



# Provider Revalidation & Application Fees



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

# Agenda

- Objectives
- Revalidation of Enrollment Overview
- Application Fees
- How to Complete the Process
- Session Review
- Closing, Questions and Answers

# Objectives

The information presented will enable participants to:

- Understand the program background;
- Identify the providers that will be affected by the revalidation process;
- Complete the revalidation screens on the GAMMIS Web Portal.

# Revalidation of Enrollment

Section 6401 (a) of the Affordable Care Act (ACA) established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation initiative applies to those providers and suppliers that were enrolled in Georgia Medicaid prior to December 31, 2012. Newly enrolled providers and suppliers who were enrolled in Georgia Medicaid on or after January 1, 2013, are not immediately affected.



# Revalidation of Enrollment

*(continued)*

- Revalidation will initially affect all providers and suppliers who were enrolled in the Georgia Medicaid program prior to December 31, 2012.
- Providers enrolled in Georgia Medicaid after January 1, 2013, will be required to revalidate by calendar year 2018.
- All states are required to revalidate enrolled providers at intervals not to exceed every five years.
- Revalidating providers are subject to all required screening activities.

# Revalidation of Enrollment

*(continued)*

- DCH expects to implement Revalidation process in April 2014.
- Providers will receive notification 60 days prior to their respective deadline to revalidate.
- Notifications for revalidation will be sent to the "Mail To" or "Email" address listed on the provider's profile.
- Providers are encouraged to verify their 'Mail To' address on file by accessing the *Demographic Maintenance* feature of GAMMIS website.

# Revalidation of Enrollment

*(continued)*

- The revalidation process will be conducted only online through the Georgia Medicaid Management Information System (GAMMIS).
- No paper applications.
- Online application will consist of:
  - Provider name, date of birth, Social Security number, NPI, Tax ID, and service location address.
  - GAMMIS will verify current data against online application.

# Revalidation of Enrollment

*(continued)*

- Providers will have 120 days from the date of the initial notification letter to revalidate. Providers who fail to Revalidate their enrollment will be suspended from participation in Georgia Medicaid.
- Claims billed with dates of service on or after the deadline or suspension date will be denied.
- Suspended providers who submit revalidation materials and meet all federal and state guidelines will be re-enrolled in Georgia Medicaid.
- Back-dating enrollments for suspended providers is prohibited.

# Revalidation of Enrollment

*(continued)*

- If data in GAMMIS matches data on a submitted application then revalidation is approved.
- If data does not match, the provider will be sent notification of discrepancy and will be required to make changes to their enrollment file. Providers will have 30 days to update their enrollment file.
- It is very important that providers update their enrollment file prior to revalidation.

# Revalidation of Enrollment

*(continued)*

42 CFR 455.460 requires that states collect an application fee in the amount of \$532 from certain institutional providers to help defray the cost of background screening and reduce fraud, waste and abuse. The application fee is collected from certain prospective (new), re-enrolling, or revalidating providers prior to executing the Statement of Participation or provider agreement. The following are exempt from the application fee:

- (1) Individual physicians or non-physician practitioners.
- (2) Providers who have paid the application fee to
  - a. A Medicare contractor; or
  - b. Another state.

# Revalidation of Enrollment

*(continued)*

- The division may reject an enrollment application from a newly enrolling provider that is not accompanied by the application fee or by the hardship waiver form.
- Applicants or current providers may request a waiver of the application fee. The hardship waiver form can be found on GAMMIS and must be submitted with the enrollment or revalidation application.
- CMS makes the decision to approve or deny the waiver.



# Revalidation of Enrollment

*(continued)*

The following institutional providers are subject to the application fee at initial enrollment, and revalidation;

- Independent Laboratories
- Pharmacies
- Durable Medical Equipment
- Orthotics and Prosthetics (Facility)
- EMS, Ground
- EMS, Air
- Non-Emergency Transportation (NET)



# Revalidation of Enrollment

*(continued)*

- Net-Non-Emergency
- Community Mental Health
- Federally Qualified Health Centers
- Hospital-Based Rural Health Clinics
- Freestanding Rural Health Clinics
- Pregnancy Related Services (Facility)
- Perinatal Case Management (Facility)

# Application Fees – Initial Enrollment

DCH will begin collecting the application fees on **July 1, 2014**, for newly enrolled institutional providers.

The fees will be payable online through the HP Convenience Pay. No paper checks, cash or money orders will be accepted.

DCH will continue to allow new providers to submit enrollment applications via paper or through GAMMIS.

# How to Complete the Process

- Logon to the GAMMIS Web Portal at:  
<https://www.mmis.georgia.gov>.
- Log in to a secure Portal account, or create a secure Portal account if the provider does not already have one. **Providers who do not have a secure log in will need to contact the EDI Help Desk at 1-877-261-8785 to request a PIN or to reset their PIN.**
- Once logged in to a secure Portal account, select the Revalidate Your Provider Enrollment link under Home Page.

# How to Complete the Process

*(continued)*

## Instructions



Welcome to the online Provider Revalidation application.

- You must complete each step in the revalidation application. When you have completed all of the steps please click on the 'Submit' button to submit your 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.

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# How to Complete the Process

(continued)

**Provider Information** ?

Medicaid Provider ID [REDACTED] 22E  
Name [REDACTED] JOEL E  
Tax ID [REDACTED] 34  
SSN\* [REDACTED] 51  
Date of Birth\* 09/13/1963

**National Provider Identifier (NPI)**

Type I (Individual) NPI\* [REDACTED] 165 Type II (Organization) NPI [REDACTED] 92

**Contact Information**

The person who should be contacted regarding this application.

Contact Last Name\* LAST  
First Name, MI\* FIRST X  
Contact Phone\* (303)111-1111 1234  
Fax (303)222-2222  
Contact E-Mail Address\* email.address@gmail.com

previous save & continue exit

# How to Complete the Process

(continued)

Address Information					
Address Type	Address 1	City	State	Zip	Phone
SERVICE LOCATION	[REDACTED] ST	NEWNAN	GA	30263	[REDACTED]
MAIL TO	[REDACTED] BLVD	NEWNAN	GA	30264	[REDACTED]

  

Address Type	SERVICE LOCATION	Phone	[REDACTED]	77111
Address 1	[REDACTED]	Fax	[REDACTED]	
Address 2	APT 432	After Hours Phone	[REDACTED]	12333
City	NEWNAN	Location Open 24 Hours	YES	
State	GA	Location TDD/TTY Equipped	YES	
Zip	[REDACTED] 1941			
County	Coweta			
E-Mail Address	[REDACTED]			
Practice Web Site Address	[REDACTED]			

  

**Address Update**

Please navigate to Demographic Maintenance within the Providers menu to make immediate changes to your MAIL TO address, email, phone, after hours and fax numbers, handicap accessible and web site address information.

**Individual Practitioners:**  
Submit a Change of Information form if the provider is changing their location address because the practice is moving. Submit an additional location application if you are joining a new practice, adding a location under your existing practice or will be working under a new taxpayer identification number.

**Licensed Facilities:**  
A Change of Information form is required with a copy of the updated license which reflects the new address.

Will you be uploading a Change of Information form with this revalidation application?  No  Yes

# How to Complete the Process

(continued)

### Credentials ?

Credential Number	Credential Type	Licensing Board/Certifying Body	Credential Classification	Issuing State
████████	License	St Brd of Physical Therapy	Osteopathy	RI

Type data below for new record.

Credential Number	████████	Credential Type	License
Licensing Board/Certifying Body	St Brd of Physical Therapy	Issuing State	RI
Credential Classification	Osteopathy	Public Board Orders	NO
Effective Date	01/01/1990	Date of Last Order	
Expiration Date	12/31/2015		

#### Credential Update

If the credential information is not complete or accurate, please upload credential documents after submitting your application.

Will you be submitting updated credential information with this revalidation application?  No  Yes

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# How to Complete the Process

*(continued)*

Other Program Enrollment ?

Other Program Enrollment

Are you currently enrolled in Medicare?\*  No  Yes

Are you currently enrolled in another state's Medicaid Program?\*  No  Yes Medicaid State

Date Enrollment Fee Paid  

If enrolled in another program, please upload a copy of your Enrollment Payment Receipt after submission of this application.

# How to Complete the Process

(continued)

## Disclosure of Ownership and Control Interest Statement - Owners



### Owners

You have reached the Disclosure of Ownership section of your application. Before proceeding, please select the following link to review the disclosure of ownership and control interest statement policies and related definitions: [Disclosure of Ownership Policy and Definitions](#)

The applicant must disclose the Owner(s) of their facility or business. *Disclosing entity* means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

An owner means a person or corporation with an ownership or control interest that:

1. Has an ownership interest totaling 5 percent or more in a disclosing entity;
2. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
5. Is an officer or director of a disclosing entity that is organized as a corporation;  
or
6. Is a partner in a disclosing entity that is organized as a partnership.

A minimum of one Owner is required. Failure to provide **all** the required information may result in a denial for participation.

For Business Owners, Business Name is required. For Individual Owners, First and Last Name, Date of Birth, SSN and Familial Relationship are required.



# How to Complete the Process

(continued)

Ownership Type	Business Name	Last Name	First Name	FEI Number	Familial Relationship	% Owner
Other		LAST	FIRST	345345345	PARENT	5

Type data below for new record.

Ownership Type	Self (Individual filing under a SSN)	FEI Number	345345345
Business Name		SSN	534534534
Last Name	SMITH	Title	
First Name, MI	JOHN	Date of Birth	01/01/1988
Address 1	123 WASHINGTON AVE	Familial Relationship	NOT APPLICABLE (NOT RELATED)
Address 2		Phone	(303)111-2222
City	ATLANTA	Fax	
State	GA	E-Mail Address	john.smith@aol.com
Zip	30033 1233	% Owner	5

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

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# How to Complete the Process

(continued)

## 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.

Affiliation	Last Name	First Name	SSN	Familial Relationship
A Chief Financial Officer (CFO)*	HENRY	JILLIAN	369852111	OTHER
A Chief Executive Officer (CEO)*	JONES	WILLIAM	343243242	NOT APPLICABLE (NOT RELATED)

Type data below for new record.

Affiliation\* Chief Financial Officer (CFO)\*

Last Name\* HENRY

First Name, MI\* JILLIAN

Address 1\* 34566 AVE K

Address 2

City\* ATLANTA

State\* GA

Zip\* 31200

SSN\* 369852111

Title

Date of Birth\* 12/16/1967

Familial Relationship\* OTHER

Phone (303)444-7777

Fax

E-Mail Address jillian.hentry@gmail.com

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

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# How to Complete the Process

*(continued)*

Disclosure of Ownership and Control Interest Statement - Additional Ownership ?

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

Owner	FEI Number	Medicaid ID	Name	Ownership Type	Familial Relationship	% Owner
						0
SMITH, JOHN	123456789	000229622E	LIGHTNER, JOEL E	Partnership	NOT APPLICABLE (NOT RELATED)	45

Type data below for new record.

Owner: SMITH, JOHN

FEI Number: 123456789

**Additional Ownership in Medicaid Entities**

Medicaid ID\*

Name  JOEL E

Address  NEWNAN GA 30263-1941

Ownership Type\*  Partnership

Familial Relationship\*  NOT APPLICABLE (NOT RELATED)

% Owner\*  45

# How to Complete the Process

(continued)

Provider revalidation application for LIGHTNER

The Application Tracking Number (ATN) is : 404065

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

When submitting hard copy attachments, please mail to:  
Provider Enrollment & EDI Services  
PO Box 105201  
Tucker, GA 30085

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

Please also remember to submit the following required documents:

- No documents are required at this time.

WHAT'S NEXT?



# How to Complete the Process

(continued)

## WHAT'S NEXT?

- Pay Required Revalidation Fee
  - You may also pay the required fee at a later time from the Enrollment Status page.
  - Application Fee Information: Within thirty (30) days from the date of submission of an application, the Division may reject an enrollment application from a prospective (new) or re-enrolling individual or institutional provider that is not accompanied by the application fee or a letter requesting a hardship exception or waiver of the application fee.
- Print a copy of the application for your records. Print Application
  - If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. Click here to obtain the latest version of the free Adobe Reader.
  - Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. Click here for help with download issues.
- Required documents can be mailed, faxed, or uploaded:
  - Enrollment forms are available on this site.
  - Upload required documents.
    - Please allow 15 business (not calendar) days for attachments to be reviewed.
    - A scanned or faxed copy of the Power of Attorney for Payee will be accepted providing that:
      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.

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# How to Complete the Process

(continued)

Statement of Participation ?

DEPARTMENT OF COMMUNITY HEALTH  
DIVISION OF MEDICAL ASSISTANCE  
STATEMENT OF PARTICIPATION

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

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

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

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

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

This is to certify that

Name of Provider or Authorizing Agent\*

Title

Date 09/02/2013

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

previous submit exit



# Waiver of Application Fees

## Waiver of Application Fee ?

**Application Fee Information**  
42 CFR 455.460 requires that certain prospective (new), re-enrolling, or revalidating providers pay an application fee. Individual physicians or non-physician practitioners are exempt from the fee as well as those providers who have already paid the fee to a Medicare contractor or another State's Medicaid program. Section 105.3, Part I Policies and Procedures for Medicaid/Peachcare for Kids®, identifies the categories of service that are required to pay the application fee. Within thirty (30) days from the date of submission of an application, the Division may reject an enrollment application from a prospective (new) or re-enrolling individual or institutional provider that is not accompanied by the application fee or a letter requesting a hardship exception or waiver of the application fee.

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

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

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

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# Provider Services Contact Center (PSCC)

PSCC assists providers with inquiries regarding claims status, eligibility coverage, prior authorization, remittance advice, demographic changes and other Medicaid questions. They are available:

- 1-800-766-4456
- Monday – Friday (excluding state holidays)
- 7 a.m. – 7 p.m. Eastern Time
- Providers can also use the “Contact Us” link on the Web Portal at [www.mmis@georgia.gov](mailto:www.mmis@georgia.gov).

# DCH Frequently Asked Questions

Providers may also review additional information on the FAQ page of the DCH website at <http://dch.georgia.gov> and click through [DCH/Publications/FAQs/Medicaid-Providers](#)

# Session Review

You should now be able to

- Complete the provider revalidation process via the GAMMIS Web Portal.

# Closing and Q & A