

CHECK LIST FOR GROUP PROVIDER ENROLLMENT

1. SINGLE SIGN ON(SSO) USER ID AND PASSWORD
2. First Name, Last Name
3. Social Security Number
4. Date of Birth
5. National Provider Identifier (NPI)
6. Applicant Type
7. Email Address
8. **Add Provider Location**
 - a. Location Type (must have Primary Practice Location)
 - b. Address
 - c. Zip Code
 - d. Office Manager First Name
 - e. Office Manager Last Name
 - f. Office Manager SSN
 - g. Office Phone Number
9. **Add Address Location Types (must have Pay to and Correspondence Addresses)**
 - a. Pay To
 - b. Correspondence
 - c. Remittance Advice – Optional
10. **Provider Type**
 - a. Group
11. **Provider Specialty/Subspecialty for Groups**
 - a. Dental
 - b. Medical
12. **Mode of Claim Submission**
 - a. Data Exchange Gateway (DEG) - How Medicaid receives electronic claims from Billing Agents
 - b. Electronic Batch – Electric batch submitted directly from a Provider/Entity
 - c. Billing Agent – If a Provider uses a Billing Agent for electronic claim submissions
 - d. Online Direct Data Entry – Provider can submit their primary, secondary or tertiary claims to Medicaid one claim at a time on a claim form
 - e. Paper - Provider submits their claim on paper
13. **Associate Billing Agent**
 - a. Start Date of Billing Agent Association or you become a Billing Agent
 - b. Billing Agent ID #
14. **Owner Type**
 - a. Corporate – Charitable 501 [c] 3 – (Not for Profit)
 - b. Corporate – Non Charitable
 - c. Corporate
 - d. Foreign, Nonresident Alien
 - e. Government
 - f. Individual/sole Proprietor
 - g. Partnership

15. Add Provider Owner Details

- a. Legal Entity Name
- b. Entity Business Name
- c. Percentage Owned of Practice - Has to be at least 5% and no more than 100%
- d. Start Date of the Ownership
- e. Address, City, State and Zip Code
- f. Phone number of the practice
- g. Social Security Number of the Owner(s) (Please specify SSN if owner is individual/Sole Proprietor or EIN/TIN if owner is Entity/Corporation)

16. Taxonomy Code(s)

- a. Taxonomy code number(s)
- b. Start Date you reported the Taxonomy Code to Medicaid

17. Enrollment Checklist Questions:

- a. Do you need to request a Retro Enrollment Date? If yes, enter the requested Retro Enrollment Date in the comment field.
- b. Have you had any malpractice settlement, judgment or agreement? If yes, enter dollar amount(s) and date(s) in the comment field.
- c. Are you currently excluded from any State program?
- d. Are you currently excluded from any Federal program?
- e. Have you ever had a criminal or health related conviction?
- f. Have you ever had a judgment under any false claims act?
- g. Have you ever had a program exclusion/debarment?
- h. Have you ever had a civil monetary penalty?
- i. Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If yes, provide details in "Add Ownership Details" step.
- j. Are you accepting new clients?

REQUIRED INFORMATION