



Georgia Medicaid Provider ID Reactivation Request Form

Doc Type	4119
1. Medicaid ID Number*	

ONLY ONE Medicaid ID per form.

Purpose of this form:

This form can be used to Reactivate Participation of ONE Suspended Georgia Medicaid Rendering Provider ID.

FIRST, go to www.mmis.georgia.gov and click on Provider Enrollment and then choose Provider Contract Status. Enter the Provider ID and click Search. You do not have to enter the ATN or Provider Name. Click anywhere in the Results field and the Contract Status will be shown. If the Provider ID is in a SUSPENDED status, this form may be used. If the Provider ID is TERMINATED, the Provider must reenroll. Instructions for reenrollment can be found at www.mmis.georgia.gov in the Provider Enrollment section

Reactivation Request Form Instructions:

- In the box at the top right-hand corner of the form under the Doc Type number (4119), enter the Medicaid Provider ID (including letter suffix) requested. Only enter ONE Medicaid ID per form. If you have multiple Medicaid IDs (i.e., 999999999A, 999999999B, etc.), a separate form will be required for EACH ID. The Provider name entered in Step 2 below must match the record for the ID entered in the box above.
- Enter the Rendering Provider's information.
 - Enter the Provider's Name in this field.
 - Enter the GA Medicaid Contract(s) to reactivate for this request, i.e. 430, 300, etc.
 - NPI is required for ALL Reactivation requests.
 - Tax ID is required for ALL Reactivation requests.
- Complete the contact information for the individual and/or organization making this request.
- By signing this form, you are attesting that you are authorized to submit this request on the Provider's behalf. Forms that are not signed, invalid, or incomplete will not be processed.

****Reactivation Requests for Contracts (440, 680, 681) need to be submitted DIRECTLY to DBHDD and Contract (590) Reactivations need to be submitted to (DHS) Department of Aging Services, not HP Provider Enrollment.****

FAX the completed form to:
HP Enterprise Services
Attn: Provider Enrollment Unit
FAX#-1-866-483-1045

2. Provider ID Information			
a. Provider's Name:*		b. Contract(s) to Reactivate:	
c. NPI:*		d. Tax ID:*	
3. Contact Information-Person Requesting the Reactivation*			
Name of Person Submitting Request:*			
Facility/Organization/Practice Name:			
Mailing Address:*			
Suite #: (if Applicable):	City: *	St:*	Zip:*
Contact Phone #:*		Contact Fax #:	
Contact E-Mail Address:			
4. Certification and Signature*			
Printed Name of Authorized Individual:*			Title:*
Signature of Authorized Individual:*			Date:*

All fields marked with "*" are REQUIRED.