Georgia Medicaid Fair Credentialing, Acquisitions, and Merger Process Overview

For access to this presentation, please visit: www.mmis.georgia.gov -> Provider Information -> Provider Notices –"Presentation – Credentialing, Acquisitions, and Merger Process Overview - Spring Medicaid Fair 2022"

Agenda

- Overview
- Provider Enrollment Application
- Documentation Requirements
- Provider Change of Ownership
- Credential Verification Organization
- Professional Liability Insurance
- Common Application 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.

New Enrollment Application

Let’s Get Started…

Select Provider Enrollment -> Enrollment Wizard

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

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 Special[illegible]plication NEMT Disclosure of Ownership Enrollment Forms Enrollment Template Manager

GAMMIS:Enrollment Wizard <- Bookmarkab[illegible] Click here for help and information about bookmarks

2

New Enrollment Application

(continued)

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.

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).

New Enrollment Application

(continued)

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

New Enrollment Application

(continued)

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

New Enrollment Application

(continued)

Requested Application Type – Indicate your requested provider type

Request Type

Application Type*

- (selected) 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? (selected) No / Yes

Would you like to also submit your application for CMO Credentialing? No / (selected) Yes

previous | save & continue | exit

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

New Enrollment Application

(continued)

Provider Type – Indicate your requested provider type save & continue

Request Type	
Application Type*	for Applicants MORE THAN 50 miles from the GA border ...itioner and Facility ...dual Non-Medicaid Provider participating with CMO ...ty Non-Medicaid Provider participating with CMO ...onal Service Location - Individual and Facility
Provider Type*	Physicians/Osteopaths

Provider Type options:

- Behavioral Health & Social Svc
- Chiropractors (Medicare Only)
- Dentist Service Providers
- Dietary Nutritional Services
- Eye and Vision Providers
- Home and Community Based Svc
- Nurse Practitioner/Physician Assistant
- Nursing Related Services
- Nursing Services
- Other Service Providers
- Physicians/Osteopaths
- Podiatrists
- Public Health Agency
- Respiratory, Rehab, & Restoration (O&P)
- Speech, Lang, & Hearing 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

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

New Enrollment Application

(continued)

Provider - Complete all fields with your information. (*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)

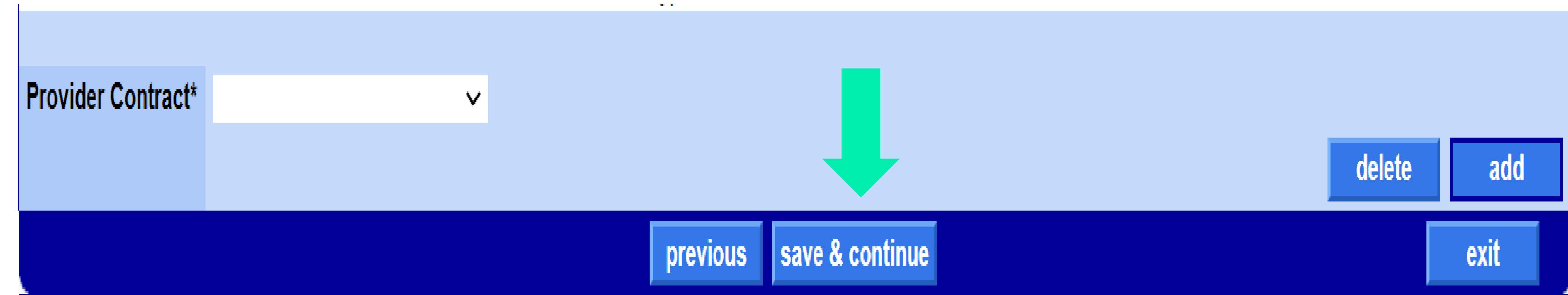
Field	Value
Individual Last Name*	TEST
First, MI*	FIRST
Doing Business As (D/B/A)	
Title/Degree	
Other Names Used (e.g. Maiden Name, Alias)	
Date of Birth*	01/01/1979 Age: 43
Gender*	(•) Male ( ) Female
Race	
Ethnicity	
SSN*	001010101
FEI Number*	000000001
Unique Physician Identification Number-UPIN	

previous | save & continue | exit

New Enrollment Application

(continued)

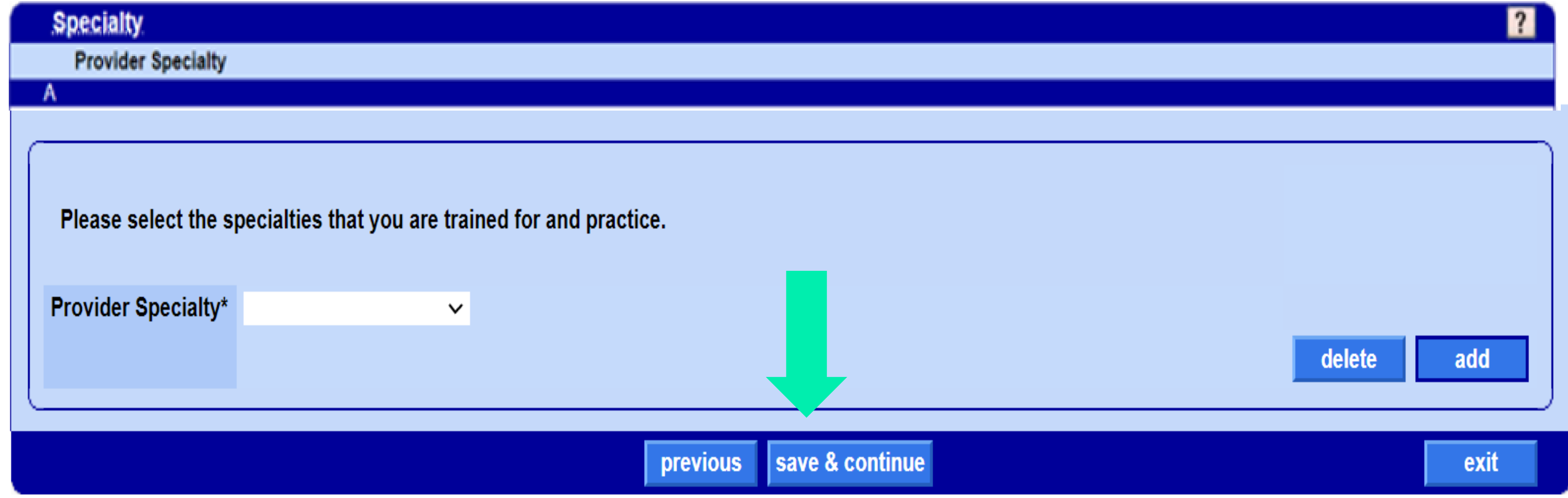
Contract - Select your provider contract, save & continue



New Enrollment Application

(continued)

Specialty – Indicate your specialty, save & continue



New Enrollment Application

(continued)

Select Ownership Type

Detail

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

Ownership Code*

Business Location

CLIA Number

- GOVERNMENT
- INVESTOR OWNED
- NON-PROFIT OR RELIGIOUS
- NOT APPLICABLE
- OTHER
- PRIVATE - FOR PROFIT
- PRIVATE - NOT FOR PROFIT
- PUBLIC
- SOLE PROPRIETOR

Practice Type Code* INDIVIDUAL PRACTITIONER

Fiscal Year End Month

Liability Insurance Amount $0.00

Are you ...

Certificatio...

...ceiver ○ Both ◉ No

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

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

New Enrollment Application

(continued)

National Provider Identifier (NPI) & Taxonomy

Type I (Individual) NPI* 1111111100

Taxonomy 1* 103T00000X [Search] Taxonomy 2 [Search]

Taxonomy 3 [Search] Taxonomy 4 [Search]

Correspondence

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

Letter Medium (selected) 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 Address will be used.

E-Mail Notifications?* ( ) No (selected) Yes

previous | save & continue | exit

New Enrollment Application

(continued)

Complete Address Information Save and Continue

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)

Field	Value
Address Type*	SERVICE LOCATION
Name of Practice (As it appears on the W-9)*	PRACTICE NAME AS INDICTATED ON YOUR (IRS DOCS)
Address 1*	SERVICE LOCATION ADDRESS HERE
Address 2	
City*	TUCKER
State*	GA
Zip*	30085
County*	DeKalb County
Phone*	(800)766-4456
Fax*	(800)766-4451
Is this location open 24 Hours?	No / Yes
After Hours Phone	
Is this location TDD/TTY equipped?	No / Yes
E-Mail Address*	Needemailaddress@email.com
Practice Web Site Address	
Does this location have 24/7 phone coverage?	No / Yes
Answering Service	No / Yes
Voicemail with Instructions	No / Yes

Add to indicate a mail to payee to address

delete add

previous save & continue exit

New Enrollment Application
(continued)

System Notification - Application Tracking Number (ATN)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

gainwell

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 from the Enrollment Status link. You will need to enter both the ATN and name to continue the application or to check the status.

OK

Search

Wednesday, February 16, 2022

Home | Contact Information | Member Infor... n Aide | EDI | Pharmacy | HFRD

Home Enrollment Application Status Er... orms

(click to hide) Alert Message

UAT Testing Site

This site is for testing purposes only ... soley for testing purposes and therefore may not reflect what prod...

User Information

Login/Manage Account Login

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 >

Please make note of your ATN: 7721460

Language

	Language	Primary Language
A	ENGLISH	YES

Type data below for new record.

Language* ENGLISH

Primary Language YES

delete add

previous save & continue exit

Application Tracking Number (ATN)

The ATN allows the provider to pause and take a little break before resuming the application.

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

New Enrollment Application

(continued)

Language - Indicate as needed, save & continue

Language

	Language	Primary Language
A	ENGLISH	YES

Type data below for new record.

Language* ENGLISH

Primary Language YES

delete add

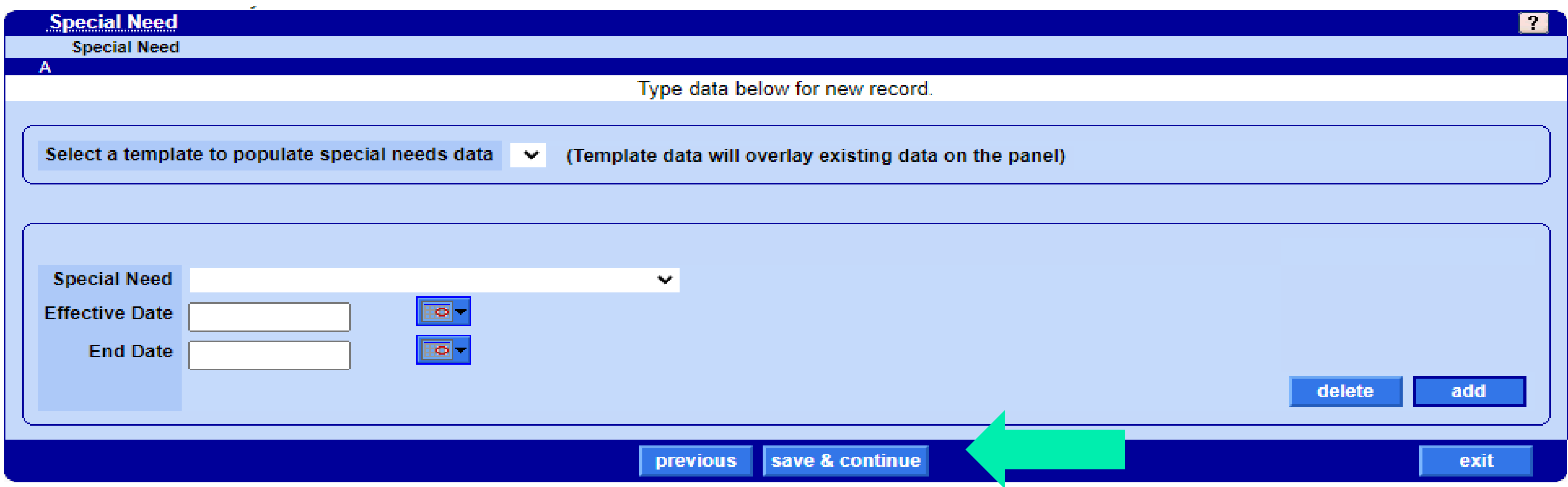
previous save & continue exit

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

New Enrollment Application

(continued)

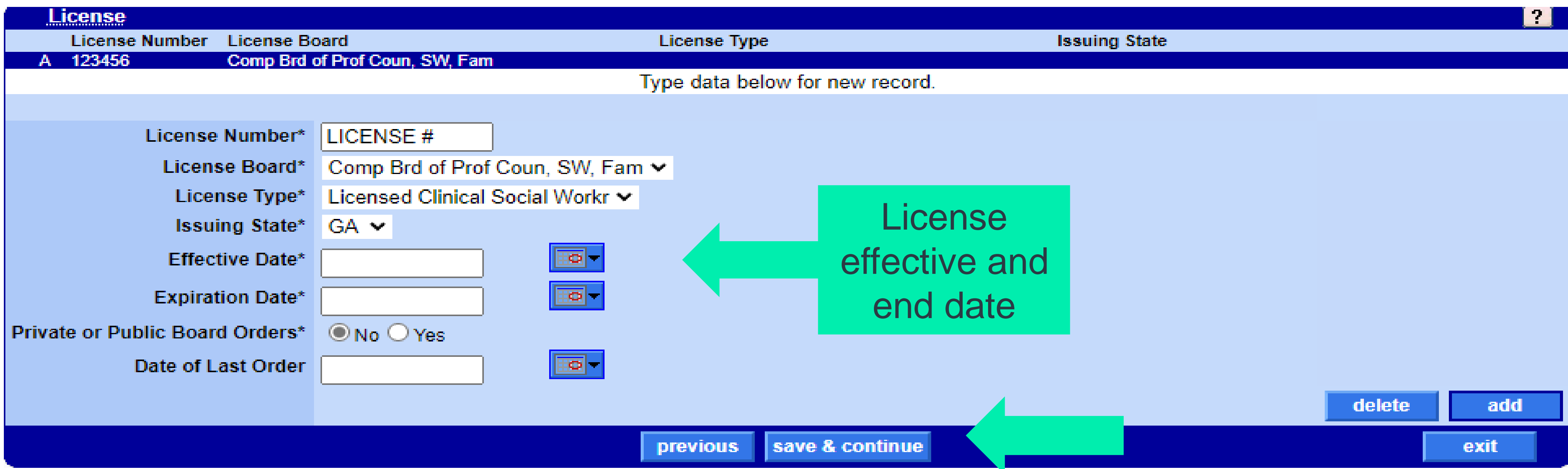
Special Need - Indicate as needed, save & continue



New Enrollment Application

(continued)

License - Indicate as needed, save & continue



New Enrollment Application

(continued)

Ownership Overview

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.

New Enrollment Application

(continued)

Owner - Indicate as needed, save & 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

Field	Value	Field	Value
Ownership Type*	Sole Proprietor (Individual filing under an EIN)	FEI Number	
Last Name*	TEST	SSN*	001010101
First Name, MI*	FIRST	Date of Birth*	01/01/1979
Title		Familial Relationship*	OTHER
	☑ Same as Service Location Address		
Address 1*	SERVICE LOCATION ADDRESS HERE	Phone	(800)766-4456
Address 2		Fax	(800)766-4451
City*	TUCKER	E-Mail Address	Needemailaddress@email.com
State*	GA		
Zip*	30085	% 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

New Enrollment Application
(continued)

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.

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

New Enrollment Application

(continued)

Employee – Indicate as needed, save & 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			
	Same as Service Location Address		
Address 1*	1 PEACHTREE	Phone	(800)766-4456
Address 2		Fax	(800)766-4451
City*	ATLANTA	E-Mail Address	
State*	GA		
Zip*	30085		

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

delete add

previous save & continue exit

New Enrollment Application

(continued)

Payee - GAMMIS will auto create a Payee Number once enrolled, save & 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

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

New Enrollment Application
(continued)

Additional Application Information as Applicable:

- Hours of Operation (military time only)
- Accessibility
- Education
- Training
- Work History (six-month gaps must have explanation)
- Insurance

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

History

Tell Us About Yourself…

History

*Note - 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
(continued)

Georgia Medicaid requires annual Fraud, Waste, and Abuse Training.

Training

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

Documentation Requirements

Don't forget to make sure that all required documents are uploaded…

Required Documents

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

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

Required Documents
(continued)

Supporting Document Overview

- **Bank Letter or Voided Check**
- **Curriculum Vitae** – Resume' *must include at least five years continuous work history. If there is a six-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.*

Required Documents
(continued)

Select Upload Required Documents to start the upload process

Select Upload

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

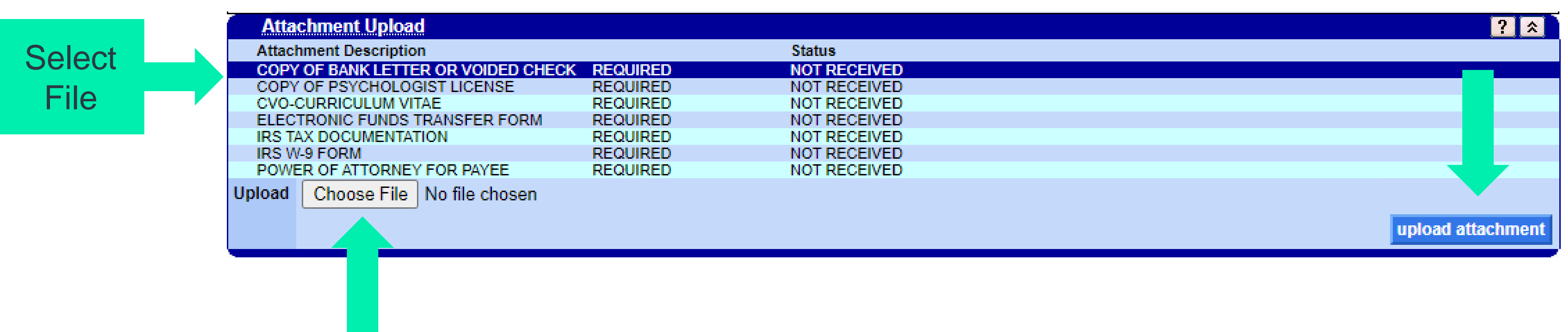
Required Documents
(continued)

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



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

Required Documents

(continued)

All Documents have been successfully uploaded.

Submitting Application

Your application still needs to be submitted

Submitting Application

(continued)

Georgia Medicaid Home | Enrollment Application | Attachment Uploads

https://www.betammis...gia.gov/portal/Default.aspx?tabid=65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GAMMIS
GEORGIA MEDICAID MANAGEMENT INFORMATION SYSTEM

gainwell

Welcome, livedummy

[Refresh session] You have approximately 17 minutes until your session will expire.

Tuesday, February 15, 2022

(click to hide) Alert Message posted 2/15/2022

UAT Testing Site

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

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

Submitting Application

(continued)

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

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

Submitting Application

(continued)

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)*: TEST | FIRST

Title:

Date: 02/15/2022

☑ I accept the terms of the Attestation Statement

Release of Information Statement

previous | save & continue | exit

Submitting Application
(continued)

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)* TEST FIRST

Title

Date 02/15/2022

☑ I accept the terms of the Statement of Participation   Statement of Participation

previous | save & continue | exit

Submitting Application

(continued)

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)*: TEST | FIRST

Title:

Date: 02/15/2022

☑ I accept the terms of the Policy Attestation Statement

previous | save & continue | exit

Submitting Application

(continued)

Application Successfully Submitted

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

Change Of Ownership

Change of Ownership Process

Three types of Change of Ownerships

1. Facilities that have been purchased by another company.
2. A practice that has been purchased by another company.
3. Facilities that have been purchased by another company and no changes are made to the business.

Change of Ownership Process
(continued)

Facilities that have been purchased by another company

Per the Part I Policy Manual, Section 105.9 2) Change of Ownership or Legal Status

The new provider/owner assumes the old provider/owner ID number. All payments, effective the date of the CMS approval date, will be paid to the new owner. The new owner must submit the facility enrollment application and appropriate support documentation. The new owner will assume all aspects of the business, including the provider ID number, NPI number and any liabilities that may have accrued.

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

Change of Ownership Process

(continued)

Facilities that have been purchased by another company

Per the Part I Policy Manual, Section 105.9 2) Change of Ownership or Legal Status

To allow for continuity of care and timely filing of claims, the successor shall submit claims using the predecessor's provider number while the Change of Ownership enrollment application is being processed. Failure to submit claims in a timely manner pursuant to Chapter 200 of this Part may result in denial of claims. Until the Change of Ownership is completed, claims will be processed, and payment will be made to the predecessor's payee number.

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

Change of Ownership Process
(continued)

Facilities that have been purchased by another company

Per the Part I Policy Manual, Section 105.9 2) Change of Ownership or Legal Status

A new payee number will be created for the new owner and claims will be paid to the newly created payee number beginning on the effective date in the system.

The DCH Provider Enrollment reviews the Change of Ownership applications for all facilities except for CCSP, Now/Comp, and Community Mental Health providers. In these cases, your enrollment documentation must be sent to Department of Behavioral Health and Developmental Disabilities (DBHDD) and Georgia Collaborative, www.georgiacollaborative.com or DCH CCSP, CCSPMessages@dch.ga.us.

The enrollment process for Change of Ownership applications is contingent upon the receipt of the CMS Tie-In Notice, if applicable. Should the CMS Tie-In Notice not be required for your contract, the application is processed upon receipt of all enrollment documentation.

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

Change of Ownership Process
(continued)

Facilities that have been purchased by another company

A practice that has been purchased by another company

To change a Tax ID for your individual practitioners resulting from a change of facility ownership, **all** of the following documents are required:

- Letter requesting and detailing the intended reason for the change.
- Power of Attorney for Payee for **all** Medicaid providers making the change.

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

Change of Ownership Process
(continued)

A practice that has been purchased by another company

- Electronic Funds Transfer Agreement (EFT) — The Electronic Funds Transfer Agreement (EFT) must ONLY reflect the Legal Business Name of the Payee and the relevant banking information. Include a voided check or letter from your bank verifying account information.
- Documentation from the Secretary of State reflecting the new name of the business.

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

Change of Ownership Process

(continued)

A practice that has been purchased by another company

- Confirmation from the IRS reflecting the legal name of the business and the tax ID number. The confirmation can be the Form 147-C, CP575-A, or Tax Coupon.
- Online Change of Information Form.
- Form W-9 — Should reflect the Legal Business name of the Payee, *(exactly as shown on the IRS confirmation documentation)*, DBA *(if applicable)*, and the mailing address for correspondence.

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

Change of Ownership Process

(continued)

Facilities that have been purchased by another company and no changes are made to the business.

If the new owner chooses to use the old owners FEIN, legal business name, staff, license or permit, the new owner will need to submit the online Disclosure of Ownership via the online change of information form to update the ownership information.

.

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

Credentials Verification Organization (CVO)

CVO Documentation Checklist

CVO Document Checklist

The following information and/or documentation is required for Enrollment or Recredentialing as an individual practitioner.

______ CVO-PROFESSIONAL CLAIMS INFORMATION FORM

______ CVO-CURRICULUM VITAE (Resume)

______ CVO-PROOF OF MALPRACTICE INSURANCE

______ CVO-BOARD CERTIFICATION (if applicable)

______ CVO-EXPLANATION OF REPORTED ACTION (REQUIRED IF ACTIONS REPORTED)

______ CVO-EXPLANATION OF WORK HISTORY GAPS

______ CVO-SPONSOR LETTER

______ CVO-RELEASE OF INFORMATION AGREEMENT

______ CVO-DEA CERTIFICATION (NURSE PRACTITIONER OR NURSE MIDWIFE, if applicable)

______ CVO REQUESTED DOCUMENT – Generic document used to upload anything the CVO requires after the application is submitted to the CVO

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

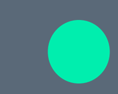
CVO Professional Liability Insurance (PLI) Policy

Practitioner Type	Minimum Malpractice Coverage Requirement (State of Georgia)
Physicians (MD/DO)	$1 million per occurrence $3 million in aggregate **Limits may not be shared**
Dentists (DMD/DDS)	$1 million per occurrence $3 million in aggregate **Limits may not be shared**
Podiatrists (DPM)	$1 million per occurrence $3 million in aggregate **Limits may not be shared**
Chiropractors (DC)	$1 million per occurrence $3 million in aggregate **Limits may not be shared**
Optometrists (OD)	$1 million per occurrence $1 million in aggregate **Limits may be shared**
Midwife	$1 million per occurrence $3 million in aggregate **Limits may not be shared**
Mid-Level Practitioners May include but not be limited to: Nurse Practitioners, Nurses, Physician Assistants, Naturopathic Physicians, Medical Psychologists	$1 million per occurrence $3 million in aggregate **Limits may be shared**
Non-Physician Behavioral Practitioners May include but not be limited to: Social Workers (Licensed, Masters), Psychologists, Counselors (Alcohol, Drug, Marriage, Family, Pastoral, etc.)	$1 million per occurrence $1 million in aggregate **Limits may be shared**
Allied Health Professionals May include but not be limited to: Speech Therapists, Physical Therapists, Occupational Therapists, Massage Therapists, Registered Dieticians	**Not applicable; malpractice coverage not required**

Umbrella policies are only acceptable if the documentation indicates professional liability (malpractice) coverage is included.

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

Common Application Denials



Common Application 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), W-9 and EFT Agreement.

- Payee Name must match on all forms i.e., Application, Power of Attorney, W-9 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.

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

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

Georgia Field Territories

Territory 1 N GA
Bartow, Catoosa, Chatooga, Cherokee, Dade, Dawson, Fannin, Floyd, Forsyth, Gilmer, Gordon, Habersham, Hall, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, Union, Walker, White, Whitfield

Territory 2 Atlanta
Fulton

Territory 3 NE GA
Banks, Barrow, Clarke, Elbert, Franklin, Gwinnett, Hart, Jackson, Madison, Oconee, Walton

Territory 4: NW GA
Carroll, Cobb, Douglas, Harolson, Paulding, Polk

Territory 5: SE Metro
Clayton, DeKalb, Rockdale

Territory 6: Middle GA
Butts, Chattahoochee, Coweta, Fayette, Harris, Heard, Henry, Jasper, Jones, Lamar, Marion, Meriwether, Monroe, Muscogee, Newton, Pike, Spalding, Talbot, Taylor, Troup, Upson

Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Territory 8: SW GA
Bibb, Bleckley, Calhoun, Clay, Crawford, Crisp, Dodge, Dooly, Dougherty, Houston, Laurens, Lee, Macon, Peach, Pulaski, Quitman, Randolph, Stewart, Schley, Sumter, Telfair, Terrell, Twiggs, Webster, Wheeler, Wilcox, Wilkinson

Territory 9: SE GA
Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Emanuel, Evans, Glynn, Jeff Davis, Long, Liberty, McIntosh, Montgomery, Pierce, Tattnall, Toombs, Treutlen, Ware, Wayne

Territory 10: South GA
Atkinson, Baker, Ben Hill, Barrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Tift, Turner, Worth

Territory 11 State Wide
Hospital Field Representative

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

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

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

Provider Relations Field Services Representatives

State-Wide Consultants

Sharée C. Daniels
Brenda Hulette
Danny Williams

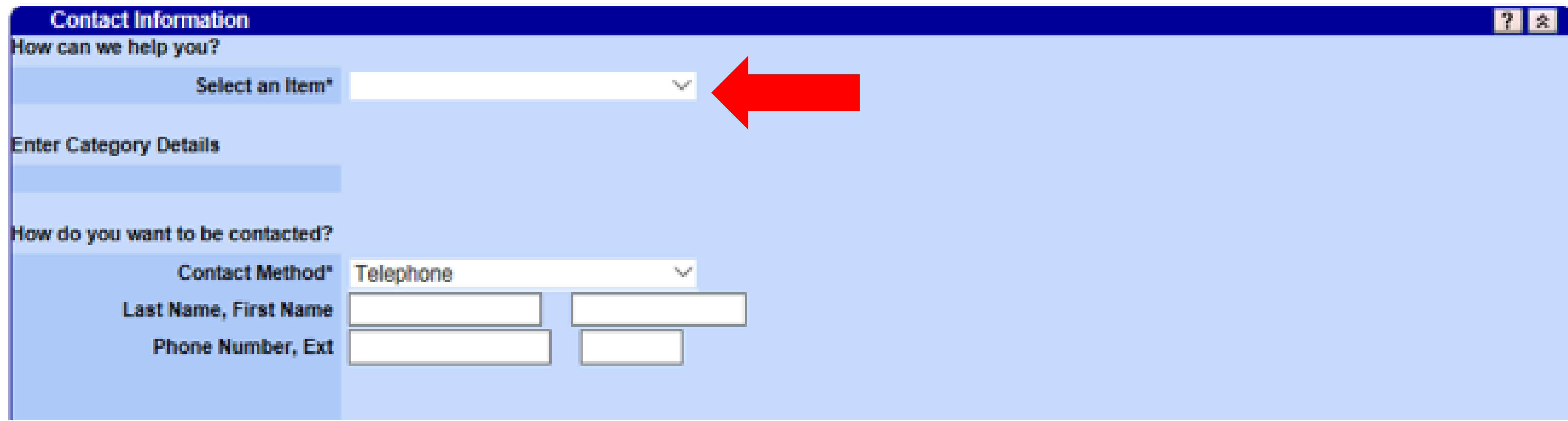
Contact My Provider Rep Directly

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

Contact My Provider Rep Directly

(continued)

Select an Item



Contact My Provider Rep Directly

(continued)

submit cancel

Contact Information

How can we help you?

Select an Item*

- 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

nter Category Details

How do you want to be contacted?

Contact Method*

Last Name, First Name

Phone Number, Ext

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) 325-9600 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

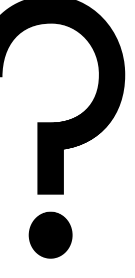
How do you want to be contacted?

Contact Method* Telephone

Last Name, First Name HP test

Phone Number, Ext (800)766-4456

Questions



Thank you

Contact
brand@gainwelltechnologies.com
gainwelltechnologies.com

Gainwell Technologies
1775 Tysons Blvd.
McLean, VA 22102