STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Dear Provider,

Thank you for your interest in the Rhode Island Medicaid Program. Enclosed are the forms of information necessary to enroll as a performing provider within an established group. Please send those that are marked mandatory for enrollment processing.

Please complete and send the following:

- Local Education Agency (LEA) Provider Linkage Form
- NPI letter
- License (if applicable)

Completed enrollment forms should be mailed to:

DXC Technology
Provider Enrollment
P.O. Box 2010
Warwick, RI 02887-2010

If you have any questions about the enrollment form or enrollment process, please call DXC at **1-401-784-8100** for in-state and long-distance callers or 1-800-964-6211 for in-state toll calls and border communities.

IMPORTANT NOTE: Please DO NOT send any claims with your application. Wait until you have received your confirmation letter.

An incomplete application will be returned.

LEA Enrollment Instructions

The following fields must be completed:

PROVIDER NAME: Enter your individual or facility name.

SERVICE LOCATION ADDRESS: Enter the complete physical address where service is being conducted.

NATIONAL PROVIDER IDENTIFIER (NPI): Enter the NPI number established by Centers for Medicare/Medicaid (CMS). If your agency has been exempt from receiving an NPI, please attach a copy of a letter stating such.

TAXONOMY: Enter the Taxonomies established by CMS.

PROVIDER TYPE/SPECIALTY: Indicate the specific service you provide (e.g., MD—Psychiatrist; Therapist – Social Worker, Psychologist, etc.

LICENSE NUMBER: If applicable, enter your license or certification number. A copy of the current valid license or certification letter must be submitted with the application.

SOCIAL SECURITY NUMBER: Enter individual social security number.

EMAIL ADDRESS: Enter the office email address for the actual provider (e.g., doctor), to receive future correspondences via email.

PROVIDER PHONE NUMBER: Enter the area code and telephone number of the location where service is being conducted.

FAX NUMBER: Enter the office fax number.

PROVIDER SIGNATURE AND DATE: Application must be signed by the Individual Applicant along with the date of signature. Stamped or photocopied signatures are not acceptable.

SCHOOL INFORMATION

NATIONAL PROVIDER IDENTIFIER (NPI): Enter the NPI number established by CMS for the School department you are joining (e.g., **the school department's group NPI**).

TAXONOMY: Enter the Taxonomies established by CMS for the School department you are joining.

SCHOOL DEPT. NAME: Enter the name of the school department.

SCHOOL DEPT. TAX IDENTIFICATION NUMBER: Enter the Federal Employer Identification Number (FEIN).

SCHOOL DEPT PAY TO ADDRESS: Enter the address where you want checks and/or Remittance Advice(s) sent.

SCHOOL DEPT MAIL TO ADDRESS: Enter the address where all other program information should be sent.

EFFECTIVE DATE: Enter the date you will begin servicing the students.

AUTHORIZED SIGNATURE OF SCHOOL DEPARTMENT REPRESENTATIVE, TITLE, AND DATE: A representative from the School Department must sign and date the form to indicate that they wish to be affiliated with the provider listed on the application.

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
LOCAL EDUCATION AGENCY (LEA) PROVIDER LINKAGE FORM

Provider Name:	**National Provider Identifier (NPI)** (School Dept. Group NPI)
Service Location Address:	**Provider Taxonomy (ies):** (School Dept. Taxonomy(ies)
National Provider Identifier NPI:	**School Dept. Name:**
Taxonomy (ies):	**School Dept. Tax Identification Number:**
Provider Type/Specialty: (please circle) If other, please specify: OT PT Speech Social Worker Psychiatrist RN Psychologist Transportation Personal Care Attendant Residential Placement Other _____	**School Dept. Mail to Address:**
	Effective Date: (Indicate the effective date when the Provider began providing services to the School Department)
License #:	**Authorized signature of School Department Representative:**
SSN #:	**Title:** **Date:**
Email address:	
Provider Phone Number:	
FAX #:	
Provider Signature:	
Date:	

For DXC Technology Use Only	
Census Track:	**County Code:**
Town Code:	**Location Code:**

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE FOR PROVIDER MEMBER LISTED*****

RETURN FORM TO: DXC Technology, PO BOX 2010, WARWICK, RI 02887-2010, ATTN: PROVIDER ENROLLMENT UNIT