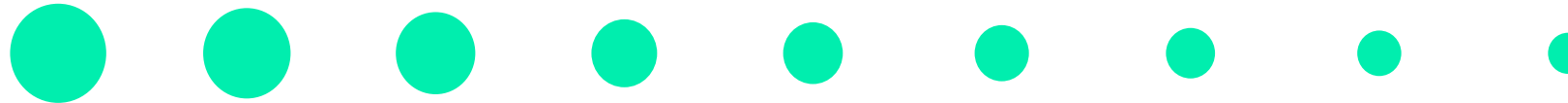


PSYCHOLOGICAL AND THERAPY SERVICES

For access to this presentation, please visit: www.mmis.georgia.gov -> Provider Information -> Provider Notices –“PSYCHOLOGICAL AND THERAPY SERVICES ENROLLMENT”



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

gainwell

Agenda

- Overview
- Provider Communication
- Application Submissions
- Documentation Requirements
- Application Common Denials

Overview of Georgia Medicaid

The Georgia Department of Community Health (DCH):

Is designated by the Official Code of Georgia (OCGA) as the single state agency to administer Medicaid.

Mission:

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing and oversight.

Overview

(continued)

Effective January 1, 2022, the Department of Community Health, Medicaid Division, will now allow providers who are licensed as a **Marriage and Family Therapist (LMFT)**, **Licensed Clinical Social Worker (LCSW)** or **Licensed Professional Counselor (LPC)** to be enrolled in the Psychological and Therapy services program to render services to individuals under age 21.

This new enrollment will offer a second account to include a new Fee for Service contract that would be effective January 1, 2022. Those providers must complete the application using the ATN number provided in the DCH mailer.

Department of Community Health, Medicaid Division, has created enrollment applications for Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselors (LPC) who are currently enrolled under category of service 998 (CMO Only).

Providers must upload required document to the application tacking numbers provided by March 31, 2022, or subject to a new application being required.

Helpful Information

****Letters were mailed December 28th, 2021 Sample attached****

- The DCH has allowed CMO providers who have received a letter to submit necessary documents by March 31, 2022. After March 31, a new application must be submitted.
- New providers that would like to enroll under these services will need to create a new application.



Brian P. Kemp, Governor

Caylee Noggle, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | www.dch.georgia.gov

December 21, 2021

PRV-9570-R/XX/0024456952

Name and address Info

RE: Application Tracking Number 123456

Dear Providers:

Effective January 1, 2022, the Department of Community Health, Medicaid Division, will now allow providers who are licensed as a Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC) to be enrolled in the Psychological and Therapy services program to render services to individuals under age 21.

To reduce the administrative burden for the provider community, the Department of Community Health, Medicaid Division, has created enrollment applications for Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselors (LPC) who are currently enrolled under category of service 998 (CMO Only). This newly created application will allow you to enroll in the Psychological and Therapy services program should you choose to do so. The ATN above is the newly created application tracking number. To complete the enrollment process, you must upload the following documents:

- Electronic Funds Transfer form
- Power of Attorney for Payee
- IRS W-9 Form
- IRS Tax Documentation
- Copy of License

This information is required in order to reimburse you for services rendered to Fee-for-Service members. If you do not upload the required payment information, we cannot pay you for services rendered to Fee-for-Service members. **You will have until March 31, 2022 to upload the required payment information. Thereafter, the application will be closed.** If you decide later that you want to participate in the Psychological and Therapy services program, you may initiate a new application.

Please visit the GAMMIS Web Portal at www.mmis.georgia.gov and go to the Provider Enrollment / Enrollment Application Status page. Key in the above ATN and last name of the provider. Scroll down to the bottom of the page and click on the "upload additional supporting documentation" link. From here upload the completed and required documents identified above. Your prompt response will allow us to finalize your application.

If you have any questions regarding the status of your application, please access the GAMMIS Web Portal at www.mmis.georgia.gov and submit a Contact Us inquiry under the Contact Information panel. Or you may contact the Provider Enrollment Unit at 1-800-766-4456.

Thank you for your continued participation in the GA Medicaid program.



PRV-9570-R/XX/0024456952

Provider Specialty for the Automated Process

Contract 570 Psychological and Therapy Services

Specialty:

- 041 - Professional Counselor
- 107 - Licenses Clinical Social Worker
- 110 - Marriage and Family Therapist

Required Documentation

The application will require these supporting documents

- Bank Letter or Voided Check
- Curriculum Vitae
- Electronic Funds Transfer Form
- IRS Tax Documentation
- IRS W-9 Form
- Power Of Attorney For Payee

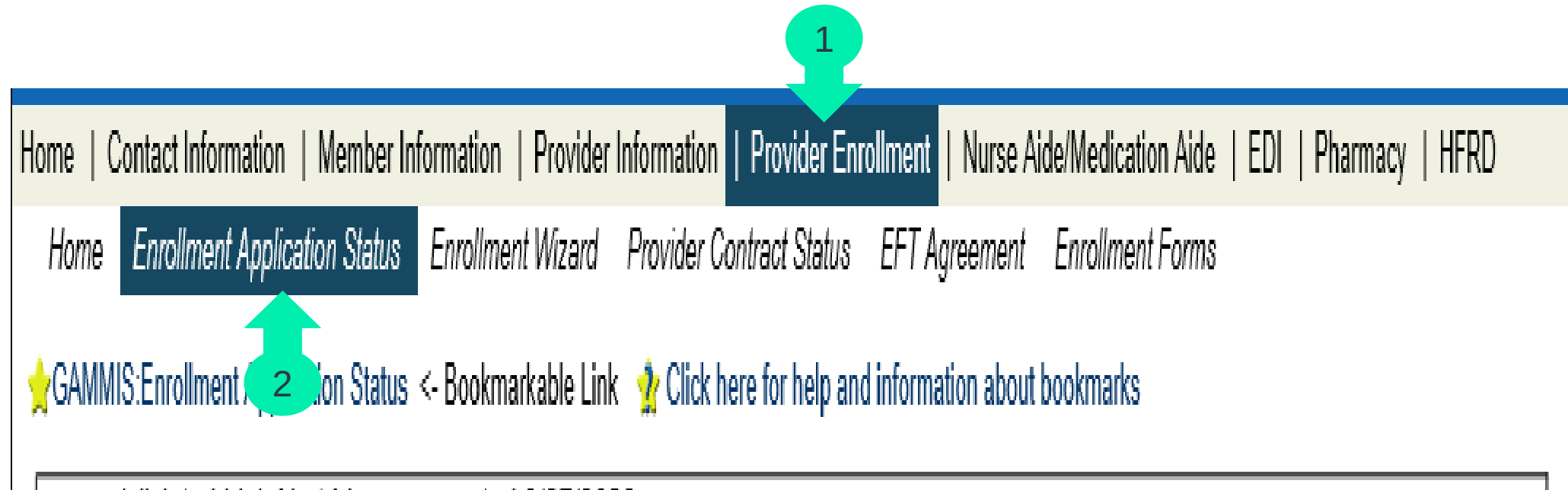
Accessing GAMMIS

- Georgia Medicaid Web Site Address: www.mmis.georgia.gov

Submitting your application with Provided ATN Number

GA Medicaid website address: www.mmis.georgia.gov

Select Provider Enrollment -> Enrollment Application Status



Enter your provided ATN, Business or Last Name, and click search

The screenshot shows a web form titled "Enrollment Tracking Search" with a dark blue header. In the top right corner of the header are three small buttons: "Top", "?", and an upward arrow. The form body is light blue and contains three input fields on the left: "ATN*" with the value "12345", "Business OR Last Name" with the value "LAST NAME HERE", and "Provider ID" which is empty. To the right of these fields are two buttons: "search" and "clear". Three green numbered callouts with arrows indicate the steps: 1 points to the "ATN*" field, 2 points to the "Business OR Last Name" field, and 3 points to the "search" button.

Enrollment Tracking Search

Top ? ↑

1 → ATN* 12345

2 → Business OR Last Name LAST NAME HERE

Provider ID

3 ↓ search

clear

Enrollment Checklist

Search Results (7 rows returned)			
Document	Date Received	Status	Status Date
	12/27/2021	IN PROCESS - APP RCVD; NO DOCUMENTS ATTACHED FOR REVIEW	
COPY OF BANK LETTER OR VOIDED CHECK		NOT RECEIVED	12/27/2021
COPY OF PROFESSIONAL LICENSE		NOT RECEIVED	12/27/2021
ELECTRONIC FUNDS TRANSFER FORM		NOT RECEIVED	12/27/2021
IRS TAX DOCUMENTATION		NOT RECEIVED	12/27/2021
IRS W-9 FORM		NOT RECEIVED	12/27/2021
POWER OF ATTORNEY FOR PAYEE		NOT RECEIVED	12/27/2021
■ Required documents must be uploaded: ● <i>Enrollment forms</i> are available on this site. ● <i>Upload Additional Supporting Documentation</i> as requested by the application review process. ○ Please allow 15 business (not calendar) days for attachments to be reviewed. ■ Provider Enrollment/Credentialing Application Status Questions and Contacts For more information related to the Provider Enrollment process including contact information, please refer to the Provider Enrollment FAQs on the FAQ for Providers page.			

Upload Supporting Documentation

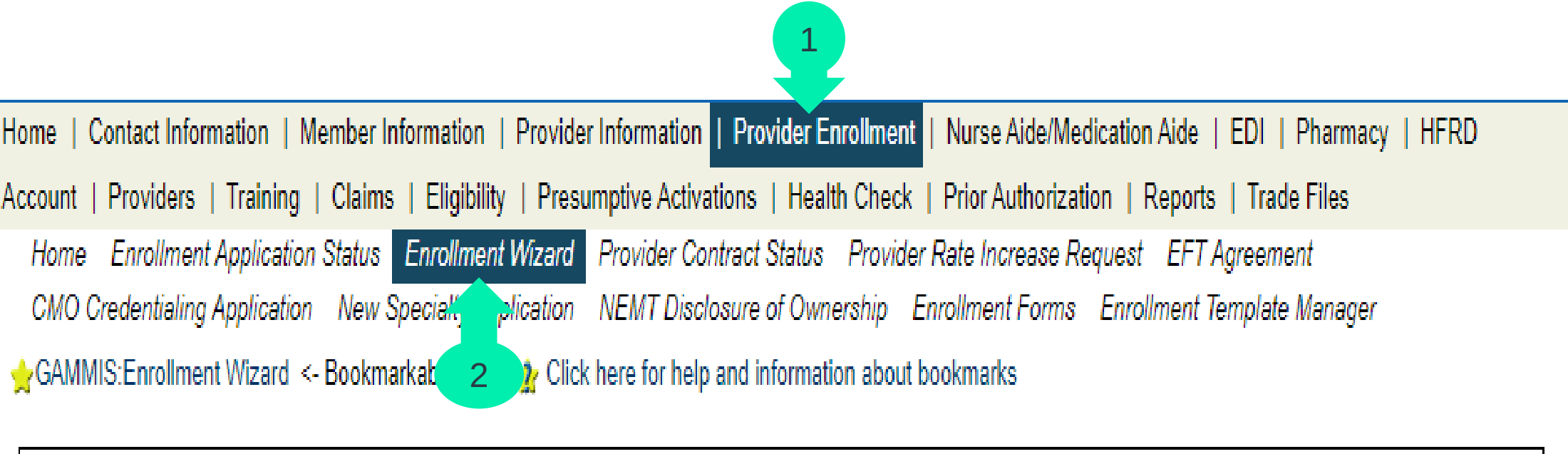
- An Overview of the Supporting Documents are indicated on slide 46
- For step by step uploading instructions, please see slide 47

New Application for COS 570

PSYCHOLOGICAL AND THERAPY SERVICES

Select Provider Enrollment -> Enrollment Wizard

GA Medicaid website address: www.mmis.georgia.gov



The screenshot shows the GA Medicaid website navigation menu. A green circle with the number '1' and a downward arrow points to the 'Provider Enrollment' link in the top navigation bar. A second green circle with the number '2' and an upward arrow points to the 'Enrollment Wizard' link in the second row of the navigation menu. The 'Enrollment Wizard' link is highlighted with a dark blue background.

1

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

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

Home Enrollment Application Status **Enrollment Wizard** Provider Contract Status Provider Rate Increase Request EFT Agreement

CMO Credentialing Application New Specialty Application NEMT Disclosure of Ownership Enrollment Forms Enrollment Template Manager

★GAMMIS:Enrollment Wizard <- Bookmark 2 Click here for help and information about bookmarks

Select Provider Enrollment Application

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).

Select New Application

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](#)

Select OK

ADDITIONAL SERVICE LOCATION APPLICANTS

In order to complete an Additional Service Location application, you must have recently submitted an application for the same provider OR be logged in to the secure web portal.

To copy a submitted application, search for the application on the Enrollment Application Status page, then select the "copy application" or the "add additional service location application" button at the bottom of the page.

CMO CREDENTIALING APPLICANTS

OK

Request Type - Indicate as shown here save & continue

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* Behavioral Health & Social Svc ▼

Do you have delegated credentialing? ☒ No ☐ Yes

Would you like to also submit your application for CMO Credentialing? ☐ No ☒ Yes

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

Provider - Complete all fields with your information save and continue

(*Asterisk – Indicates require fields)

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

Other Names Used (e.g. Maiden Name, Alias)

Date of Birth* Age: 43

Gender* ☒ Male ☐ Female

Race

Ethnicity

SSN*

FEI Number*

Unique Physician Identification Number-UPIN

Contract = 570 - Psychological and Therapy Services

save and continue

The screenshot shows a software window titled "Contract" with a help icon (?). Below the title bar is a section labeled "Provider Contract" with a sub-label "A". The main area contains the text "Type data below for new record." and a form field labeled "Provider Contract*" with the value "570 - Psychol and Therapy" and a dropdown arrow. To the right of this field are "delete" and "add" buttons. At the bottom of the window are three buttons: "previous", "save & continue", and "exit". A red arrow points to the "Provider Contract*" field, and a green arrow points to the "save & continue" button.

Specialty – Indicate as applicable

save and continue

The screenshot shows a web application window titled "Specialty" with a help icon in the top right corner. Below the title bar is a header section labeled "Provider Specialty" and a sub-header "A". The main content area contains the instruction "Type data below for new record." and a larger instruction "Please select the specialties that you are trained for and practice." Below this is a form field labeled "Provider Specialty*" with a dropdown arrow. The dropdown menu is open, displaying a list of specialties: "ADDICTION PSYCHOLOGY (ADDICTION MEDICINE)", "COUNSELOR, PROFESSIONAL", "LICENSED CLINICAL SOCIAL WORKER", "MARRIAGE AND FAMILY THERAPY", and "PSYCHOLOGY". To the right of the dropdown are "delete" and "add" buttons. At the bottom of the form are "save & continue" and "exit" buttons. A large green arrow points from the dropdown menu towards the "save & continue" button.

Detail - Complete this template

(*An asterisk - Indicates require fields)

Select
Ownership
Type

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

Ownership Code* **GOVERNMENT**

Business Location

CLIA Number

Practice Type Code* **INDIVIDUAL PRACTITIONER**

Fiscal Year End Month

Liability Insurance Amount \$0.00

Are you a Sole Proprietor?

Certification

Are you enrolled in Medicare? ☐ No ☐ Yes

Medicare Effective Date

Drug Enforcement Agency (DEA)

DEA Number

DEA Expiration Date

All Schedules? (2, 2N, 3, 3N, 4, 5) ☐ No ☐ Yes

Controlled Dangerous Substance (CDS)

CDS Number

CDS Effective Date

CDS End Date

National Provider Identifier (NPI) & Taxonomy

Type I (Individual) NPI* 1111111100

Taxonomy 1* 103T00000X

Taxonomy 2

Taxonomy 3

Taxonomy 4

Correspondence

Please select your preferred method for receiving letters from the Department.

Letter Medium ☒ E-Mail ☐ Fax ☐ Paper

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* CREATEYOUROWN

The person who should be contacted regarding this application.

Contact Last Name TEST

Contact First, MI FIRST

Contact Phone, Ext.* (800)766-4456

Contact Fax

Contact E-Mail Address* Needemailaddress@email.com

Re-Enter E-Mail Address* Needemailaddress@email.com

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

Address – Complete this template

(*Asterisk – Indicates require fields)

Address

Address Type

Address 1

City

State

Zip

Phone

SERVICE LOCATION

TUCKER

GA

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*

NAME OF PRACTICE

Address 1*

Address 2

City*

State*

Zip*

County*

Phone*

Fax*

Is this location open 24 Hours?

After Hours Phone

Is this location TDD/TTY equipped?

E-Mail Address*

Practice Web Site Address

Does this location have 24/7 phone coverage?

Answering Service

Voicemail with Instructions

SERVICE LOCATION

PRACTICE NAME AS INDICATED ON YOUR (IRS DOCS)

SERVICE LOCATION ADDRESS HERE

TUCKER

GA

30085

DeKalb County

(800)766-4456

(800)766-4451

☒ No
☐ Yes

☒ No
☐ Yes

Needemailaddress@email.com

☒ No
☐ Yes

☒ No
☐ Yes

☒ No
☐ Yes

delete

add

previous

save & continue

exit

Add to indicate a mail to and pay to address

System Notification - Application Tracking Number (ATN)

The screenshot displays the Gainwell application interface. At the top left is the Georgia Department of Community Health logo. A central notification box, titled "www.betammis.georgia.gov says", informs the user that their application has been assigned an ATN of 7721460 and the name is TEST. It instructs the user to write down both the ATN and name. Below this, a green arrow points to an "OK" button. To the right, the Gainwell logo and a search bar are visible, along with the date "Wednesday, February 16, 2022". The main navigation bar includes links for Home, Contact Information, Member Information, Enrollment Application Status, and UAT Testing Site. The UAT Testing Site section contains a message: "This site is for testing purposes only therefore may not reflect what prod". Below this is the "User Information" section with a "Login/Manage Account" link and a "Login" button. A long list of navigation links follows, including 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, and more. A red box highlights the text "Please make note of your ATN: 7721460". Below this is a form for language selection. The form has a "Language" section with a dropdown menu set to "ENGLISH" and a "Primary Language" section with a dropdown menu set to "YES". A red arrow points to the "save & continue" button at the bottom of the form.

www.betammis.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) 7721460 and the name entered for this Application is TEST. 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 of the Enrollment Status link. You will need to enter both the ATN and name to continue the application or to check the status.

OK

Language

Language
A ENGLISH

Primary Language
YES

Type data below for new record.

Language* ENGLISH

Primary Language YES

delete add

previous save & continue exit

Language - Indicate as needed

save and continue

The screenshot shows a web-based form titled "Language" with a help icon (?) in the top right corner. The form has a header section with two columns: "Language" and "Primary Language". Below the header, the first row shows "A ENGLISH" under "Language" and "YES" under "Primary Language". A message "Type data below for new record." is displayed in the center. The main data entry area contains two dropdown menus: "Language*" with "ENGLISH" selected and "Primary Language" with "YES" selected. At the bottom right of the form are two buttons: "delete" and "add". At the very bottom of the form are three buttons: "previous", "save & continue", and "exit". A red arrow points to the "save & continue" button.

Language	Primary Language
A ENGLISH	YES

Type data below for new record.

Language* ENGLISH ▼

Primary Language YES ▼

delete add

previous save & continue exit

Special Need - Indicate as needed

save and continue

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

License - Indicate as needed

save and continue

License ?

License Number	License Board	License Type	Issuing State
A 123456	Comp Brd of Prof Coun, SW, Fam		

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 

License effective and end date

Owner - Complete this template

(*Asterisk – Indicates required fields)

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.

Owner - Indicate as needed

save and continue

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

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

Ownership Type* Sole Proprietor (Individual filing under an EIN) ▼

Last Name* TEST

First Name, MI* FIRST

Title

☒ Same as Service Location Address

Address 1* SERVICE LOCATION ADDRESS HERE

Address 2

City* TUCKER

State* GA ▼

Zip* 30085

FEI Number

SSN* 001010101

Date of Birth* 01/01/1979

Familial Relationship* OTHER ▼

Phone (800)766-4456

Fax (800)766-4451

E-Mail Address Needemailaddress@email.com

% Owner* 100

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

delete add

previous save & continue exit

Employee – Disclosure of Ownership and Control Interest Statement – Managing Employees

Employee



Disclosure of Ownership and Control Interest Statement - Managing Employees

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

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

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

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

Employee – Indicate as needed save and continue

Logon to secure site to use enrollment template feature.
Select a template to populate employee data

Affiliation*		SSN*	001010101
Last Name*	TEST	Date of Birth*	01/01/1976
First Name, MI*	TWO	Familial Relationship*	
Title		Phone	(800)766-4456
☐ Same as Service Location Address		Fax	(800)766-4451
Address 1*	1 PEACHTREE		
Address 2			
City*	ATLANTA		
State*	GA		
Zip*	30085		

E-Mail Address

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

Subcontractor (Not Required) - Indicate as needed save and continue

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 ▼ (Template data will overlay existing data on the panel)					
Business Name			FEI Number		
Last Name			SSN		
First Name, MI			Date of Birth		
☐ Same as Service Location Address			Familial Relationship		
Address 1					
Address 2					
City					
State					
Zip					
			delete add		
previous			save & continue		exit

Payee - GAMMIS will auto create a Payee Number once enrolled save and continue

Payee ?

- The Payee Medicaid ID is used for money designation.
- In addition, the following required documentation must be submitted:
 1. **Form W-9** should reflect the address for the provider's payments and/or remittance advices.
 2. **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.
 3. **EFT Agreement** contains the Payee's Routing and Account Number. These will be used to disburse monies to the provider for rendered services.
 4. **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 - Indicate with military time format

save and continue

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	08:00	18:00	(24HH:MM)	☐ Open 24 Hours	☐ Closed
Tuesday Open/Close	08:00	18:00	(24HH:MM)	☐ Open 24 Hours	☐ Closed
Wednesday Open/Close	08:00	19:00	(24HH:MM)	☐ Open 24 Hours	☐ Closed
Thursday Open/Close	08:00	18:00	(24HH:MM)	☐ Open 24 Hours	☐ Closed
Friday Open/Close	08:00	18:00	(24HH:MM)	☐ Open 24 Hours	☐ Closed
Saturday Open/Close			(24HH:MM)	☐ Open 24 Hours	☒ Closed
Sunday Open/Close			(24HH:MM)	☐ Open 24 Hours	☒ Closed

Practice Hours Comments

Patient Age Range
Patient Age Range* Age 0 - 21 years ▼ Beginning Age Range 0 Ending Age Range 21 (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* 03 ▼ 2020 (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

Max Age
is 21 for
COS-570

Access - Indicate as needed

save and continue

The screenshot shows a web form titled "Access" with a help icon in the top right corner. At the top, there is a dropdown menu labeled "Select a template to populate accessibility data" with a note "(Template data will overlay existing data on the panel)". The main content area contains several sections of questions with radio button options:

- Does this office meet ADA accessibility requirements?** with options ☒ No and ☐ Yes.
- Does this site offer handicapped access for the following:**
 - Parking** with options ☒ No and ☐ Yes.
 - Restroom** with options ☒ No and ☐ Yes.
- Does this site offer other services for the disabled?**
 - American Sign Language** with options ☒ No and ☐ Yes.
 - Mental/Physical Impairment Services** with options ☒ No and ☐ Yes.
- Accessible by Public Transportation?**
 - Bus** with options ☒ No and ☐ Yes.
 - Subway** with options ☒ No and ☐ Yes.
 - Regional Train** with options ☒ No and ☐ Yes.
- List other Handicapped Access / Other Disability Services / or Other Transportation Access:** followed by a large text input field.

At the bottom of the form, there are three buttons: "previous", "save & continue", and "exit". A large red arrow points directly to the "save & continue" button.

Education – Indicate as needed

save and continue

Education

Level

School

City

State

Country

Degree

A

Bachelors

US COLLEGE

ATLANTA

GA

UNITED STATES

Type data below for new record.

Education - Provide the appropriate information for the schools that you attended.

Level of Education*

☒ Bachelors☐ Masters☐ Doctorate☐ Other

School Name*

US COLLEGE

Address 1*

1 PEACHTREE

Address 2

City*

ATLANTA

State

GA

Zip*

30331

Country*

UNITED STATES

Phone*

(800)766-4456

Start Date*

03

2015

(MM / YYYY)

End Date / Graduation Date*

05

2021

(MM / YYYY)

Degree Awarded

delete

add

previous

save & continue

exit

Add to
indicate
additional
education



Training - Indicate as needed

save and continue

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 (MM / YYYY)

End Date (MM / YYYY)

Department / Specialty

delete add

previous save & continue exit

Work – Indicate as needed

save and continue

The screenshot shows a web form titled 'Work' with a header bar containing fields for Employer, City, State, Country, Start (MM/YYYY), End (MM/YYYY), and Current. Below the header, a red box highlights instructions: '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.' The form fields include: Practice / Employer Name (RESUME REQUIREMENTS), Address 1* (1 PEACHTREE), Address 2, City* (ATLANTA), State (GA), Zip* (30331), Country* (UNITED STATES), and Phone* ((800)766-4456). Below these are fields for Current Position (checkbox), Start Date* (02 / 2015), and End Date* (03 / 2021). A red box at the bottom left contains the instruction: 'If there is a six(6) month or more gap from your next position, please explain.' On the right, a green box with a downward arrow says 'Add to indicate additional work history'. At the bottom, there are buttons for 'previous', 'save & continue' (highlighted with a red arrow), 'delete', 'add', and 'exit'.

Work

Employer	City	State	Country	Start (MM/YYYY)	End (MM/YYYY)	Current
A RESUME REQUIREMENTS			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: RESUME REQUIREMENTS

Address 1*: 1 PEACHTREE

Address 2:

City*: ATLANTA

State: GA

Zip*: 30331

Country*: UNITED STATES

Phone*: (800)766-4456

Current Position: ☐

Start Date*: 02 / 2015 (MM / YYYY)

End Date*: 03 / 2021 (MM / YYYY)

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

delete add

previous save & continue exit

Add to indicate additional work history

Insurance – Indicate as needed

save and continue

The screenshot shows a web form titled "Insurance" with a header bar containing "Carrier", "Policy Number", "Address 1", "City", and "State". Below the header is a tab labeled "A". A dropdown menu is set to "Select a template to populate liability insurance data" with a note: "(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*: NEED GROUP INSURANCE DETAILS
Policy Number*: 012345678
☐ Same as Service Location Address
Address 1*: 5 PEACHTREE
Address 2*:
City*: ATLANTA
State*: GA
Zip*: 30331
County*: Fulton

Effective Date*:
Expiration Date*:
Do you have unlimited coverage with this insurance carrier? ☐ No ☐ Yes
Amount of Coverage Per Occurrence*: \$1,000,000.00
Amount of Coverage Per Aggregate*: \$3,000,000.00

Annotations: A green arrow points to the "Effective Date*" and "Expiration Date*" fields with the text "Insurance effective and end date". A green arrow points to the "Amount of Coverage Per Occurrence*" and "Amount of Coverage Per Aggregate*" fields with the text "Minimum Coverage". A red arrow points to the "save & continue" button.

Buttons: delete, add, previous, save & continue, exit

History - Indicate as needed

(All information will be verified)

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.

History CVO – Indicate as needed

(All information will be verified)

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.

History CVO - Indicate as needed

(All information will be verified)

- Georgia Medicaid require annual Fraud, Waste and Abuse Training

Training

Are you and your staff annually trained on Fraud, waste, and abuse?* ☐ No ☐ Yes

Required Document Checklist

Doco ?	
Document Description	
COPY OF BANK LETTER OR VOIDED CHECK	REQUIRED
COPY OF PSYCHOLOGIST LICENSE	REQUIRED
CVO-CURRICULUM VITAE	REQUIRED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED
IRS TAX DOCUMENTATION	REQUIRED
IRS W-9 FORM	REQUIRED
POWER OF ATTORNEY FOR PAYEE	REQUIRED

Supporting Document Overview

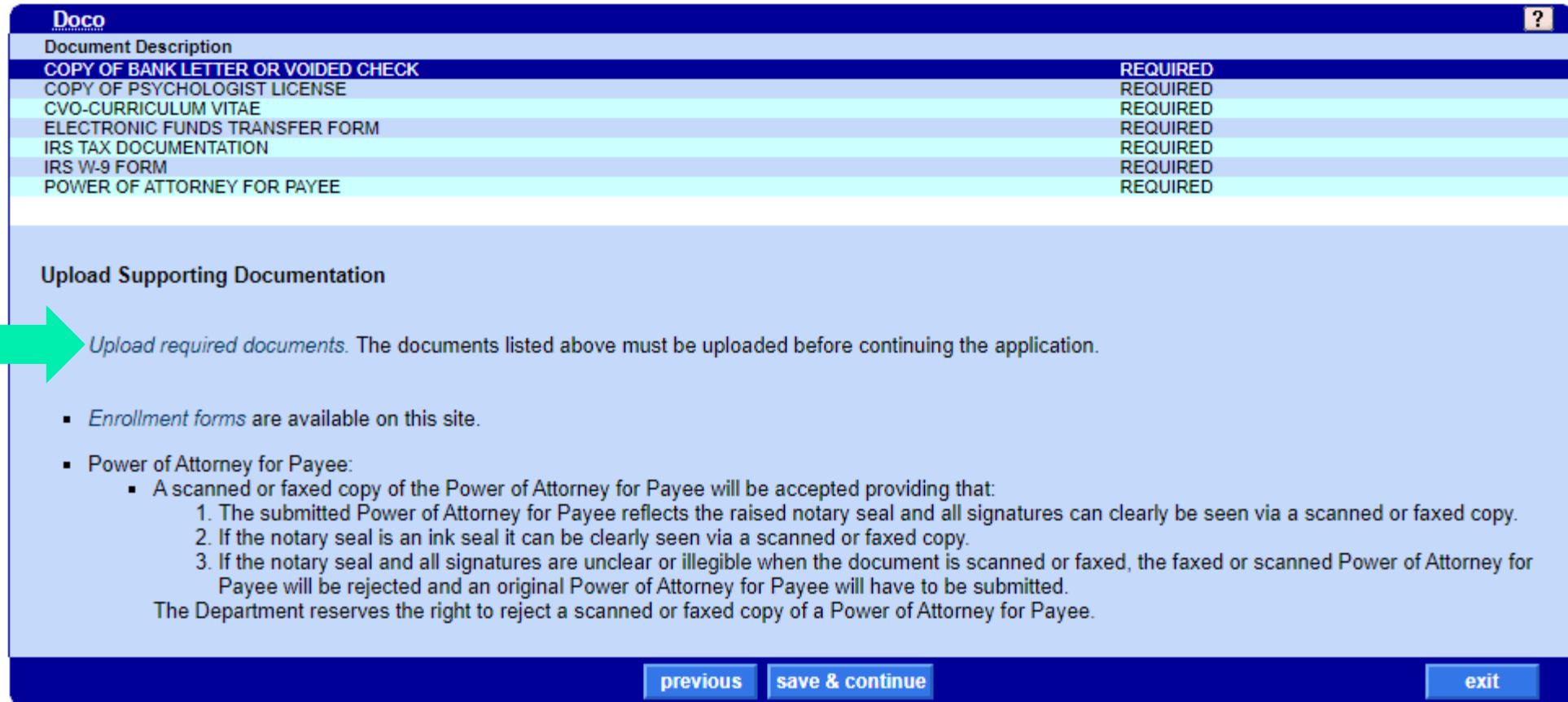
- **Bank Letter or Voided Check**
- **Curriculum Vitae – Resume'** *must include at least 5 years continues work history. If there is a 6-month gap in work history, it must be clarified.*
- **Electronic Funds Transfer Form**
- **IRS Tax Documentation**
- **IRS W-9 Form**
- **Power Of Attorney For Payee** - *Must be signed/ sealed in the presence of the Notary*

**POA cannot be altered*

*EFT Agreement, POA, W-9, and Bank letter must include the legal business name **exactly** as it is shown on the IRS 147-C certification*

**Name of the application must be listed exactly how it is shown on license.*

Select Upload Required Documents to start the upload process



Doco ?

Document Description	
COPY OF BANK LETTER OR VOIDED CHECK	REQUIRED
COPY OF PSYCHOLOGIST LICENSE	REQUIRED
CVO-CURRICULUM VITAE	REQUIRED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED
IRS TAX DOCUMENTATION	REQUIRED
IRS W-9 FORM	REQUIRED
POWER OF ATTORNEY FOR PAYEE	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](#)

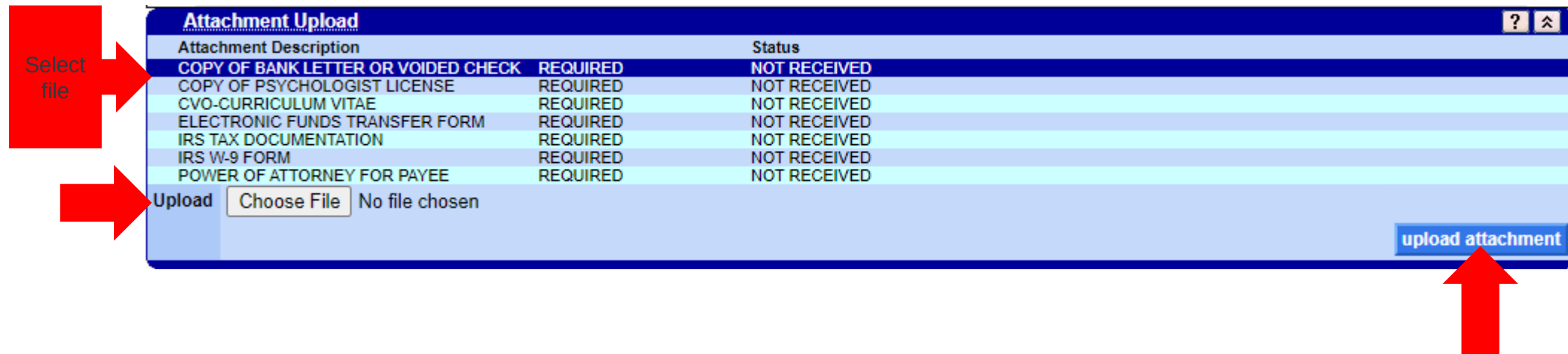
Uploading Documentation

Each document must be individually uploaded

Select the first item to be attached to the application

1. Choose File and select file from your computer
2. Upload Attachment

A system message indicating a document was uploaded successfully



The screenshot shows a web interface titled "Attachment Upload". It features a table with three columns: "Attachment Description", "REQUIRED", and "Status". The table lists seven required documents, all with a status of "NOT RECEIVED". Below the table is an "Upload" section with a "Choose File" button and the text "No file chosen". A red arrow points to the "Choose File" button with the text "Select file". Another red arrow points to the "upload attachment" button in the bottom right corner.

Attachment Description	REQUIRED	Status
COPY OF BANK LETTER OR VOIDED CHECK	REQUIRED	NOT RECEIVED
COPY OF PSYCHOLOGIST LICENSE	REQUIRED	NOT RECEIVED
CVO-CURRICULUM VITAE	REQUIRED	NOT RECEIVED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED	NOT RECEIVED
IRS TAX DOCUMENTATION	REQUIRED	NOT RECEIVED
IRS W-9 FORM	REQUIRED	NOT RECEIVED
POWER OF ATTORNEY FOR PAYEE	REQUIRED	NOT RECEIVED

Upload No file chosen

upload attachment

Uploading Documentation

No remaining items

The following messages were generated:

Message Description	Panel	Field	Row
Test Documentation.pdf has been uploaded successfully.	Attachment Upload		

Attachment Upload

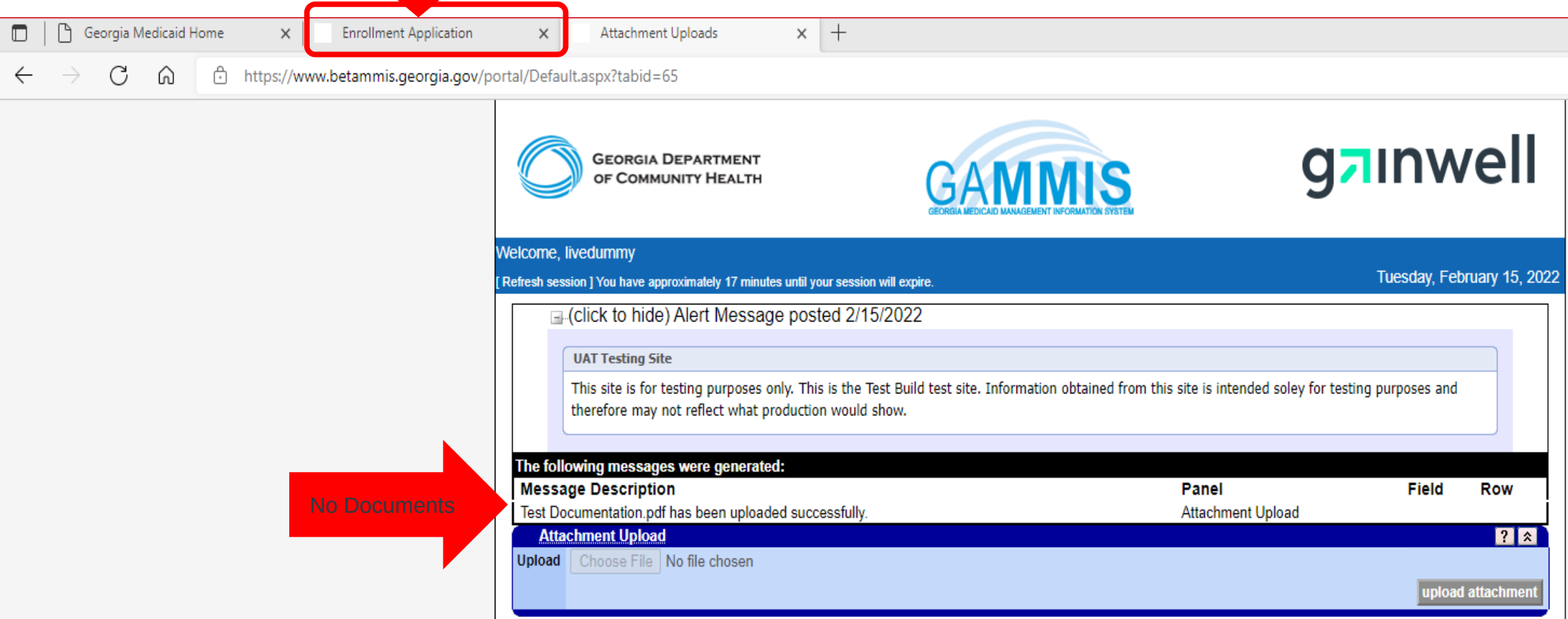
Upload

Choose File

No file chosen

upload attachment

Returning to the Application



No Documents

Save and Continue the Application

Doco ?

Document Description	
COPY OF BANK LETTER OR VOIDED CHECK	REQUIRED
COPY OF PSYCHOLOGIST LICENSE	REQUIRED
CVO-CURRICULUM VITAE	REQUIRED
ELECTRONIC FUNDS TRANSFER FORM	REQUIRED
IRS TAX DOCUMENTATION	REQUIRED
IRS W-9 FORM	REQUIRED
POWER OF ATTORNEY FOR PAYEE	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

Release Of Information (ROA)

ROI

?

Georgia Department of Community Health (DCH)/
Centralized Credentialing Verification Organization (CVO)
AUTHORIZATION AND RELEASE

review must take place within six (6) months of the date of this Application and my proposed corrections must be submitted in writing to the CVO within thirty (30) days of commencement of the review. The CVO is not required to allow a practitioner to review references or recommendations or other information that is peer-review protected.

11. I understand that if my Application is rejected for reasons relating to my professional conduct or competence, CVO may report the rejection to the appropriate state licensing board, the National Practitioner Data Bank, and/or the Health Care Integrity and Protection Data Bank.

12. I certify that (i) the information provided in or attached to my Application is accurate and complete; (ii) I have adequate current insurance; (iii) or the facility is a Federally Qualified Health Center and a grantee of the Department of Health and Human Services(DHHS) and Services Administration(HRSA) and is covered under the Federal Tort Claims Act(FTCA) Public law 102-5; (iv) I hold a full, unrestricted license to practice in the state(s) in which I practice or I have indicated on this application the limitations and/or restrictions imposed; and (v) I have reported any loss or limitation of hospital privileges or any disciplinary activity to the CVO.

13. The CVO does not discriminate on the basis of race, color, national origin, sex, religion, age or disability.

14. I have read and fully understand this Authorization and Release, which constitutes my written authorization and request to provide and release any and all relevant information (including supportive records and documents) regarding my Application and any further reappraisals and evaluations by the CVO. I agree to execute any additional releases as may be reasonably required by the CVO in connection with any further reappraisal and evaluations.

Select the appropriate option

☐ As a physician, I attest that I will continue to maintain active admitting and staff privileges at a CVO-participating hospital or I have otherwise indicated on this application.

☐ As a health care professional requiring a supervising physician relationship, I attest that I have a written agreement with a physician who oversees my clinical decision in compliance with the professional licensing laws in the state(s) in which I practice.

☒ I am not a physician or a health care professional who is required to have a supervising physician relationship.

This is to certify that

Name of Provider (Last, First)*

TESTFIRST

Title

Date

02/15/2022

☒ I accept the terms of the Attestation Statement

[Release of Information Statement](#)

previous

save & continue

exit

 GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

© Gainwell Technologies Proprietary and Confidential.. The information contained herein is subject to change without notice. 53

 gainwell

Statement OF Participation (SOP)

SOP

DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
STATEMENT OF PARTICIPATION

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

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

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

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

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

This is to certify that

Name of Provider (Last, First)*

Title

Date 02/15/2022

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

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

Verification Of Policy Manuals

Policy Attest ?

VERIFICATION OF POLICY MANUALS

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

//

This is to certify that

Name of Provider (Last, First)*

Title

Date 02/15/2022

☒ I accept the terms of the Policy Attestation Statement

Medicaid Provider Attestation Statement

Attestation

?

MEDICAID PROGRAM PROVIDER ATTESTATION STATEMENT

This is to certify that

Name of Provider (Last, First)*

TEST

FIRST

Title

Date

02/15/2022

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

Submit your application Here

After submission of this application, a pop-up window will appear to allow you to print a copy of this application for your records. 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

Application Completion Status page

Provider enrollment application for TEST

The Application Tracking Number (ATN) is : 7721458

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 this enrollment, 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 must be 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:
 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.
- You can check the status of this application from the [Enrollment Status](#) page.

previous

exit

add additional service location application

Application Processing Time Frames

Application are completely processed within 30 - 51 working days

- Documents are reviewed within 15 business days
- Rejection letters are mailed to the address indicated on the application
- Missing document letters are mailed to the address indicated on the application
- Rejection items or Missing items must be uploaded within 10 days

*Providers must continue to check the status of your application

Application Common Denials

- W9 - Business Name should be listed exactly as it appears on the 147C letter.
- Electronic Funds Transfer form should have a business name listed exactly how it appears on 147C.
- Electronic Funds Transfer form must have a provider signature.
- Tax ID number must match on all forms i.e., Application, Power of Attorney (POA), W9 and EFT Agreement.
- Payee Name must match on all forms i.e., Application, Power of Attorney, W9 and EFT Agreement.
- POA and the application **must** be signed by the enrollee.
- POA must be a clean copy with no white-out, or correctional Tape.

Session Review

- Submitting a COS 570 Application
- Documentation Requirements
- Application Common Denials

Contacting Gainwell Technologies



Contact Us

Our Provider Services Contact Center (PSCC)
can be reached at

800-766-4456

and is available 7 a.m. to 7 p.m. EST

Monday through Friday (except state holidays) for service inquiries.

Please note the Web Portal is available 24/7

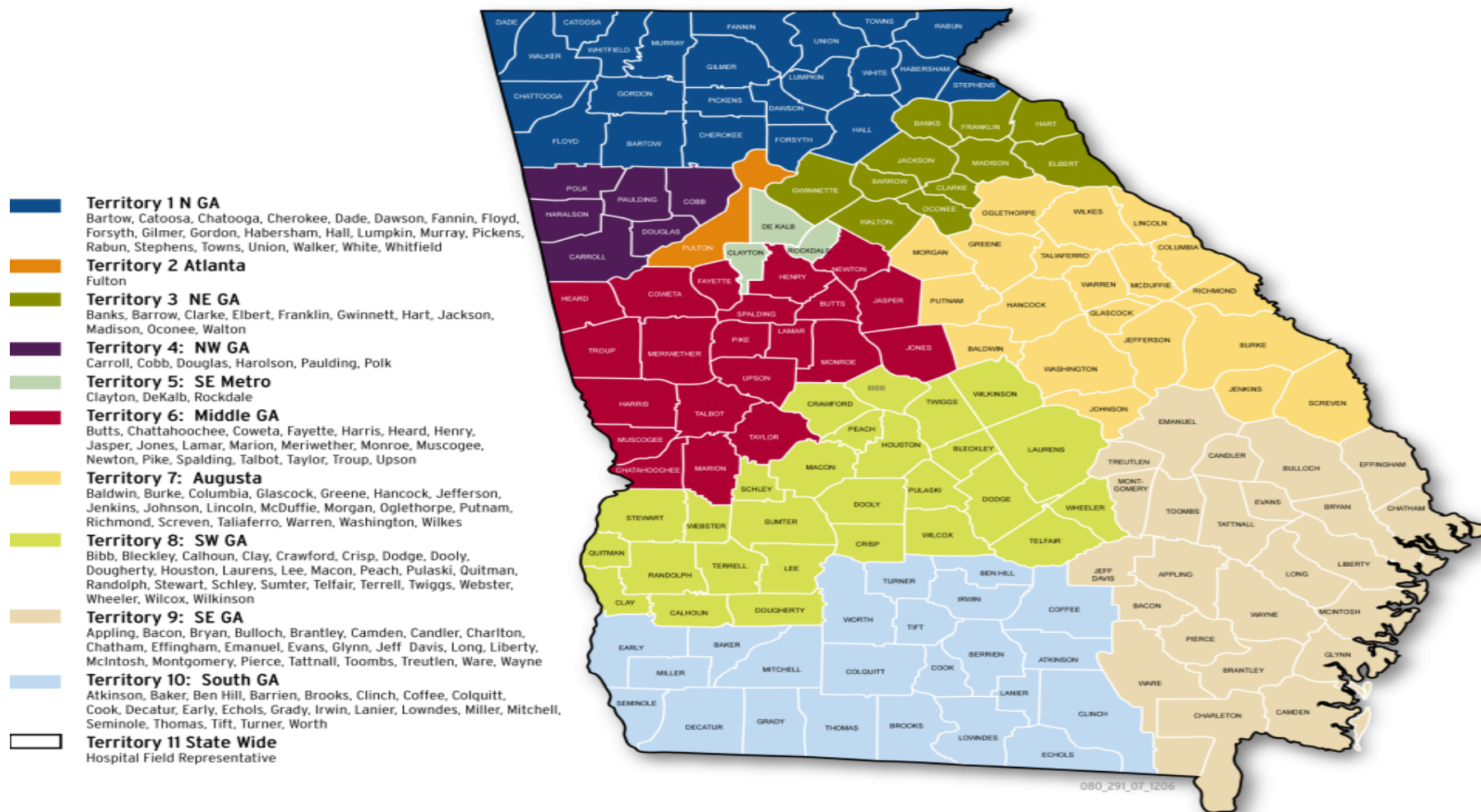


IVRS Overview

The Interactive Voice Response System (IVRS) allows users to call and conduct inquiries or transactions on the Georgia Medicaid Management Information System (GAMMIS) using a touch-tone telephone.

800-766-4456	
Option 1	Member Eligibility
Option 2	Claims Status
Option 3	Payment Information
Option 4	Provider Enrollment
Option 5	Prior Authorization
Option 6	GAMMIS website password reset, Pharmacy Benefits, the Nurse Aide Registry or Nurse Aide Training program, PeachCare for Kids® EDI submission or electronic claim submission, or a system overview

Georgia Field Territories



Provider Relations Field Services Representatives

Territory	Region	Rep
1	North Georgia	Mercedes Liddell
2	Fulton	Deandre Murray
3	NE Georgia	Carolyn Thomas
4	NW Georgia	Tierra Johnson
5	SE Metro	Ebony Hill
6	Middle Georgia	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

Provider Relations Field Services Representatives

State-Wide Consultants

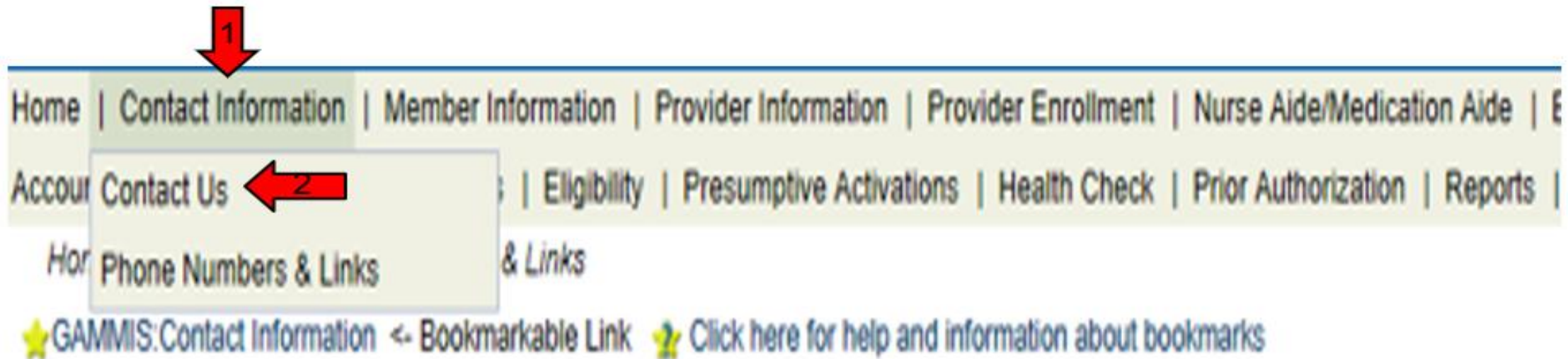
Sharée C. Daniels

Brenda Hulette

Danny Williams

Contact My Provider Rep Directly

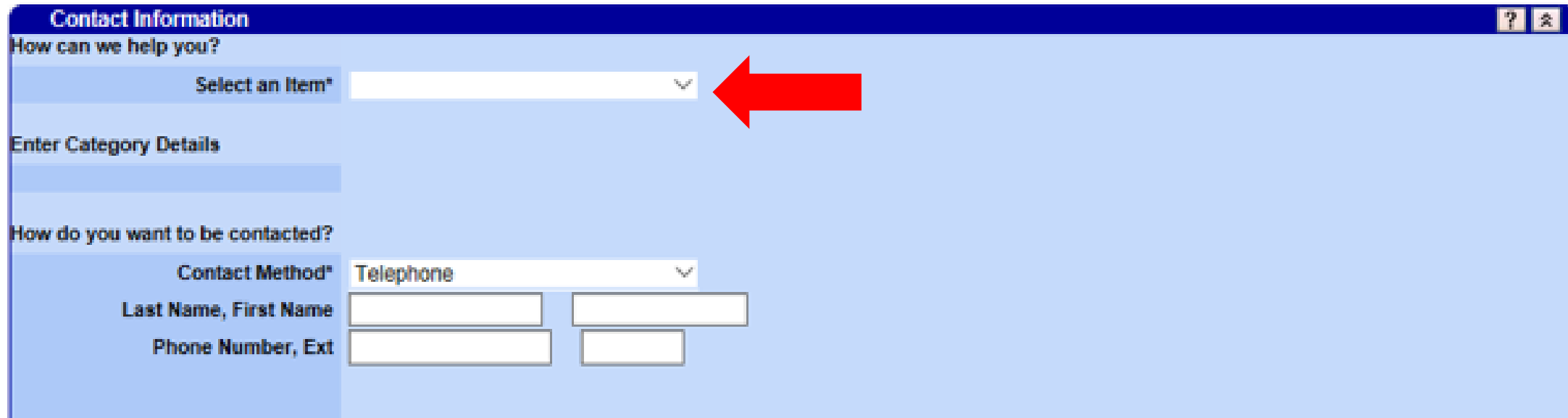
After logging into the GAMMIS System, select Contact Information then Contact Us



Contact My Provider Rep Directly

(continued)

Select an Item



The screenshot shows a web form titled "Contact Information" with a dark blue header bar containing a question mark icon and a user icon. The form is divided into several sections:

- How can we help you?**: This section contains a dropdown menu labeled "Select an Item*" with a downward arrow. A large red arrow points to this dropdown.
- Enter Category Details**: This section is currently empty.
- How do you want to be contacted?**: This section contains a dropdown menu labeled "Contact Method*" with "Telephone" selected and a downward arrow.
- Last Name, First Name**: Two text input fields for the user's name.
- Phone Number, Ext**: Two text input fields for the phone number and extension.

Contact My Provider Rep Directly

(continued)

The screenshot shows a web form interface. On the left is a sidebar with sections: 'Contact Information' (with a dropdown 'How can we help you?' and 'Select an Item*'), 'Enter Category Details', and 'How do you want to be contacted?' (with a dropdown 'Contact Method*' and fields for 'Last Name, First Name' and 'Phone Number, Ext'). The main content area has a blue header with 'submit' and 'cancel' buttons. Below the header is a list of service options: Claim Status Inquiry, Eligibility Inquiry, Contact My Provider Service Rep, Provider Enrollment, Request a Provider Rep Visit, ICD-10 Inquiry, Favors Review Inquiry, MAPIR Inquiry, Web Registration, Member ID Cards, Member PCP Assignments, Customer Service, Complaint about a Provider, Complaint about a Member, Other Complaint, Having a Technical Problem, Other, EDI Submission Problem, and Provider PIN Issue. Red arrows point from the 'Contact My Provider Service Rep' and 'Request a Provider Rep Visit' options to a large yellow oval containing the text 'OR'. To the right of this oval is a large black starburst button with the text 'Click Here'. At the bottom of the form are two 'top of page' buttons.

submit cancel

Contact Information
How can we help you?
Select an Item*
Enter Category Details
How do you want to be contacted?
Contact Method*
Last Name, First Name
Phone Number, Ext

Claim Status Inquiry
Eligibility Inquiry
Contact My Provider Service Rep
Provider Enrollment
Request a Provider Rep Visit
ICD-10 Inquiry
Favors Review Inquiry
MAPIR Inquiry
Web Registration
Member ID Cards
Member PCP Assignments
Customer Service
Complaint about a Provider
Complaint about a Member
Other Complaint
Having a Technical Problem
Other
EDI Submission Problem
Provider PIN Issue

OR

Click Here

top of page top of page

Contact My Provider Rep Directly

(continued)

Please provide all details pertaining to your issue, including the ICN, member ID, etc.



submit cancel

Contact Information ?

How can we help you?

Select an Item* Contact My Provider Service Rep ▾

Enter Category Details

How can we help you?

I Need some help with ICN 2017123456777

How do you want to be contacted?

Contact Method* Telephone ▾

Last Name, First Name DXC

Phone Number, Ext (800)766-4456

Contact My Provider Rep Directly

(continued)

The following messages were generated:

Your request has been processed. Your tracking number is 20763193.

Providers may call the Provider Contact Center at (770) 325-5666 or toll-free at (800) 766-4456. Members may call the Member Contact Center at (770) 325-2331 or toll-free at (866) 211-0950.

Contact Information

How can we help you?

Select an Item*

Contact My Provider Service Rep

Enter Category Details

How can we help you?

test

How do you want to be contacted?

Contact Method*

Telephone

Last Name, First Name

HPtest

Phone Number, Ext

(800)766-4456

Questions?

Thank you

Contact

brand@gainwelltechnologies.com
gainwelltechnologies.com

Gainwell Technologies

1775 Tysons Blvd.
McLean, VA 22102