Provider Enrollment

Initial Application

Web Portal Training

Georgia Department of Community Health

gainwell

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. add
- Fields marked with an asterisk are always required.

Last Name*

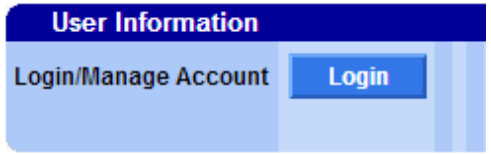
- Fields with [search] links allow users to easily search for related values.

Taxonomy 1 [Search]

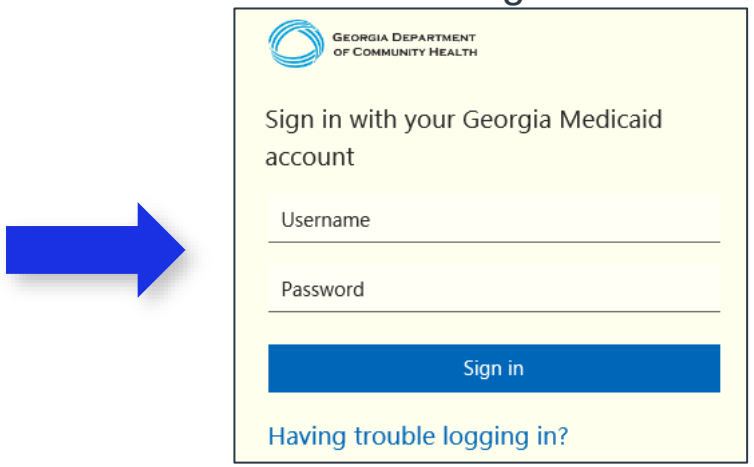
Logging into the secure Web Portal

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

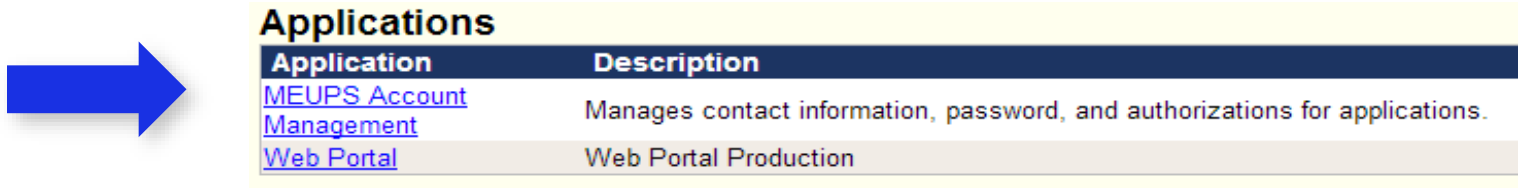
Click the Login button.



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



Click the Web Portal link.



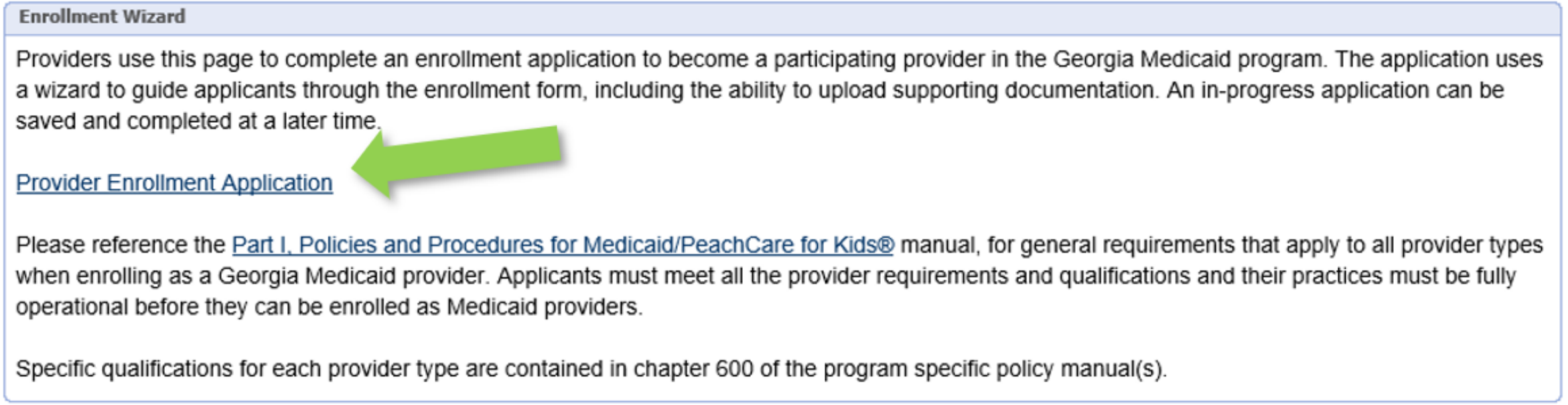
NOTE: If acting as a billing agent, please select the appropriate provider ID from the Switch Provider panel to begin navigating on behalf of that provider.

Navigating to the Application

Go to: www.mmis.georgia.gov
Select Enrollment Wizard from the Provider Enrollment menu.

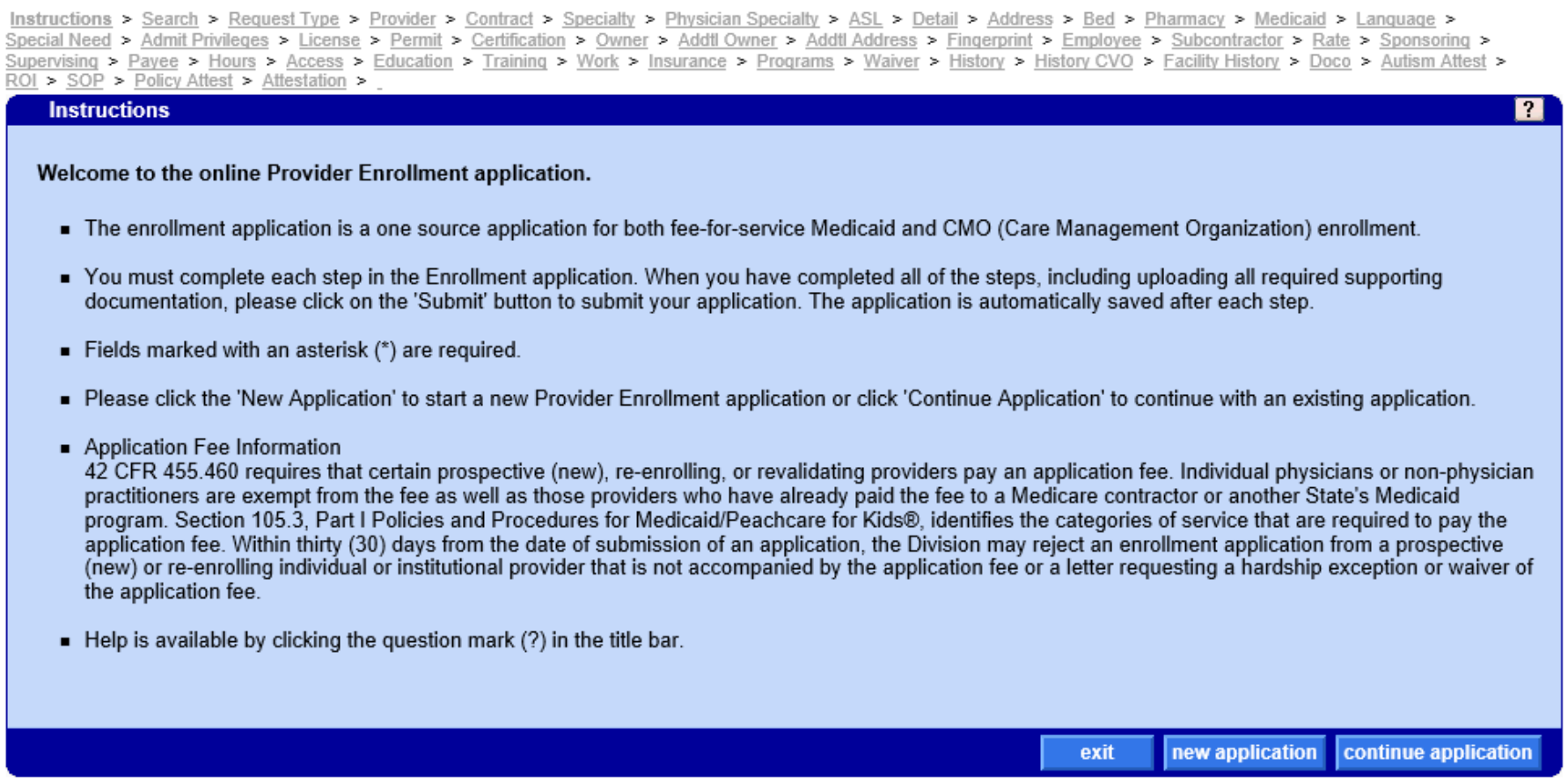
Navigating to the Application

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



Completing the Application

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



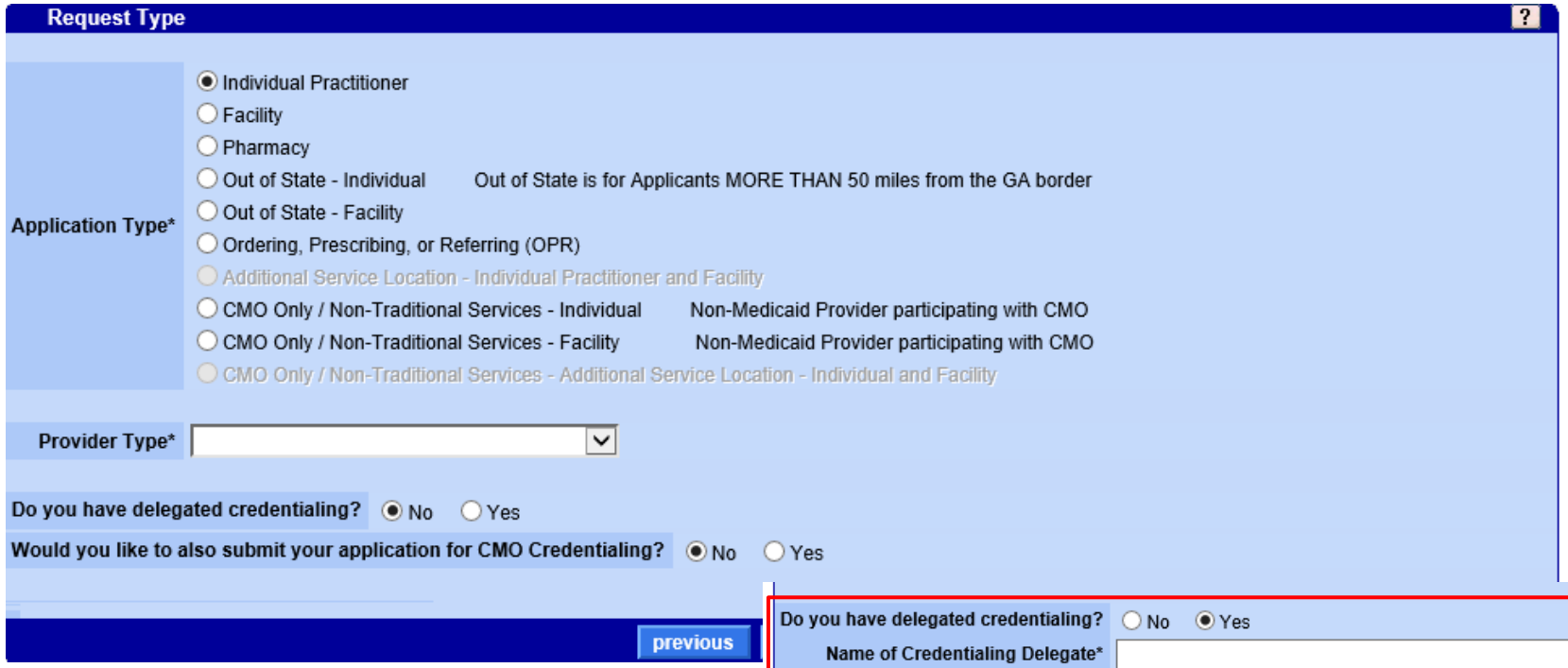
To begin a new application, select the new application button.

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

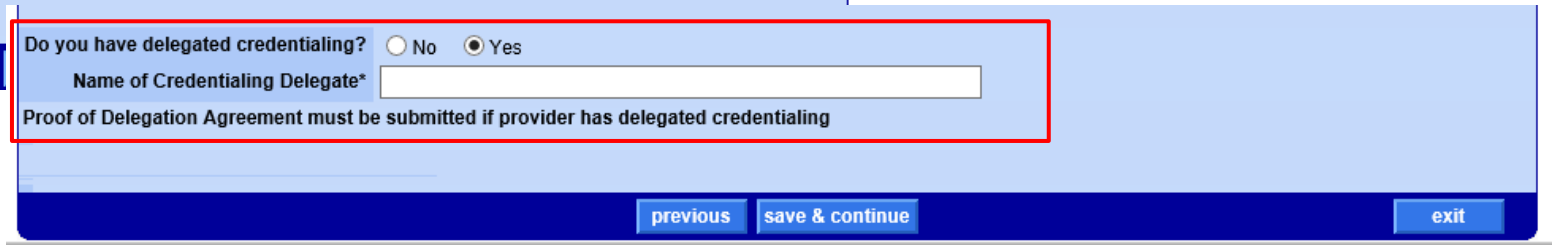
New Application – Request Type

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.



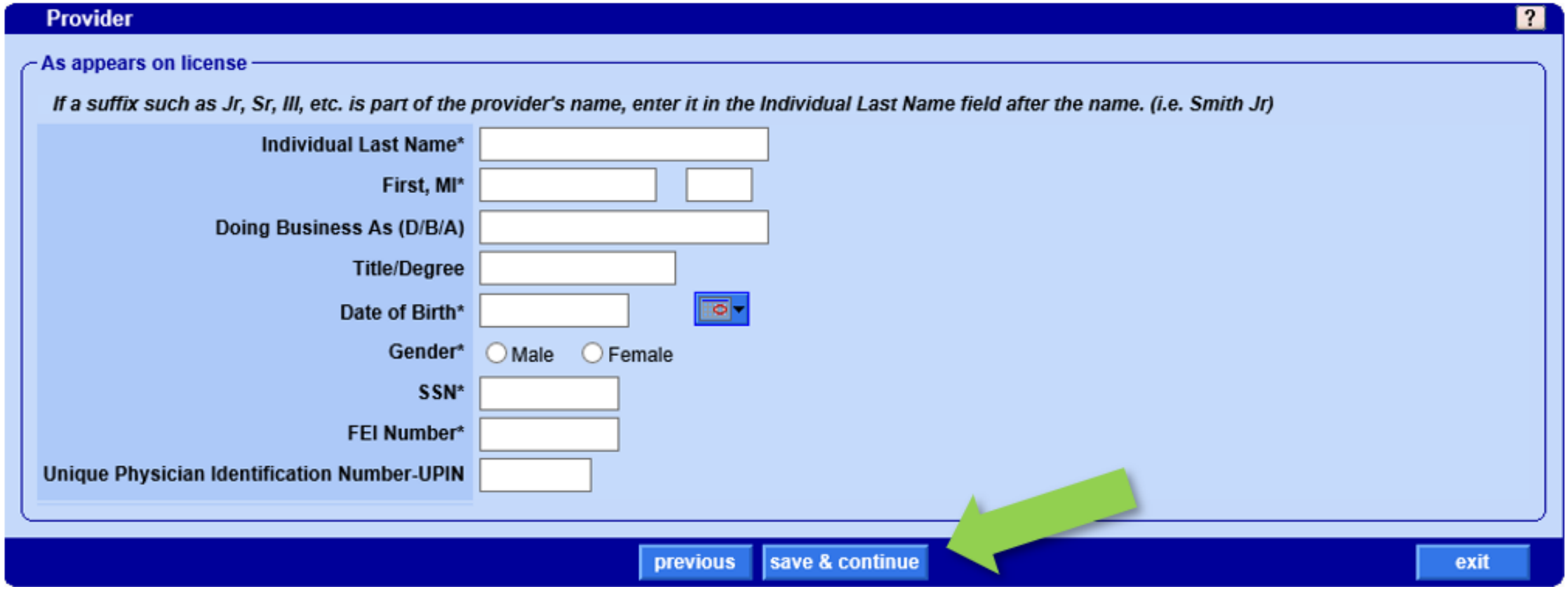
If you answered 'Yes' for delegated credentialing, you will be required to enter the Credentialing Delegate.



Click "save & continue" to proceed.

Provider Contracts

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



Click “save & continue” to proceed.

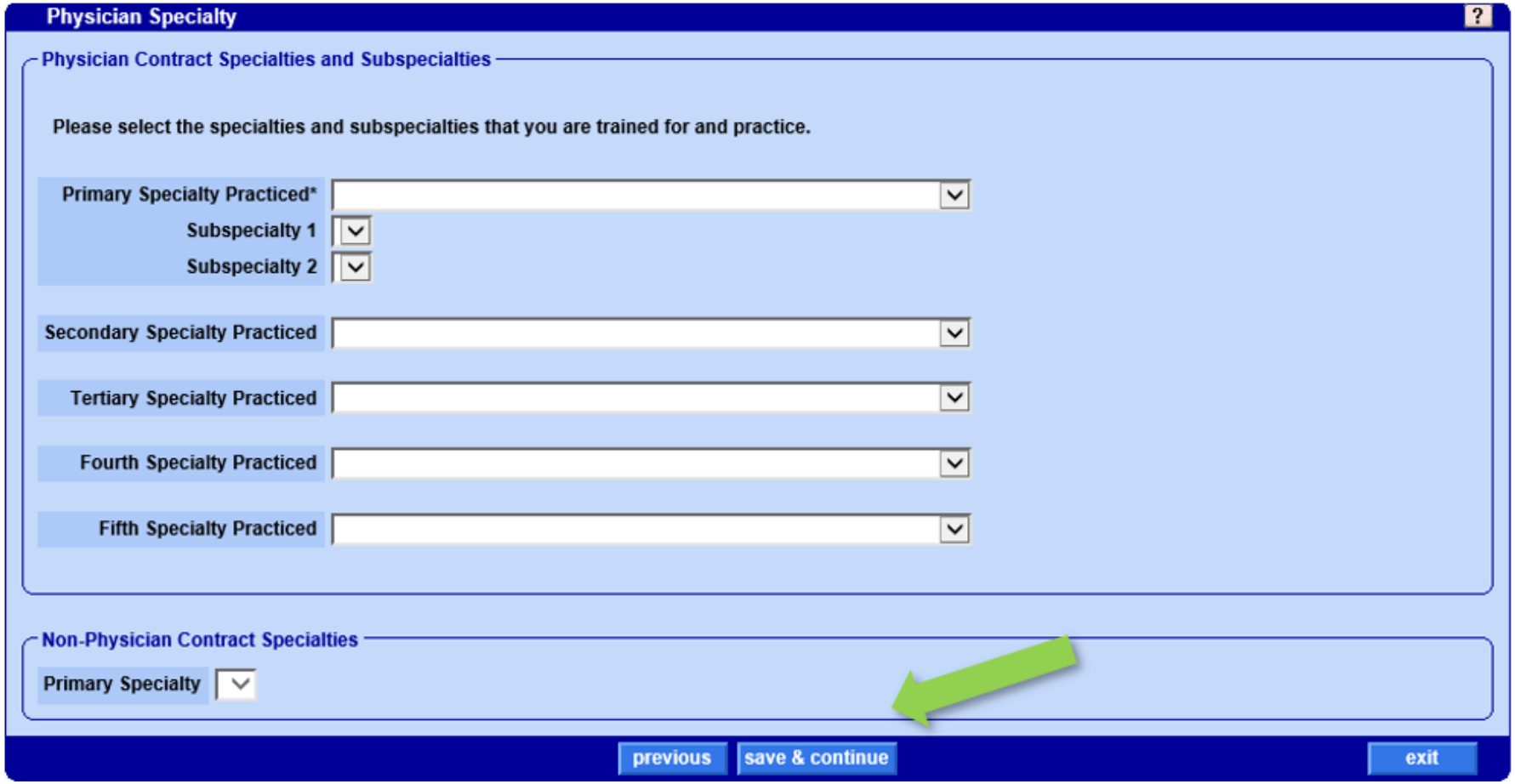
Provider Specialty

Select the Provider Contract from the drop down menu.

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

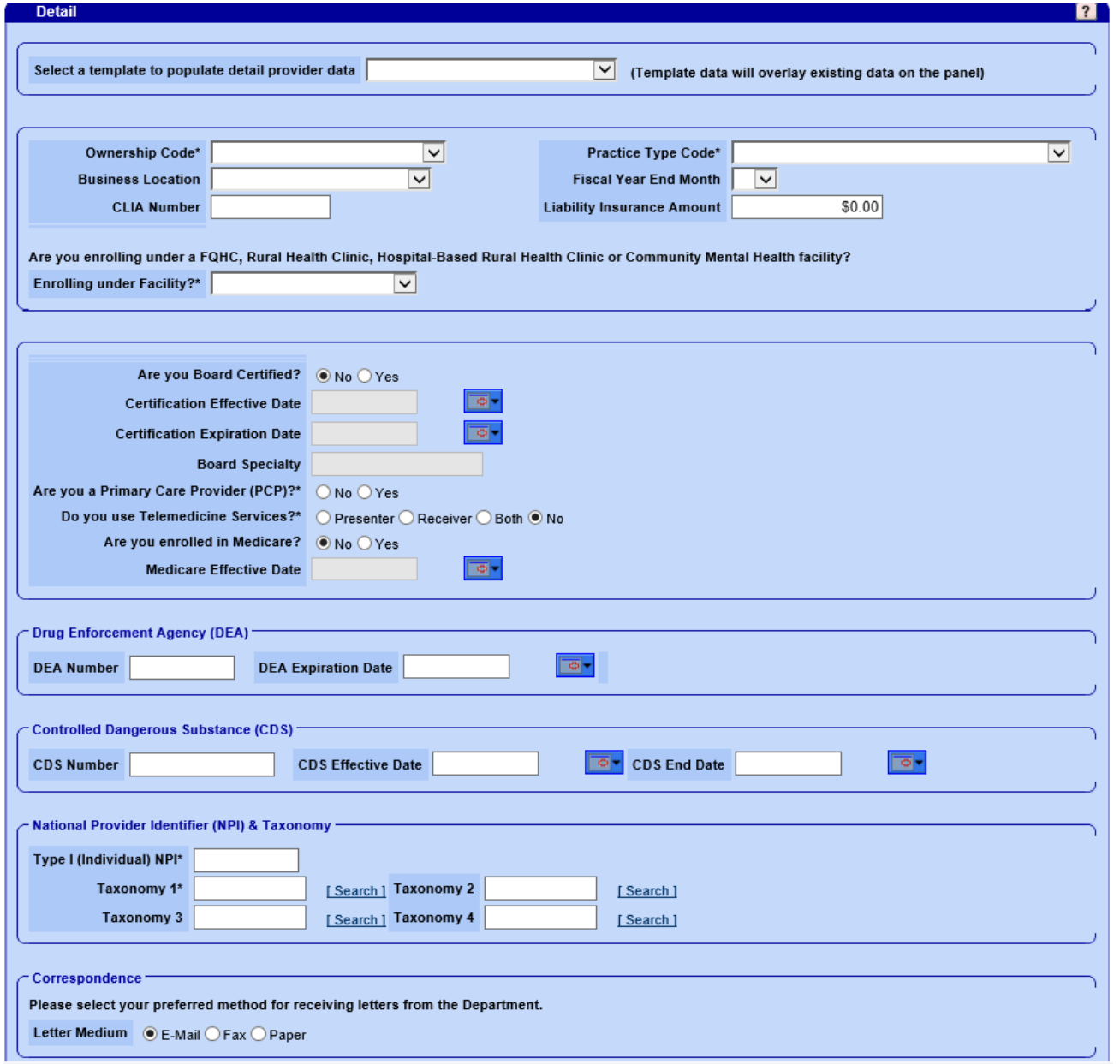
Next, select the Provider Specialty. A minimum of one Specialty (Primary) is required.



Click “save & continue” to proceed.

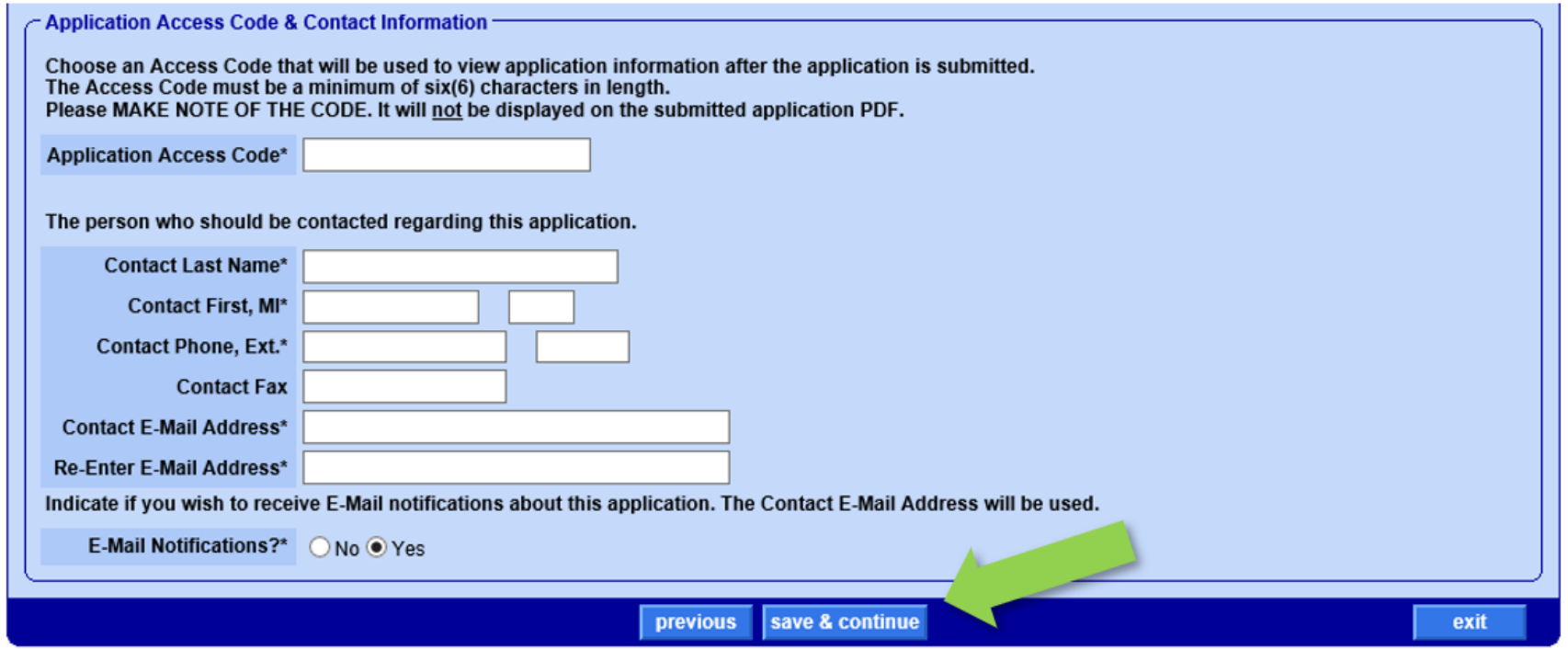
Detail Information

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



Detail Information, continued

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

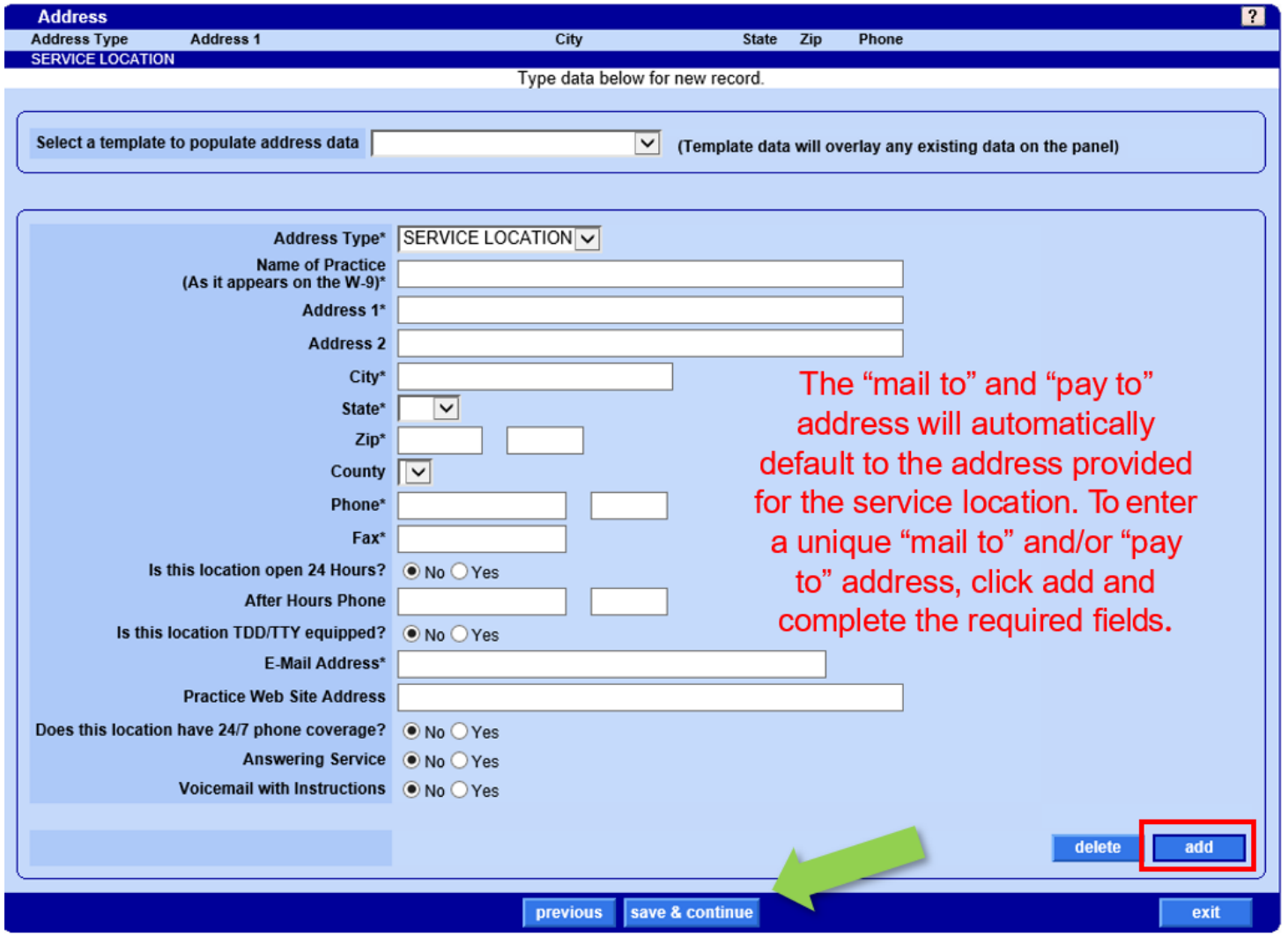


Click “save & continue” to proceed.

Address Information

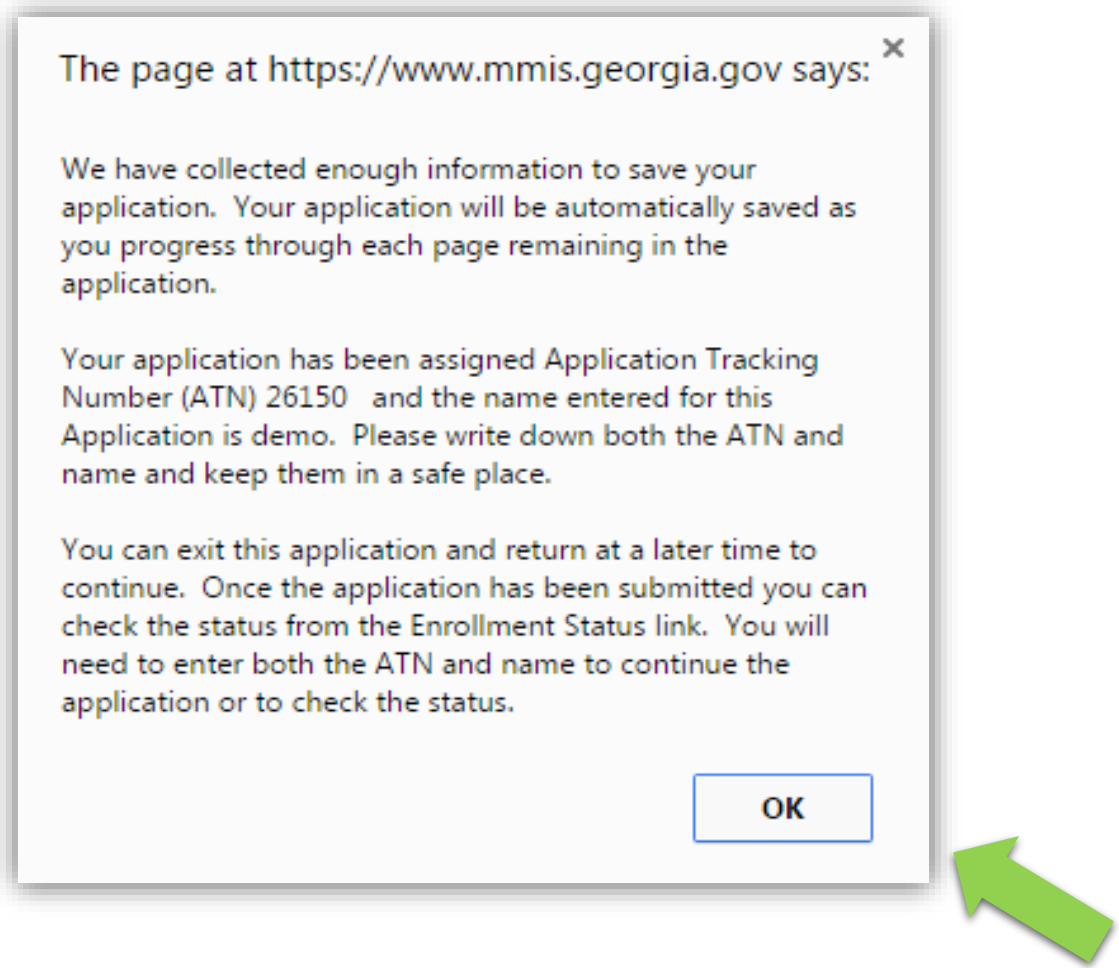
On the Address Panel, enter the service location address for the facility.

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



Click "save & continue" to proceed.

Application Tracking Number (ATN)

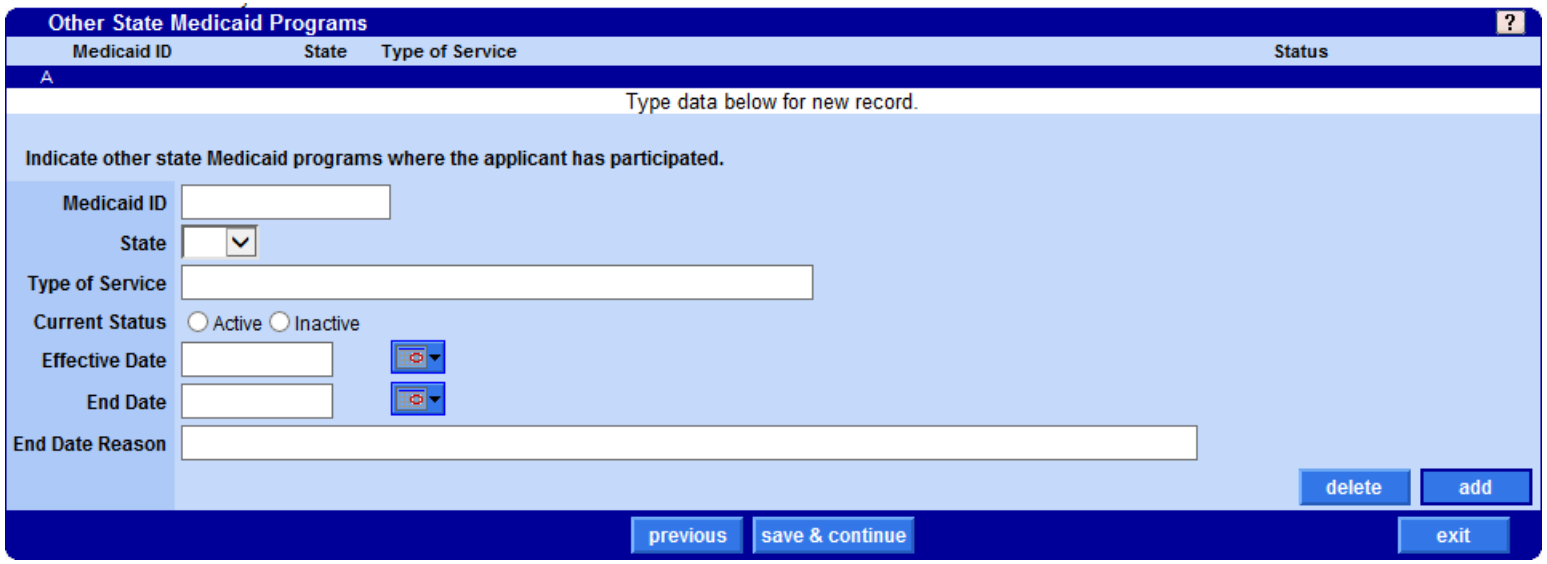


Midway through the enrollment process, you will receive a message with your assigned Application Tracking Number (ATN). Please make note of your ATN assignment and the name entered for the application. You will need this information to check on the status of your application, or to continue the application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

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

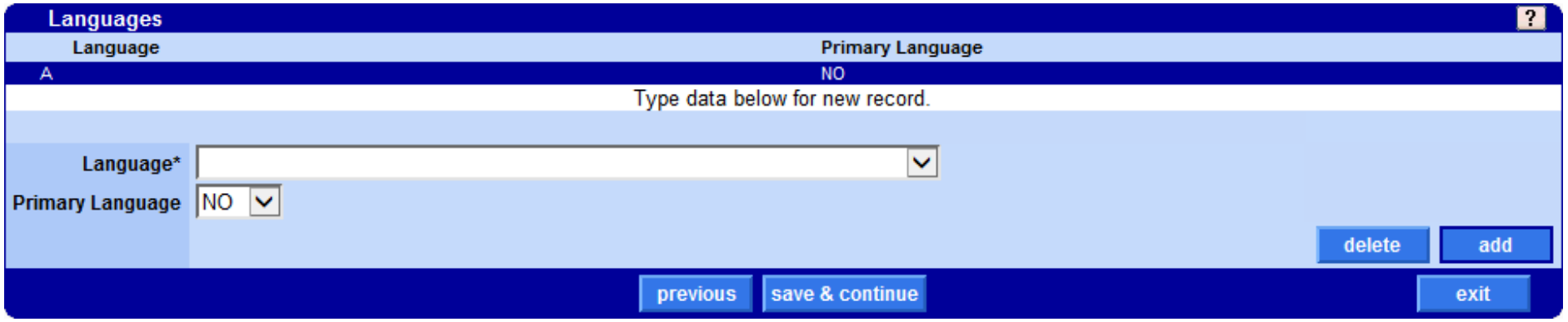
Other State Medicaid Programs

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



Languages

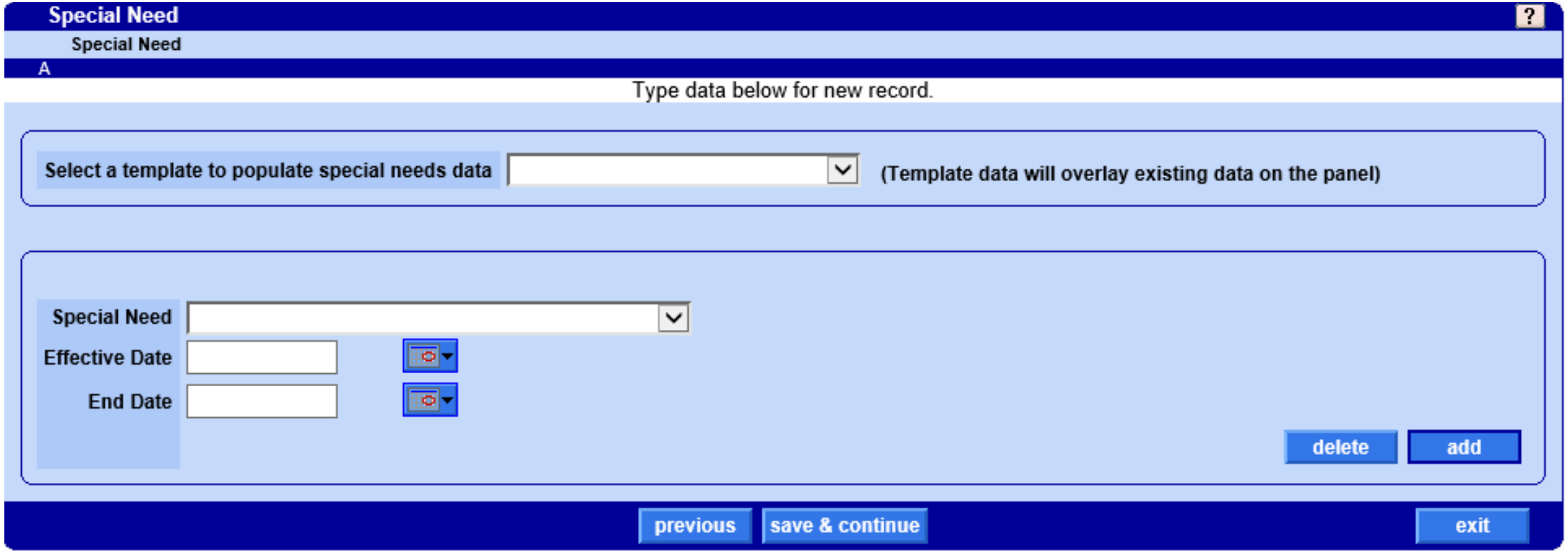
Complete the information requested in the Languages Panel.
Note: At least one primary language is required.



Special Needs

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

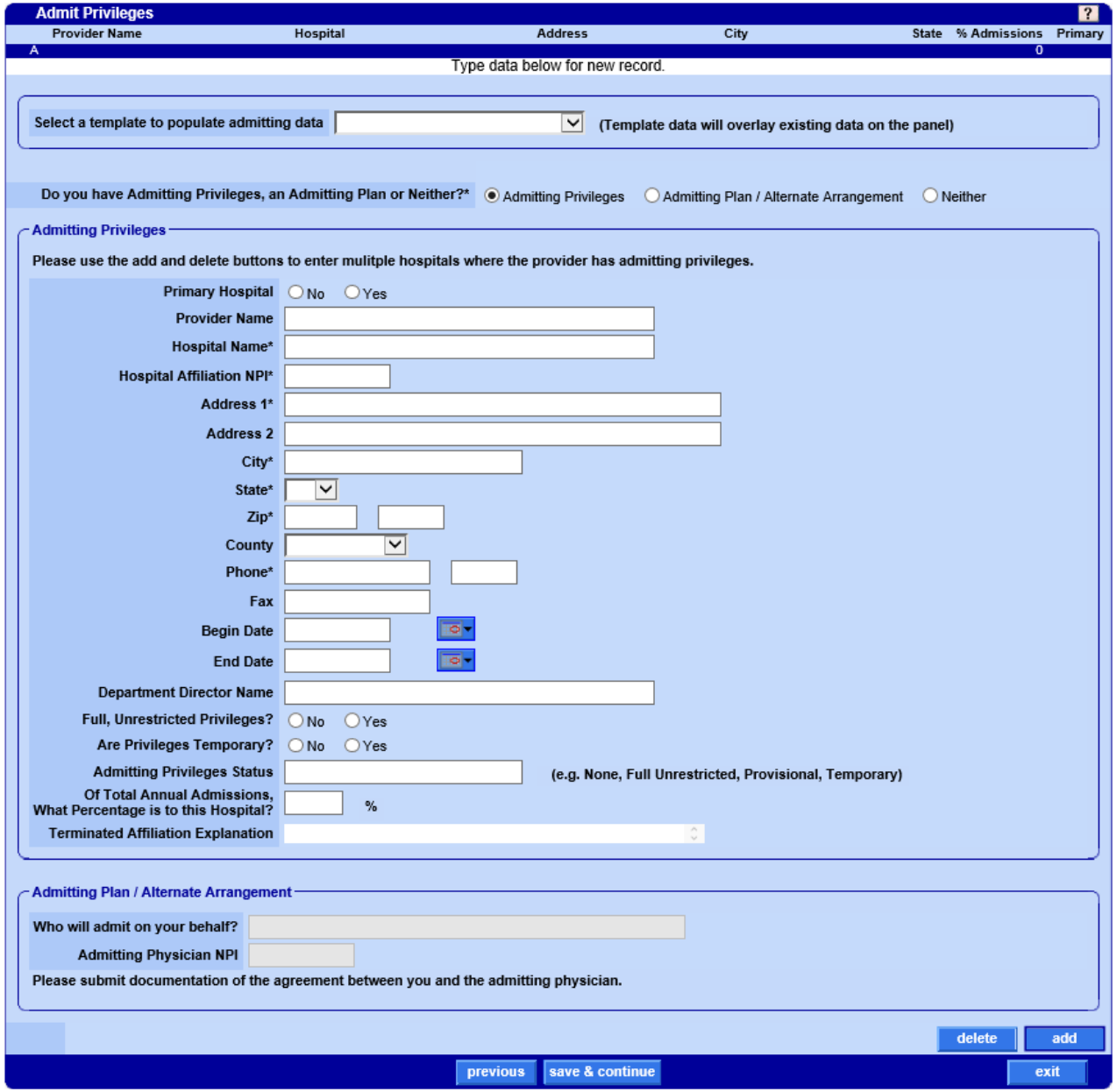
Complete the information requested in this panel as it applies to the applicant.



Hospital Admitting Privileges

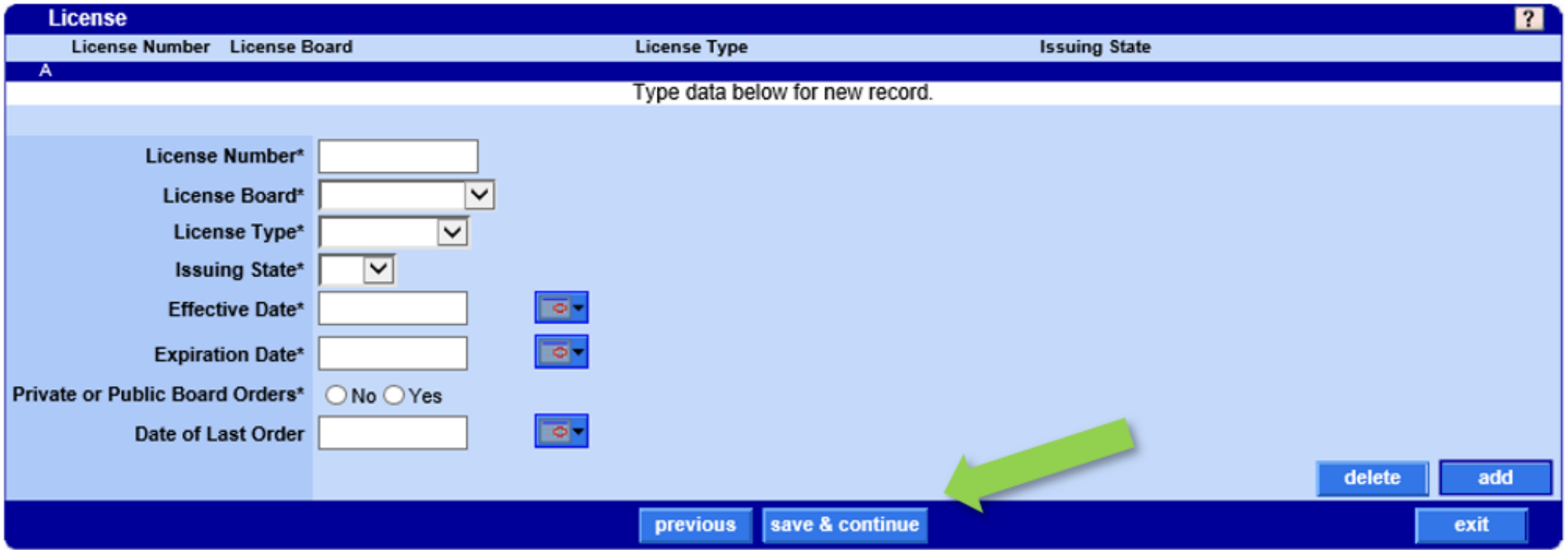
Input all information relating to the Hospital Admitting Privileges of the applicant.

Click “save & continue” to proceed.



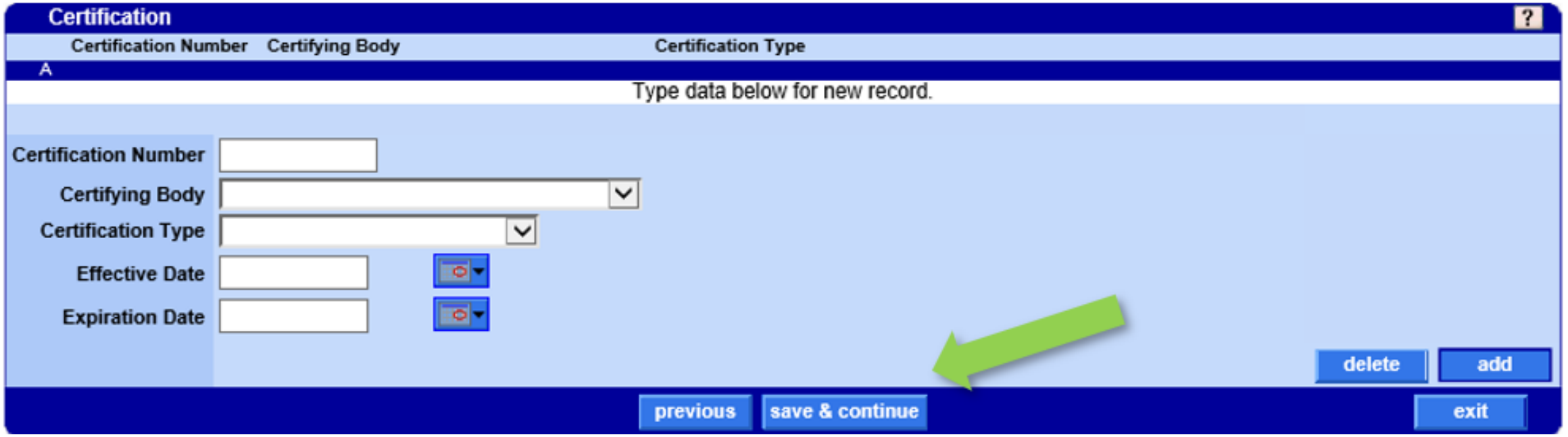
Licenses

Input all information relating to the Licenses of the applicant



Certifications

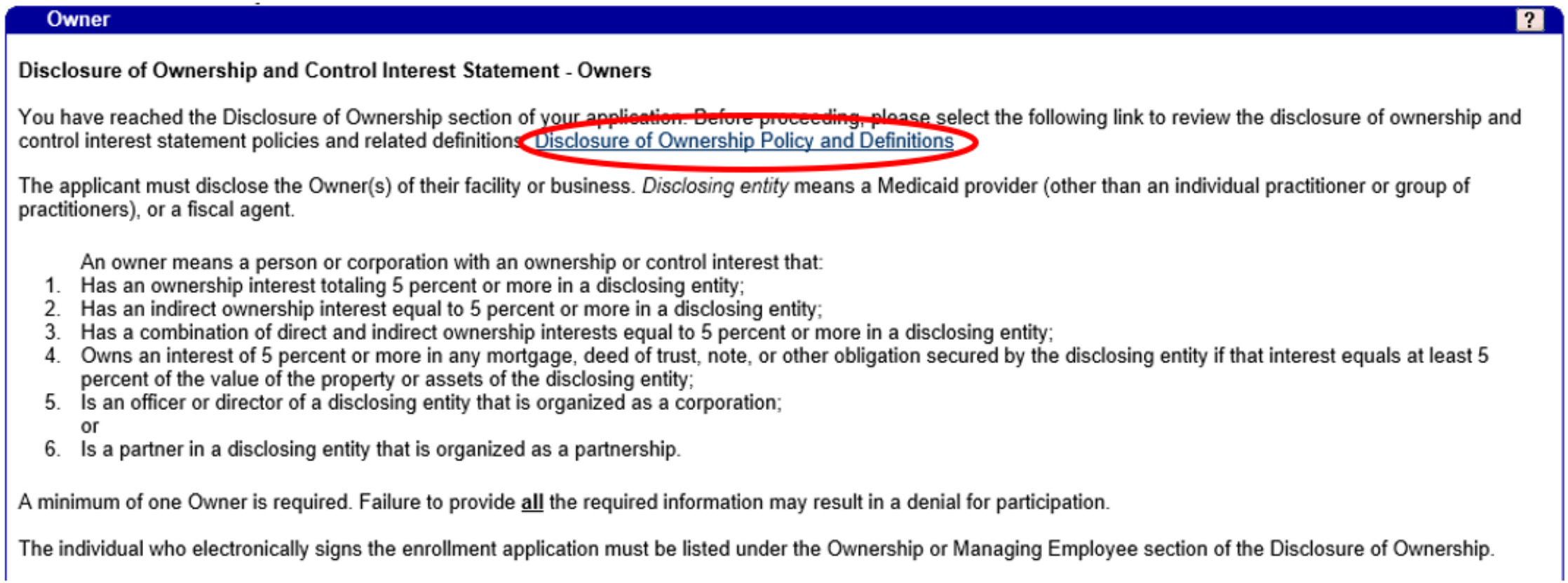
Input all information relating to the Certifications of the applicant.



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:

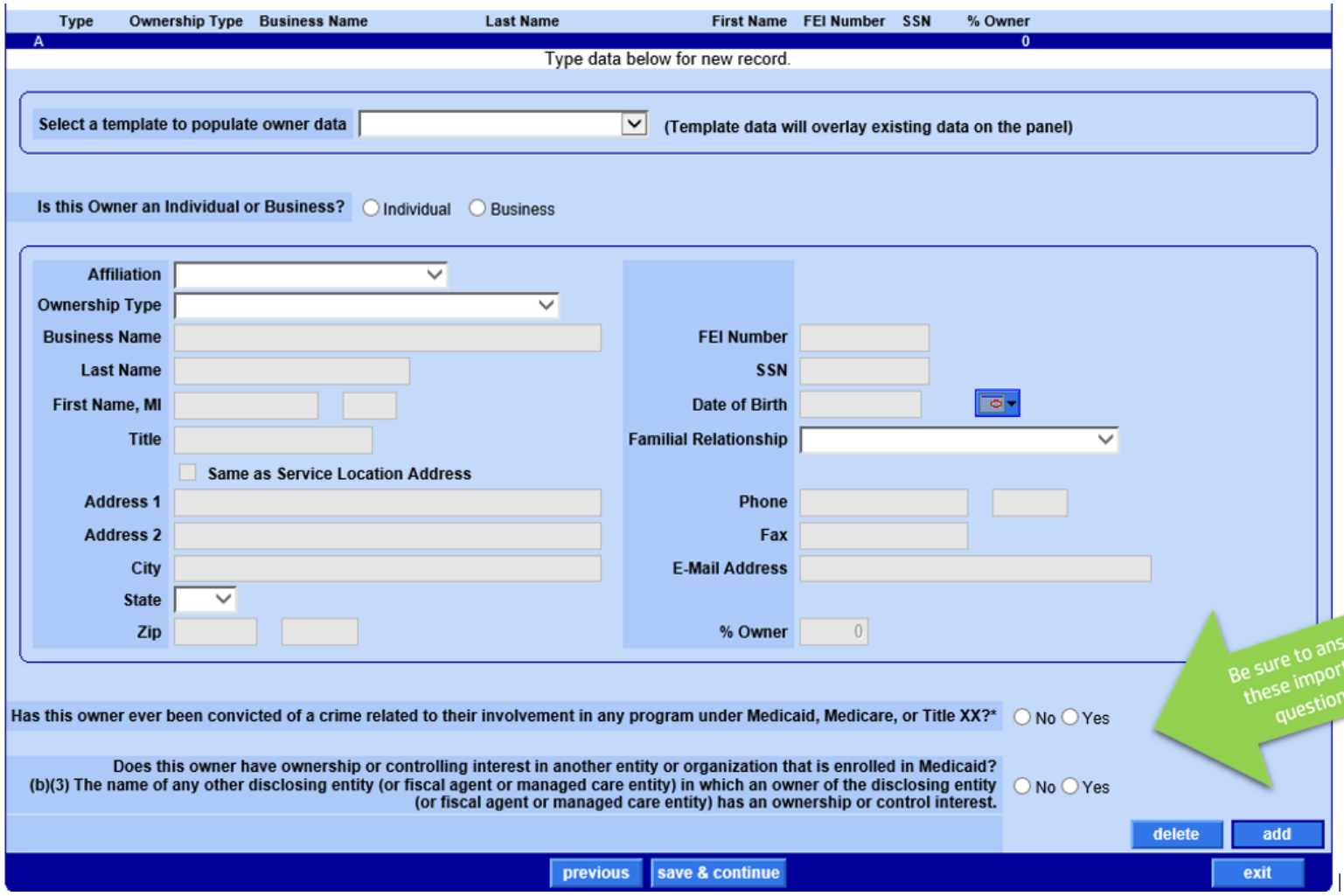
1. Has an ownership interest totaling 5 percent or more in a disclosing entity;
2. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
4. Owns an interest 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.

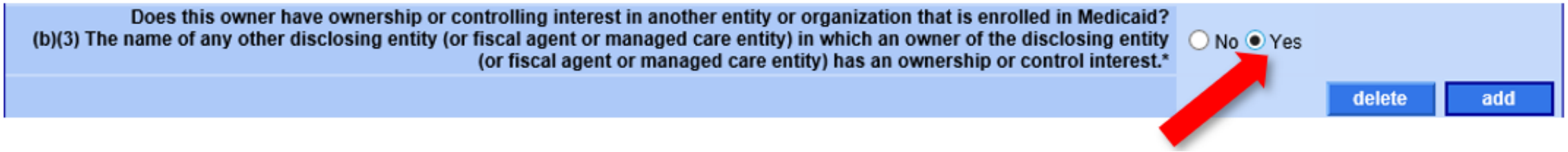
The individual who electronically signs the enrollment application must be listed under the Ownership or Managing Employee section of the Disclosure of Ownership.

Disclosure of Ownership

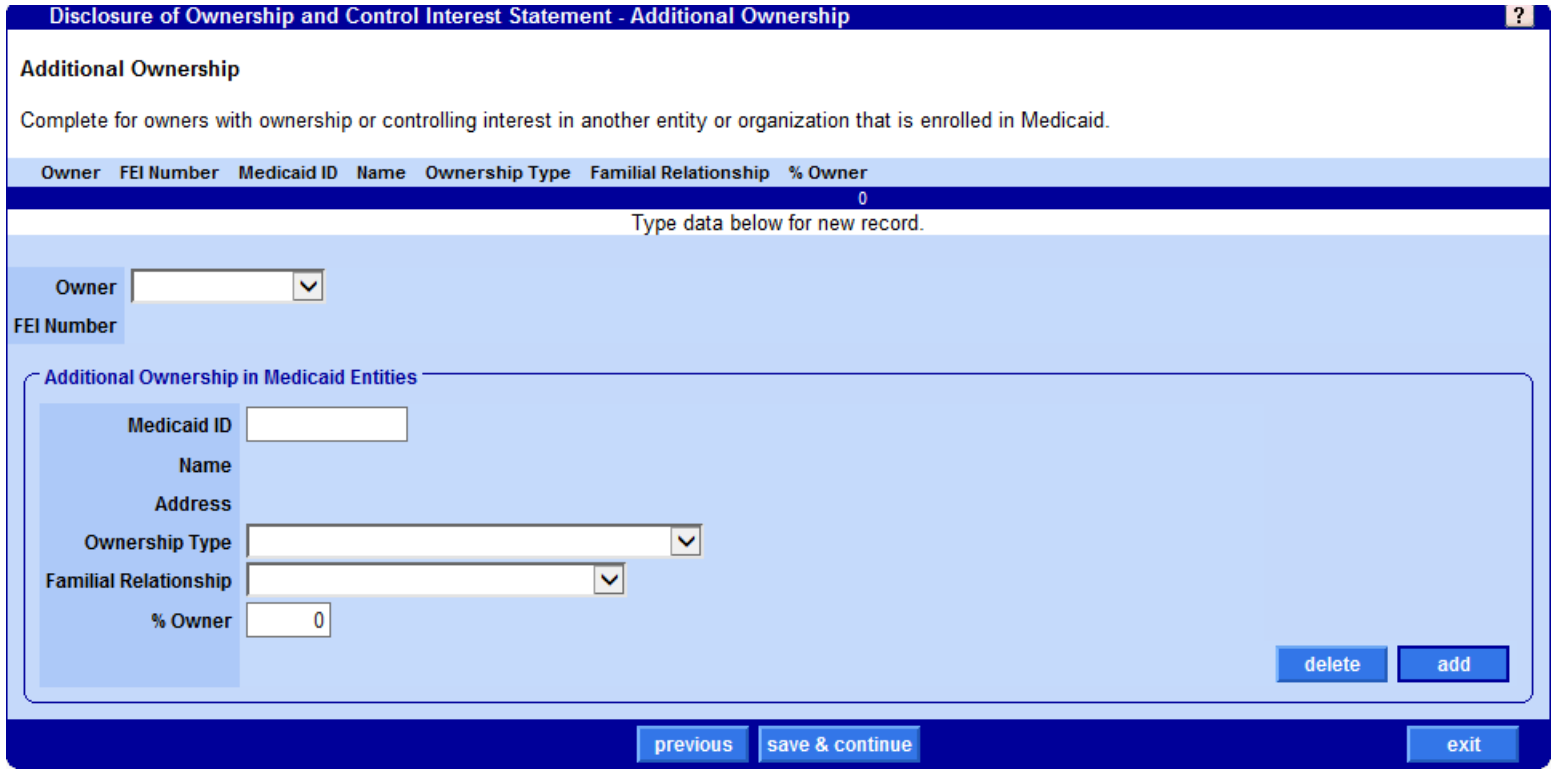
After reviewing the document, indicate if the Owner is a Business or Individual and complete the remaining fields as they relate to the owner(s) of the facility.



Disclosure of Ownership



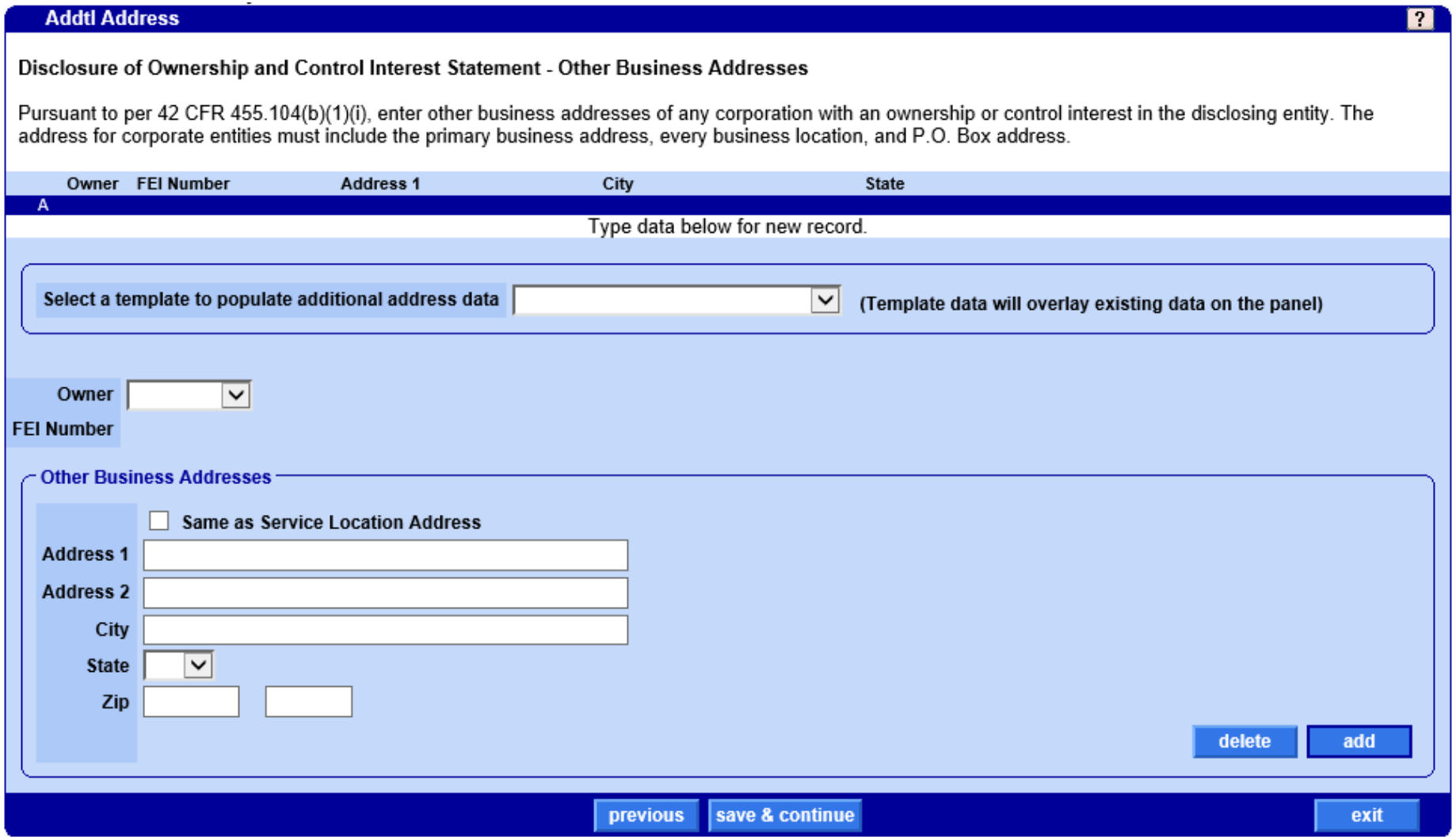
If you answered yes to this question, the following panel will display.



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

Disclosure of Ownership

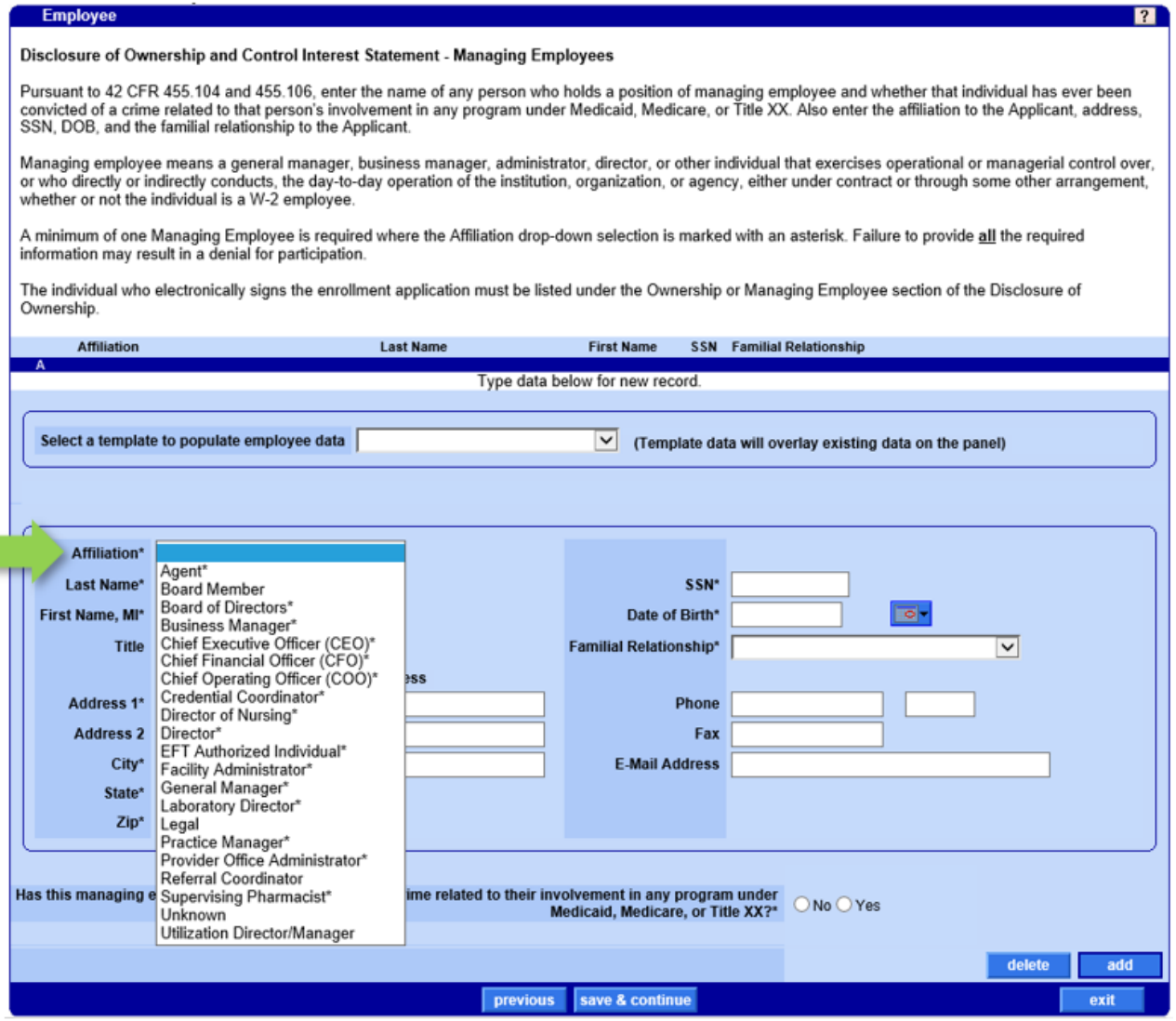
Complete the information requested in this panel as it applies to the business owner.



Disclosure of Ownership

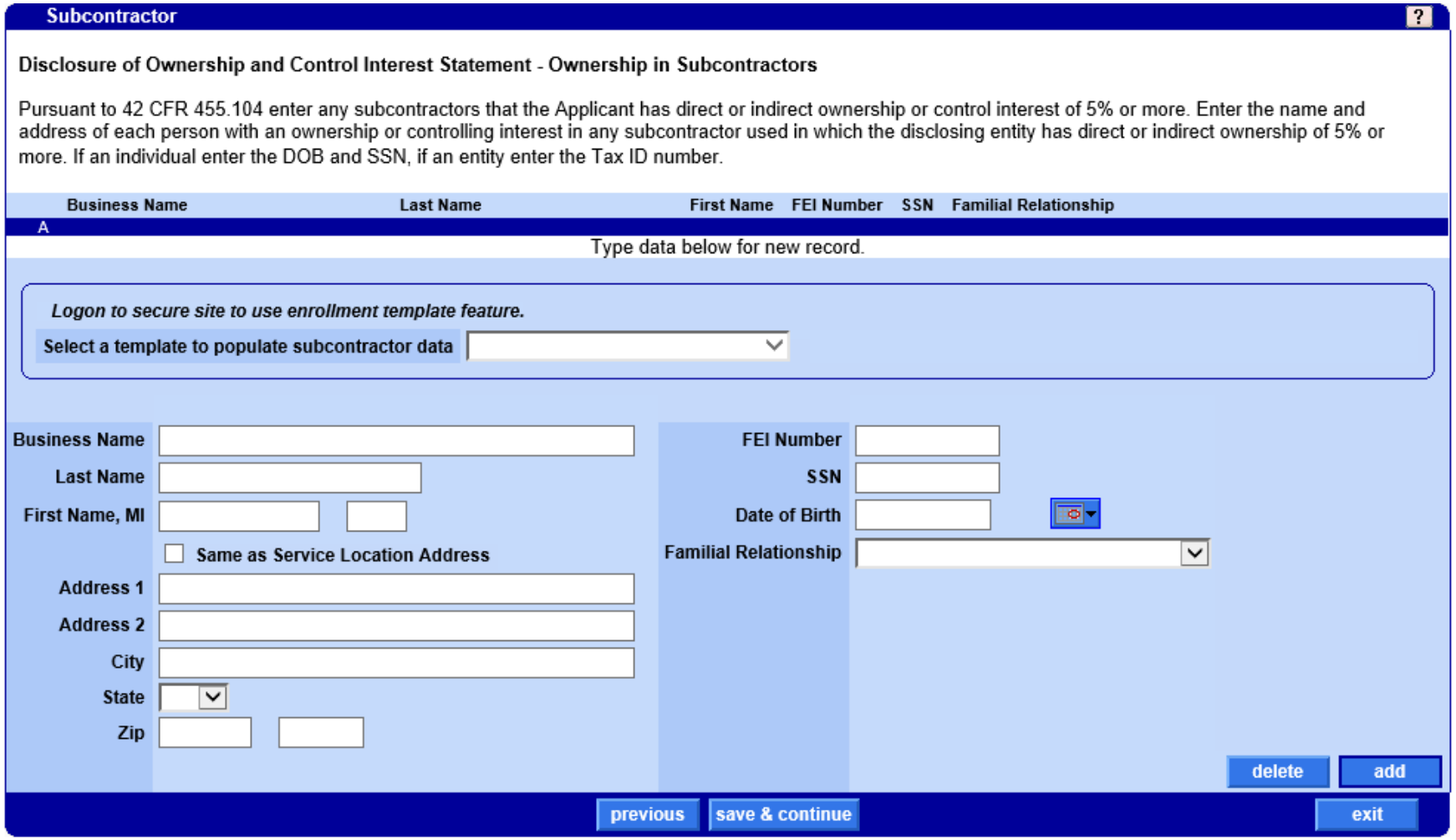
Complete the information requested in this panel as it applies to the facility.

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



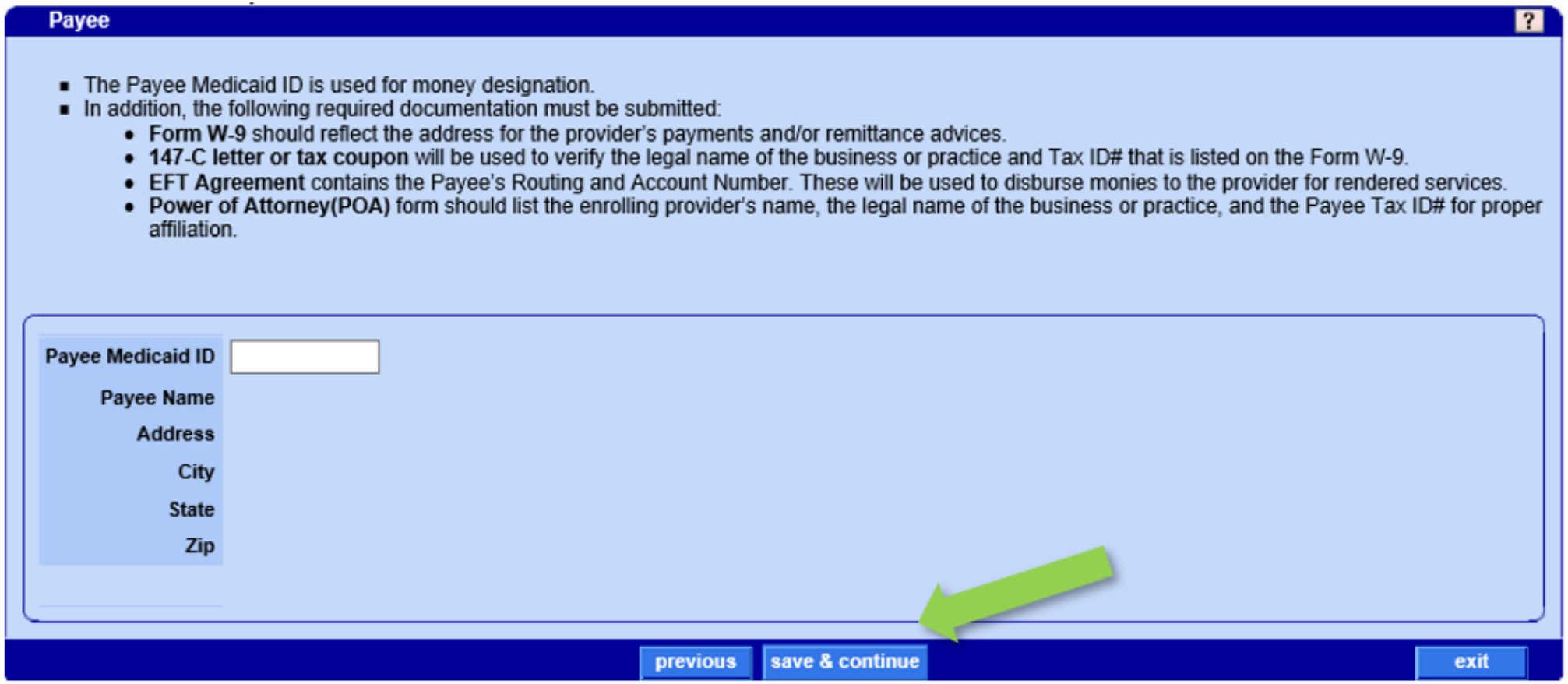
Disclosure of Ownership

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

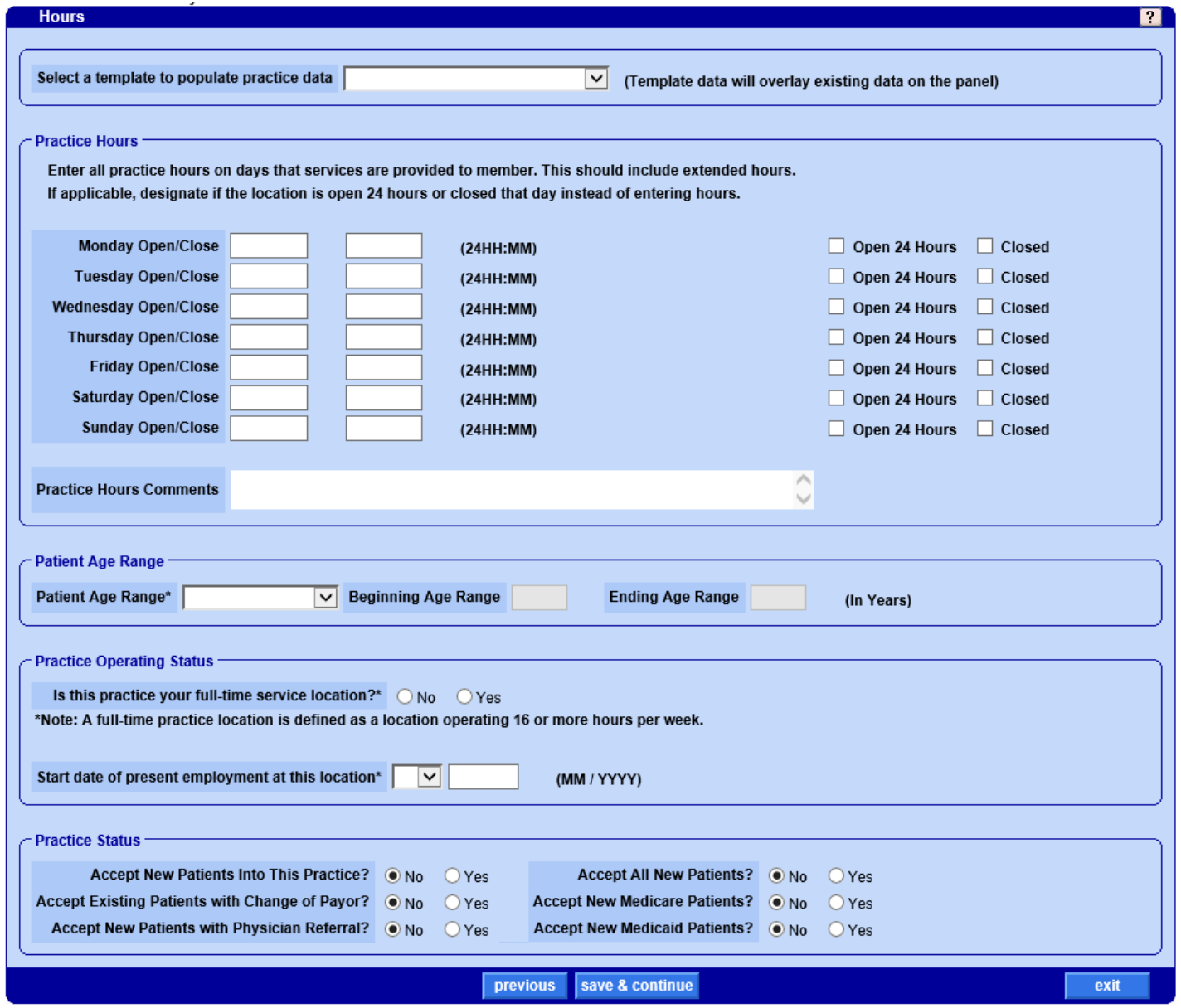


Payee Designation

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

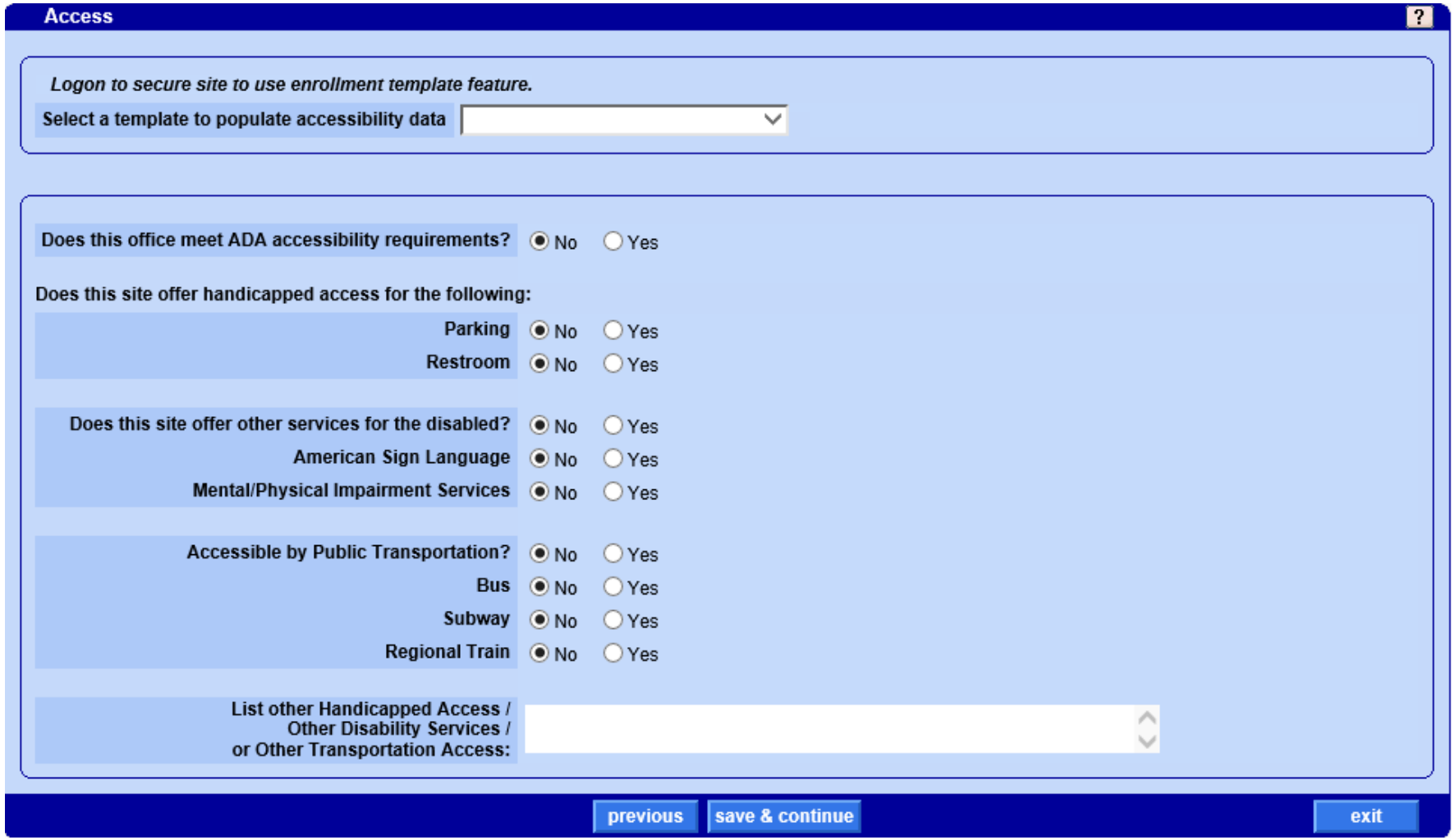


Hours



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

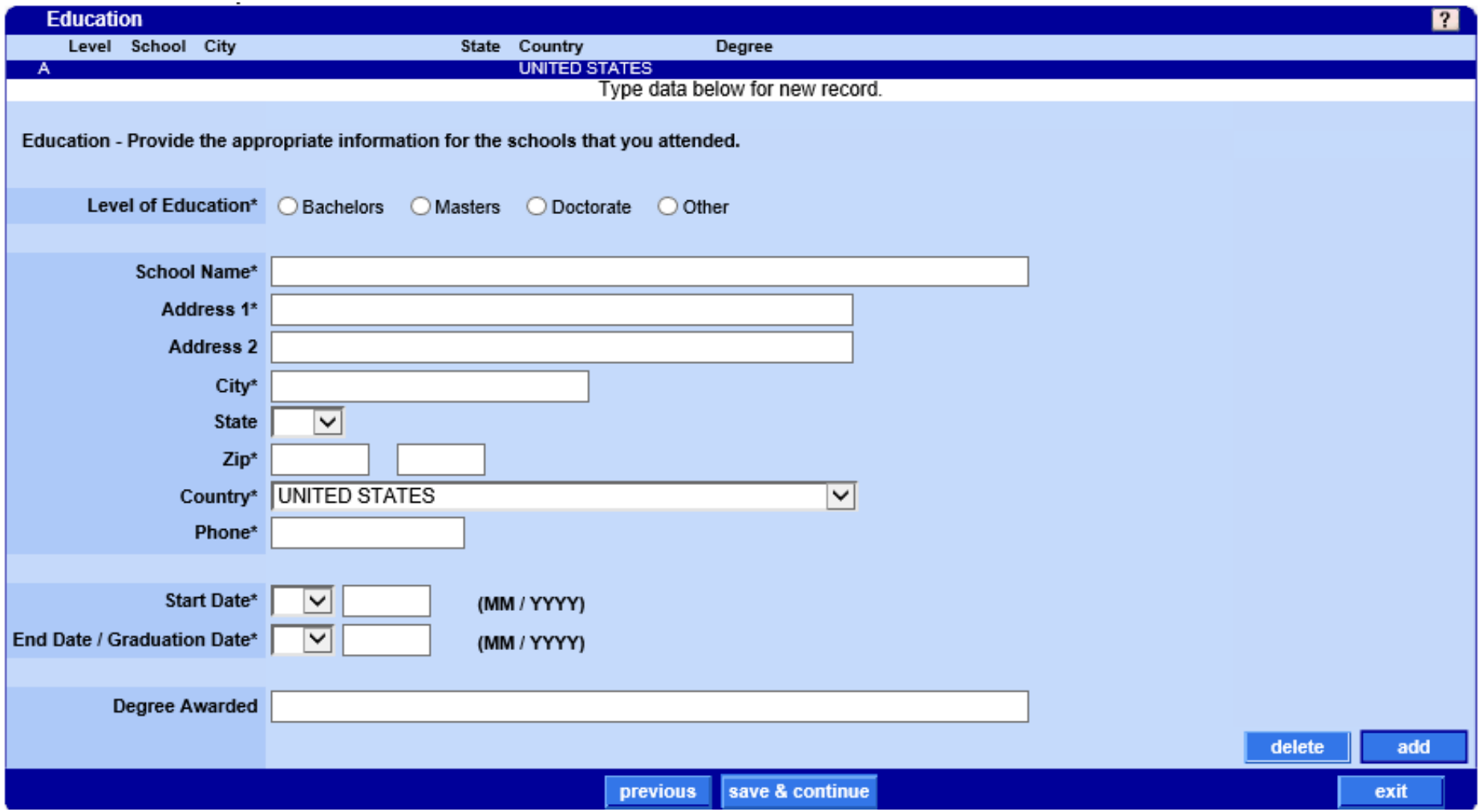
Access



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

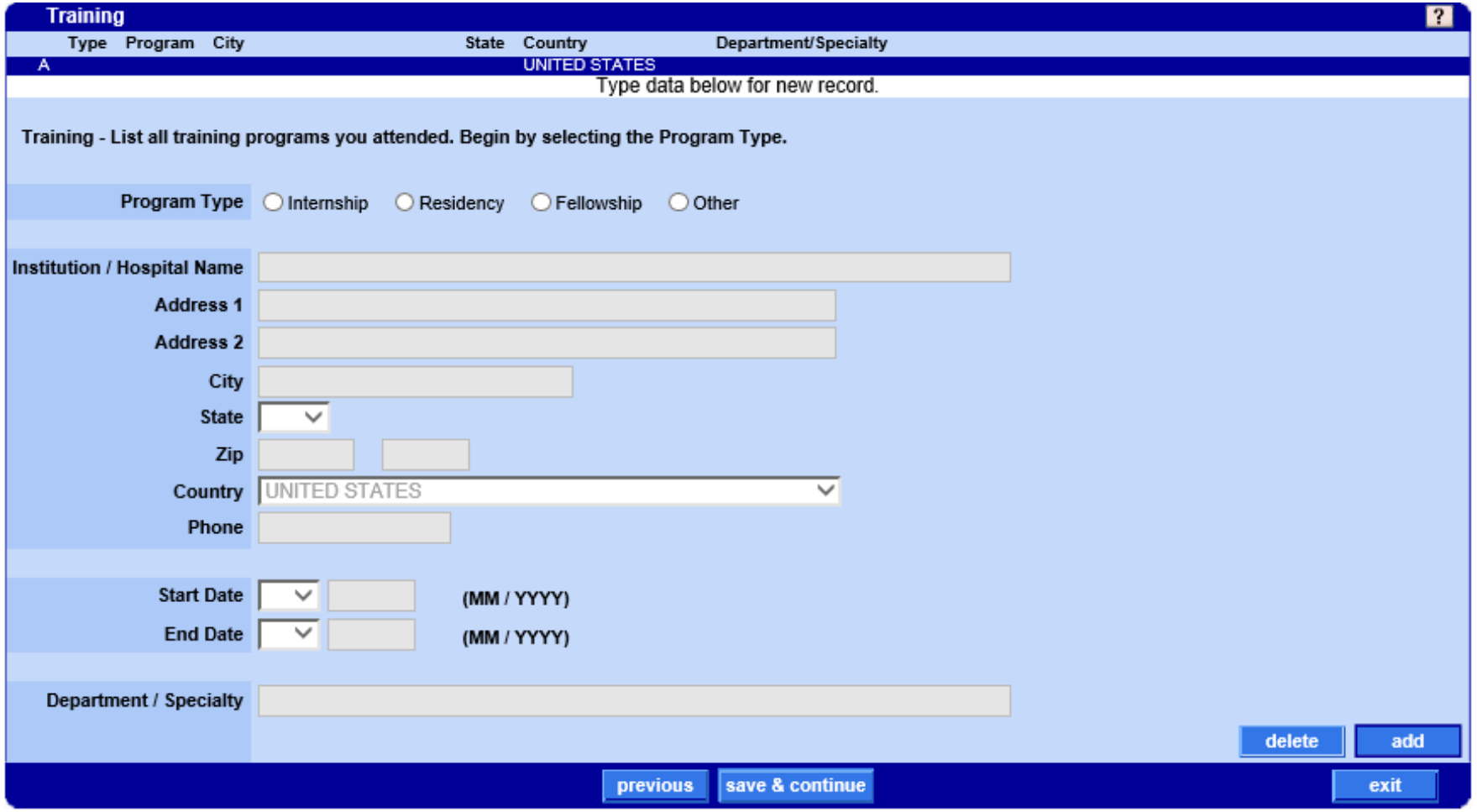
Education

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



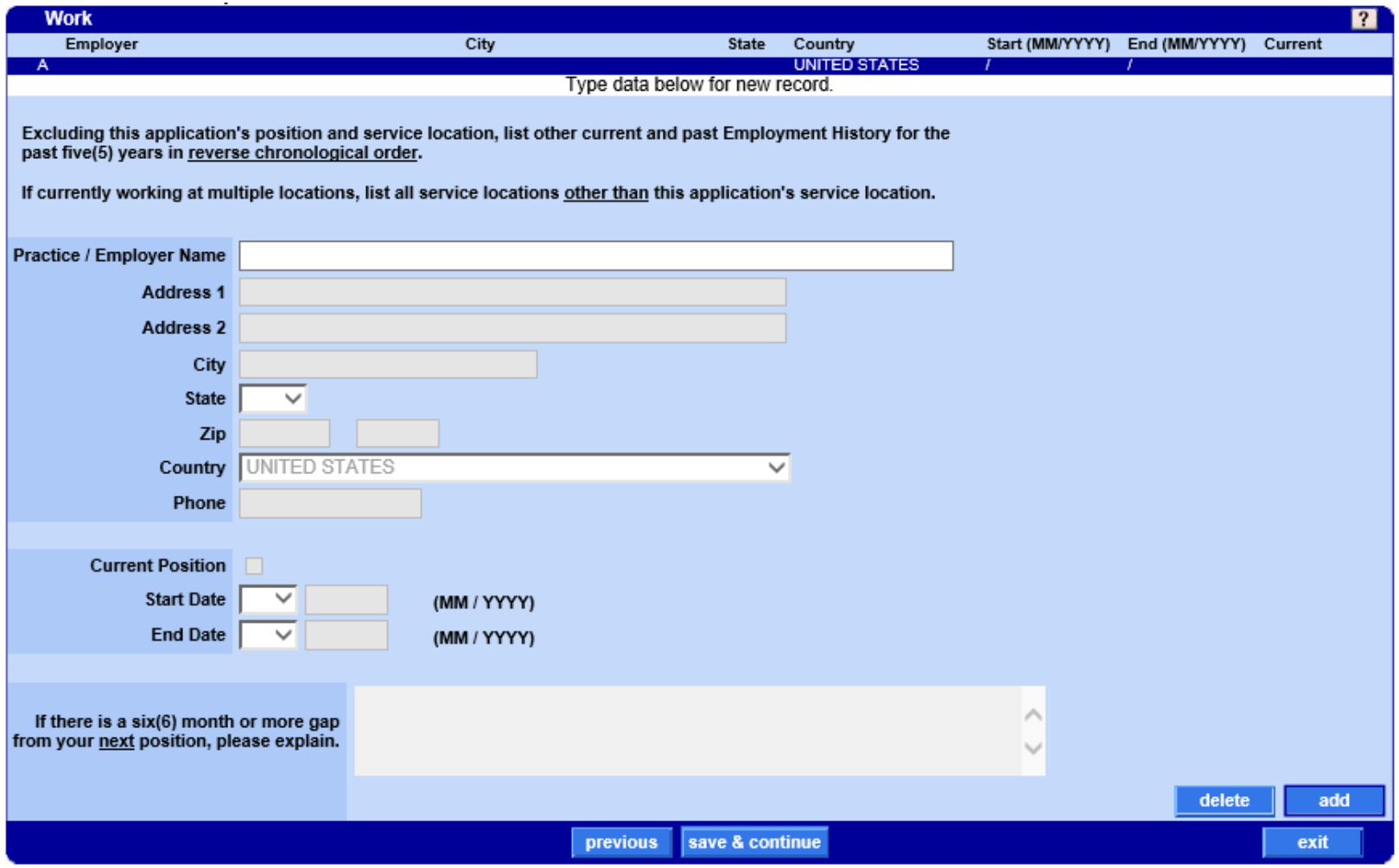
Training

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

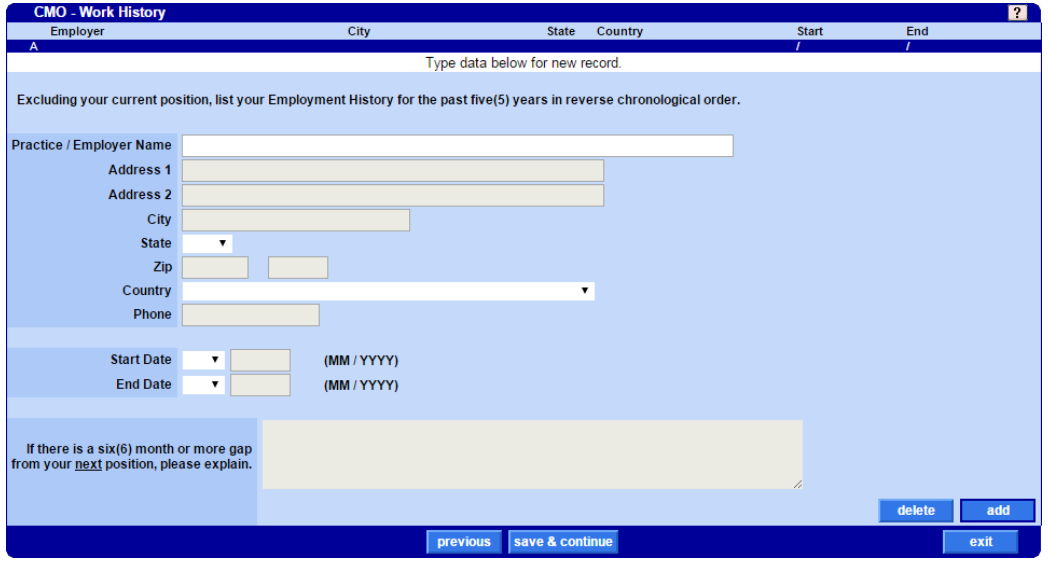


Work History

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

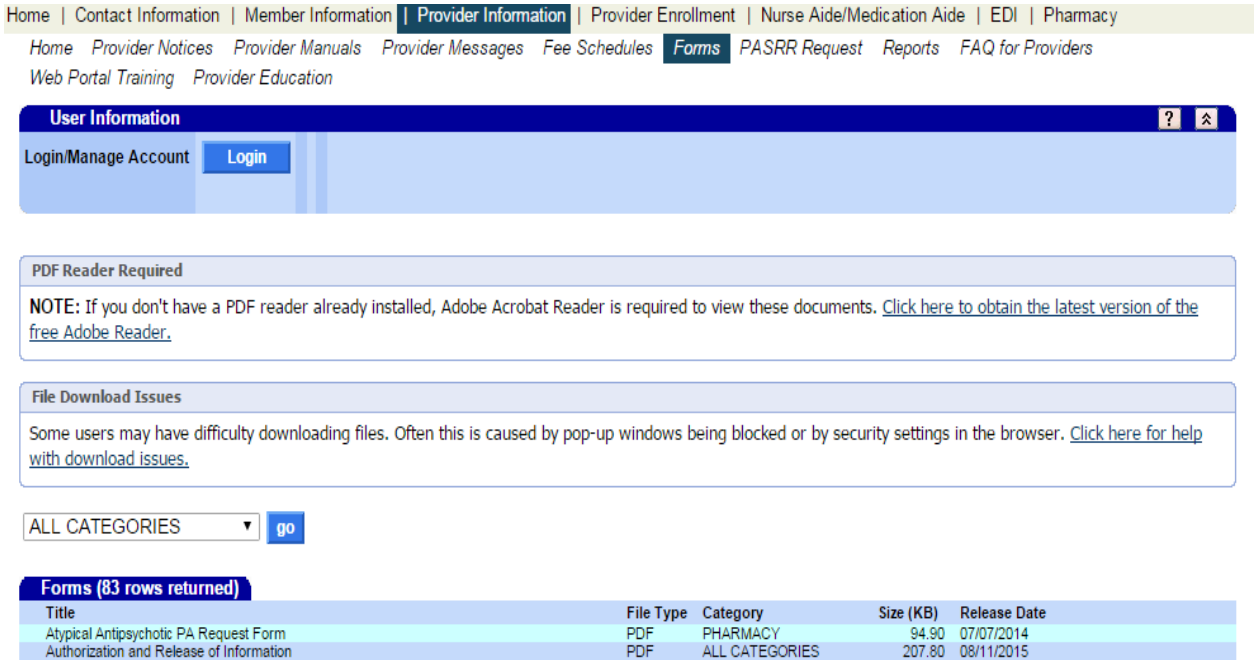


Work History



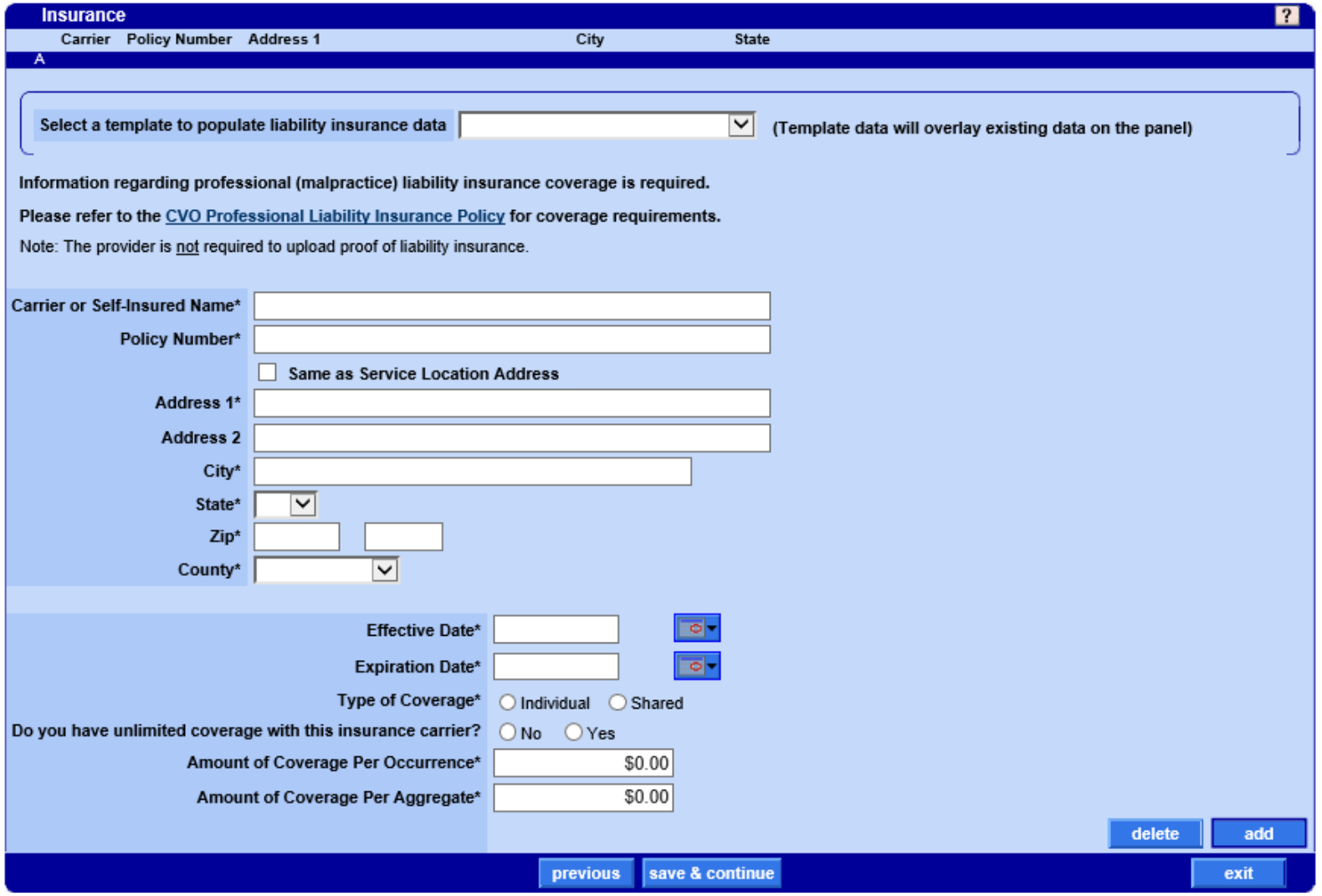
If there is a gap in the work history, the provider will be required to attach the “Work History Gap Form” before submitting the application.

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

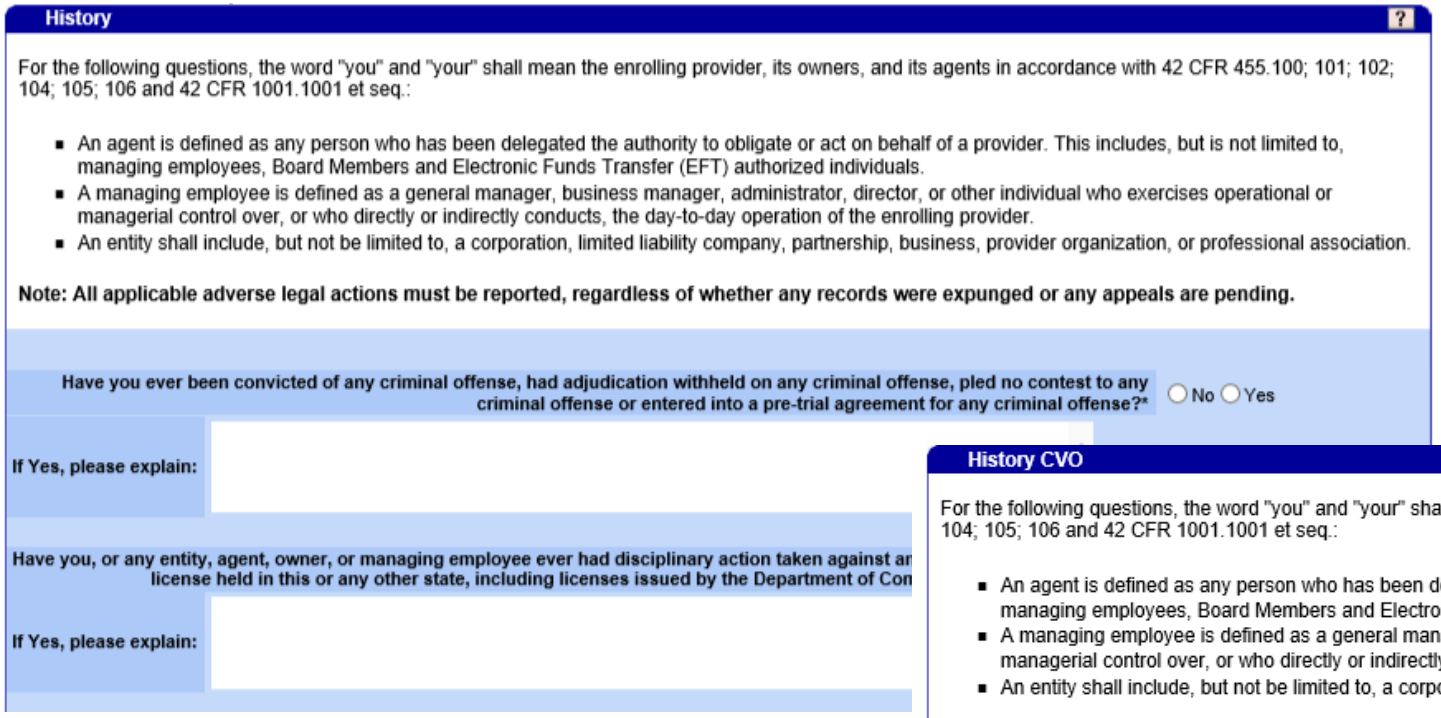


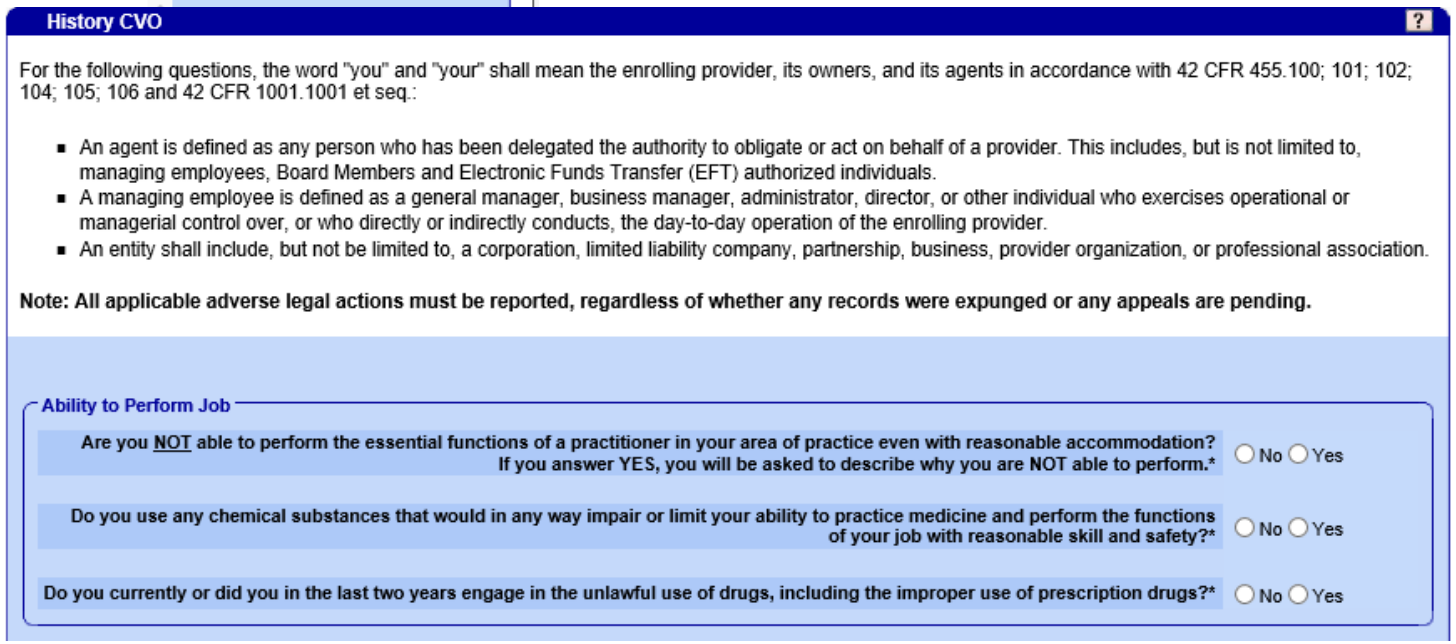
Insurance

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



Applicant History and History CVO panels

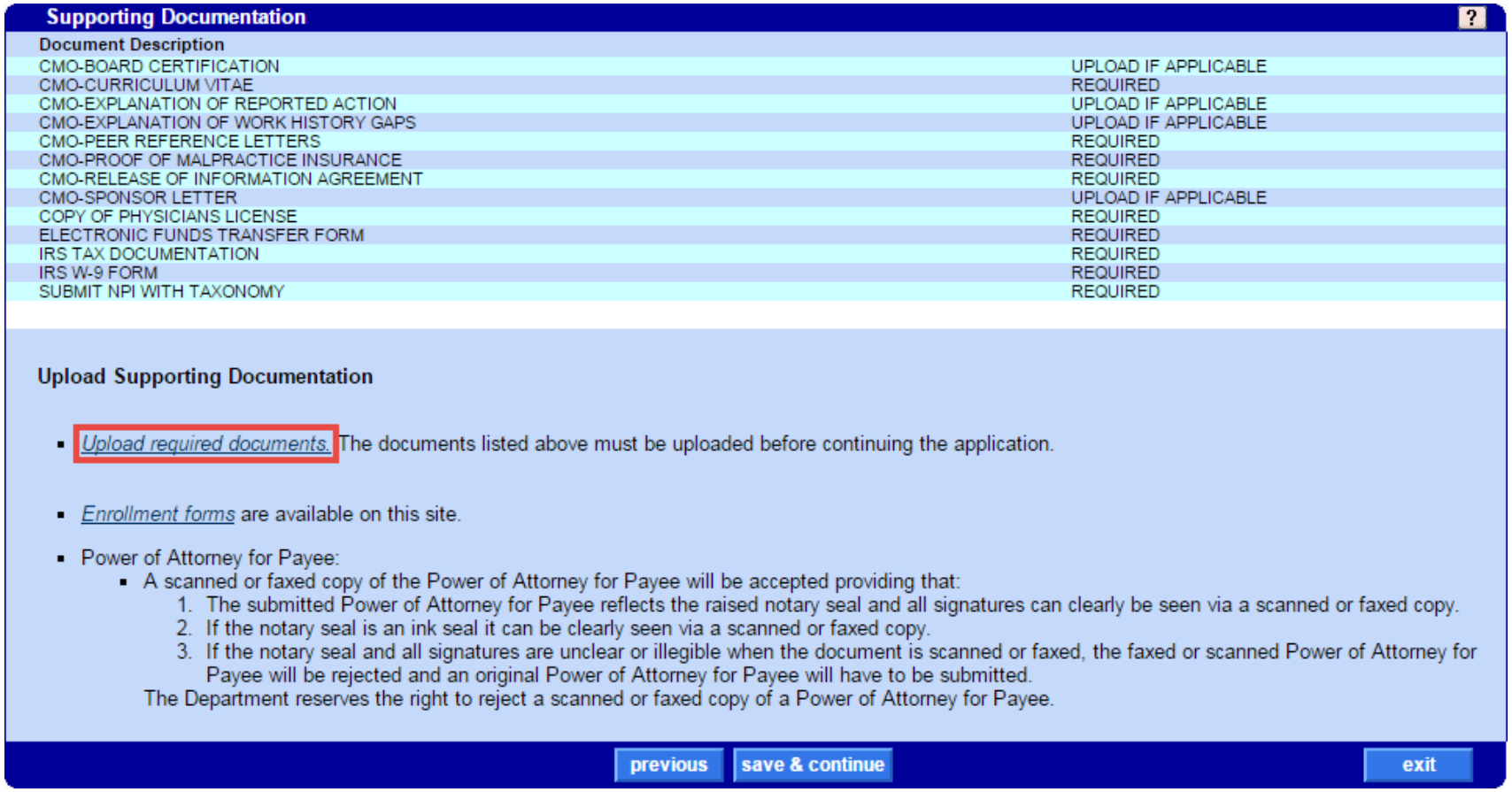




Complete the information requested in each panel as it applies to the applicant.

Supporting Documentation

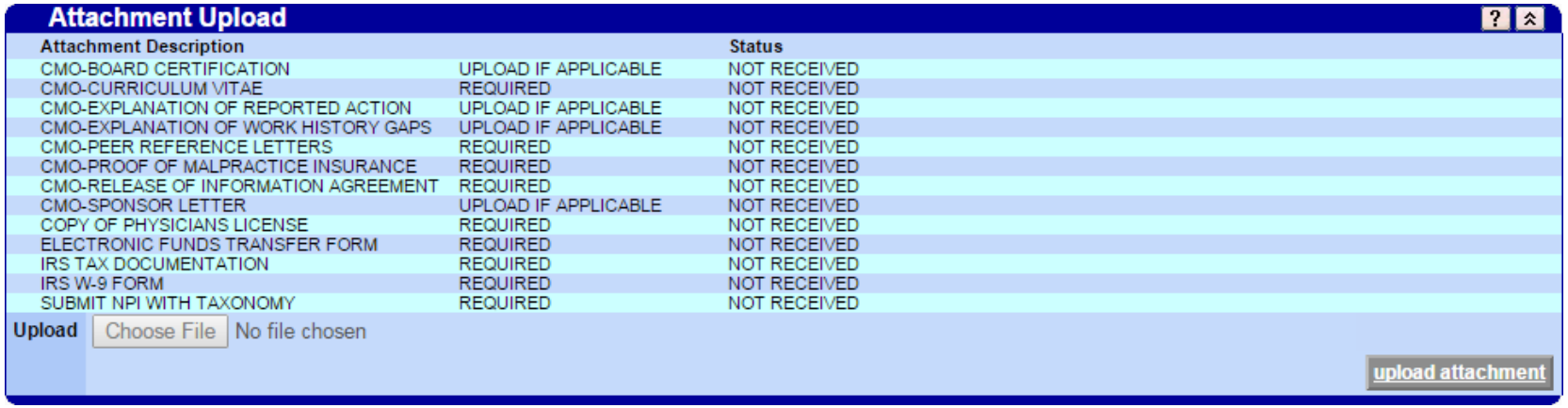
Click on “Upload required documents” to continue with the application process.
In order to submit the application, all required items must be attached.



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

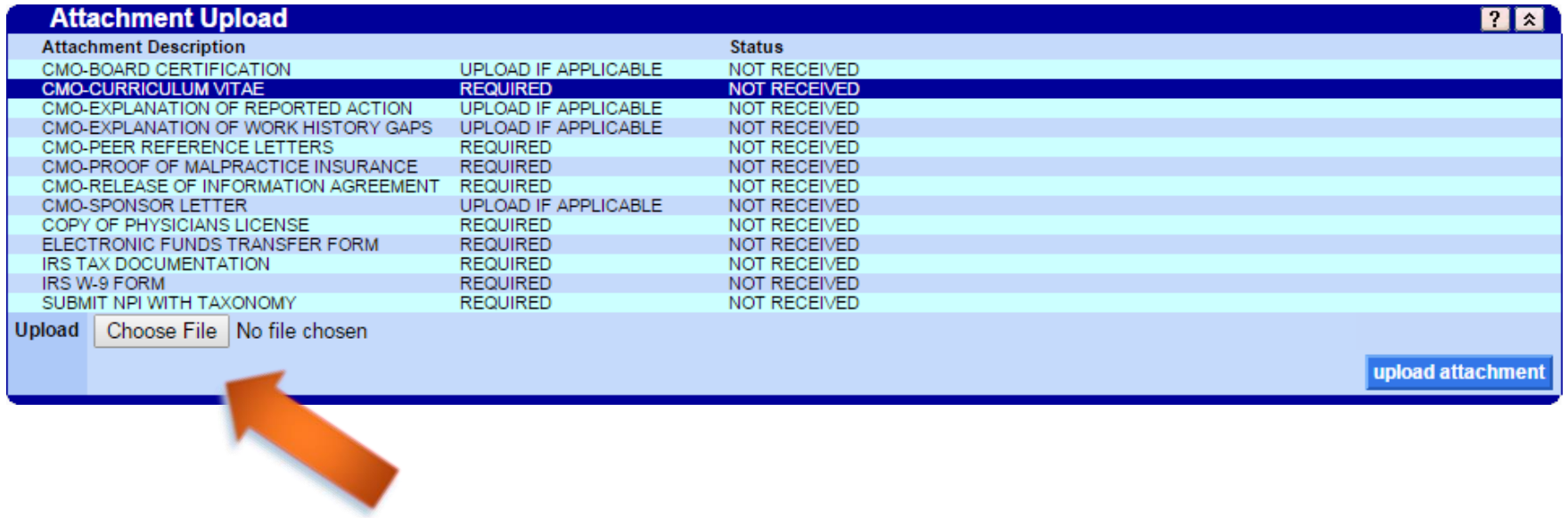
Attachment Description		Status
CMO-BOARD CERTIFICATION	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-CURRICULUM VITAE	REQUIRED	NOT RECEIVED
CMO-EXPLANATION OF REPORTED ACTION	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-EXPLANATION OF WORK HISTORY GAPS	UPLOAD IF APPLICABLE	NOT RECEIVED
CMO-PEER REFERENCE LETTERS	REQUIRED	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

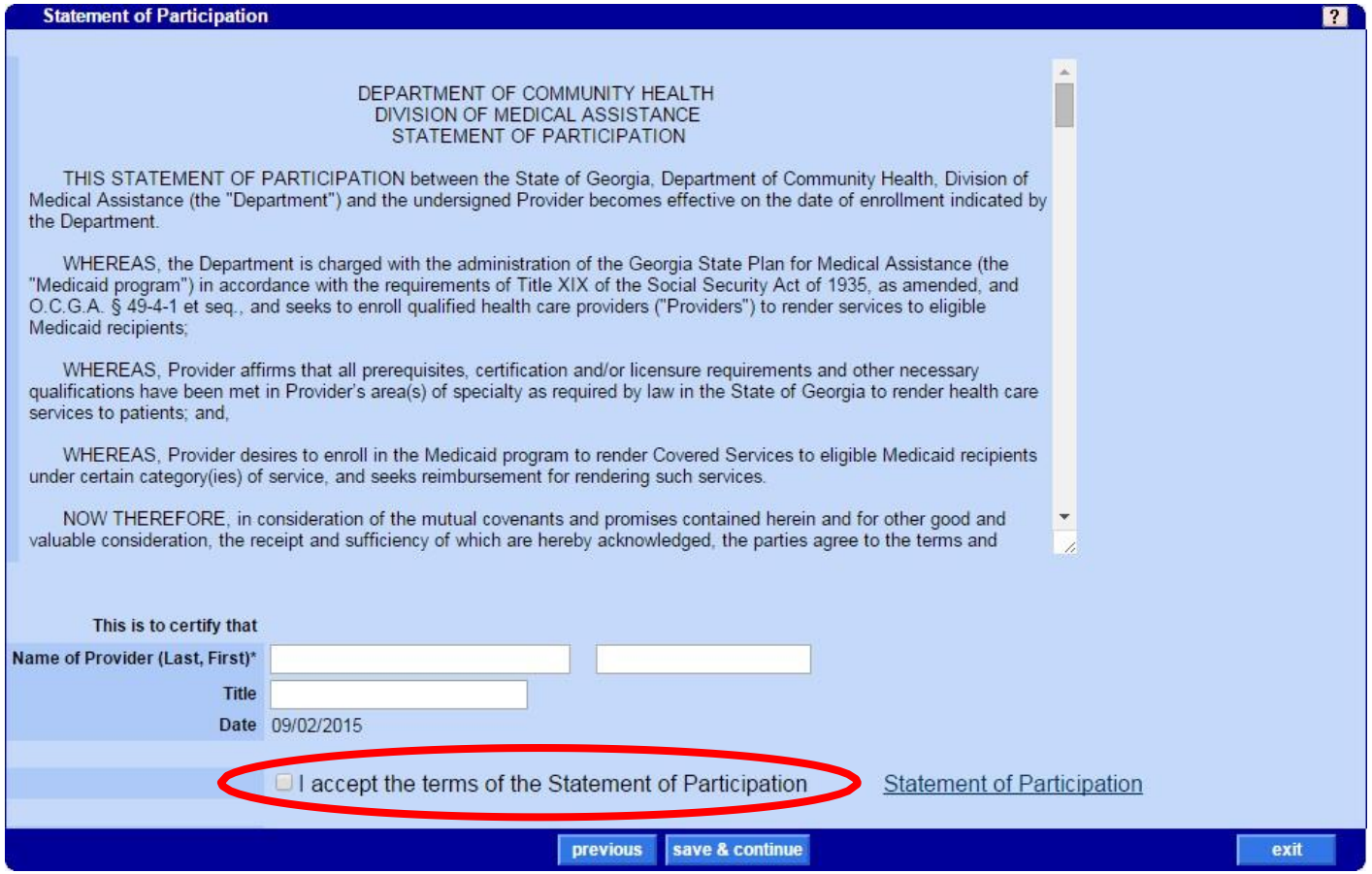
Attachment Upload
(continued)

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.



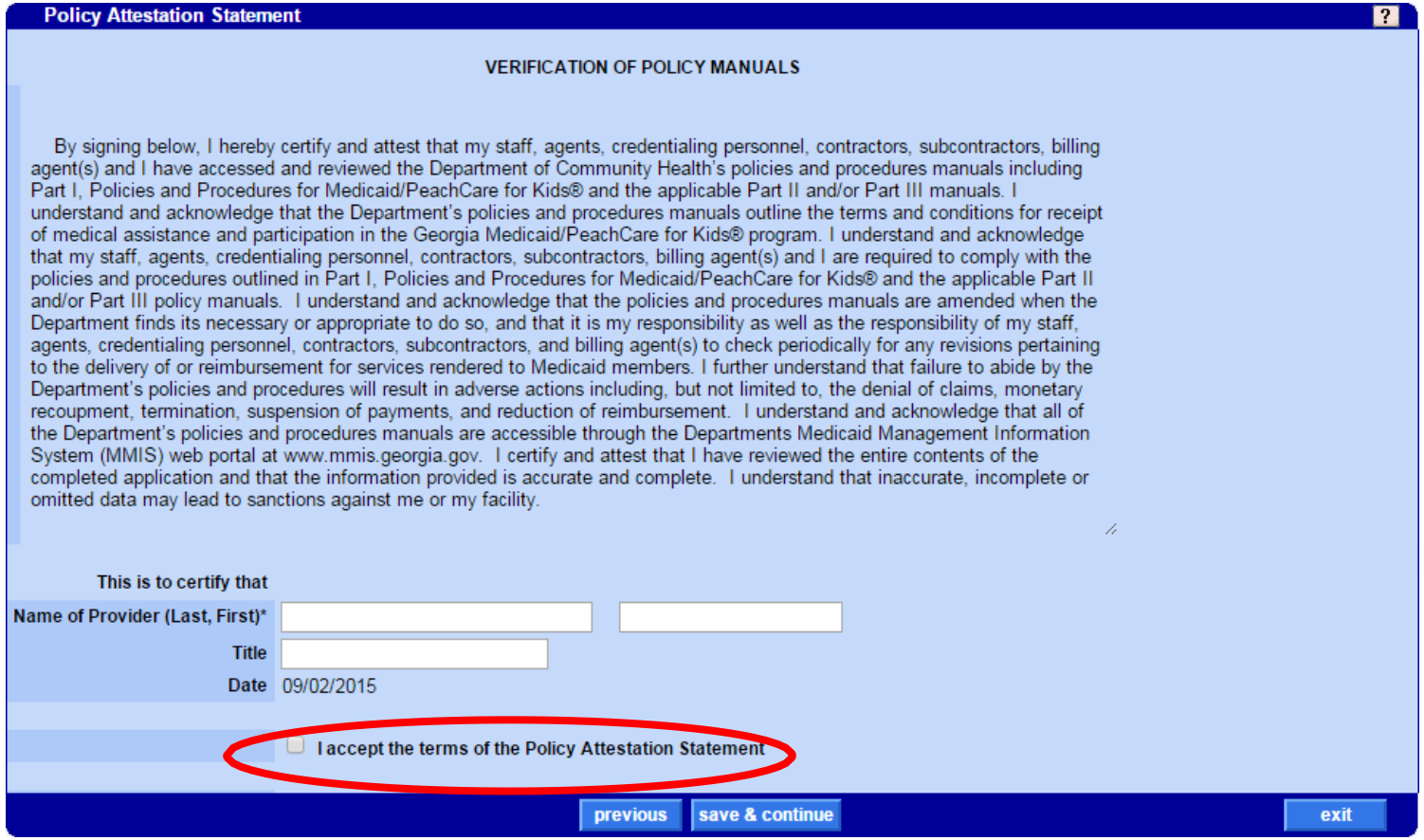
Statement of Participation

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.



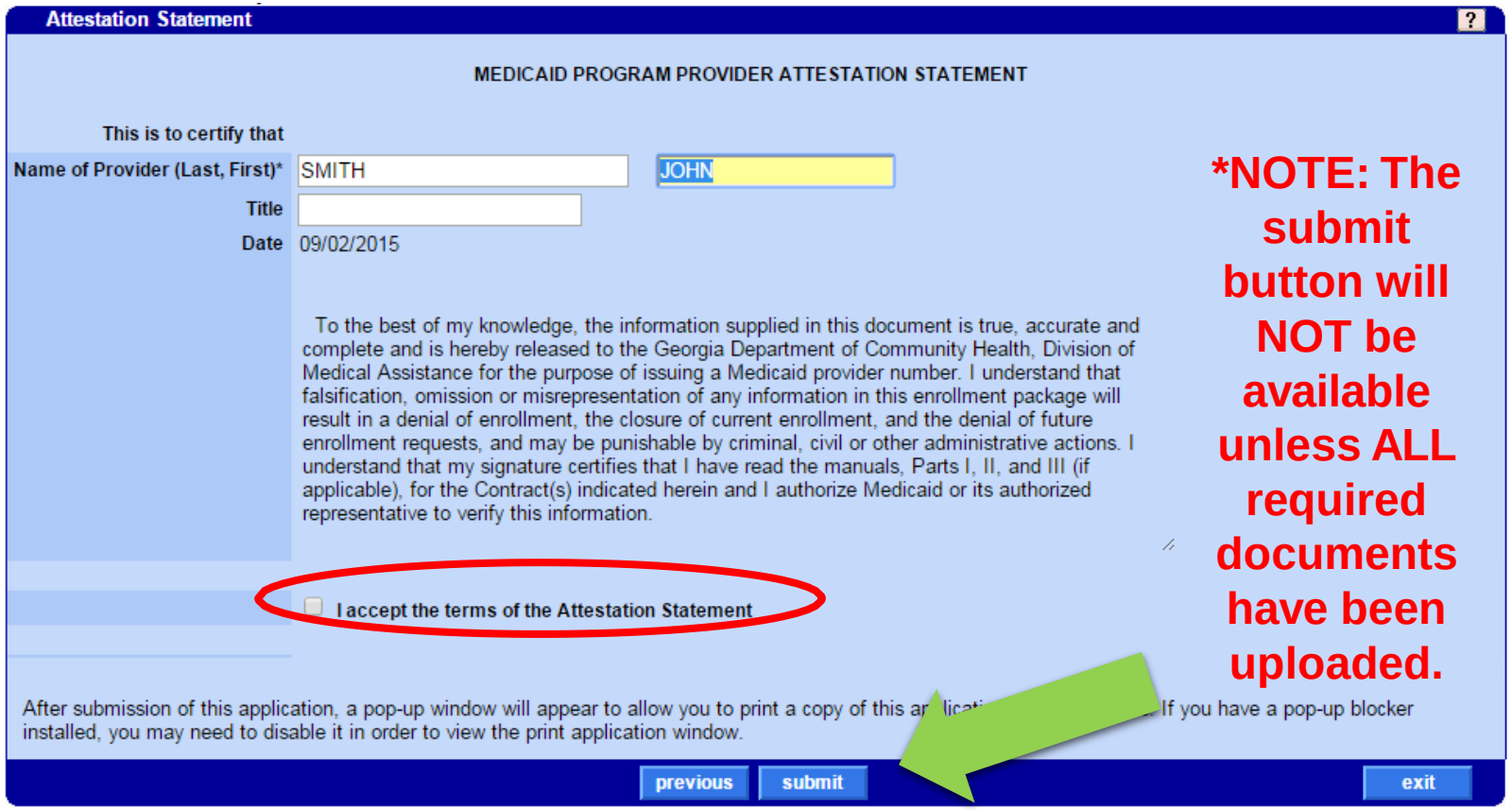
Policy Attestation Statement

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.



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.

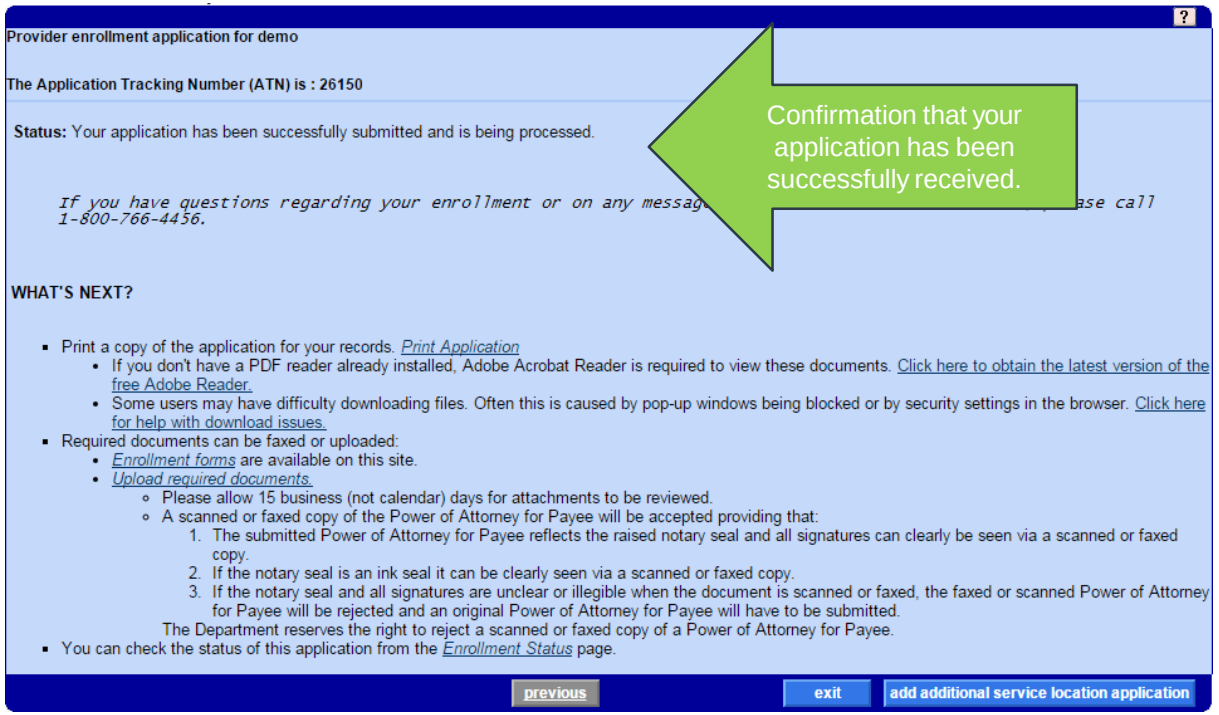


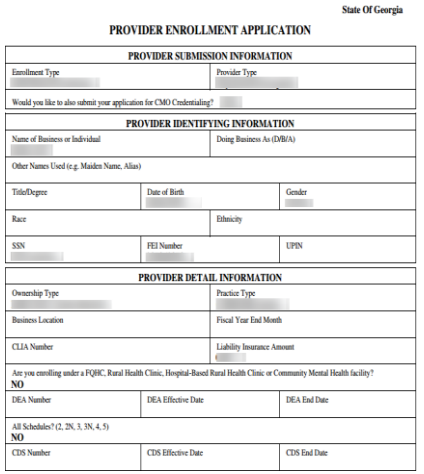
***NOTE: The submit button will NOT be available unless ALL required documents have been uploaded.**

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:





State Of Georgia

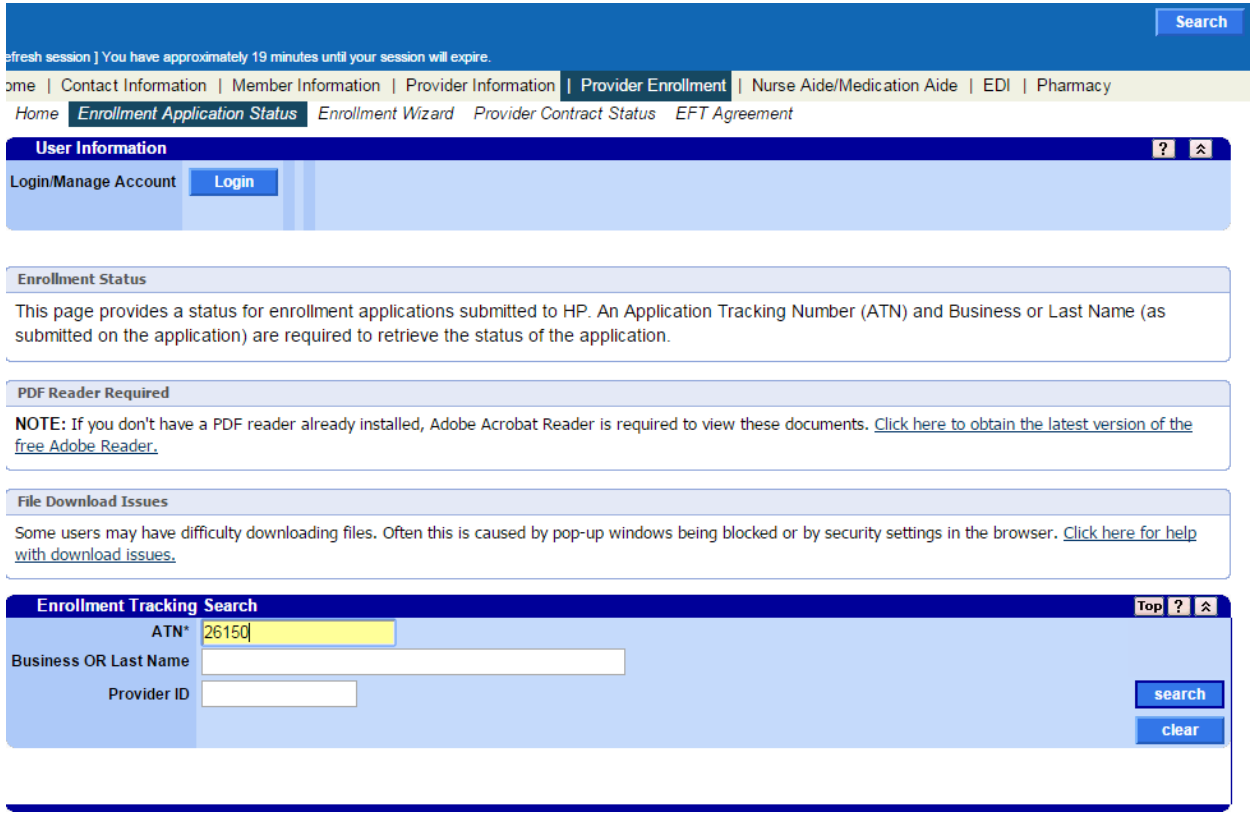
PROVIDER ENROLLMENT APPLICATION

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, 2N, 3, 3N, 4, 5) NO		
CDS Number	CDS Effective Date	CDS End Date

Application Tracking and Documentation



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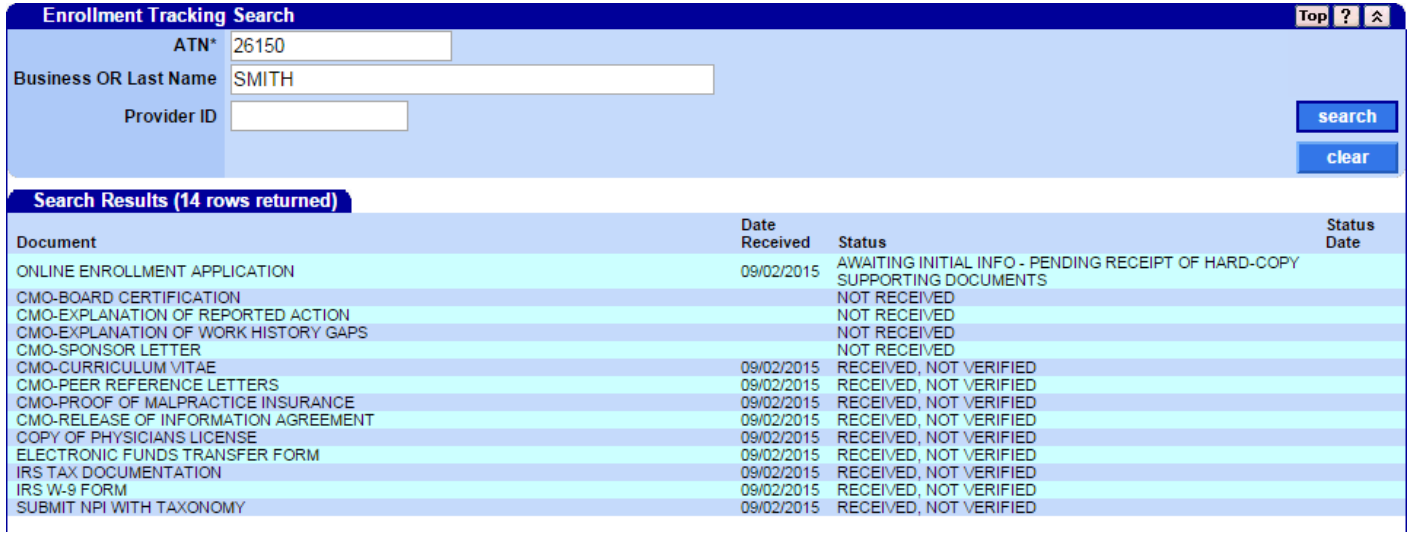
Application Tracking and Documentation



Enrollment Tracking Search Top ? ⌃⌃

ATN* 26150

Business OR Last Name SMITH

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
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