

Provider Enrollment

Initial Application


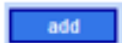
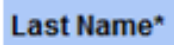
Web Portal Training



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.

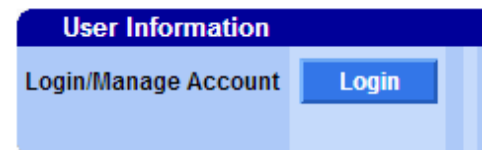
- The panel help icon displays an overall narrative, navigation information, field descriptions, and panel edits assigned to the panel. 
- Field help (click on a label of a field) provides information specific to that field.
- The add button is used to create additional records for the panel. 
- Fields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

- Fields with [search] links allow users to easily search for related values.

Taxonomy 1 [\[Search\]](#)

Logging into the secure Web Portal

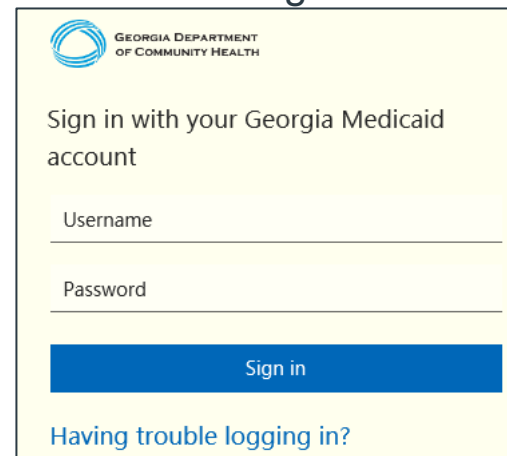
To get started, login to the secure GAMMIS Web Portal at www.mmis.georgia.gov.

Click the Login button.



A blue box titled "User Information" containing a link "Login/Manage Account" and a blue "Login" button.

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



A login form for the Georgia Department of Community Health. It includes the department logo, the text "Sign in with your Georgia Medicaid account", fields for "Username" and "Password", a blue "Sign in" button, and a link "Having trouble logging in?".

Click the Web Portal link.



Applications	
Application	Description
MEUPS Account Management	Manages contact information, password, and authorizations for applications.
Web Portal	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

Go to: www.mmis.georgia.gov

Select Enrollment Wizard from the Provider Enrollment menu.



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 initial individual application.

Select the application type 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 - Facility

☐ Ordering, Prescribing, or Referring (OPR)

☐ Additional Service Location - Individual Practitioner and Facility

☐ CMO Only / Non-Traditional Services - Individual

☐ CMO Only / Non-Traditional Services - Facility

☐ CMO Only / Non-Traditional Services - Additional Service Location - Individual and Facility

Out of State is for Applicants MORE THAN 50 miles from the GA border

Non-Medicaid Provider participating with CMO

Non-Medicaid Provider participating with CMO

Provider Type*

Do you have delegated credentialing?

☒ No

☐ Yes

Would you like to also submit your application for CMO Credentialing?

☒ No

☐ Yes

previous

Do you have delegated credentialing?

☐ No

☒ Yes

Name of Credentialing Delegate*

Proof of Delegation Agreement must be submitted if provider has delegated credentialing

previous

save & continue

exit

If you answered ‘Yes’ for delegated credentialing, you will be required to enter the Credentialing Delegate.

Click “save & continue” to proceed.

Provider Contracts

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

Provider ?

As appears on license


If a suffix such as Jr, Sr, III, etc. is part of the provider's name, enter it in the Individual Last Name field after the name. (i.e. Smith Jr)

Individual Last Name*

First, MI*

Doing Business As (D/B/A)

Title/Degree

Date of Birth* 


Gender* ☐ Male ☐ Female

SSN*

FEI Number*

Unique Physician Identification Number-UPIN

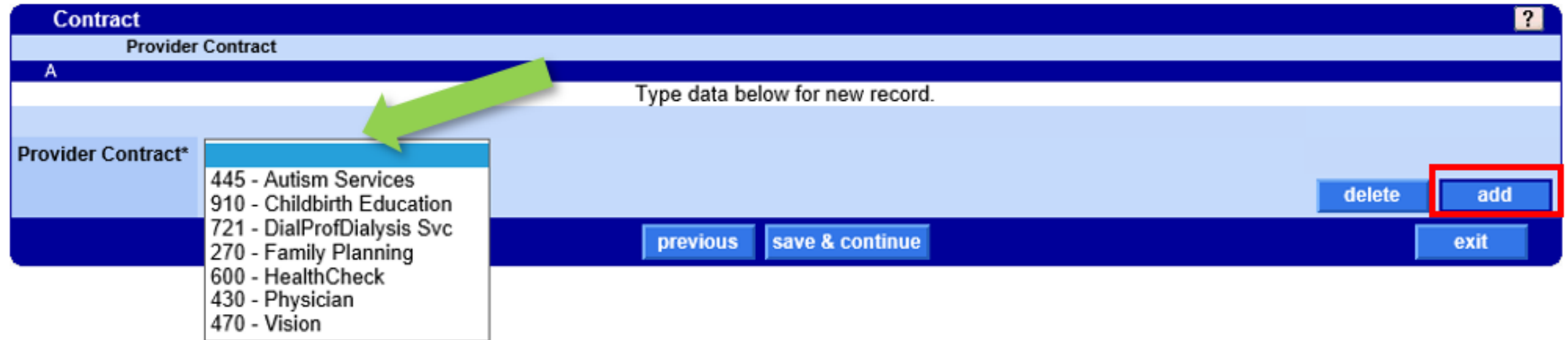
[previous](#) [save & continue](#) [exit](#)



Click “save & continue” to proceed.

Provider Specialty

Select the Provider Contract from the drop down menu.



Contract ?

Provider Contract

A

Type data below for new record.

Provider Contract*

- 445 - Autism Services
- 910 - Childbirth Education
- 721 - DialProfDialysis Svc
- 270 - Family Planning
- 600 - HealthCheck
- 430 - Physician
- 470 - Vision

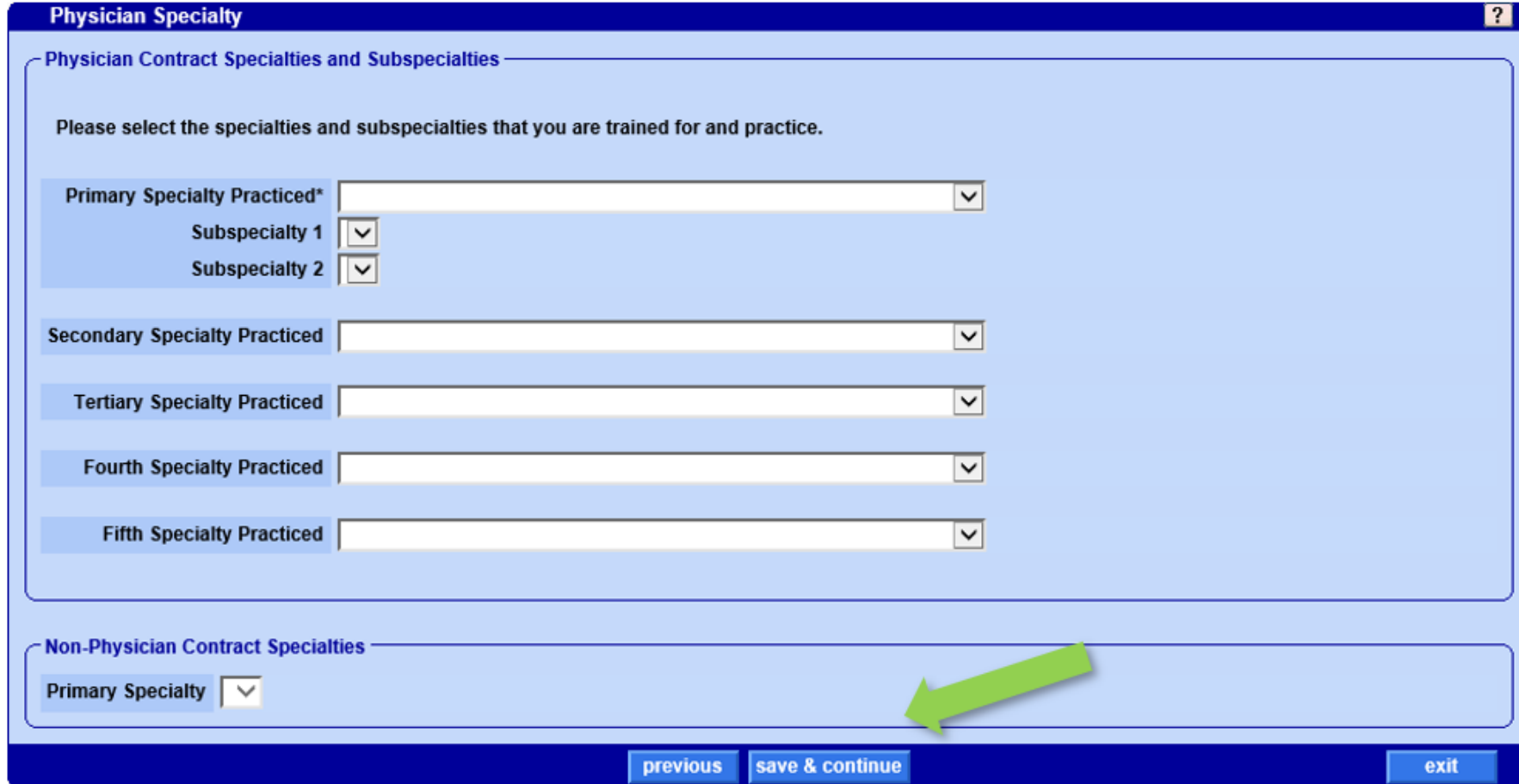
delete add

previous save & continue exit

If you have more than one contract, click the **add** button to include additional information on that contract. When all contracts have been added, click **save & continue**.

Provider Specialty

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



The screenshot shows a web form titled "Physician Specialty" with a help icon in the top right corner. The form is divided into two main sections: "Physician Contract Specialties and Subspecialties" and "Non-Physician Contract Specialties".

Physician Contract Specialties and Subspecialties

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

Primary Specialty Practiced* [dropdown menu]

Subspecialty 1 [dropdown menu]

Subspecialty 2 [dropdown menu]

Secondary Specialty Practiced [dropdown menu]

Tertiary Specialty Practiced [dropdown menu]

Fourth Specialty Practiced [dropdown menu]

Fifth Specialty Practiced [dropdown menu]

Non-Physician Contract Specialties

Primary Specialty [dropdown menu]

A green arrow points to the "Primary Specialty" dropdown menu in the Non-Physician section.

At the bottom of the form, there are three buttons: "previous", "save & continue", and "exit".

Click "save & continue" to proceed.

Detail Information

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

Detail

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

Ownership Code*

Business Location

CLIA Number

Practice Type Code*

Fiscal Year End Month

Liability Insurance Amount

\$0.00

Are you enrolling under a FQHC, Rural Health Clinic, Hospital-Based Rural Health Clinic or Community Mental Health facility?
Enrolling under Facility?*

Are you Board Certified? ☒ No ☐ Yes

Certification Effective Date

Certification Expiration Date

Board Specialty

Are you a Primary Care Provider (PCP)?* ☐ No ☐ Yes

Do you use Telemedicine Services?* ☐ Presenter ☐ Receiver ☐ Both ☒ No

Are you enrolled in Medicare? ☒ No ☐ Yes

Medicare Effective Date

Drug Enforcement Agency (DEA)
DEA Number DEA Expiration Date

Controlled Dangerous Substance (CDS)
CDS Number CDS Effective Date CDS End Date

National Provider Identifier (NPI) & Taxonomy
Type I (Individual) NPI*

Taxonomy 1*

[Search]

 Taxonomy 2

[Search]

Taxonomy 3

[Search]

 Taxonomy 4

[Search]

Correspondence
Please select your preferred method for receiving letters from the Department.
Letter Medium ☒ E-Mail ☐ Fax ☐ Paper

Detail Information, continued

Complete this section of the Detail panel to have access to view application information after the application is submitted.

Application Access Code & Contact Information

Choose an Access Code that will be used to view application information after the application is submitted. The Access Code must be a minimum of six(6) characters in length. Please MAKE NOTE OF THE CODE. It will not be displayed on the submitted application PDF.

Application Access Code*

The person who should be contacted regarding this application.

Contact Last Name*

Contact First, MI*

Contact Phone, Ext.*

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

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

Click “save & continue” to proceed.

Address Information

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

Enter the Name of Practice as it appears on the W-9 form.

Address

Address Type Address 1 City State Zip Phone

SERVICE LOCATION

Type data below for new record.

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

Address Type* SERVICE LOCATION

Name of Practice (As it appears on the W-9)*

Address 1*

Address 2*

City*

State*

Zip*

County*

Phone*

Fax*

Is this location open 24 Hours? ☒ No ☐ Yes

After Hours Phone

Is this location TDD/TTY equipped? ☒ No ☐ Yes

E-Mail Address*

Practice Web Site Address

Does this location have 24/7 phone coverage? ☒ No ☐ Yes

Answering Service ☒ No ☐ Yes

Voicemail with Instructions ☒ No ☐ Yes

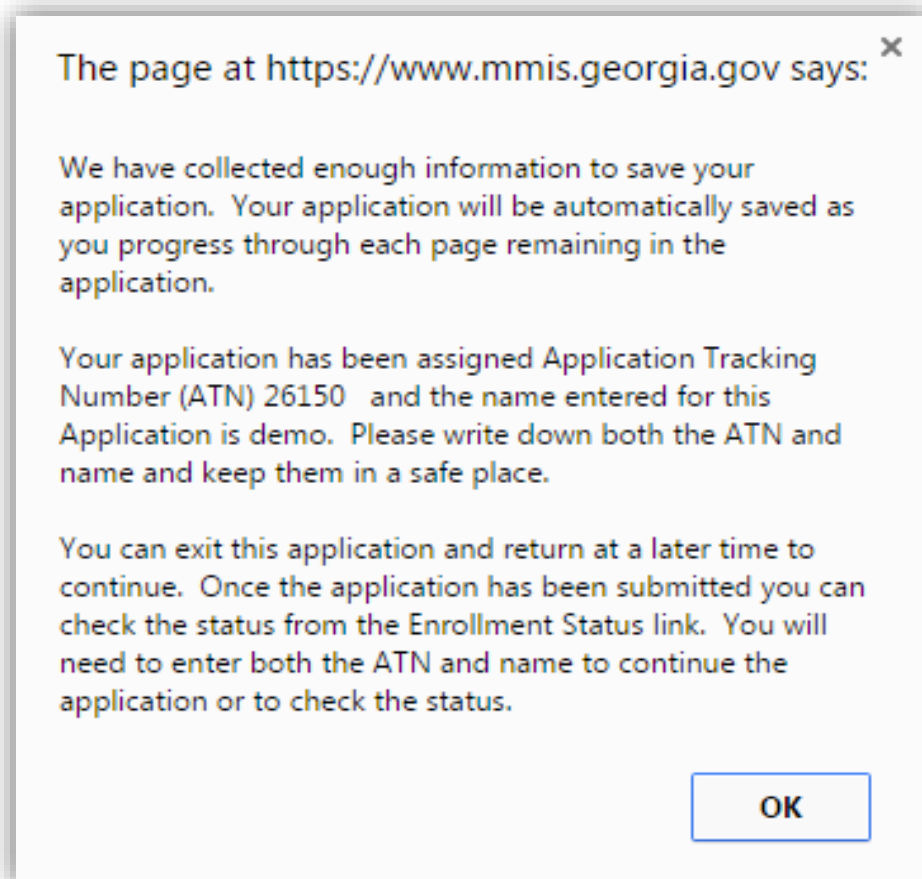
The "mail to" and "pay to" address will automatically default to the address provided for the service location. To enter a unique "mail to" and/or "pay to" address, click add and complete the required fields.

delete add

previous save & continue exit

Click "save & continue" to proceed.

Application Tracking Number (ATN)



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.

Other State Medicaid Programs

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

Other State Medicaid Programs

Medicaid ID

State

Type of Service

Status

A

Type data below for new record.

Indicate other state Medicaid programs where the applicant has participated.

Medicaid ID

State

Type of Service

Current Status

Effective Date

End Date

End Date Reason

Active

Inactive

delete

add

previous

save & continue

exit

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 & 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 applicant.

Special Need

Special Need

A

Type data below for new record.

Select a template to populate special needs data

(Template data will overlay existing data on the panel)

Special Need

Effective Date

End Date

delete

add

previous

save & continue

exit

Hospital Admitting Privileges

Input all information relating to the Hospital Admitting Privileges of the applicant.

Click “save & continue” to proceed.

Admit Privileges							
Provider Name	Hospital	Address	City	State	% Admissions	Primary	
Type data below for new record.							
Select a template to populate admitting data		(Template data will overlay existing data on the panel)					
Do you have Admitting Privileges, an Admitting Plan or Neither? <input checked="" type="radio"/> Admitting Privileges <input type="radio"/> Admitting Plan / Alternate Arrangement <input type="radio"/> Neither							
Admitting Privileges							
Please use the add and delete buttons to enter multiple hospitals where the provider has admitting privileges.							
Primary Hospital <input type="radio"/> No <input type="radio"/> Yes							
Provider Name							
Hospital Name*							
Hospital Affiliation NPI*							
Address 1*							
Address 2							
City*							
State*							
Zip*							
County							
Phone*							
Fax							
Begin Date							
End Date							
Department Director Name							
Full, Unrestricted Privileges? <input type="radio"/> No <input type="radio"/> Yes							
Are Privileges Temporary? <input type="radio"/> No <input type="radio"/> Yes							
Admitting Privileges Status (e.g. None, Full Unrestricted, Provisional, Temporary)							
Of Total Annual Admissions, What Percentage is to this Hospital? %							
Terminated Affiliation Explanation							
Admitting Plan / Alternate Arrangement							
Who will admit on your behalf?							
Admitting Physician NPI							
Please submit documentation of the agreement between you and the admitting physician.							
<div>delete add</div> <div>previous save & continue exit</div>							

Licenses

Input all information relating to the Licenses of the applicant

License ?

License Number	License Board	License Type	Issuing State
A			

Type data below for new record.

License Number*

License Board*

License Type*

Issuing State*

Effective Date*

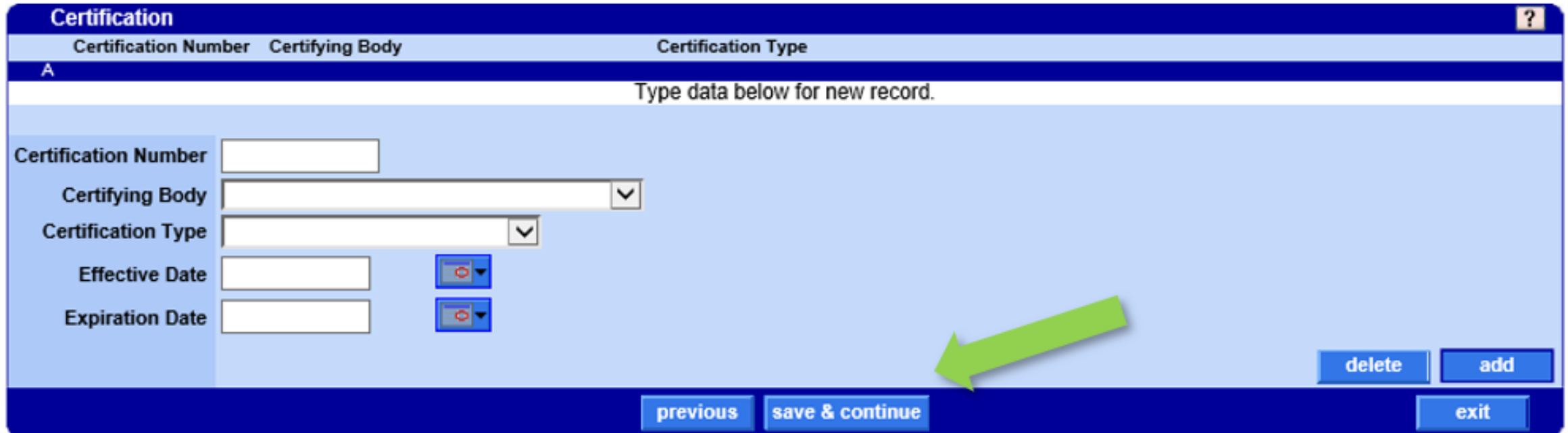
Expiration Date*

Private or Public Board Orders* ☐ No ☐ Yes

Date of Last Order

Certifications

Input all information relating to the Certifications of the applicant.



The screenshot shows a web application window titled "Certification" with a help icon (?) in the top right corner. Below the title bar, there are three columns: "Certification Number", "Certifying Body", and "Certification Type". A tab labeled "A" is active. A message "Type data below for new record." is displayed. The form contains five input fields: "Certification Number" (text box), "Certifying Body" (dropdown menu), "Certification Type" (dropdown menu), "Effective Date" (text box with a calendar icon), and "Expiration Date" (text box with a calendar icon). At the bottom of the form, there are four buttons: "previous", "save & continue", "delete", and "add". A green arrow points to the "save & continue" button.

Click “save & continue” to proceed.

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.

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

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.							
Select a template to populate owner data <input type="text"/> (Template data will overlay existing data on the panel)							
Is this Owner an Individual or Business? <input type="radio"/> Individual <input type="radio"/> Business							
<div><div><div>Affiliation <input type="text"/></div><div>Ownership Type <input type="text"/></div><div>Business Name <input type="text"/></div><div>Last Name <input type="text"/></div><div>First Name, MI <input type="text"/></div><div>Title <input type="text"/></div><div><input type="checkbox"/> Same as Service Location Address</div><div>Address 1 <input type="text"/></div><div>Address 2 <input type="text"/></div><div>City <input type="text"/></div><div>State <input type="text"/></div><div>Zip <input type="text"/></div></div><div><div>FEI Number <input type="text"/></div><div>SSN <input type="text"/></div><div>Date of Birth <input type="text"/></div><div>Familial Relationship <input type="text"/></div><div>Phone <input type="text"/></div><div>Fax <input type="text"/></div><div>E-Mail Address <input type="text"/></div><div>% Owner <input type="text"/></div></div></div>							
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							
<div>delete</div> <div>add</div>							
<div>previous</div> <div>save & continue</div> <div>exit</div>							

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

delete

add

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	<div></div>					
FEI Number						
Additional Ownership in Medicaid Entities						
Medicaid ID	<div></div>					
Name						
Address						
Ownership Type	<div></div>					
Familial Relationship	<div></div>					
% Owner	<div>0</div>					
						<div>delete</div> <div>add</div>
<div>previous</div>		<div>save & continue</div>			<div>exit</div>	

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.

Addtl Address ?

Disclosure of Ownership and Control Interest Statement - 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.				
Select a template to populate additional address data <div></div> (Template data will overlay existing data on the panel)				
Owner	<div></div>			
FEI Number				
Other Business Addresses				
	<input type="checkbox"/> Same as Service Location Address			
Address 1	<div></div>			
Address 2	<div></div>			
City	<div></div>			
State	<div></div>			
Zip	<div></div>	<div></div>		
<div>delete</div> <div>add</div>				

previous

save & continue

exit

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
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)				
Affiliation*	Last Name*	First Name, MI*	SSN*	Date of Birth*
	Title			Familial Relationship*
Address 1*	Address 2	City*	Phone	Fax
State*	Zip*		E-Mail Address	
Has this managing employee 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				
<input type="button" value="delete"/> <input type="button" value="add"/>				
<input type="button" value="previous"/> <input type="button" value="save & continue"/> <input type="button" value="exit"/>				

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.					
Logon to secure site to use enrollment template feature.					
Select a template to populate subcontractor data					
Business Name			FEI Number		
Last Name			SSN		
First Name, MI			Date of Birth		
<input type="checkbox"/> Same as Service Location Address			Familial Relationship		
Address 1					
Address 2					
City					
State					
Zip					
			delete add		
previous			save & continue		
			exit		

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.

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)

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

Practice Hours Comments

Patient Age Range

Patient Age Range*

Beginning Age Range

Ending Age Range

(In Years)

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)

Practice Status

Accept New Patients Into This Practice?

☒ No ☐ Yes

Accept Existing Patients with Change of Payor?

☒ No ☐ Yes

Accept New Patients with Physician Referral?

☒ No ☐ Yes

Accept All New Patients?

☒ No ☐ Yes

Accept New Medicare Patients?

☒ No ☐ Yes

Accept New Medicaid Patients?


☒ No ☐ Yes

previous

save & continue

exit

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


**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

© Gainwell Technologies Proprietary and Confidential.. The information contained herein is subject to change without notice. 28

gainwell

Access

Access ?

Logon to secure site to use enrollment template feature.

Select a template to populate accessibility data

Does this office meet ADA accessibility requirements? ☒ No ☐ Yes

Does this site offer handicapped access for the following:

Parking	<input checked="" type="radio"/> No	<input type="radio"/> Yes
Restroom	<input checked="" type="radio"/> No	<input type="radio"/> Yes

Does this site offer other services for the disabled? ☒ No ☐ Yes

American Sign Language	<input checked="" type="radio"/> No	<input type="radio"/> Yes
Mental/Physical Impairment Services	<input checked="" type="radio"/> No	<input type="radio"/> Yes

Accessible by Public Transportation? ☒ No ☐ Yes

Bus	<input checked="" type="radio"/> No	<input type="radio"/> Yes
Subway	<input checked="" type="radio"/> No	<input type="radio"/> Yes
Regional Train	<input checked="" type="radio"/> No	<input type="radio"/> Yes

List other Handicapped Access / Other Disability Services / or Other Transportation Access:

previous

save & continue

exit

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

Education

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

Education					
Level	School	City	State	Country	Degree
A UNITED STATES					
Type data below for new record.					
Education - Provide the appropriate information for the schools that you attended.					
Level of Education* <input type="radio"/> Bachelors <input type="radio"/> Masters <input type="radio"/> Doctorate <input type="radio"/> Other					
School Name* <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"/>					
Country* UNITED STATES <input type="text"/>					
Phone* <input type="text"/>					
Start Date* <input type="text"/> (MM / YYYY)					
End Date / Graduation Date* <input type="text"/> (MM / YYYY)					
Degree Awarded <input type="text"/>					
<div>delete add</div> <div>previous save & continue exit</div>					

Training

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

Training

Type

Program

City

State

Country

Department/Specialty

A

UNITED STATES

Type data below for new record.

Training - List all training programs you attended. Begin by selecting the Program Type.

Program Type

☐ Internship

☐ Residency

☐ Fellowship

☐ Other

Institution / Hospital Name

Address 1

Address 2

City

State

Zip

Country

Phone

Start Date

End Date

Department / Specialty

delete

add

previous

save & continue

exit

Work History

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

Work

Employer

City

State

Country

Start (MM/YYYY)

End (MM/YYYY)

Current

A

UNITED STATES

/

/

Type data below for new record.

Excluding this application's position and service location, list other current and past Employment History for the past five(5) years in reverse chronological order.

If currently working at multiple locations, list all service locations other than this application's service location.

Practice / Employer Name

Address 1

Address 2

City

State

Zip

Country

Phone

UNITED STATES

Current Position

Start Date

End Date

(MM / YYYY)

(MM / YYYY)

If there is a six(6) month or more gap from your next position, please explain.

delete

add

previous

save & continue

exit

Work History

CMO - Work History ?

Employer	City	State	Country	Start	End
Type data below for new record.					
Excluding your current position, list your Employment History for the past five(5) years in reverse chronological order.					
Practice / Employer Name					
Address 1					
Address 2					
City					
State					
Zip					
Country					
Phone					
Start Date	(MM / YYYY)				
End Date	(MM / YYYY)				
If there is a six(6) month or more gap from your <u>next</u> position, please explain.					
delete add					
previous save & continue exit					

If there is a gap in the work history, the provider will be required to attach the “Work History Gap Form” before submitting the application.

Home | Contact Information | Member Information | **Provider Information** | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy
Home Provider Notices Provider Manuals Provider Messages Fee Schedules **Forms** PASRR Request Reports FAQ for Providers
Web Portal Training Provider Education

User Information ?

Login/Manage Account Login

PDF Reader Required

NOTE: 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.](#)

File Download Issues

Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. [Click here for help with download issues.](#)

ALL CATEGORIES go

Forms (83 rows returned)

Title	File Type	Category	Size (KB)	Release Date
Atypical Antipsychotic PA Request Form	PDF	PHARMACY	94.90	07/07/2014
Authorization and Release of Information	PDF	ALL CATEGORIES	207.80	08/11/2015

That form can also be accessed in the Web Portal under
Provider Information, Forms.

Insurance

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

Insurance

CarrierPolicy NumberAddress 1CityState

A

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

Information regarding professional (malpractice) liability insurance coverage is required.
Please refer to the [CVO Professional Liability Insurance Policy](#) for coverage requirements.
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*

Amount of Coverage Per Aggregate*

delete

add

previous

save & continue

exit

Applicant History and History CVO panels

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 an license held in this or any other state, including licenses issued by the Department of Con

If Yes, please explain:

Complete the information requested in each panel as it applies to the applicant.

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

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	
CMO-BOARD CERTIFICATION	UPLOAD IF APPLICABLE
CMO-CURRICULUM VITAE	REQUIRED
CMO-EXPLANATION OF REPORTED ACTION	UPLOAD IF APPLICABLE
CMO-EXPLANATION OF WORK HISTORY GAPS	UPLOAD IF APPLICABLE
CMO-PEER REFERENCE LETTERS	REQUIRED
CMO-PROOF OF MALPRACTICE INSURANCE	REQUIRED
CMO-RELEASE OF INFORMATION AGREEMENT	REQUIRED
CMO-SPONSOR LETTER	UPLOAD IF APPLICABLE
COPY OF PHYSICIANS LICENSE	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:
 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
CMO-BOARD CERTIFICATION	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-CURRICULUM VITAE	REQUIRED	NOT RECEIVED
CMO-EXPLANATION OF REPORTED ACTION	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-EXPLANATION OF WORK HISTORY GAPS	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-PEER REFERENCE LETTERS	REQUIRED	NOT RECEIVED
CMO-PROOF OF MALPRACTICE INSURANCE	REQUIRED	NOT RECEIVED
CMO-RELEASE OF INFORMATION AGREEMENT	REQUIRED	NOT RECEIVED
CMO-SPONSOR LETTER	UPLOAD IF APPLICABLE	NOT RECEIVED
COPY OF PHYSICIANS LICENSE	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

Choose File

No file chosen

upload attachment

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 Upload ? ^

Attachment Description		Status
CMO-BOARD CERTIFICATION	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-CURRICULUM VITAE	REQUIRED	NOT RECEIVED
CMO-EXPLANATION OF REPORTED ACTION	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-EXPLANATION OF WORK HISTORY GAPS	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-PEER REFERENCE LETTERS	REQUIRED	NOT RECEIVED
CMO-PROOF OF MALPRACTICE INSURANCE	REQUIRED	NOT RECEIVED
CMO-RELEASE OF INFORMATION AGREEMENT	REQUIRED	NOT RECEIVED
CMO-SPONSOR LETTER	UPLOAD IF APPLICABLE	NOT RECEIVED
COPY OF PHYSICIANS LICENSE	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

Choose File

No file chosen

upload attachment

Statement of Participation

Complete the information requested in this panel as it applies to the applicant.
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 Provider (Last, First)*

Title

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 applicant.
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. 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 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 applicant.
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 Provider (Last, First)* SMITH JOHN

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

***NOTE: The submit button will NOT be available unless ALL required documents have been uploaded.**

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 demo

The Application Tracking Number (ATN) is : 26150

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

If you have questions regarding your enrollment or on any message, please call 1-800-766-4456.

WHAT'S NEXT?

- 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.](#)
 - Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. [Click here for help with download issues.](#)
- Required documents can be faxed or uploaded:
 - [Enrollment forms](#) are available on this site.
 - [Upload required documents.](#)
 - Please allow 15 business (not calendar) days for attachments to be reviewed.
 - 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 faxed or scanned Power of Attorney for Payee will be rejected and an original Power of Attorney for Payee will have to be submitted.
- You can check the status of this application from the [Enrollment Status](#) page.

[previous](#) [exit](#) [add additional service location application](#)

State Of Georgia

PROVIDER ENROLLMENT APPLICATION

PROVIDER SUBMISSION INFORMATION		
Enrollment Type	Provider Type	
Would you like to also submit your application for CMO Credentialing?		
PROVIDER IDENTIFYING INFORMATION		
Name of Business or Individual	Doing Business As (DBA)	
Other Names Used (e.g. Maiden Name, Alias)		
Title/Degree	Date of Birth	Gender
Race	Ethnicity	
SSN	FEI Number	UPIN
PROVIDER DETAIL INFORMATION		
Ownership Type	Practice Type	
Business Location	Fiscal Year End Month	
CLIA Number	Liability Insurance Amount	
Are you enrolling under a FQHC, Rural Health Clinic, Hospital-Based Rural Health Clinic, or Community Mental Health facility?		
NO		
DEA Number	DEA Effective Date	DEA End Date
All Schedules? (2, 2X, 3, 3X, 4, 5)		
NO		
CDS Number	CDS Effective Date	CDS End Date

Application Tracking and Documentation

Search

Refresh session] You have approximately 19 minutes until your session will expire.

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy

Home | Enrollment Application Status | Enrollment Wizard | Provider Contract Status | EFT Agreement

User Information

Login/Manage Account Login

Enrollment Status

This page provides a status for enrollment applications submitted to HP. An Application Tracking Number (ATN) and Business or Last Name (as submitted on the application) are required to retrieve the status of the application.

PDF Reader Required

NOTE: 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.](#)

File Download Issues

Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. [Click here for help with download issues.](#)

Enrollment Tracking Search

Top ?

ATN* 26150

Business OR Last Name

Provider ID

search

clear

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:

Application Tracking and Documentation

Enrollment Tracking Search

ATN*26150

Business OR Last NameSMITH

Provider ID

search

clear

Search Results (14 rows returned)

Document	Date Received	Status	Status Date
ONLINE ENROLLMENT APPLICATION	09/02/2015	AWAITING INITIAL INFO - PENDING RECEIPT OF HARD-COPY SUPPORTING DOCUMENTS	
CMO-BOARD CERTIFICATION		NOT RECEIVED	
CMO-EXPLANATION OF REPORTED ACTION		NOT RECEIVED	
CMO-EXPLANATION OF WORK HISTORY GAPS		NOT RECEIVED	
CMO-SPONSOR LETTER		NOT RECEIVED	
CMO-CURRICULUM VITAE	09/02/2015	RECEIVED, NOT VERIFIED	
CMO-PEER REFERENCE LETTERS	09/02/2015	RECEIVED, NOT VERIFIED	
CMO-PROOF OF MALPRACTICE INSURANCE	09/02/2015	RECEIVED, NOT VERIFIED	
CMO-RELEASE OF INFORMATION AGREEMENT	09/02/2015	RECEIVED, NOT VERIFIED	
COPY OF PHYSICIANS LICENSE	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

brand@gainwelltechnologies.com
gainwelltechnologies.com

Gainwell Technologies

1775 Tysons Blvd.
McLean, VA 22102