

GROUP PROVIDER ENROLLMENT FORM

INSTRUCTIONS

GROUP NAME (field 1) – Enter the group provider name exactly as it is entered on the attached W-9 form. **This is the name you will use to bill the program.**

BUSINESS NAME (field 2) – Enter the name you will be doing business as, if different from above.

BUSINESS TYPE (field 3) – Enter your type of business.

OWNER/ADMINISTRATOR, MANAGING EMPLOYEE or OFFICER OF CORPORATION NAME – (field 4) – Enter the name of the owner/administrator, manager or chief operating officer of your business or facility.

FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)– (field 5) –Enter the group FEIN (9 - digits).

SERVICE LOCATION ADDRESS – (field 6) – Enter the complete physical address of the location of the business or where the actual services are conducted. **P.O. Box alone is not acceptable as a service location.**

PAY TO ADDRESS – (field 7) – Enter the complete address of the location where financial correspondences should be forwarded. Examples: Remittance Advice/RA, Explanation of Benefits/EOB.

MAIL TO ADDRESS – (field 8) – Enter the complete address of the location where correspondences should be forwarded. Examples: Direct Mailings regarding billing, policy related changes, etc.

TELEPHONE/FAX – (field 8) – Enter the area code and telephone and fax number of the location where direct mailings are mailed.

BILLING SERVICE ADDRESS – (field 9) – Enter the complete address of the location where the billing information is prepared.

BILLING TELEPHONE/FAX – (field 9) – Enter the area code and telephone and fax number of the location where the billing information is prepared for billing inquiries. Also, provide a Mobil number, if applicable.

ADDITIONAL PRACTICE LOCATIONS ADDRESS – (field 10) – Enter the complete physical address of additional location(s) of the business or where the actual services are conducted. If more than 3 locations please provide information on a separate sheet of paper and include with this application.

OFFICE EMAIL ADDRESS – (field 11) – List the office email address for the actual provider (doctor) to receive future correspondences via email.

CONTACT PERSON – (field 11) – Please indicate who the main contact person is for the group.

CURRENT ENROLLMENT WITH MEDICAID – (field 12) – If you have been enrolled previously with RI Medicaid as an individual or within an established group, please provide your Medicaid ID number/s.

MERGER/BUY OUT – (field 13) – Is this enrollment due to a purchase of an established practice?

OUTSTANDING BALANCE – (field 14) – List any outstanding balance owed to RI Medicaid from a previous enrollment.

MEDICAL SPECIALTY – (field 15) – Enter the appropriate Specialty; e.g., MD - Internist; DDS - Oral Surgeon. (Disregard if you provided your NPI & Taxonomy/ies).

NATIONAL PROVIDER IDENTIFIER – (field 16) – Enter the CMS (Centers for Medicare/Medicaid) established NPI number for the group. (CMS is stating that providers who are incorporated need to be enrolled as a group with their group (type 2) NPI.) Also include your authorization letter from the Enumerator/contractor NPPES. If your agency has been exempt from receiving an NPI, please attach a copy of a letter stating such.

TAXONOMY(ies) – (field 17) – Enter the Taxonomies established by CMS.

ELECTRONIC BILLER – (field 18) – If you intend to bill electronically, please fill out the Trading Partner Agreement. <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/tpa.pdf>.

FISCAL YEAR END – (field 19) – Enter the month in which your fiscal year ends.

ENROLLMENT EFFECTIVE DATE or DATE FIRST SERVED RIMA client – (field 20) – If a Medicaid client is currently under your care, please provide the date in which you began services, **or** Provide a date in which you are interested in establishing your practice as a Medicaid Provider.

EXCLUSIONS UNDER THE CODE OF FEDERAL REGULATIONS – (field 21) – If YES, provide information relating to any exclusions under Chapter 42, Public Health, Department of Health and Human Services.

DOCUMENT DEBARMENT, SUSPENSION, EXCLUSION, CRIMINAL OFFENCE FROM FEDERAL PROGRAM – (field 22) – Provide any information/documentation pertaining to any debarment, suspension, exclusion, or criminal offence from a federal program.

PROVIDER SIGNATURE AND DATE – Application must be signed by the Authorized Group Agent. Only one signature is permitted, and signature on all enrollment documents must be the same. If applicant is a corporation, the signature must be one member of the Board of Directors, and consistent for all enrollment documents. **Stamped or photocopied signatures are not acceptable.**

MAIL TO:

**HP Enterprise Services/ Provider Enrollment Unit
P.O. Box 2010
Warwick, RI 02887-2010**

Requests for updates to your provider file, such as name or address changes, must be signed by the provider or authorized administrator and sent to the address above.

**An incomplete application will be returned for completion.
Avoid this delay by submitting a complete application.**