

# Provider Enrollment

## Additional Service Location – Facility Application



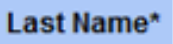
Web Portal Training



# Helpful hints to assist in completing your application



**NOTE:** The screenshots used in this module are based on one example. Information contained in drop-down menus and panels will change depending on the selections made throughout the application process.

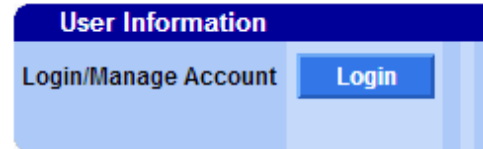
- The panel help icon displays an overall narrative, navigation information, field descriptions, and panel edits assigned to the panel. 
- Field help (click on a label of a field) provides information specific to that field.
- The add button is used to create additional records for the panel. 
- Fields marked with an asterisk are always required. 
- Fields with [search] links allow users to easily search for related values.

Taxonomy 1  

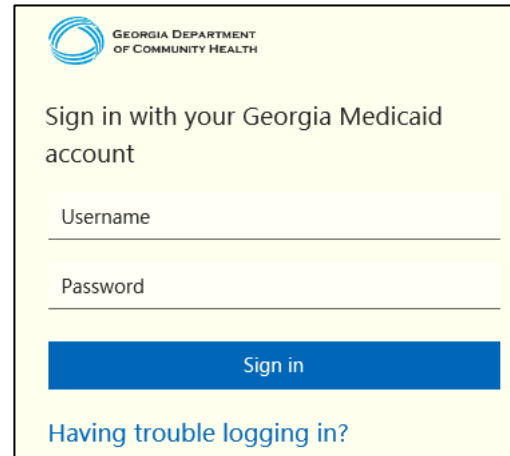
# Logging into the secure Web Portal

To get started, login to the secure GAMMIS Web Portal at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

Click the Login button.



Enter your Username and Password and click the Sign In button.

A screenshot of a sign-in form for the Georgia Department of Community Health. It features the department's logo, the text "Sign in with your Georgia Medicaid account", and input fields for "Username" and "Password". A blue "Sign in" button is at the bottom, along with a link "Having trouble logging in?". An orange arrow points from the left towards the form.

Click the Web Portal link.



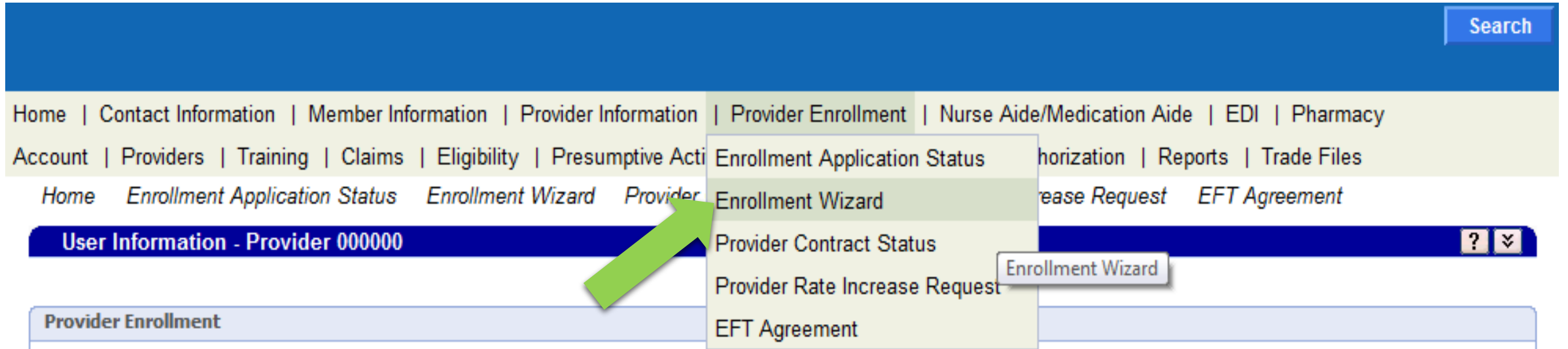
## Applications

Application	Description
<a href="#">MEUPS Account Management</a>	Manages contact information, password, and authorizations for applications.
<a href="#">Web Portal</a>	Web Portal Production

**NOTE:** If acting as a billing agent, please select the appropriate provider ID from the Switch Provider panel to begin navigating on behalf of that provider.

# Navigating to the Application

Select Enrollment Wizard from the Provider Enrollment menu.



The screenshot shows a web application interface with a blue header bar containing a search box. Below the header is a navigation menu with the following items: Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | Account | Providers | Training | Claims | Eligibility | Presumptive Acti. A dropdown menu is open under 'Provider Enrollment', listing: Enrollment Application Status, Enrollment Wizard, Provider Contract Status, Provider Rate Increase Request, and EFT Agreement. A green arrow points to the 'Enrollment Wizard' option. Below the navigation menu is a blue bar with the text 'User Information - Provider 000000' and a help icon. Below that is a light blue bar with the text 'Provider Enrollment'.

# Navigating to the Application

In the middle of the Enrollment Wizard page, select the Provider Enrollment Application link.

## Enrollment Wizard

Providers use this page to complete an enrollment application to become a participating provider in the Georgia Medicaid program. The application uses a wizard to guide applicants through the enrollment form, including the ability to upload supporting documentation. An in-progress application can be saved and completed at a later time.

[Provider Enrollment Application](#)



Please reference the [Part I. Policies and Procedures for Medicaid/PeachCare for Kids®](#) manual, for general requirements that apply to all provider types when enrolling as a Georgia Medicaid provider. Applicants must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Specific qualifications for each provider type are contained in chapter 600 of the program specific policy manual(s).

# Completing the Application

Above the instructions panel, breadcrumbs will be provided to guide you through the enrollment application.

[Instructions](#) > [Search](#) > [Request Type](#) > [Provider](#) > [Contract](#) > [Specialty](#) > [Physician Specialty](#) > [ASL](#) > [Detail](#) > [Address](#) > [Bed](#) > [Pharmacy](#) > [Medicaid](#) > [Language](#) > [Special Need](#) > [Admit Privileges](#) > [License](#) > [Permit](#) > [Certification](#) > [Owner](#) > [Addtl Owner](#) > [Addtl Address](#) > [Fingerprint](#) > [Employee](#) > [Subcontractor](#) > [Rate](#) > [Sponsoring](#) > [Supervising](#) > [Payee](#) > [Hours](#) > [Access](#) > [Education](#) > [Training](#) > [Work](#) > [Insurance](#) > [Programs](#) > [Waiver](#) > [History](#) > [History CVO](#) > [Facility History](#) > [Doco](#) > [Autism Attest](#) > [ROI](#) > [SOP](#) > [Policy Attest](#) > [Attestation](#) > .

**Instructions** ?

Welcome to the online Provider Enrollment application.

- The enrollment application is a one source application for both fee-for-service Medicaid and CMO (Care Management Organization) enrollment.
- You must complete each step in the Enrollment application. When you have completed all of the steps, including uploading all required supporting documentation, please click on the 'Submit' button to submit your application. The application is automatically saved after each step.
- 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, or revalidating 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](#)



To begin a new application, select the **new application** button.

If you wish to continue to edit an existing application, select the **continue application** button.

# New Application – Request Type

*The following slides are an example of an additional service location - facility application.*

Select the application type “Additional Service Location – Individual Practitioner and Facility” and complete the remaining fields as they relate to your enrollment.

**Request Type** ?

**Application Type\***

- Individual Practitioner
- Facility
- Pharmacy
- Out of State - Individual      Out of State is for Applicants MORE THAN 50 miles from the GA border
- Out of State - Facility
- Ordering, Prescribing, or Referring (OPR)
- Additional Service Location - Individual Practitioner and Facility
- CMO Only / Non-Traditional Services - Individual      Non-Medicaid Provider participating with CMO
- CMO Only / Non-Traditional Services - Facility      Non-Medicaid Provider participating with CMO
- CMO Only / Non-Traditional Services - Additional Service Location - Individual and Facility

**Provider Type** Home and Community Based Svc ▼

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

Click “save & continue” to proceed.

# Provider Contracts

Select the Provider Contract from the drop-down menu.

Contract ?

Provider Contract

A

Type data below for new record.

Provider Contract\*

- 600 - HealthCheck
- 541 - Hospital-Based RHC
- 010 - Inpatient Hospital
- 020 - Inpatient PRTF
- 070 - Outpatient Hospital
- 080 - SwingBed

delete add

previous save & continue exit

If you have more than one contract, click the **add** button to include an additional contract.

If there is only one contract, click **save & continue**.

# Provider Specialty

Next, select the Provider Specialty.  
A minimum of one Specialty (Primary) is required.



Specialty

Provider Specialty

A

Type data below for new record.

Please select the specialties that you are trained for and practice.

Provider Specialty\*

delete add

previous save & continue exit

If you have more than one specialty, click the **add** button to include an additional specialty.

If there is only one contract, click **save & continue**.

# Additional Service Location

ASL ?

Select a template to populate service location data  (Template data will overlay existing data on the panel)

Ownership Code\*

Practice Type Code\*

CLIA Number

Tax ID Type\* FEIN

Tax ID

**Identifiers**

Type II (Organization) NPI

Taxonomy 1  [ Search ]

Taxonomy 2  [ Search ]

Taxonomy 3  [ Search ]

Taxonomy 4  [ Search ]

DEA Number

DEA Expiration Date

Do you use Telemedicine Services?\*  Presenter  Receiver  Both  No

**Contact Information**

The person who should be contacted regarding this application.

Contact Last Name\*

Contact First Name, MI\*

Contact Phone\*

Contact 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 the information requested in this panel as it applies to the additional service location.

# Address Information

On the Address Information Panel, enter the additional service location address for the facility.

The screenshot shows a web-based form titled "Address Information" with a blue header and a light blue background. The form is designed for entering a new record for a service location. At the top, there is a table header with columns: "Address Type", "Address 1", "City", "State", "Zip", and "Phone". Below the header, the text "SERVICE LOCATION" is displayed. A prompt "Type data below for new record." is centered above the input fields. The form contains the following fields and controls:

- Address Type\***: A dropdown menu currently set to "SERVICE LOCATION".
- Address 1\***: A single-line text input field.
- Address 2**: A single-line text input field.
- City\***: A single-line text input field.
- State\***: A dropdown menu.
- Zip\***: Two separate text input fields for the zip code.
- County\***: A dropdown menu.
- Phone\***: Two separate text input fields for the phone number.
- Fax\***: A single-line text input field.
- Is this location open 24 Hours?**: Radio buttons for "No" (selected) and "Yes".
- After Hours Phone**: Two separate text input fields.
- Is this location TDD/TTY equipped?**: Radio buttons for "No" (selected) and "Yes".
- E-Mail Address\***: A single-line text input field.
- Practice Web Site Address**: A single-line text input field.

At the bottom right of the form area, there are two buttons: "delete" and "add". At the bottom of the entire page, there are three buttons: "previous", "save & continue", and "exit".


# Application Tracking Number (ATN)

The page at <https://www.mmis.georgia.gov> 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) 26154 and the name entered for this Application is FACILITY APPLICATION. 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 continue the application or to check the status.



Midway through the enrollment process, you will receive a message with your assigned Application Tracking Number (ATN). Please make note of your ATN assignment and the name entered for the application. You will need this information to check on the status of your application, or to continue the application at a later date.

Click "OK" to exit the pop up window and return to the application.

# Languages

Complete the information requested in the Languages Panel.  
Note: At least one primary language is required.

Languages		?
Language	Primary Language	
A	NO	
Type data below for new record.		
Language*	<input type="text"/>	
Primary Language	NO <input type="button" value="v"/>	
		<input type="button" value="delete"/> <input type="button" value="add"/>
<input type="button" value="previous"/> <input type="button" value="save &amp; continue"/>		<input type="button" value="exit"/>

# Special Needs

The information requested on the Special Needs panel will vary depending on the selections made on previous panels.

Complete the information requested in this panel as it applies to the facility.

The screenshot shows a software interface titled "Special Need" with a help icon in the top right corner. Below the title bar, the text "Special Need" and "A" are visible. The main area contains the instruction "Type data below for new record." followed by a form with the following elements:

- A label "Select a template to populate special needs data" next to a dropdown menu. A note to the right states "(Template data will overlay existing data on the panel)".
- A "Special Need" dropdown menu.
- An "Effective Date" field with a calendar icon.
- An "End Date" field with a calendar icon.
- Buttons for "delete" and "add" on the right side of the form.
- Navigation buttons at the bottom: "previous", "save & continue", and "exit".

# Permit

Complete the information requested in this panel as it applies to the facility.

Permit		?	
License/Permit Number	License/Permit Board	License/Permit Type	Issuing State
A			
Type data below for new record.			
License/Permit Number*	<input type="text"/>		
License/Permit Board*	<input type="text"/>		
License/Permit Type*	<input type="text"/>		
Issuing State*	<input type="text"/>		
Effective Date*	<input type="text"/>	<input type="button" value="calendar"/>	
Expiration Date*	<input type="text"/>	<input type="button" value="calendar"/>	
		<input type="button" value="delete"/>	<input type="button" value="add"/>
	<input type="button" value="previous"/>	<input type="button" value="save &amp; continue"/>	<input type="button" value="exit"/>

# Certifications

Complete the information requested in this panel as it applies to the facility.

**Certifications** ?

Certification Number	Certifying Body	Certification Type
A Type data below for new record.		
Certification Number	<input type="text"/>	
Certifying Body	<input type="text"/>	
Certification Type	<input type="text"/>	
Effective Date	<input type="text"/>	<input type="button" value="⚙"/>
Expiration Date	<input type="text"/>	<input type="button" value="⚙"/>
		<input type="button" value="delete"/> <input type="button" value="add"/>
<input type="button" value="previous"/> <input type="button" value="save &amp; continue"/>		<input type="button" value="exit"/>

# Introduction to Disclosure of Ownership

You have reached the Disclosure of Ownership section of the application. Before proceeding, please select the “Disclosure of Ownership Policy and Definitions” document as provided to you on the Owners panel.

**Disclosure of Ownership and Control Interest Statement - Owners** ?

**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.

# Disclosure of Ownership

After reviewing the document, indicate if the Owner is a Business or Individual and complete the remaining fields as they relate to the owner(s) of the facility.

Type	Ownership Type	Business Name	Last Name	First Name	FEI Number	SSN	% Owner
A							0
Type data below for new record.							
Is this Owner an Individual or Business? <input type="radio"/> Individual <input type="radio"/> Business							
Affiliation		Ownership Type		FEI Number		SSN	
Business Name		Last Name		Date of Birth		Familial Relationship	
First Name, MI		Title		Phone		Fax	
Address 1		Address 2		E-Mail Address		% Owner	
City		State					
Zip							
Has this owner ever been convicted of a crime related to their involvement in any program under Medicaid, Medicare, or Title XX?*							
<input type="radio"/> No <input type="radio"/> Yes							
Does this owner have ownership or controlling interest in another entity or organization that is enrolled in Medicaid? (b)(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.							
<input type="radio"/> No <input type="radio"/> Yes							
		delete		add			
previous		save & continue				exit	

Be sure to answer these important questions.

# Disclosure of Ownership

Does this owner have ownership or controlling interest in another entity or organization that is enrolled in Medicaid?  
(b)(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.\*  No  Yes



If you answered yes to this question, the following panel will display.

Disclosure of Ownership and Control Interest Statement - Additional Ownership

**Additional Ownership**

Complete for owners with ownership or controlling interest in another entity or organization that is enrolled in Medicaid.

Owner	FEI Number	Medicaid ID	Name	Ownership Type	Familial Relationship	% Owner
0						
Type data below for new record.						
Owner	<input type="text"/>					
FEI Number	<input type="text"/>					
<b>Additional Ownership in Medicaid Entities</b>						
Medicaid ID	<input type="text"/>					
Name	<input type="text"/>					
Address	<input type="text"/>					
Ownership Type	<input type="text"/>					
Familial Relationship	<input type="text"/>					
% Owner	<input type="text" value="0"/>					
						<input type="button" value="delete"/> <input type="button" value="add"/>
<input type="button" value="previous"/>		<input type="button" value="save &amp; continue"/>			<input type="button" value="exit"/>	

Complete the information requested in this panel as it applies to the owner.

# Disclosure of Ownership

Complete the information requested in this panel as it applies to the business owner.

**Disclosure of Ownership and Control Interest Statement - Other Business Addresses** ?

**Other Business Addresses**

Pursuant to per 42 CFR 455.104(b)(1)(i), enter other business addresses of any corporation with an ownership or control interest in the disclosing entity. The address for corporate entities must include the primary business address, every business location, and P.O. Box address.

Owner	FEI Number	Address 1	City	State
A				
Type data below for new record.				

Owner

FEI Number

**Other Business Addresses**

Address 1

Address 2

City

State

Zip

# Disclosure of Ownership

Complete the information requested in this panel as it applies to the facility.

Be sure to select at least one 'Affiliation' from the drop-down menu that contains an asterisk.

**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.

Affiliation	Last Name	First Name	SSN	Familial Relationship
A				
Type data below for new record.				
Select a template to populate employee data <input type="text"/> (Template data will overlay existing data on the panel)				
<b>Affiliation*</b>	<b>Last Name*</b>	<b>First Name, MI*</b>	<b>Title</b>	<b>Address 1*</b>
<b>Address 2*</b>	<b>City*</b>	<b>State*</b>	<b>Zip*</b>	<b>SSN*</b>
<b>Date of Birth*</b>	<b>Familial Relationship*</b>	<b>Phone</b>	<b>Fax</b>	<b>E-Mail Address</b>
<b>Has this managing e</b>	<b>ime related to their involvement in any program under Medicaid, Medicare, or Title XX?*</b> <input type="radio"/> No <input type="radio"/> Yes			
<b>delete</b> <b>add</b>				
<b>previous</b> <b>save &amp; continue</b> <b>exit</b>				

**Affiliation\***  
Agent\*  
Board Member  
Board of Directors\*  
Business Manager\*  
Chief Executive Officer (CEO)\*  
Chief Financial Officer (CFO)\*  
Chief Operating Officer (COO)\*  
Credential Coordinator\*  
Director of Nursing\*  
Director\*  
EFT Authorized Individual\*  
Facility Administrator\*  
General Manager\*  
Laboratory Director\*  
Legal  
Practice Manager\*  
Provider Office Administrator\*  
Referral Coordinator  
Supervising Pharmacist\*  
Unknown  
Utilization Director/Manager

# Disclosure of Ownership

Complete the information requested in this panel as it applies to the facility.

**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.					
Select a template to populate subcontractor data <input type="text"/> (Template data will overlay existing data on the panel)					
Business Name	<input type="text"/>		FEI Number	<input type="text"/>	
Last Name	<input type="text"/>		SSN	<input type="text"/>	
First Name, MI	<input type="text"/>	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Same as Service Location Address			Familial Relationship <input type="text"/>		
Address 1	<input type="text"/>				
Address 2	<input type="text"/>				
City	<input type="text"/>				
State	<input type="text"/>				
Zip	<input type="text"/>	<input type="text"/>			

# Payee Designation

If the payee is enrolled with Georgia Medicaid, enter their Georgia Medicaid Provider ID. This information can be found on past remittance advices.

**Payee** ?

- The Payee Medicaid ID is used for money designation.
- In addition, the following required documentation must be submitted:
  - **Form W-9** should reflect the address for the provider's payments and/or remittance advices.
  - **147-C letter or tax coupon** will be used to verify the legal name of the business or practice and Tax ID# that is listed on the Form W-9.
  - **EFT Agreement** contains the Payee's Routing and Account Number. These will be used to disburse monies to the provider for rendered services.
  - **Power of Attorney(POA)** form should list the enrolling provider's name, the legal name of the business or practice, and the Payee Tax ID# for proper affiliation.

Facility Providers: A Power of Attorney for Payee must be submitted if the Payee Tax ID listed on the W-9 is different from the applicant's Tax ID.

Is the Payee Tax ID different from the applicant's Tax ID?\*  No  Yes

Payee Medicaid ID

Payee Name


Address

City

State

Zip

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



# Hours

**Hours** ?

Select a template to populate practice data  (Template data will overlay existing data on the panel)

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**Practice Hours**

Enter all practice hours on days that services are provided to member. This should include extended hours.  
If applicable, designate if the location is open 24 hours or closed that day instead of entering hours.

Monday Open/Close	<input type="text"/>	<input type="text"/>	(24HH:MM)	<input type="checkbox"/> Open 24 Hours	<input type="checkbox"/> Closed
Tuesday Open/Close	<input type="text"/>	<input type="text"/>	(24HH:MM)	<input type="checkbox"/> Open 24 Hours	<input type="checkbox"/> Closed
Wednesday Open/Close	<input type="text"/>	<input type="text"/>	(24HH:MM)	<input type="checkbox"/> Open 24 Hours	<input type="checkbox"/> Closed
Thursday Open/Close	<input type="text"/>	<input type="text"/>	(24HH:MM)	<input type="checkbox"/> Open 24 Hours	<input type="checkbox"/> Closed
Friday Open/Close	<input type="text"/>	<input type="text"/>	(24HH:MM)	<input type="checkbox"/> Open 24 Hours	<input type="checkbox"/> Closed
Saturday Open/Close	<input type="text"/>	<input type="text"/>	(24HH:MM)	<input type="checkbox"/> Open 24 Hours	<input type="checkbox"/> Closed
Sunday Open/Close	<input type="text"/>	<input type="text"/>	(24HH:MM)	<input type="checkbox"/> Open 24 Hours	<input type="checkbox"/> Closed

Practice Hours Comments

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**Patient Age Range**

Patient Age Range\*  Beginning Age Range  Ending Age Range  (In Years)

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**Practice Operating Status**

Is this practice your full-time service location?\*  No  Yes  
\*Note: A full-time practice location is defined as a location operating 16 or more hours per week.

Start date of present employment at this location\*  (MM / YYYY)

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**Practice Status**

Accept New Patients Into This Practice?	<input checked="" type="radio"/> No <input type="radio"/> Yes	Accept All New Patients?	<input checked="" type="radio"/> No <input type="radio"/> Yes
Accept Existing Patients with Change of Payor?	<input checked="" type="radio"/> No <input type="radio"/> Yes	Accept New Medicare Patients?	<input checked="" type="radio"/> No <input type="radio"/> Yes
Accept New Patients with Physician Referral?	<input checked="" type="radio"/> No <input type="radio"/> Yes	Accept New Medicaid Patients?	<input checked="" type="radio"/> No <input type="radio"/> Yes

Complete the information requested in this panel as it is required for credentialing and provider directory search.

# Insurance

**Insurance** ?

Carrier	Policy Number	Address 1	City	State
A				

Select a template to populate liability insurance data  (Template data will overlay existing data on the panel)

Information regarding general liability insurance coverage is required.  
Note: The provider is not required to upload proof of liability insurance.

Carrier or Self-Insured Name\*

Policy Number\*

Same as Service Location Address

Address 1\*

Address 2

City\*

State\*

Zip\*

County\*

Effective Date\*

Expiration Date\*

Type of Coverage\*  Individual  Shared

Do you have unlimited coverage with this insurance carrier?  No  Yes

Amount of Coverage Per Occurrence\*  \$0.00

Amount of Coverage Per Aggregate\*  \$0.00

Complete the information requested in this panel as it is required for credentialing.

# Other Program Enrollment

Answer the questions below to identify if the facility is enrolled in Medicare or another states Medicaid program for the service location specified.

This panel only appears if a fee is required for your application.

**Other Program Enrollment** ?

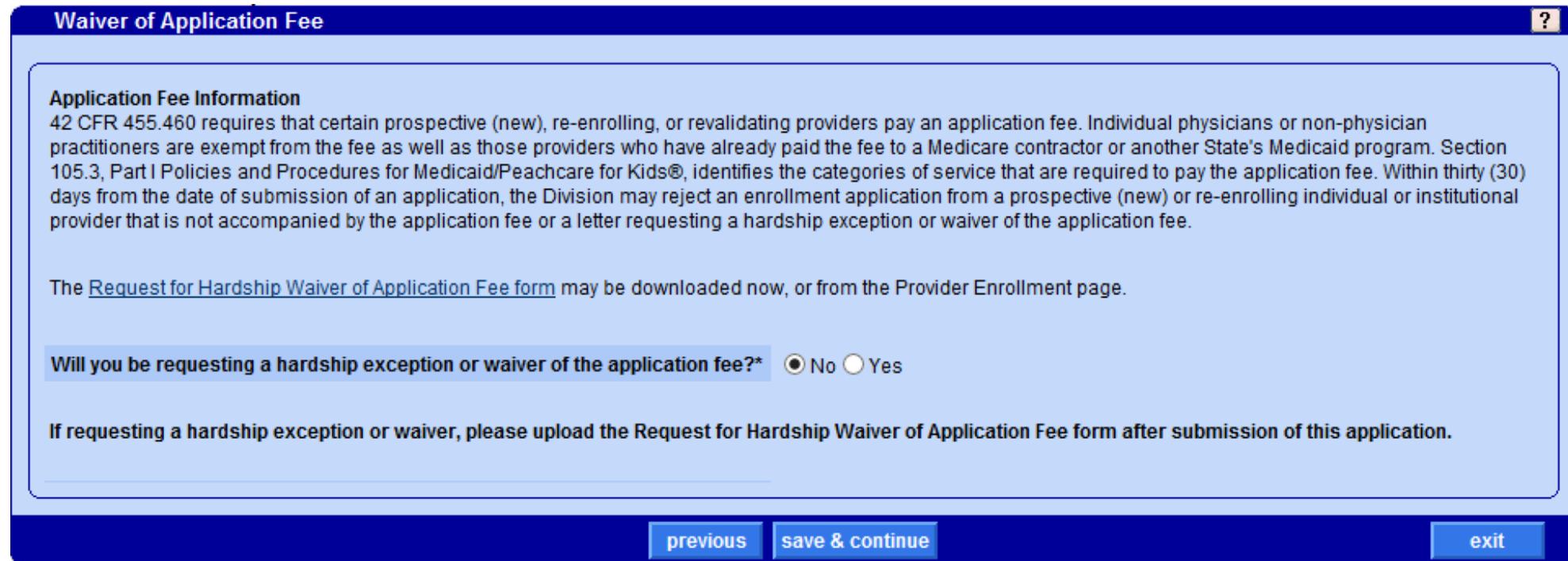
Other Program Enrollment

Are you currently enrolled in Medicare at the service location address identified in this enrollment application?\*  No  Yes

Are you currently enrolled in another state's Medicaid Program at the service location address identified in this enrollment application?\*  No  Yes Medicaid State

# Waiver of Application Fee

This panel only appears if a fee is required and the applicant answered “No” to the other program enrollment questions.



**Waiver of Application Fee** ?

**Application Fee Information**  
42 CFR 455.460 requires that certain prospective (new), re-enrolling, or revalidating 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.

The [Request for Hardship Waiver of Application Fee form](#) may be downloaded now, or from the Provider Enrollment page.

Will you be requesting a hardship exception or waiver of the application fee?\*  No  Yes

If requesting a hardship exception or waiver, please upload the Request for Hardship Waiver of Application Fee form after submission of this application.

previous save & continue exit

If requesting a waiver for the application fee, download and complete the Request for Hardship Waiver of Application Fee form.

# Applicant History

**Applicant 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.**

Have you ever 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:

Have you, or any entity, agent, owner, or managing employee ever 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:

Complete the information requested in this panel as it applies to the facility.

## Additional questions...

Have you, or any entity, agent, owner, or managing employee ever been found to have violated federal or state laws, rules or regulations in any program established under Medicare, Georgia's Medicaid program, any other state's Medicaid program, or Title XX, any other publicly funded federal or state health care, or health insurance program?\*  No  Yes

If Yes, please explain:

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

# Supporting Documentation

Click on “Upload required documents” to continue with the application process.  
In order to submit the application, all required items must be attached.

Supporting Documentation	
Document Description	
COPY OF BUSINESS LICENSE	REQUIRED
COPY OF LIABILITY INSURANCE	REQUIRED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED
IRS TAX DOCUMENTATION	REQUIRED
IRS W-9 FORM	REQUIRED

**Upload Supporting Documentation**

- [Upload required documents](#) The documents listed above must be uploaded before continuing the application.
- [Enrollment forms](#) are available on this site.
- Power of Attorney for Payee:
  - A scanned or faxed copy of the Power of Attorney for Payee will be accepted providing that:
    1. The submitted Power of Attorney for Payee reflects the raised notary seal and all signatures can clearly be seen via a scanned or faxed copy.
    2. If the notary seal is an ink seal it can be clearly seen via a scanned or faxed copy.
    3. If the notary seal and all signatures are unclear or illegible when the document is scanned or faxed, the faxed or scanned Power of Attorney for Payee will be rejected and an original Power of Attorney for Payee will have to be submitted.The Department reserves the right to reject a scanned or faxed copy of a Power of Attorney for Payee.

previous    save & continue    exit

# Attachment Upload

All supporting documentation must be uploaded by the applicant if it is listed as “REQUIRED”. The applicant will not be able to submit the application without the required documentation.

- Upload required documents. The documents listed above must be uploaded before continuing the application.

Attachment Upload			?	^
Attachment Description		Status		
APVL DHR-MHM RSA APPROVAL LTR	REQUIRED	NOT RECEIVED		
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED	NOT RECEIVED		
IRS TAX DOCUMENTATION	REQUIRED	NOT RECEIVED		
IRS W-9 FORM	REQUIRED	NOT RECEIVED		
SUBMIT NPI WITH TAXONOMY	REQUIRED	NOT RECEIVED		

Upload  No file chosen

# Attachment Upload (continued)

Once the applicant selects an attachment, the “upload attachment” button will activate and attachments may be selected and uploaded by using the Choose File button.

Attachment Description	Status
APVL DHR-MHM RSA APPROVAL LTR	REQUIRED NOT RECEIVED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED NOT RECEIVED
IRS TAX DOCUMENTATION	REQUIRED NOT RECEIVED
IRS W-9 FORM	REQUIRED NOT RECEIVED
SUBMIT NPI WITH TAXONOMY	REQUIRED NOT RECEIVED

Upload  No file chosen

Document Description	REQUIRED
APVL DHR-MHM RSA APPROVAL LTR	REQUIRED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED
IRS TAX DOCUMENTATION	REQUIRED
IRS W-9 FORM	REQUIRED
SUBMIT NPI WITH TAXONOMY	REQUIRED

Upload Supporting Documentation

- Upload required documents. The documents listed above must be uploaded before continuing the application.
- Enrollment forms are available on this site.
- Power of Attorney for Payee:
  - A scanned or faxed copy of the Power of Attorney for Payee will be accepted providing that:
    - The submitted Power of Attorney for Payee reflects the raised notary seal and all signatures can clearly be seen via a scanned or faxed copy.
    - If the notary seal is an ink seal it can be clearly seen via a scanned or faxed copy.
    - If the notary seal and all signatures are unclear or illegible when the document is scanned or faxed, the scanned or faxed Power of Attorney for Payee will be rejected and an original Power of Attorney for Payee will have to be submitted.

The Department reserves the right to reject a scanned or faxed copy of a Power of Attorney for Payee.

After all of the attachments have been uploaded, return to the main window and select save & continue.

# Statement of Participation

Complete the information requested in this panel as it applies to the facility.  
Read and accept the terms of the Statement of Participation to continue.

**Statement of Participation** ?

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

This is to certify that

Name of Owner or Authorizing Agent*	<input type="text"/>
Title	<input type="text"/>
Date	09/02/2015

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

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

# Policy Attestation Statement

Complete the information requested in this panel as it applies to the facility.  
Read and accept the terms of the Policy Attestation Statement to continue.

**Policy Attestation Statement** ?

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](http://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 Owner or Authorizing Agent*	<input type="text" value="John Smith"/>
Title	<input type="text"/>
Date	<input type="text" value="09/02/2015"/>

I accept the terms of the Policy Attestation Statement

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

# Medicaid Program Provider Attestation Statement

Complete the information requested in this panel as it applies to the facility.  
Read and accept the terms of the Medicaid Program Provider Attestation Statement to submit your application.

**Attestation Statement** ?

MEDICAID PROGRAM PROVIDER ATTESTATION STATEMENT

This is to certify that

Name of Owner or Authorizing Agent\* John Smith

Title

Date 09/02/2015

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

After submission of this application, a pop-up window will appear to allow you to print a copy of this application. If you have a pop-up blocker installed, you may need to disable it in order to view the print application window.

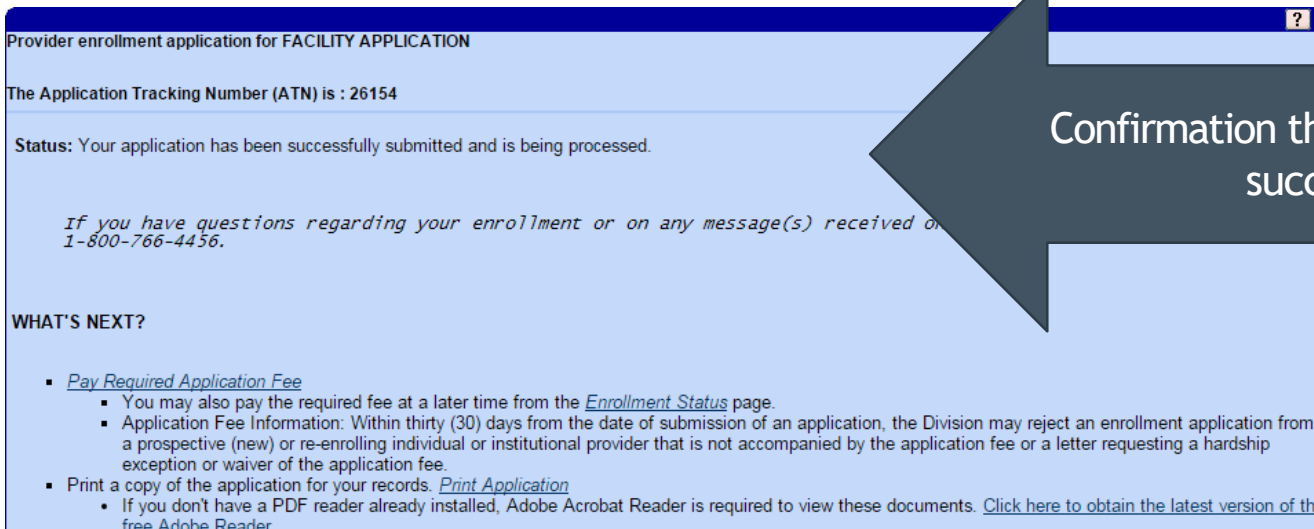
previous submit exit

You will now submit the application.

# Application Tracking and Documentation

Once the application is submitted, a pop up window will open with a PDF version of your application which may be saved for future reference.

The confirmation panel will then be visible:



Provider enrollment application for FACILITY APPLICATION

The Application Tracking Number (ATN) is : 26154

**Status:** Your application has been successfully submitted and is being processed.

*If you have questions regarding your enrollment or on any message(s) received on 1-800-766-4456.*

**WHAT'S NEXT?**

- [Pay Required Application Fee](#)
  - You may also pay the required fee at a later time from the [Enrollment Status](#) page.
  - Application Fee Information: 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.
- Print a copy of the application for your records. [Print Application](#)
  - If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. [Click here to obtain the latest version of the free Adobe Reader.](#)

State Of Georgia

**PROVIDER ENROLLMENT APPLICATION**

PROVIDER SUBMISSION INFORMATION	
Enrollment Type <b>Facility</b>	Provider Type
Would you like to also submit your application for CMO Credentialing?	
Is this application based on a change of ownership (CHOW)?	

PROVIDER IDENTIFYING INFORMATION	
Name of Business or Individual	Doing Business As (D/B/A)
Tax ID	
State Where Incorporated	Does this Organization operate other sites, locations or units?
Where	

PROVIDER DETAIL INFORMATION	
Ownership Type	Practice Type
Business Location	Fiscal Year End Month

Confirmation that your application has been successfully received.

# Application Tracking and Documentation

The screenshot shows a web application interface for tracking enrollment applications. At the top, there is a blue navigation bar with a 'Search' button and a session expiration notice: 'Refresh session | You have approximately 12 minutes until your session will expire.' Below this is a breadcrumb trail: 'Home | Contact Information | Member Information | Provider Information | **Provider Enrollment** | Nurse Aide/Medication Aide | EDI | Pharmacy'. Underneath, a sub-menu is visible: 'Home | **Enrollment Application Status** | Enrollment Wizard | Provider Contract Status | EFT Agreement'. The main content area is divided into several sections: 1. 'User Information' with a 'Login/Manage Account' link and a 'Login' button. 2. 'Enrollment Status' with a text box explaining that an Application Tracking Number (ATN) and Business or Last Name are required to retrieve application status. 3. 'PDF Reader Required' with a note that Adobe Acrobat Reader is needed to view documents, accompanied by a link to the latest version. 4. 'File Download Issues' with a note about pop-up windows and security settings, accompanied by a link for help. 5. 'Enrollment Tracking Search' which contains three input fields: 'ATN\*' (with the value '26154' entered), 'Business OR Last Name', and 'Provider ID'. There are 'search' and 'clear' buttons to the right of these fields.

To check the status of your enrollment, navigate to Enrollment Application Status page from the Provider Enrollment menu.

Enter the ATN and Business or Last Name and click search.

# Application Tracking and Documentation

**Enrollment Tracking Search** Top ? ↕

ATN\*

Business OR Last Name

Provider ID

**Search Results (14 rows returned)**

Document	Date Received	Status	Status Date
APVL DHR-MHM RSA APPROVAL LTR	09/02/2015	RECEIVED, NOT VERIFIED	
ELECTRONIC FUNDS TRANSFER FORM	09/02/2015	RECEIVED, NOT VERIFIED	
IRS TAX DOCUMENTATION	09/02/2015	RECEIVED, NOT VERIFIED	
IRS W-9 FORM	09/02/2015	RECEIVED, NOT VERIFIED	
SUBMIT NPI WITH TAXONOMY	09/02/2015	RECEIVED, NOT VERIFIED	

Information about the application will be provided on this panel. The status of documents will be updated as they are reviewed and verified.

# Provider Enrollment Materials

- For Enrollment forms, select the Forms page from the Provider Information menu.
  - On the forms page, choose enrollment from the drop-down menu and click go to filter and view only enrollment related forms.
- Additional materials can be found by selecting Provider Enrollment and scrolling down.
- To access Frequently Asked Questions (such as materials pertaining to fee payments), select FAQ for Providers from the Provider Information page.



# Thank you

**Contact**

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gainwelltechnologies.com

**Gainwell Technologies**

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