

CHECK LIST FOR INDIVIDUAL RENDERING & SERVICING 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. **Provider Type**
 - a. Chiropractic
 - b. Dental
 - c. Non-Physicians
 - d. Optometry
 - e. Physicians
 - f. Podiatry
9. **Provider Specialty/Subspecialty Information for Physicians**
 - a. If you select Provider Type (Physicians), then Board Certified and Certificate number may be required
10. **Associate Billing Provider**
 - a. Billing Provider NPI number
 - b. Start Date (when the association began)
11. **License/Certification Type (drop down list)**
 - a. Depending on Provider Type

| Provider Type | Required | Optional | Provider Type | Required | Optional |
|---|----------|----------|--------------------------|----------|----------|
| | | | | | |
| Physicians | | | Chiropractic | | |
| Medical Professional License | X | | License | X | |
| DEA | | X | Optometry | | |
| CLIA | | X | License | X | |
| Non-Physicians | | | Podiatry | | |
| Nurse Practitioners/ Clinical Nurse Specialists - Acute Care | | | License | X | |
| License | X | | | | |
| State Certificate | X | | Dental Physicians | | |
| Certified Nurse Midwife | | | | | |
| License | X | | License | X | |
| State Certificate | X | | | | |

- b. License/Certification #
- c. Effective Date of License/Certification #

12. Taxonomy Code(s)

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

13. 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. Are you accepting new clients?
- c. Have you had any malpractice settlement, judgment or agreement? If yes, enter dollar amount(s) and date(s) in the comment field.
- d. If a Nurse Practitioner or Nurse Midwife a collaborative agreement is required.
- e. Are you currently excluded from any State program?
- f. Are you currently excluded from any Federal program?
- g. Have you ever had a criminal or health related conviction?
- h. Have you ever had a judgment under any false claims act?
- i. Have you ever had a program exclusion/debarment?
- j. Have you ever had a civil monetary penalty?
- k. Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?
- l. Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If yes, provide details in “Add Ownership Details” step.

REQUIRED INFORMATION