

Provider Revalidation Process



Watch a “live” demonstration on YouTube at <https://youtu.be/IXE2Q5cBG9k>.

GAMMIS Login

 **GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Sign in with your Georgia Medicaid
account

Sign in

[Having trouble logging in?](#)

If you are the Office Administrator
authorized by the Provider,
register [here](#).

[Gainwell Helpdesk](#)

[Disclaimer](#)

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- Sign in to the secure area of the GAMMIS Web Portal, mmis.georgia.gov.
- Select Web Portal.

Provider Revalidation Process

Account | **Providers** | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

[Home](#) [Secure Home](#) [Demographic Maintenance](#) [Direct Exchange Addresses](#) [Provider Rates](#) [Bed Registry](#) [Procedure Search](#) [EOB Search](#)

[MAPIR Registration](#) **[Recredential/Revalidation](#)** [Patient Profile](#) [Change of Information](#)

★GAMMIS:Recredential/Revalidation <- Bookmarkable Link ✨ Click here for help and information about bookmarks

 (click to hide) Alert Message posted 8/24/2023

MO Testing Site

This site is for testing purposes only. This is the Test Build test site. Information obtained from this site is intended solely for testing purposes and therefore may not reflect what production would show.

User Information: Acting Provider: 006200329A | Provider Account: 006200329AMO  

[Instructions](#) > [Search](#) > [Delegation](#) > [Provider](#) > [Addtl Info](#) > [Specialty](#) > [Physician Specialty](#) > [Address](#) > [Medicaid](#) > [Admit Privileges](#) > [Credentials](#) > [Programs](#) > [Waiver](#) > [Owner](#) > [Addtl Owner](#) > [Addtl Address](#) > [Fingerprint](#) > [Employee](#) > [Subcontractor](#) > [Rate](#) > [Supervising](#) > [Hours](#) > [Access](#) > [Education](#) > [Training](#) > [Work](#) > [Insurance](#) > [History](#) > [History CVO](#) > [Facility History](#) > [Doco](#) > [Autism Attest](#) > [ROI](#) > [Policy Attest](#) > [Attestation](#) > [SOP](#) >

Instructions 

Welcome to the online Provider Recredential/Revalidation application.

- You must complete each step in the Recredential/Revalidation application, including uploading all required supporting documentation. When you have completed all of the steps please click on the 'Submit' button to submit your application.
- Fields marked with an asterisk (*) are required.
- Please click the 'New Application' to start a new Provider Enrollment application or click 'Continue Application' to continue with an existing application.
- **Application Fee Information**
42 CFR 455.460 requires that certain prospective (new), re-enrolling, revalidating, or recredentialing providers pay an application fee. Individual physicians or non-physician practitioners are exempt from the fee as well as those providers who have already paid the fee to a Medicare contractor or another State's Medicaid program. Section 105.3, Part I Policies and Procedures for Medicaid/Peachcare for Kids®, identifies the categories of service that are required to pay the application fee. Within thirty (30) days from the date of submission of an application, the Division may reject an enrollment application from a prospective (new) or re-enrolling individual or institutional provider that is not accompanied by the application fee or a letter requesting a hardship exception or waiver of the application fee.
- Help is available by clicking the question mark (?) in the title bar.

[exit](#) [new application](#) [continue application](#)

Provider Revalidation Application

Account | **Providers** | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

Home Secure Home Demographic Maintenance Direct Exchange Addresses Provider Rates Bed Registry Procedure Search EOB Search

MAPIR Registration **Recredential/Revalidation** Patient Profile Change of Information

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User Information: Acting Provider: 006200329A | Provider Account: 006200329AMO

Instructions > Search > Delegation > Provider > Addtl Info > Specialty > Physician Specialty > Address > Medicaid > Admit Privileges > Credentials > Programs > Waiver > Owner > Addtl Owner > Addtl Address > Fingerprint > Employee > Subcontractor > Rate > Supervising > Hours > Access > Education > Training > Work > Insurance > History > History CVO > Facility History > Doco > Autism Attest > ROI > Policy Attest > Attestation > SOP >

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- Help is available by clicking the question mark (?) in the title bar.

exit new application continue application

- Select New Application from the bottom of page.

Provider Revalidation Application

(continued)

Medicaid Provider ID	006200329A	Name	DEMOLAST, SAMMY	
Tax ID	288889999	Provider Type	PHYSICIANS/OSTEOPATHS	
SSN*	555229999	Date of Birth*	07/01/1975	Age: 48
		Gender*	☒ Male ☐ Female	
Do you use Telemedicine Services?*				

Identifiers

Type I (Individual) NPI*	1234567893		
Taxonomy 1*	203BN0300X	[Search]	Taxonomy 2 [Search]
Taxonomy 3	[Search]	Taxonomy 4	[Search]
CDS Number			
DEA Number		DEA Expiration Date	
Do you prescribe controlled substances?*	☒ No ☐ Yes		
Are you Board Certified?	☒ No ☐ Yes	Board Specialty	
Certification Effective Date		Certification Expiration Date	
Are you a Primary Care Provider (PCP)?*	☐ No ☐ Yes	Medicare Certification	☒ No ☐ Yes

Contact Information

The person who should be contacted regarding this application.

Contact Last Name*	
First Name, MI*	
Contact Phone*	
Fax	
Contact E-Mail Address*	
Re-Enter E-Mail Address*	

Indicate if you wish to receive E-Mail notifications about this application. The Contact E-Mail Address will be used.

E-Mail Notifications?* ☐ No ☒ Yes

- Complete all fields with an asterisk (*).
- Save & Continue.

Provider Revalidation Application

(continued)

Addtl Info?

Contracts

Provider Contract

430 Physician

600 HealthCheck

Specialties

Primary

Specialty

YES

INTERNAL MEDICINE

NO

GENERAL PRACTICE

previous

save & continue

exit

- Review: Provider Contract and Specialty Information.
- Save & Continue.

Provider Revalidation Service Location Address Panel

Address ?					
Address Type	Address 1	City	State	Zip	Phone
SERVICE LOCATION	1000 MEDICAL DRIVE	ATLANTA	GA	30308	(707)555-0000
MAIL TO	1000 MEDICAL DRIVE	ATLANTA	GA	30308	(707)555-0000

Address Type	SERVICE LOCATION				
Address 1	1000 MEDICAL DRIVE				
Address 2					
City	ATLANTA				
State	GA ▼				
Zip	30308		0000		
County*	Fulton County ▼				
E-Mail Address*	test@email.com				
Practice					
Web Site Address					
Name of Practice (As it appears on the W-9)	PREVENTION INC				

Phone*	(707)555-0000	
Fax*	(707)555-3333	
After Hours Phone		
Location Open 24 Hours	☒ No ☐ Yes	
Location TDD/TTY Equipped	☒ No ☐ Yes	

Individual Practitioners:
Submit a [Change of Information Request](#) if the provider is changing their location address because the practice is moving. Submit an additional location application using the [Provider Enrollment Wizard](#) if you are joining a new practice, adding a location under your existing practice or will be working under a new taxpayer identification number.

Licensed Facilities:
A [Change of Information Request](#) is required with a copy of the updated license which reflects the new address.

[previous](#) [save & continue](#) [exit](#)

Provider Revalidation Service Location Address Panel

(continued)

Update the following asterisk information:

- County
- E-mail Address
- Telephone Number
- Save and Continue

Note: If a provider is changing their location address because the practice is moving, a Change of Information Request must be submitted.

Provider Revalidation Application

(continued)

/Providers/Provider%20Revalidation/tabId/96/Default.aspx

**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Welcome, 006200329amo

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[Account](#) | **[Providers](#)** | [Training](#) | [Claims](#) |
[Home](#) | [Secure Home](#) | [Demographic Mail](#)
[MAPIR Registration](#) | **[Recredential/Revalidation](#)**
★ [GAMMIS: Recredential/Revalidation](#) <- Back

mo-portal.gaummis.com says
We have collected enough information to save your application. Your application will be automatically saved as you progress through each page remaining in the application.

Your application has been assigned Application Tracking Number (ATN) 6702275 and the name entered for this Application is DEMOLAST. Please write down both the ATN and name and keep them in a safe place.

You can exit this application and return at a later time to continue. Once the application has been submitted you can check the status from the Enrollment Status link. You will need to enter both the ATN

OK

(click to hide) Alert Message

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Please make note of your ATN: 6702275

Credentials

Credential Number	Credential Type	Licensing Board/Certifying Body	Credential Classification	Issuing State
LIC555000	License	Medical Board	Physician	GA

Credential Number	LIC555000	Credential Type	License
Licensing Board/Certifying Body	Medical Board	Issuing State	GA
Credential Classification	Physician	Private or Public Board Orders	NO
Effective Date	01/01/2010	Date of Last Order	
Expiration Date	12/31/2299		

Credential Update
If the credential information is not complete or accurate, please upload credential documents with other supporting documentation.
Will you be submitting updated credential information with this application? ☒ No ☐ Yes

[previous](#) [save & continue](#) [exit](#)

English | Español | Accessibility | Privacy | AMA & ADA Copyright

 **REPORT**

- The ATN for your application request will appear in the information box at the top of the screen.
- All your information has been saved. You may Exit the application and return later to complete.

Provider Revalidation Process

+/Providers/Provider%20Revalidation/tabId/96/Default.aspx

**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Welcome, 006200329amo

[Home](#) | [Contact Information](#) | [Member Information](#)
[Account](#) | **[Providers](#)** | [Training](#) | [Claims](#) |
[Home](#) | [Secure Home](#) | [Demographic Mail](#) |
[MAPIR Registration](#) | **[Recredential/Revalidation](#)**
★ [GAMMIS: Recredential/Revalidation](#) <- Back

mo-portal.gaummis.com says
We have collected enough information to save your application. Your application will be automatically saved as you progress through each page remaining in the application.
Your application has been assigned Application Tracking Number (ATN) 6702275 and the name entered for this Application is DEMOLAST. Please write down both the ATN and name and keep them in a safe place.
You can exit this application and return at a later time to continue. Once the application has been submitted you can check the status from the Enrollment Status link. You will need to enter both the ATN and name to reenter the application.
OK

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Credential Classification	Physician	Private or Public Board Orders	NO
Effective Date	01/01/2010	Date of Last Order	
Expiration Date	12/31/2299		

Credential Update
If the credential information is not complete or accurate, please upload credential documents with other supporting documentation.
Will you be submitting updated credential information with this application? ☒ No ☐ Yes

previous **save & continue** **exit**

English | Español | Accessibility | Privacy | AMA & ADA Copyright

 **REPORT**

- Select OK *in the information panel.
- Review Credentialing Information.
- Save & Continue.

Application Search Panel

Search

?

ATN*

Business OR Last Name*

DEMOLAST

search

clear

previous

continue

exit

- If you exit the application, enter your ATN number and select Search.

Disclosure of Ownership

Owner



Disclosure of Ownership and Control Interest Statement - Owners

You have reached the Disclosure of Ownership section of your application. Before proceeding, please select the following link to review the disclosure of ownership and control interest statement policies and related definitions: [Disclosure of Ownership Policy and Definitions](#)

The applicant must disclose the Owner(s) of their facility or business. *Disclosing entity* means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

An owner means a person or corporation with an ownership or control interest that:

1. Has an ownership interest totaling 5 percent or more in a disclosing entity;
2. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
5. Is an officer or director of a disclosing entity that is organized as a corporation;
- or
6. Is a partner in a disclosing entity that is organized as a partnership.

A minimum of one Owner is required. Failure to provide **all** the required information may result in a denial for participation.

The individual who electronically signs the enrollment application must be listed under the Ownership or Managing Employee section of the Disclosure of Ownership.

Disclosure of Ownership

(continued)

Type	Ownership Type	Business Name	Last Name	First Name	FEI Number	SSN	% Owner
A	Individual	Corporation	DEMOLAST	DEMOFIRST	199999992	444433322	50

Type data below for new record.

Is this Owner an Individual or Business?* ☒ Individual ☐ Business

Ownership Type* Corporation

Last Name* DEMOLAST

First Name, MI* DEMOFIRST S

Title

☐ Same as Service Location Address

Address 1* TESTING AVE

Address 2 PO BOX 4460

City* CANTON

State* GA

Zip* 30114 0000

FEI Number 199999992

SSN* 444433322

Date of Birth* 08/08/1968

Familial Relationship* NOT APPLICABLE (NOT RELATED)

Phone (770)444-0000

Fax (770)333-0000

E-Mail Address test@gmail.com

% Owner* 50

Has this owner ever been convicted of a crime related to their involvement in any program under Medicaid, Medicare, or Title XX?* ☐ No ☐ Yes

[delete](#) [add](#)

[previous](#) [save & continue](#) [exit](#)

- Review, confirm, and answer all items marked with an asterisk (*).
- Save & Continue.

Disclosure of Ownership and Control Interest Statement - Managing Employees

Employee



Disclosure of Ownership and Control Interest Statement - Managing Employees

Pursuant to 42 CFR 455.104 and 455.106, enter the name of any person who holds a position of managing employee and whether that individual has ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX. Also enter the affiliation to the Applicant, address, SSN, DOB, and the familial relationship to the Applicant.

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.

A minimum of one Managing Employee is required where the Affiliation drop-down selection is marked with an asterisk. Failure to provide **all** the required information may result in a denial for participation.

The individual who electronically signs the enrollment application must be listed under the Ownership or Managing Employee section of the Disclosure of Ownership.

Disclosure of Ownership and Control Interest Statement - Managing Employees

(continued)

Affiliation	Last Name	First Name	SSN	Familial Relationship	
A	Practice Manager*	DEMOLAST	DEMOfIRST	333999999	NOT APPLICABLE (NOT RELATED)

Type data below for new record.

Affiliation* Practice Manager* ▼

Last Name* DEMOLAST

First Name, MI* DEMOfIRST R

Title

☐ Same as Service Location Address

Address 1* TESTING AVE

Address 2 PO BOX 4460

City* CANTON

State* GA ▼

Zip* 30114 0000

SSN* 333999999

Date of Birth* 08/08/1968

Familial Relationship* NOT APPLICABLE (NOT RELATED) ▼

Phone (770)999-5555

Fax (770)722-2200

E-Mail Address test@gmail.com

Has this managing employee ever been convicted of a crime related to their involvement in any program under Medicaid, Medicare, or Title XX?* ☐ No ☐ Yes

previous save & continue

delete add

exit

- Review, confirm, and answer all items marked with an asterisk (*).
- Save & Continue.

Disclosure of Ownership and Control Interest Statement - Ownership in Subcontractors

Subcontractor ?

Disclosure of Ownership and Control Interest Statement - Ownership in Subcontractors

Pursuant to 42 CFR 455.104 enter any subcontractors that the Applicant has direct or indirect ownership or control interest of 5% or more. Enter the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. If an individual enter the DOB and SSN, if an entity enter the Tax ID number.

Business Name	Last Name	First Name	FEI Number	SSN	Familial Relationship
A					
Type data below for new record.					
Business Name			FEI Number		
Last Name			SSN		
First Name, MI			Date of Birth		
☐ Same as Service Location Address			Familial Relationship		
Address 1					
Address 2					
City					
State					
Zip					
			delete		add
previous		save & continue		exit	

- If applicable, enter information for any subcontractors that the Applicant has direct or indirect ownership or control interest of 5%.
- Save & Continue.

History

History ?

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

- An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.
- A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.
- An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Within the last 3 years, have you been convicted of any criminal offense, had adjudication withheld on any criminal offense, pled no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense?*

☐ No ☐ Yes

If Yes, please explain:

Within the last 3 years, have you, or any entity, agent, owner, or managing employee had disciplinary action taken against any business or professional license held in this or any other state, including licenses issued by the Department of Community Health (GA DCH)?*

☐ No ☐ Yes

If Yes, please explain:

- Answer Yes or No to all 12 questions as it pertains to the enrolling provider, its owners, and its agents.
- All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.
- Save & Continue.

History CVO

History CVO ?

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

- An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.
- A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.
- An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Ability to Perform Job

Are you **NOT** able to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? If you answer YES, you will be asked to describe why you are NOT able to perform.* ☐ No ☐ Yes

Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?* ☐ No ☐ Yes

Do you currently or did you in the last two years engage in the unlawful use of drugs, including the improper use of prescription drugs?* ☐ No ☐ Yes

If Yes, please explain:

Education and Board Certification

Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you even been placed on probation, disciplined, formally reprimanded, suspended, or asked to resign?* ☐ No ☐ Yes

Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?* ☐ No ☐ Yes

Have any of your board certifications or eligibility ever been revoked?* ☐ No ☐ Yes

Have you ever chosen not to re-certify or voluntarily surrendered your board certifications(s) while under investigation?* ☐ No ☐ Yes

- Answer Yes or No to all 18 questions as it pertains to the enrolling provider, its owners, and its agents.
- All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.
- Save & Continue.

Documentation (DOCO)

Doco	
Document Description	
BANK LETTER OR VOIDED CHECK	REQUIRED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED
PLEASE PROVIDE A LETTER STATING WHO WILL PRESCRIBE CONTROLLED SUBSTANCES ON YOUR BEHALF	REQUIRED

ACTION REQUIRED:

- **Copy of Bank Letter or Voided Check** is Required: If submitting a Bank Letter, verify it is signed and dated within **180 days** of request submission.

Upload Supporting Documentation

- *Upload required documents.* The documents listed above must be uploaded before continuing the application.
- *Enrollment forms* are available on this site.

[previous](#) [save & continue](#) [exit](#)

- Select “Upload required documents.”

Documents Required

Attachment Upload

Attachment Description		Status
BANK LETTER OR VOIDED CHECK	REQUIRED	NOT RECEIVED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED	NOT RECEIVED
PLEASE PROVIDE A LETTER STATING WHO WILL PRESCRIBE CONTROLLED SUBSTANCES ON YOUR BEHALF	REQUIRED	NOT RECEIVED

Upload

Choose File

No file chosen

upload attachment

Attachment Upload

Attachment Description		Status
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED	NOT RECEIVED
PLEASE PROVIDE A LETTER STATING WHO WILL PRESCRIBE CONTROLLED SUBSTANCES ON YOUR BEHALF	REQUIRED	NOT RECEIVED

Upload

Choose File

No file chosen

upload attachment

- The Attachment Upload panel will appear in a separate screen.
 - Highlight the line for the item you will be uploading.

Documents Required

(continued)

A screenshot of a web application interface for uploading attachments. The interface has a dark blue header bar with the text "Attachment Upload" on the left and a help icon (?) and an upward arrow icon on the right. Below the header, there is a light blue area. On the left of this area is the word "Upload". To its right is a button labeled "Choose File" and the text "No file chosen". On the far right of this area is a button labeled "upload attachment".

Attachment Upload ? ↑

Upload Choose File No file chosen

upload attachment

- Once all documents have been uploaded close page and you will return back to the application.

Documents Required

(continued)

Doco ?	
Document Description	
BANK LETTER OR VOIDED CHECK	REQUIRED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED
PLEASE PROVIDE A LETTER STATING WHO WILL PRESCRIBE CONTROLLED SUBSTANCES ON YOUR BEHALF	REQUIRED

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[previous](#) [save & continue](#) [exit](#)

- Once documents have been uploaded click “save & continue.”

Policy Attestation

Policy Attest?

VERIFICATION OF POLICY MANUALS

By signing below, I hereby certify and attest that my staff, agents, credentialing personnel, contractors, subcontractors, billing agent(s) and I have accessed and reviewed the Department of Community Health's policies and procedures manuals including Part I, Policies and Procedures for Medicaid/PeachCare for Kids® and the applicable Part II and/or Part III manuals. I understand and acknowledge that the Department's policies and procedures manuals outline the terms and conditions for receipt of medical assistance and participation in the Georgia Medicaid/PeachCare for Kids® program. I understand and acknowledge that my staff, agents, credentialing personnel, contractors, subcontractors, billing agent(s) and I are required to comply with the policies and procedures outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids® and the applicable Part II and/or Part III policy manuals. I understand and acknowledge that the policies and procedures manuals are amended when the Department finds its necessary or appropriate to do so, and that it is my responsibility as well as the responsibility of my staff, agents, credentialing personnel, contractors, subcontractors, and billing agent(s) to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to Medicaid members. I further understand that failure to abide by the Department's policies and procedures will result in adverse actions including, but not limited to, the denial of claims, monetary recoupment, termination, suspension of payments, and reduction of reimbursement. I understand and acknowledge that all of the Department's policies and procedures manuals are accessible through the Departments Medicaid Management Information System (MMIS) web portal at www.mmis.georgia.gov. I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to sanctions against me or my facility.

This is to certify that

Name of Provider (Last, First)*		
Title		
Date	08/25/2023	

☐ I accept the terms of the Policy Attestation Statement

previoussave & continueexit

- Read Verification of Policy Manuals Statement.
- Certify with name of provider.
- Accept the terms of the Policy Attestation Statement.

Attestation Statement

Attestation

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MEDICAID PROGRAM PROVIDER ATTESTATION STATEMENT

This is to certify that

Name of Provider (Last, First)*

DEMOLAST

SAMMY

Title

Date

08/25/2023

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I, II, and III (if applicable), for the Contract(s) indicated herein and I authorize Medicaid or its authorized representative to verify this information.

☐

I accept the terms of the Attestation Statement

previous

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- Read Medicaid Program Provider Attestation Statement.
- Accept the terms of the Attestation Statement.

Statement of Participation

SOP?

DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
STATEMENT OF PARTICIPATION

THIS STATEMENT OF PARTICIPATION between the State of Georgia, Department of Community Health, Division of Medical Assistance (the "Department") and the undersigned Provider becomes effective on the date of enrollment indicated by the Department.

WHEREAS, the Department is charged with the administration of the Georgia State Plan for Medical Assistance (the "Medicaid program") in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. § 49-4-1 et seq., and seeks to enroll qualified health care providers ("Providers") to render services to eligible Medicaid recipients;

WHEREAS, Provider affirms that all prerequisites, certification and/or licensure requirements and other necessary qualifications have been met in Provider's area(s) of specialty as required by law in the State of Georgia to render health care services to patients; and,

WHEREAS, Provider desires to enroll in the Medicaid program to render Covered Services to eligible Medicaid recipients under certain category(ies) of service, and seeks reimbursement for rendering such services.

NOW THEREFORE, in consideration of the mutual covenants and promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree to the terms and conditions named herein as follows:

1. THE DEPARTMENT'S OBLIGATIONS

This is to certify that

Name of Provider (Last, First)*	DEMOLAST	SAMMY
Title		
Date	08/25/2023	

☐ I accept the terms of the Statement of Participation [Statement of Participation](#)

previoussubmitexit

- Read Statement Of Participation.
- Accept the terms of the Statement of Participation.
- Submit.

Application not Submitted

Search

ATN*

6702275

Business OR Last Name*

DEMOLAST

search

clear

Search Results (4 rows returned)

ATN	Name	Document	Date Received	Status	Status Date
6702275	DEMOLAST SAMMY	ONLINE ENROLLMENT APPLICATION	08/24/2023	NOT SUBMITTED - INITIAL APP ENTRY IN PROGRESS	
6702275	DEMOLAST SAMMY	BANK LETTER OR VOIDED CHECK	08/25/2023	RECEIVED, NOT VERIFIED	
6702275	DEMOLAST SAMMY	ELECTRONIC FUNDS TRANSFER FORM	08/25/2023	RECEIVED, NOT VERIFIED	
6702275	DEMOLAST SAMMY	PLEASE PROVIDE A LETTER STATING WHO WILL PRESCRIBE CONTROLLED SUBSTANCES ON YOUR BEHALF	08/25/2023	RECEIVED, NOT VERIFIED	

previous

continue

exit

- Read the Medicaid Program Provider Attestation Statement.
- Accept the terms of the Attestation Statement.

Successfully Submitted

Search

ATN*

6702275

Business OR Last Name*

DEMOLAST

search

clear

Search Results (4 rows returned)

ATN	Name	Document	Date Received	Status	Status Date
6702275	DEMOLAST SAMMY	ONLINE ENROLLMENT APPLICATION	08/25/2023	IN PROCESS - IN PROCESS	
6702275	DEMOLAST SAMMY	BANK LETTER OR VOIDED CHECK	08/25/2023	RECEIVED, NOT VERIFIED	
6702275	DEMOLAST SAMMY	ELECTRONIC FUNDS TRANSFER FORM	08/25/2023	RECEIVED, NOT VERIFIED	
6702275	DEMOLAST SAMMY	PLEASE PROVIDE A LETTER STATING WHO WILL PRESCRIBE CONTROLLED SUBSTANCES ON YOUR BEHALF	08/25/2023	RECEIVED, NOT VERIFIED	

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- Status: IN-PROCESS

Thank you!



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