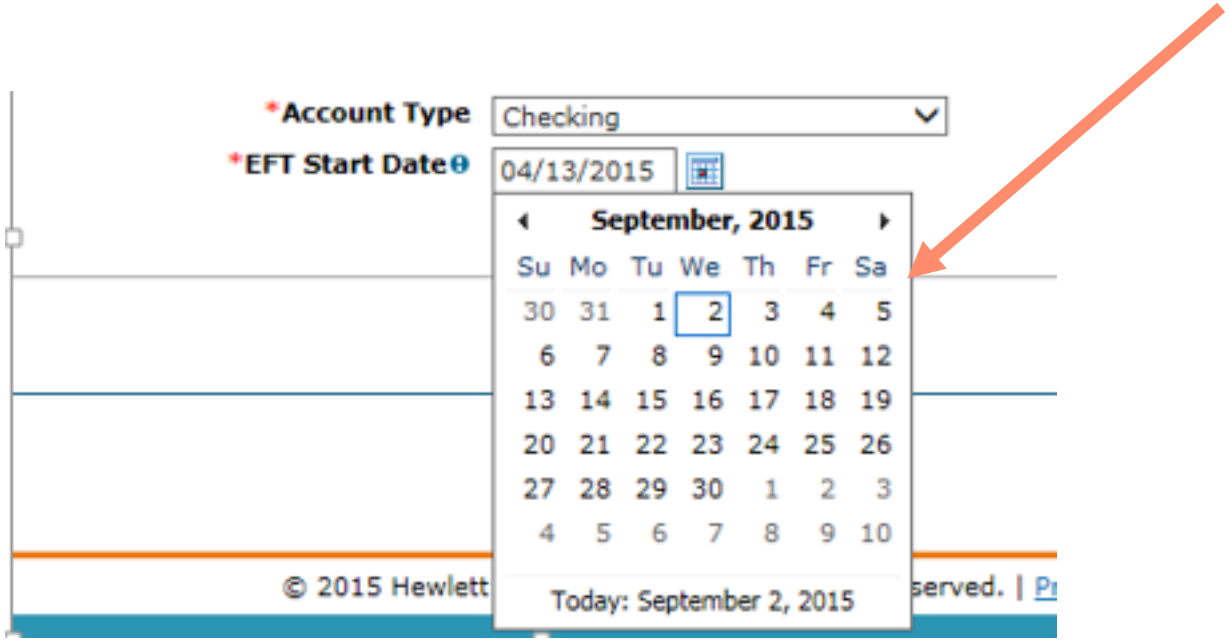
Providers that have the ability to interpret multiple languages should select the appropriate languages from the list.
Select the Add button after each language.
When finished, select continue.

Banking Information



All providers must enroll in EFT for payment.

- Enter the routing number for your bank.
- Enter the account number.
- Select the account type.
- Select today's date on the calendar or enter today's date.
- End date not required.



Other Information – Group or Facility

Additional information is provided for each enrollment, for group/facility and individual providers.

Certification Information

*Certification

*Effective Date

End Date

Facility Providers

Number of Licensed Beds

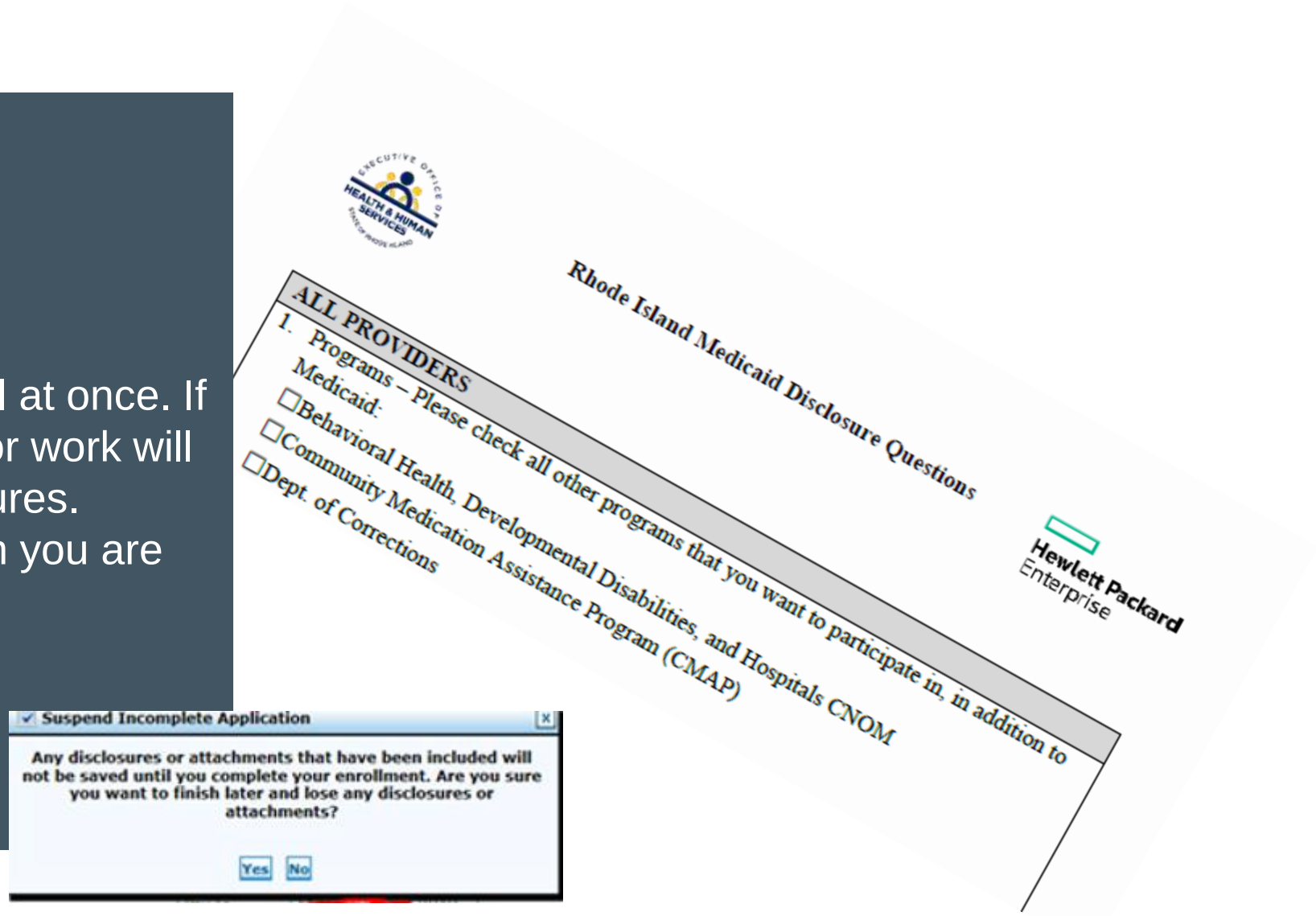
Number of Swing Beds

Continue | Finish Later | Cancel

Complete all information on this screen.
Items marked with (*) must have an answer selected.
If Not Applicable was selected, today's date should be entered for Effective Date.

Disclosures

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



Disclosures

Answer Yes or No to each question.
If you answer Yes, answer any additional questions and enter an explanation. If the answer is Not Applicable, enter NA without a slash (/).

Remember, if you do not complete and confirm the application, the disclosure question responses will be lost.

The next few slides highlight a few of the disclosure questions.

Rhode Island Medicaid Disclosure Questions

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

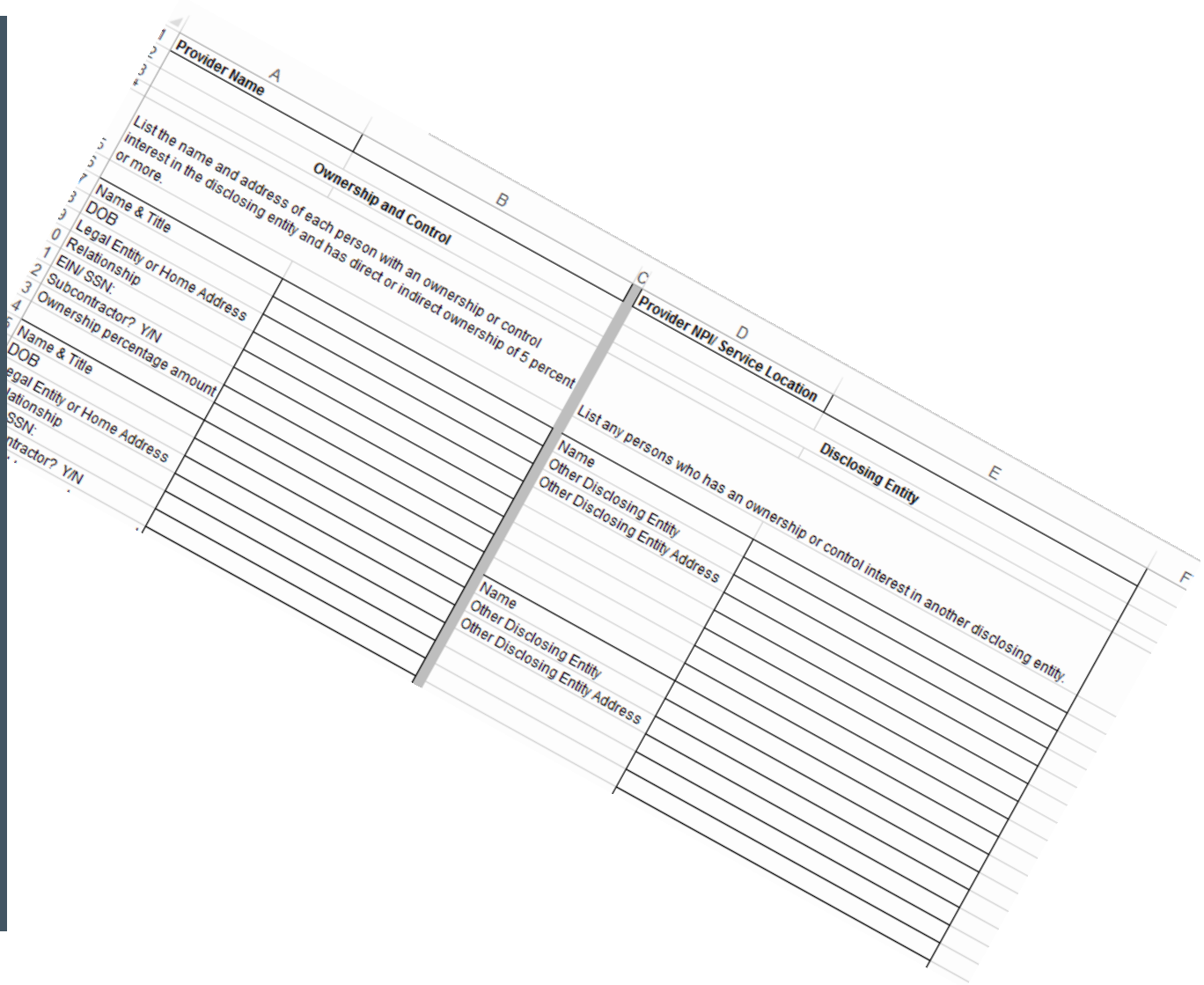
Important:
Question 4 requires the owner/administrator's name, title, and **home address**.

Also, the **Social Security number and date of birth** 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, you MUST complete and upload the Additional Federally Required Disclosures form, found on the Agreement page, following the disclosures.

If controlled by a board of directors, information on all members must be completed.



Disclosure Question #12

12. List any outstanding balance owed to the RI Executive Office of Health and Human Services Medicaid Program by a previous provider.

_____

If the answer is no outstanding balance, enter 0.
Do not enter decimals or dollar signs.

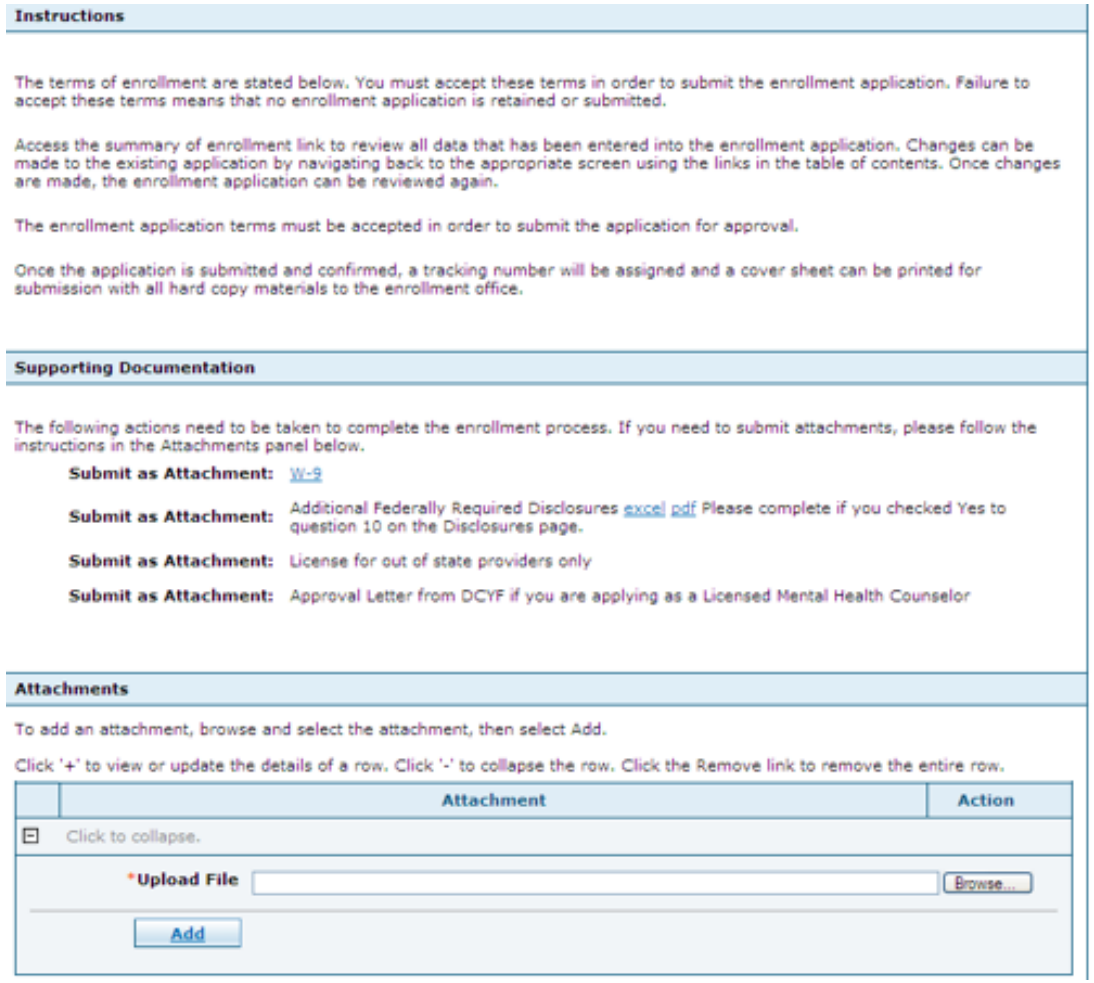
Agreement Screen – Supporting Documents

The Agreement screen enables you to submit supporting documents as attachments to your application.

Use the browse button to find the file, and then upload to your application.

Documents can be loaded in the following formats: .jpg or.pdf

Files larger than 2MB should be faxed to 401-784-3892.



Instructions

The terms of enrollment are stated below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.

Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.

The enrollment application terms must be accepted in order to submit the application for approval.

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.

Supporting Documentation

The following actions need to be taken to complete the enrollment process. If you need to submit attachments, please follow the instructions in the Attachments panel below.

Submit as Attachment: W-9

Submit as Attachment: Additional Federally Required Disclosures excel pdf Please complete if you checked Yes to question 10 on the Disclosures page.

Submit as Attachment: License for out of state providers only

Submit as Attachment: Approval Letter from DCYF if you are applying as a Licensed Mental Health Counselor

Attachments

To add an attachment, browse and select the attachment, then select Add.

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click the Remove link to remove the entire row.

	Attachment	Action
⊟	Click to collapse.	

*Upload File [ ] Browse...

Add

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

You are unable to sign your document until you open and read 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.

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

Provider Agreements

Read and Print: Provider Agreement

Read and Print: Provider Addendum 1 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

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 application process
- Finish Later – Saves the information **EXCLUDING** Disclosure information
- Cancel – Erases all entered information

Summary Page

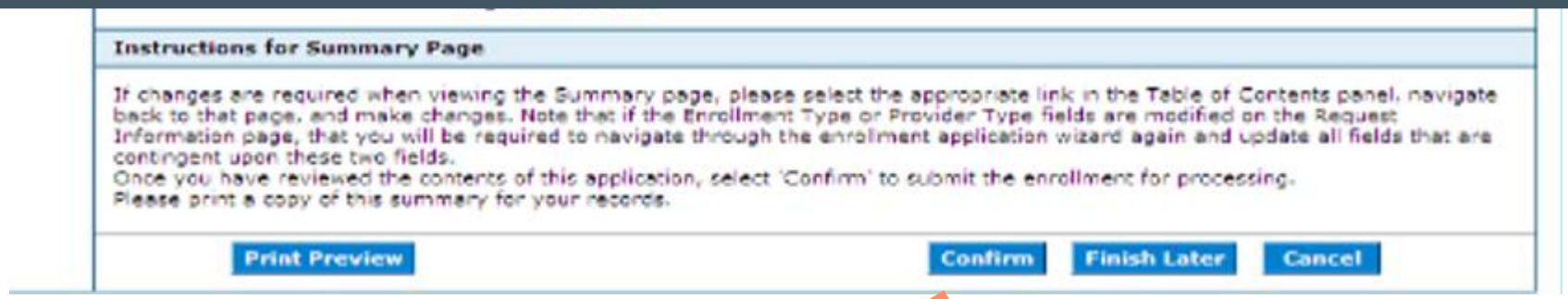
- Welcome
- Request Information
- Specialties
- Provider Identification
- Addresses
- Languages
- Banking Information
- Other Information
- **Disclosures**
- Agreement
- Summary

Your summary page allows you to print and review all information.

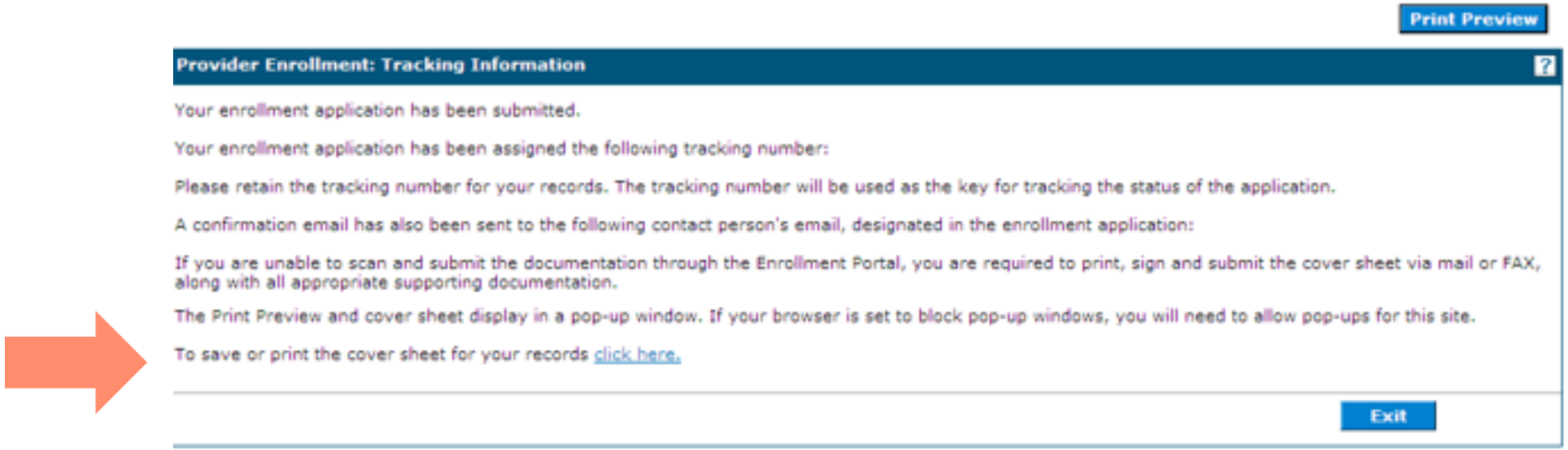
If changes are needed, you must return to the appropriate page, by clicking on the correct section in the table of contents on the left side of the screen.

Confirming Your Application

IMPORTANT:
Your enrollment application WILL NOT be submitted for processing until you click the confirm button.



Tracking Information Page and Cover Sheet



After selecting Confirm, you will receive a tracking number.
Make note of this number.
You are also able to print a cover sheet for your records,
or to attach to items you must mail or fax.

Printing the Cover Sheet

Print

Provider Enrollment: Cover Sheet

Date 2/21/2012

Tracking Number 37652-221-1458-915-3503

Hewlett Packard Enterprise

Att: Provider Enrollment
PO Box 2010
Warwick, RI 02887-2010

Enrollment form for the following provider:

Listed below is the additional information necessary (if applicable) to successfully complete your enrollment as a Rhode Island Medical Assistance provider. The information listed below must be sent in order to complete your Provider Enrollment Application. Please check mark the items below that will be included with this cover sheet.

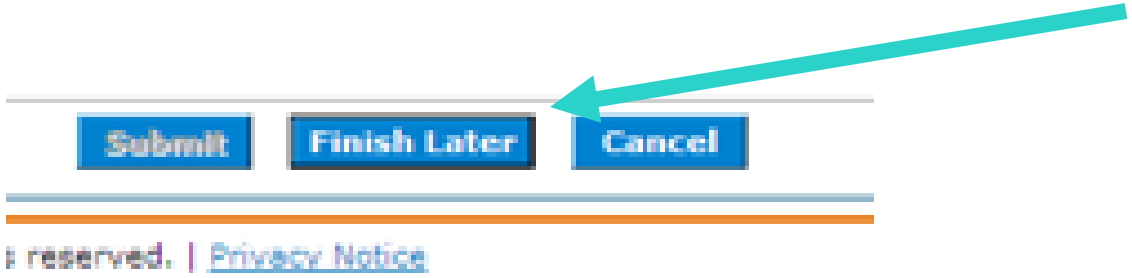
- __ Federal W-9 Form, required
- __ Additional Federally Required Disclosures, if applicable
- __ Copy of DCYF Letter, if applicable
- __ Copy of Principal Counselor Certificate, if applicable
- __ Copy of Out of State License, if applicable
- __ Copy of BHDDH License, if applicable

All of the documents that are checked above must be mailed to HP Enterprise Services (address listed above) or faxed to (401) 784-3892 with this document as a coversheet.

Print Close

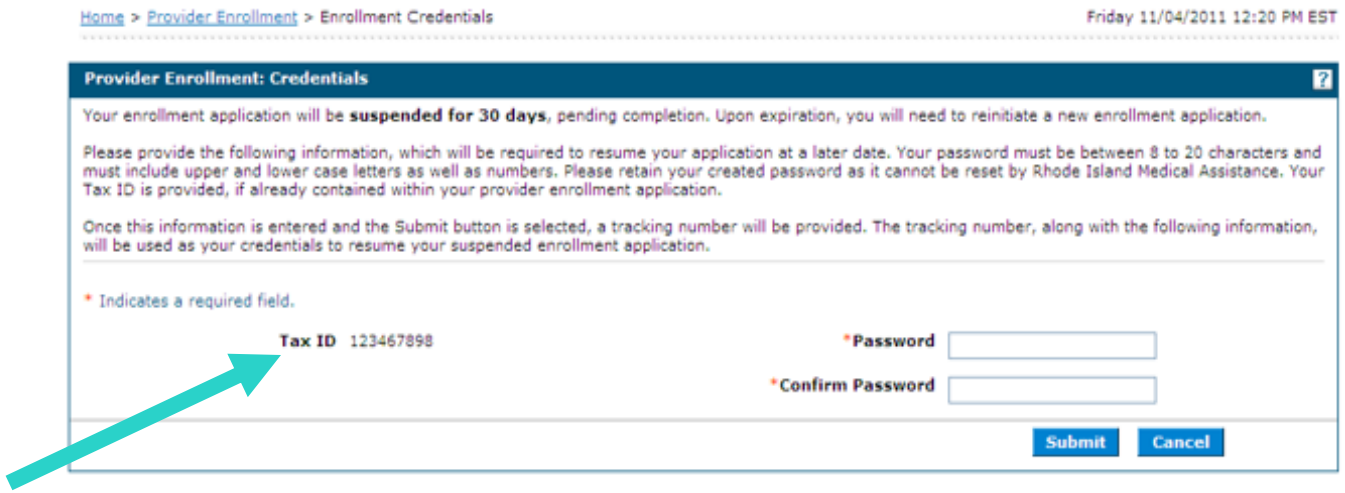
Use the Print button to print a copy of the Cover Sheet.
Select Close when completed.

Finish Application Later



- Once you have started the provider enrollment application process, you can save the enrollment application and finish it later. You must finish the enrollment process within thirty days or your data will be lost. Note: the responses to the disclosure questions will need to be re-entered when you resume your application.
- On any screen, click **Finish Later**. The Suspend Incomplete Application dialog box appears.
  - REMINDER: Any disclosures or attachments that have been included will not be saved until you complete your enrollment.
- Click **Yes** to finish the enrollment application within the next thirty days. The Provider Enrollment: Credentials page appears.

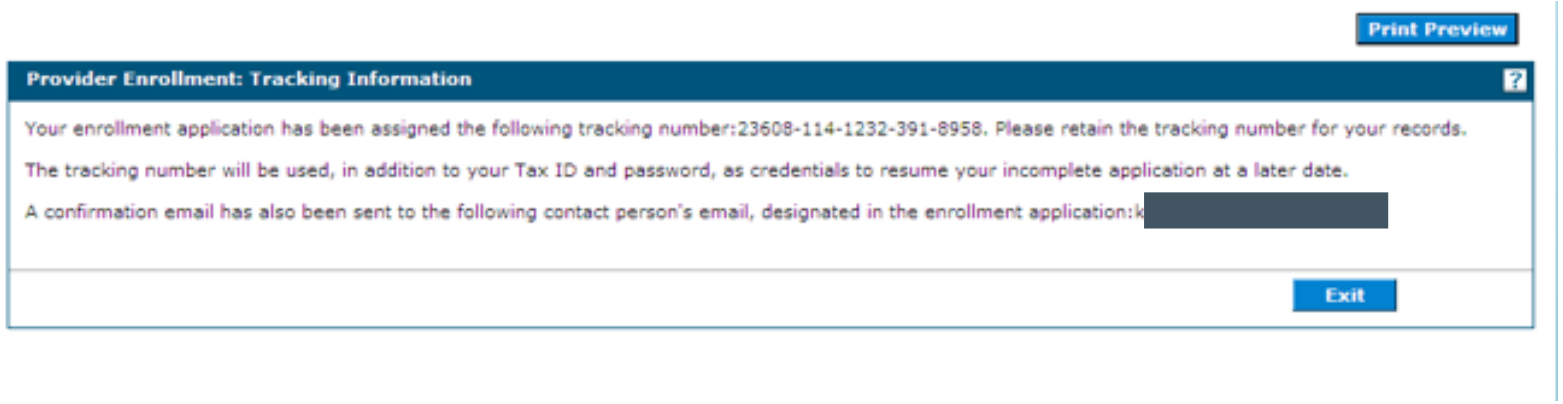
Credentials Page



- If you have entered your tax ID, it will appear on this screen. If not, enter it here.
- Enter a password. The password must contain 8 characters including upper and lower case letters as well as numbers. This will be the password you will use to resume your application.

- Select SUBMIT to submit the credentials.

Tracking Information – Incomplete Application

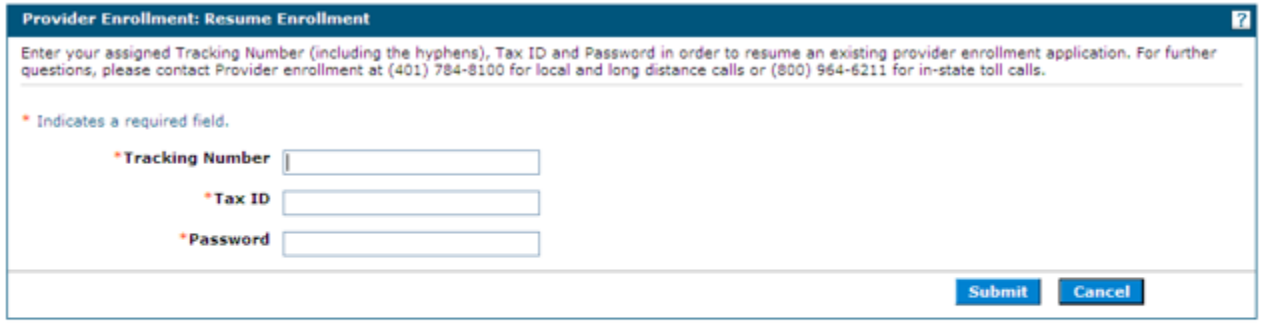


- You will receive a tracking number. Print or write this number in a secure place.
- This tracking number, with your password will allow you to resume your application.

Resume Enrollment

To resume an application:

- Enter the Healthcare Portal by clicking on Provider Enrollment (see slide 4)
- Select Resume Enrollment.



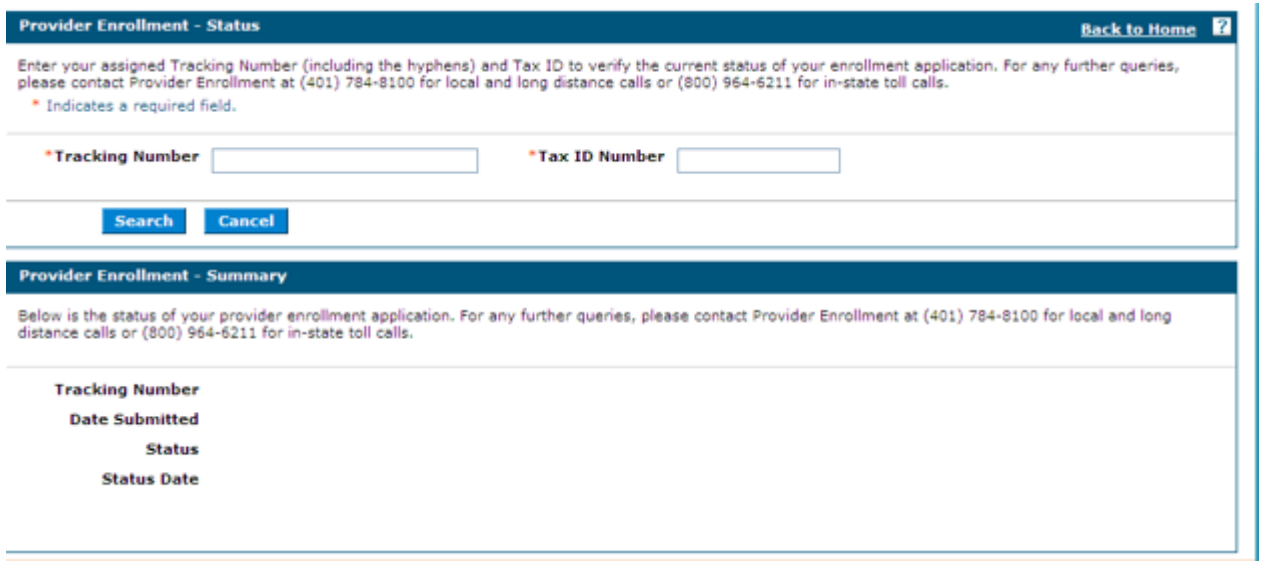
Enter the Tracking Number, Tax ID and Password to resume your application.
Reminder: Disclosure Question Responses are not saved on incomplete applications.

View Enrollment Status

To view enrollment status:

- Enter the Healthcare Portal by clicking on Provider Enrollment (see slide 4)
- Select Enrollment Status.

View Enrollment Status



- Enter your Tracking Number and Tax ID. Select Search.
- Any of the following statuses may appear:
  - **Approved** – The enrollment application has been approved for enrollment.
  - **Denied** – The enrollment application has been denied.
  - **Enrolled** – The enrollment application has been enrolled.
  - **Pending** – The enrollment application is waiting to be processed.
  - **Resubmit** – The enrollment application was incomplete, please resubmit

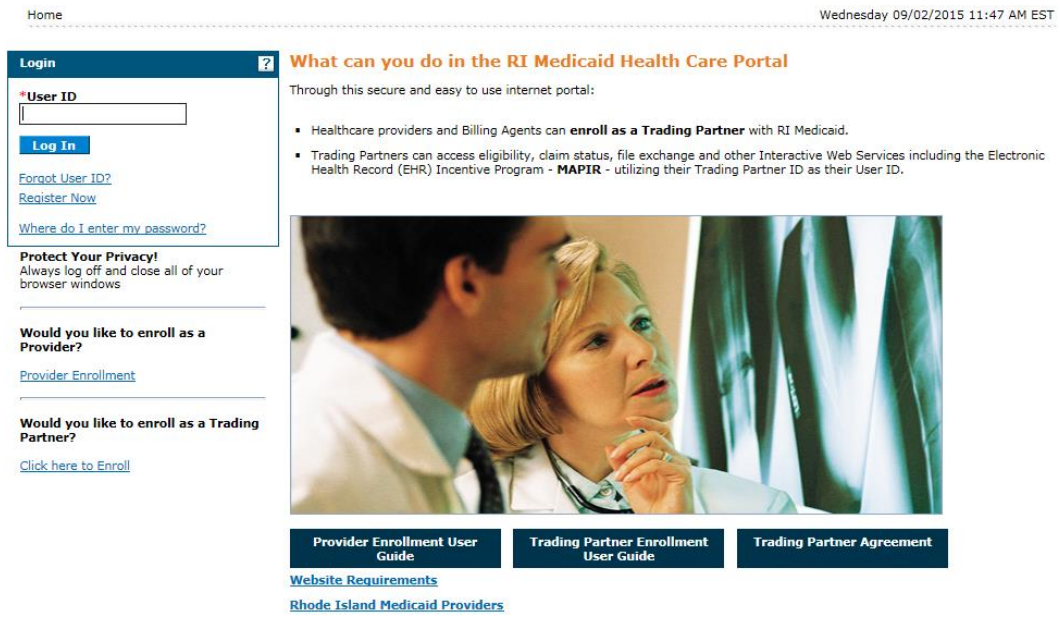
Time Out!

For security purposes, your session will time out after 30 minutes of inactivity. If you anticipate that your application will be idle for more than 30 minutes, 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.

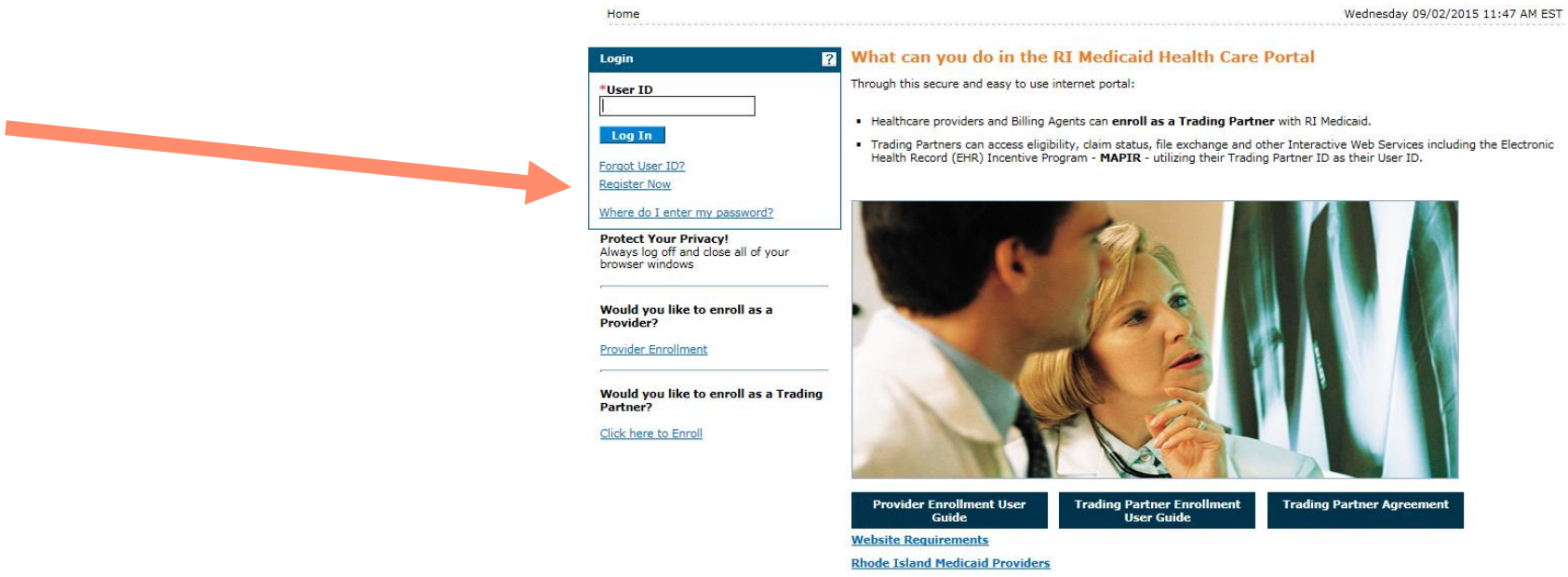
Next Steps

- After you receive confirmation that you are enrolled as a RI Medicaid provider, you must enroll as a Trading Partner in the Healthcare Portal. This allows you to exchange information electronically with RI Medicaid.
- From the Healthcare Portal homepage, select “Enroll as a Trading Partner” and complete the application.
- For additional help, review the instruction guide at : http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/HCP_Enrolling_as_TP.pdf



Next Steps

- Once you receive your Trading Partner number, you must register that Trading Partner number in the Healthcare Portal and set up your security credentials.
- From the Healthcare Portal homepage, select “Register Now” and complete the registration process.
- For additional help, review the instruction guide at : http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/HCP_Registering_to_use.pdf



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