# MS Medicaid Provider Enrollment

Important Updates to Mississippi Medicaid Provider Enrollment

MISSISSIPPI DIVISION OF MEDICAID

CONDUENT

# Agenda

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# Provider Enrollment Tips

- Please print or type your application.
- Complete all applicable areas of the application.
- Be sure to review the Credentialing Checklist for your Provider Type for any specific information that may be required.
- Do not use Correction fluid/white-out on any part of the application.
- Original signatures are no longer required, however:
  - Individual applications must be signed by the individual applying.
  - Group applications must be signed by the owner of the group or a person granted signature authority by the Board of Directors Resolution Form.
- Retain a copy of your completed application for your records.

# Enrollment Package

# General Application Information

- Complete all addresses in Section 1 (page 2).
- The Social Security Number (individual) or Tax-id Number (group) should be entered in Section 2 (page 3).
- Be sure to select the appropriate Provider Type in which you are applying for. **For all Waiver Services provider types, a proposal approval letter from the Division of Medicaid, as well as an approval letter from the Department of Health (for some waiver type cases) must be submitted with your completed enrollment application. (Effective July 1)**
- For MD's and DO's, you must list your Specialty in Section 3 (page 5) of the application.
- If applying as a Group Provider, please indicate the active Individual Provider information in Section 4 (page 6).

# General Application Information Cont.

- The Ownership Section (Section 7), pages 8-10 must be completed for all groups whether the owner is an Individual, County, City, or Corporation.
- Answer all sanction questions on page 10, and please mark none of these on page 10 if none of the questions apply.
- The application must be signed by the appropriate person on page 13 directly below the 6 statements (Section 11).
- NPI verification must be submitted. Must have confirmation from the NPPES site: https://nppes.cms.hhs.gov/NPPES/Welcome.do

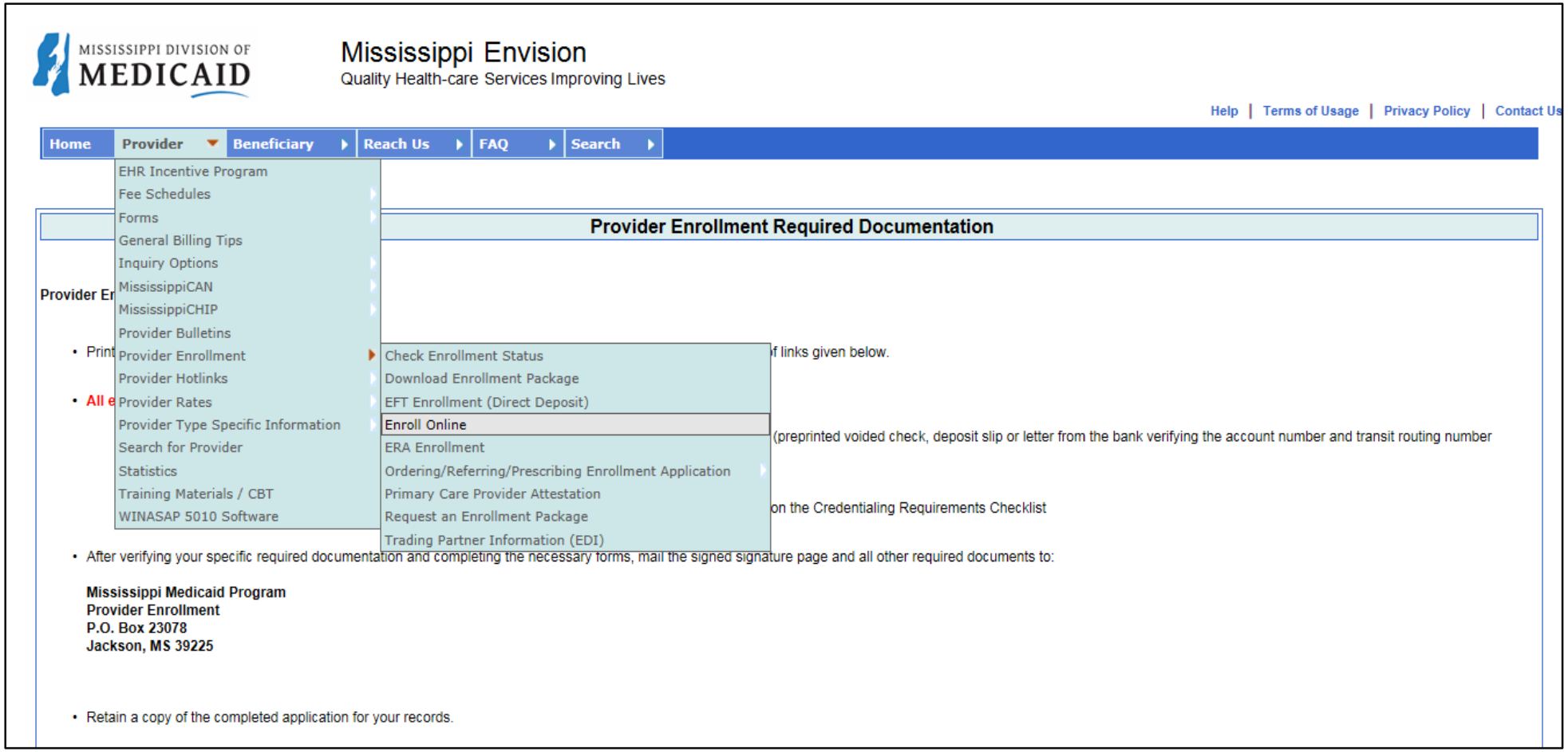
# General Application Information Cont.

**Completed applications may be mailed in its entirety to the address below:**

Xerox State Healthcare
ATTENTION: Provider Enrollment
P.O. Box 23078
Jackson, MS 39225

**Or faxed to:**
1-888-495-8169

# Enrollment Online



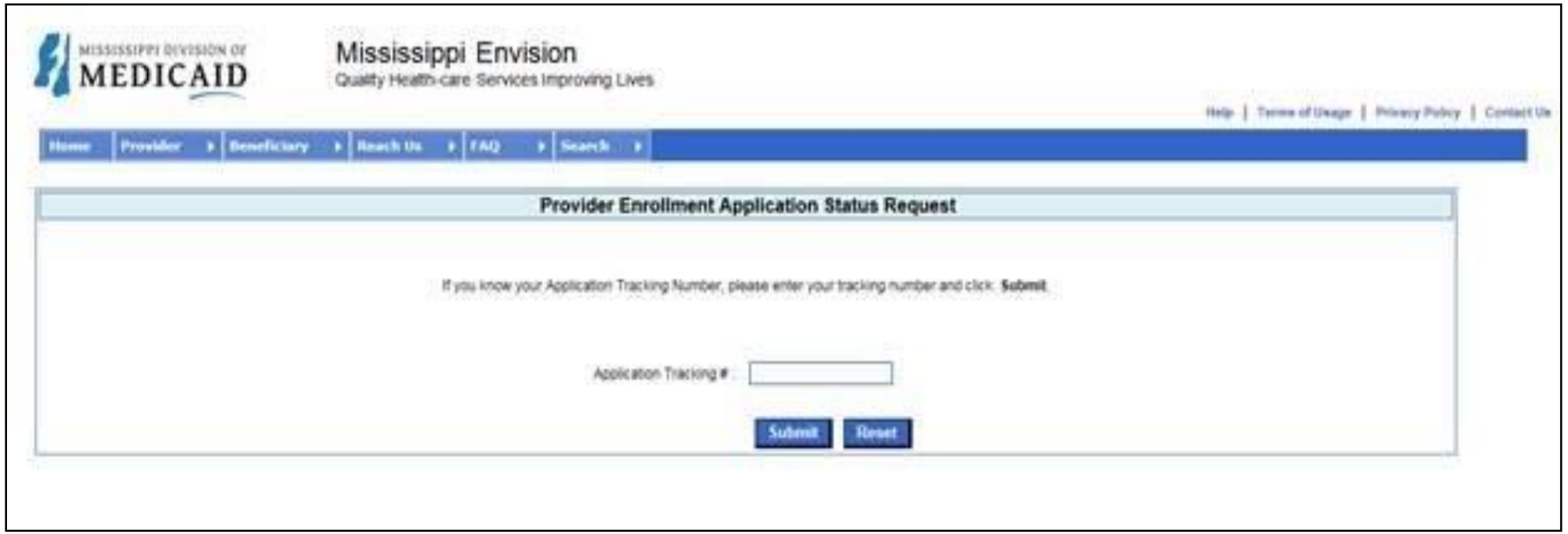
# Enrollment Online


***Provider < Provider Enrollment < Enroll Online***

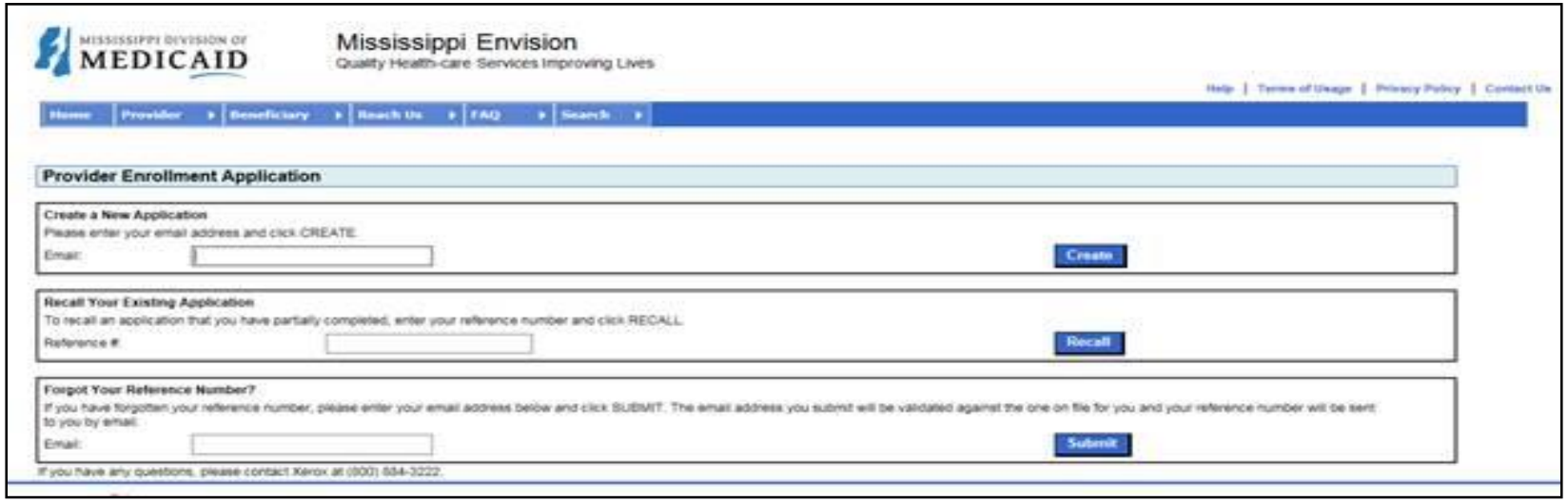
**Create a New Application** – To submit a Provider Enrollment Application online, the Provider must enter a valid email address to start the online application.

# Checking Application Status

# Checking Application Status Cont.

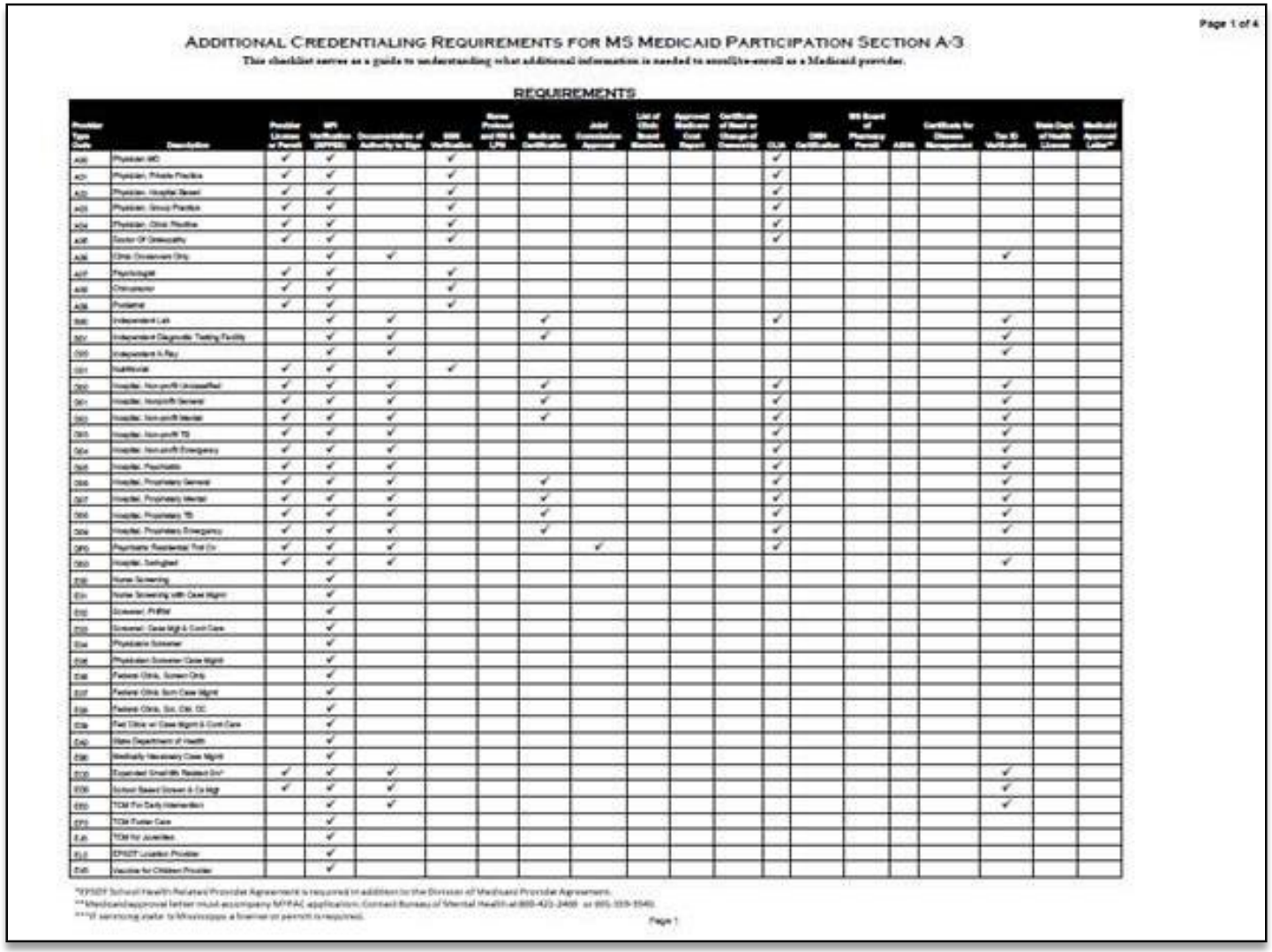


# Checking Application Status Cont.




- **Recall Your Existing Application** – Once the Provider starts the online application, the application will be given a Reference Number. The Provider can save the application and use the Reference Number to refer back to the saved application.
- **Forgot Your Reference Number** – The Provider can enter valid email to get the Reference Number associated with that email address.

# Credentialing Checklist



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ADDITIONAL CREDENTIALING REQUIREMENTS FOR MS MEDICAID PARTICIPATION SECTION A/3

This checklist serves as a guide to understanding what additional information is needed to enroll/re-enroll as a Medicaid provider.

REQUIREMENTS

| Provider Type Code | Description | Provider License or Permit | MS Verification (MPPAC) | Documentation of Authority to Sign | SSN Verification | Home Protocol and RN & LPN | Medicare Certification | Joint Commission Approval | List of Clinic Board Members | Approved Medicare Cost Report | Certificate of Need or Change of Ownership | CLIA | CMS Certification | MS Board of Pharmacy Permit | ASHA | Certificate for Disease Management | Tax ID Verification | State Dept. of Health License | Medicaid Approval Letter** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A00 | Physician MD | ✓ | ✓ | | ✓ | | | | | | | ✓ | | | | | | | |
| A01 | Physician, Private Practice | ✓ | ✓ | | ✓ | | | | | | | ✓ | | | | | | | |
| A02 | Physician, Hospital Based | ✓ | ✓ | | ✓ | | | | | | | ✓ | | | | | | | |
| A03 | Physician, Group Practice | ✓ | ✓ | | ✓ | | | | | | | ✓ | | | | | | | |
| A04 | Physician, Clinic Practice | ✓ | ✓ | | ✓ | | | | | | | ✓ | | | | | | | |
| A05 | Doctor Of Osteopathy | ✓ | ✓ | | ✓ | | | | | | | ✓ | | | | | | | |
| A06 | Clinic, Dictation Only | | ✓ | ✓ | | | | | | | | | | | | | ✓ | | |
| A07 | Psychologist | ✓ | ✓ | | ✓ | | | | | | | | | | | | | | |
| A08 | Chiropractor | ✓ | ✓ | | ✓ | | | | | | | | | | | | | | |
| A09 | Podiatrist | ✓ | ✓ | | ✓ | | | | | | | | | | | | | | |
| B00 | Independent Lab | | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| B01 | Independent Diagnostic Testing Facility | | ✓ | ✓ | | | ✓ | | | | | | | | | | ✓ | | |
| D00 | Independent X-Ray | | ✓ | ✓ | | | | | | | | | | | | | ✓ | | |
| D01 | Nutritionist | ✓ | ✓ | | ✓ | | | | | | | | | | | | | | |
| D02 | Hospital, Non-profit Unclassified | ✓ | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| D03 | Hospital, Non-profit General | ✓ | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| D04 | Hospital, Non-profit Mental | ✓ | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| D05 | Hospital, Non-profit TB | ✓ | ✓ | ✓ | | | | | | | | ✓ | | | | | ✓ | | |
| D06 | Hospital, Non-profit Emergency | ✓ | ✓ | ✓ | | | | | | | | ✓ | | | | | ✓ | | |
| D07 | Hospital, Psychiatric | ✓ | ✓ | ✓ | | | | | | | | ✓ | | | | | ✓ | | |
| D08 | Hospital, Proprietary General | ✓ | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| D09 | Hospital, Proprietary Mental | ✓ | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| D10 | Hospital, Proprietary TB | ✓ | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| D11 | Hospital, Proprietary Emergency | ✓ | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | ✓ | | |
| D12 | Psychiatric Residential Trt Ctr | ✓ | ✓ | ✓ | | | | ✓ | | | | ✓ | | | | | | | |
| D13 | Hospital, Swingbed | ✓ | ✓ | ✓ | | | | | | | | | | | | | ✓ | | |
| E00 | Nurse Screening | | ✓ | | | | | | | | | | | | | | | | |
| E01 | Nurse Screening with Case Mgmt | | ✓ | | | | | | | | | | | | | | | | |
| E02 | Screener, Profile | | ✓ | | | | | | | | | | | | | | | | |
| E03 | Screener, Case Mgt & Cont Care | | ✓ | | | | | | | | | | | | | | | | |
| E04 | Physicians Screener | | ✓ | | | | | | | | | | | | | | | | |
| E05 | Physician Screener Case Mgmt | | ✓ | | | | | | | | | | | | | | | | |
| E06 | Patient Clinic, Screen Only | | ✓ | | | | | | | | | | | | | | | | |
| E07 | Patient Clinic Scrn Case Mgmt | | ✓ | | | | | | | | | | | | | | | | |
| E08 | Patient Clinic, Scr, Clin, CC | | ✓ | | | | | | | | | | | | | | | | |
| E09 | Pat Clinic w/ Case Mgmt & Cont Care | | ✓ | | | | | | | | | | | | | | | | |
| E40 | State Department of Health | | ✓ | | | | | | | | | | | | | | | | |
| E80 | Medically Necessary Case Mgmt | | ✓ | | | | | | | | | | | | | | | | |
| E00 | Expanded Small Rural Scr* | ✓ | ✓ | ✓ | | | | | | | | | | | | | ✓ | | |
| E00 | School Based Screen & Ca Mgt | ✓ | ✓ | ✓ | | | | | | | | | | | | | ✓ | | |
| E01 | TCM Trt Daily Intervention | | ✓ | ✓ | | | | | | | | | | | | | ✓ | | |
| E11 | TCM Foster Care | | ✓ | | | | | | | | | | | | | | | | |
| E-A | TCM for Juveniles | | ✓ | | | | | | | | | | | | | | | | |
| E-J | EPSDT Location Provider | | ✓ | | | | | | | | | | | | | | | | |
| E45 | Vaccine for Children Provider | | ✓ | | | | | | | | | | | | | | | | |

*EPSDT School Health Related Provider Agreement is required in addition to the Division of Medicaid Provider Agreement.

**Medicaid approval letter must accompany MPPAC application. Contact Bureau of Mental Health at 800-421-2408 or 601-359-1640.

***If servicing state is Mississippi a license or permit is required.

Page 1

# Supporting Documentation

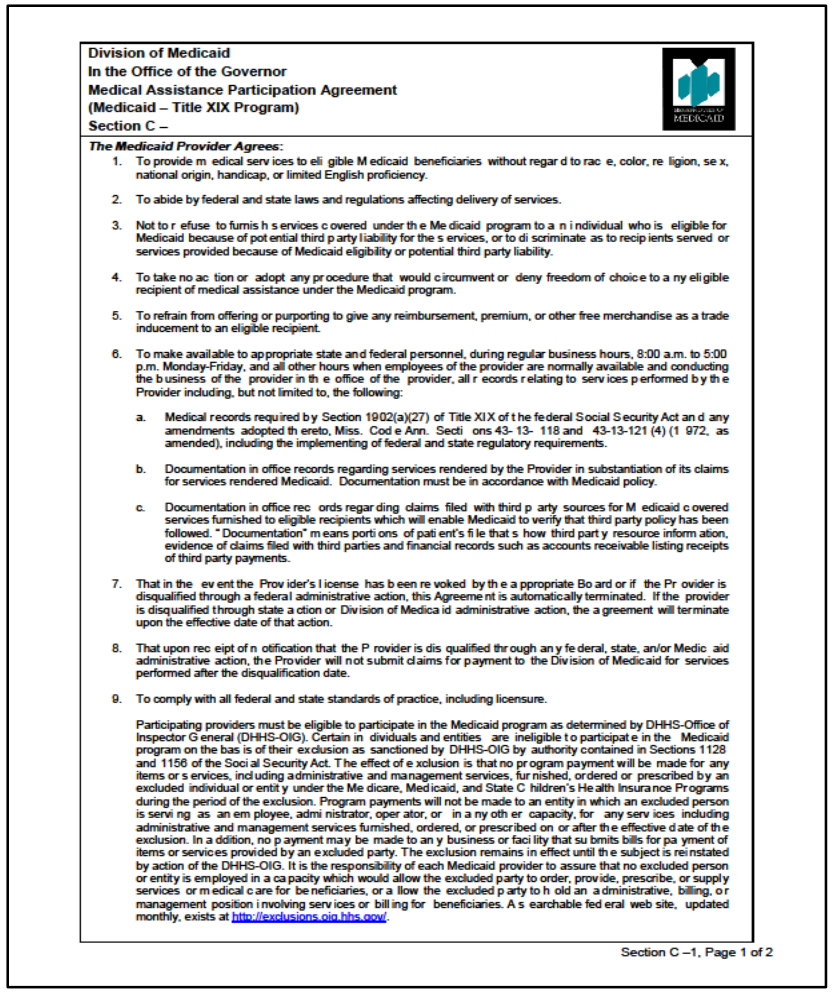
Additional or Supporting Documents will vary by Provider Types. You can find these requirements on the Credentialing Checklist within the application. However, the most basic requirements that are the same across the board are listed below:

- Application with signature
- Direct Deposit Authorization Agreement
- Voided check or other acceptable bank verification
- License
- Provider Participation Agreement
- W-9
- Social Security or IRS Verification
- Civil Rights Compliance Packet
- NPI Verification
- CLIA form, if applicable

**Note: When completing the application online, please include the Application Tracking number on each supporting document.**

# Forms

## Provider Participation Agreement



**Division of Medicaid**
**In the Office of the Governor**
**Medical Assistance Participation Agreement**
**(Medicaid – Title XIX Program)**
**Section C –**

***The Medicaid Provider Agrees:***

1. To provide medical services to eligible Medicaid beneficiaries without regard to race, color, religion, sex, national origin, handicap, or limited English proficiency.
2. To abide by federal and state laws and regulations affecting delivery of services.
3. Not to refuse to furnish services covered under the Medicaid program to an individual who is eligible for Medicaid because of potential third party liability for the services, or to discriminate as to recipients served or services provided because of Medicaid eligibility or potential third party liability.
4. To take no action or adopt any procedure that would circumvent or deny freedom of choice to any eligible recipient of medical assistance under the Medicaid program.
5. To refrain from offering or purporting to give any reimbursement, premium, or other free merchandise as a trade inducement to an eligible recipient.
6. To make available to appropriate state and federal personnel, during regular business hours, 8:00 a.m. to 5:00 p.m. Monday-Friday, and all other hours when employees of the provider are normally available and conducting the business of the provider in the office of the provider, all records relating to services performed by the Provider including, but not limited to, the following:
   a. Medical records required by Section 1902(a)(27) of Title XIX of the federal Social Security Act and any amendments adopted thereto, Miss. Code Ann. Sections 43-13-118 and 43-13-121 (4) (1972, as amended), including the implementing of federal and state regulatory requirements.
   b. Documentation in office records regarding services rendered by the Provider in substantiation of its claims for services rendered Medicaid. Documentation must be in accordance with Medicaid policy.
   c. Documentation in office records regarding claims filed with third party sources for Medicaid covered services furnished to eligible recipients which will enable Medicaid to verify that third party policy has been followed. " Documentation" means portions of patient's file that show third party resource information, evidence of claims filed with third parties and financial records such as accounts receivable listing receipts of third party payments.
7. That in the event the Provider's license has been revoked by the appropriate Board or if the Provider is disqualified through a federal administrative action, this Agreement is automatically terminated. If the provider is disqualified through state action or Division of Medicaid administrative action, the agreement will terminate upon the effective date of that action.
8. That upon receipt of notification that the Provider is disqualified through any federal, state, and/or Medicaid administrative action, the Provider will not submit claims for payment to the Division of Medicaid for services performed after the disqualification date.
9. To comply with all federal and state standards of practice, including licensure.

   Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children's Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries. A searchable federal web site, updated monthly, exists at http://exclusions.oig.hhs.gov/.

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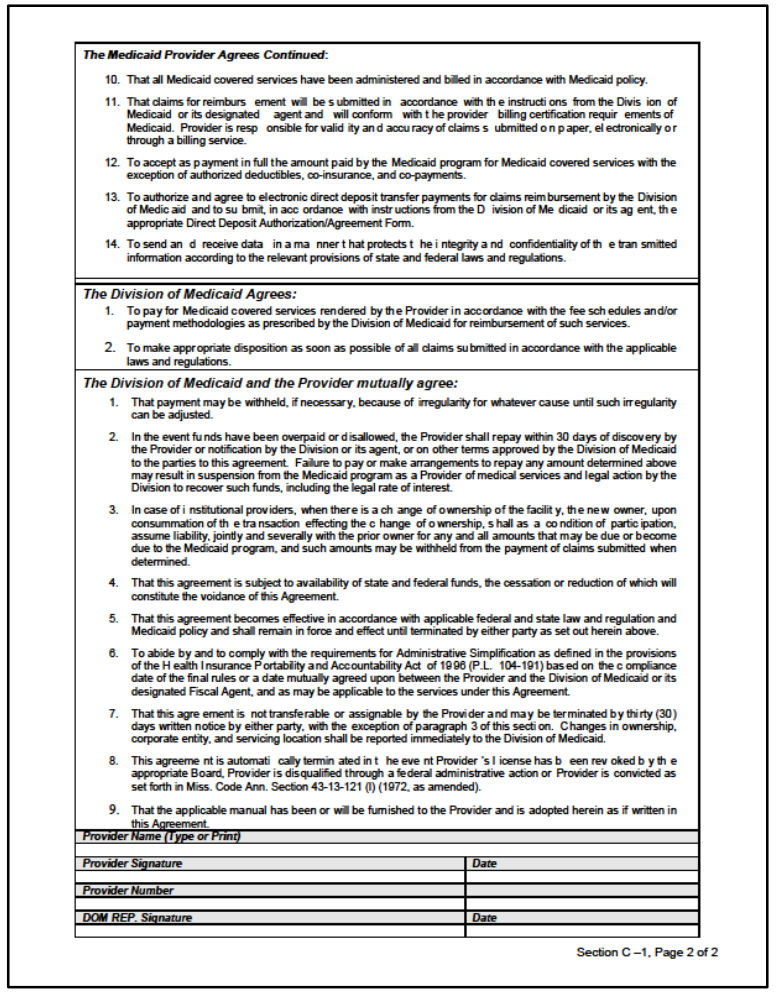


***The Medicaid Provider Agrees Continued:***

10. That all Medicaid covered services have been administered and billed in accordance with Medicaid policy.
11. That claims for reimbursement will be submitted in accordance with the instructions from the Division of Medicaid or its designated agent and will conform with the provider billing certification requirements of Medicaid. Provider is responsible for validity and accuracy of claims submitted on paper, electronically or through a billing service.
12. To accept as payment in full the amount paid by the Medicaid program for Medicaid covered services with the exception of authorized deductibles, co-insurance, and co-payments.
13. To authorize and agree to electronic direct deposit transfer payments for claims reimbursement by the Division of Medicaid and to submit, in accordance with instructions from the Division of Medicaid or its agent, the appropriate Direct Deposit Authorization/Agreement Form.
14. To send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of state and federal laws and regulations.

***The Division of Medicaid Agrees:***

1. To pay for Medicaid covered services rendered by the Provider in accordance with the fee schedules and/or payment methodologies as prescribed by the Division of Medicaid for reimbursement of such services.
2. To make appropriate disposition as soon as possible of all claims submitted in accordance with the applicable laws and regulations.

***The Division of Medicaid and the Provider mutually agree:***

1. That payment may be withheld, if necessary, because of irregularity for whatever cause until such irregularity can be adjusted.
2. In the event funds have been overpaid or disallowed, the Provider shall repay within 30 days of discovery by the Provider or notification by the Division or its agent, or on other terms approved by the Division of Medicaid to the parties to this agreement. Failure to pay or make arrangements to repay any amount determined above may result in suspension from the Medicaid program as a Provider of medical services and legal action by the Division to recover such funds, including the legal rate of interest.
3. In case of institutional providers, when there is a change of ownership of the facility, the new owner, upon consummation of the transaction effecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined.
4. That this agreement is subject to availability of state and federal funds, the cessation or reduction of which will constitute the voidance of this Agreement.
5. That this agreement becomes effective in accordance with applicable federal and state law and regulation and Medicaid policy and shall remain in force and effect until terminated by either party as set out herein above.
6. To abide by and to comply with the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Provider and the Division of Medicaid or its designated Fiscal Agent, and as may be applicable to the services under this Agreement.
7. That this agreement is not transferable or assignable by the Provider and may be terminated by thirty (30) days written notice by either party, with the exception of paragraph 3 of this section. Changes in ownership, corporate entity, and servicing location shall be reported immediately to the Division of Medicaid.
8. This agreement is automatically terminated in the event Provider's license has been revoked by the appropriate Board, Provider is disqualified through a federal administrative action or Provider is convicted as set forth in Miss. Code Ann. Section 43-13-121 (i) (1972, as amended).
9. That the applicable manual has been or will be furnished to the Provider and is adopted herein as if written in this Agreement.

| ***Provider Name (Type or Print)*** | |
|---|---|
| ***Provider Signature*** | ***Date*** |
| ***Provider Number*** | |
| ***DOM REP. Signature*** | ***Date*** |

Section C –1, Page 2 of 2

# Forms

## Board of Directors

**Board of Directors Resolution Form**
**Section C - 2**
Required for non-individual applicants only and must be an original, notarized form.

**For non-individual applicants, this form must only be filled out once and submitted with the application for the group/payee number.**

State of _____

County of _____

On the _____ day of _____ . _____ at a meeting of the Board

of Directors of _____ , held in the City of _____ .

in _____ County, with a quorum of the directors present, the following business was conducted:

It was duly moved and seconded that the following resolution be adopted:
Be it resolved that the Board of Directors does hereby authorize

_____

and his/her successors in office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Mississippi Medicaid agency and to execute said contract or contracts, and further we do hereby give him/her the power and authority to do all things necessary to implement, maintain, amend, or renew said contract.

The above resolution was passed by a majority of those present and voting in accordance with the bylaws.

I certify that the above constitutes a true and correct copy of a part of the minutes of a meeting of the

Board of Directors of _____

Held on the _____ day of _____ . _____

_____
Signature of Board Member

Subscribed and sworn before me, _____, a Notary Public for the

County of _____, on the _____ day of _____

| *Notary Stamp/Seal* | *Notary County Of* |
| --- | --- |
| | |
| | *State Of* |
| | |

# Forms

## Board of Directors Resolution Forms

- This form is only required when there is more than one owner or if the owner is a corporation, group, city or county entity.
- This form is also required if there is only one owner, yet that owner would like to grant someone else signature authority.
- A person cannot authorize themselves.
- The form must be notarized.
- Only the person authorized is allowed to sign any and all documents contained in the application with the exception of the W-9.
- In lieu of this form, an organization may include their meeting minutes if it lists the person authorized to sign on behalf of the group. The minutes must be signed and notarized.

# Forms

## Direct Deposit Authorization Agreement

**DIRECT DEPOSIT AUTHORIZATION /AGREEMENT Form**
**Section C – 4 (Page 1 of 1)**

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to:

**Mississippi Medicaid Program**
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

☐ New Application ☐ Change Bank Account Information

*NOTE*: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding $20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would other wise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than $10 million per year. This process has been underway since October 26, 1992 and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically.

**Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.**

| *Provider Name* | *Provider Contact* |
|---|---|
| | |
| *Provider Number* | *Provider Telephone Number* |
| | |

*Provider's Address (City, State and Zip Code)*

*Bank Name*

*Bank Address (City, State and Zip Code)*

*Bank Account Number*

*Bank Transit/Routing Number*

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Medicaid agency to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered.

**I further understand that in the event my bank account information were to change, I must notify the Mississippi Medicaid agency in order to change my bank account information immediately. I will not hold the Mississippi Medicaid agency liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.**

| *Provider Signature* | *Date* |
|---|---|
| | |

# Forms

IRS Form W-9

Form **W-9**
(Rev. January 2002)
Department of the Treasury
Internal Revenue Service

**Section C-5 Request for Taxpayer Identification Number and Certification**

**Give form to the requester. Do not send to the IRS.**

Print or type
See Specific Instructions on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

**Part I** Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

**Note:** *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
___ - ___ - ____

or

Employer identification number
__ - _______

**Part II** Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

**Sign Here** Signature of U.S. person ► Date ►

## Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**Use Form W-9 only if you are a U.S. person** (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

**If you are a foreign person, use the appropriate Form W-8.** See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities.

**Note:** *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments **after** December 31, 2001 (29% **after** December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You **will not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate **Instructions for the Requester of Form W-9.**

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

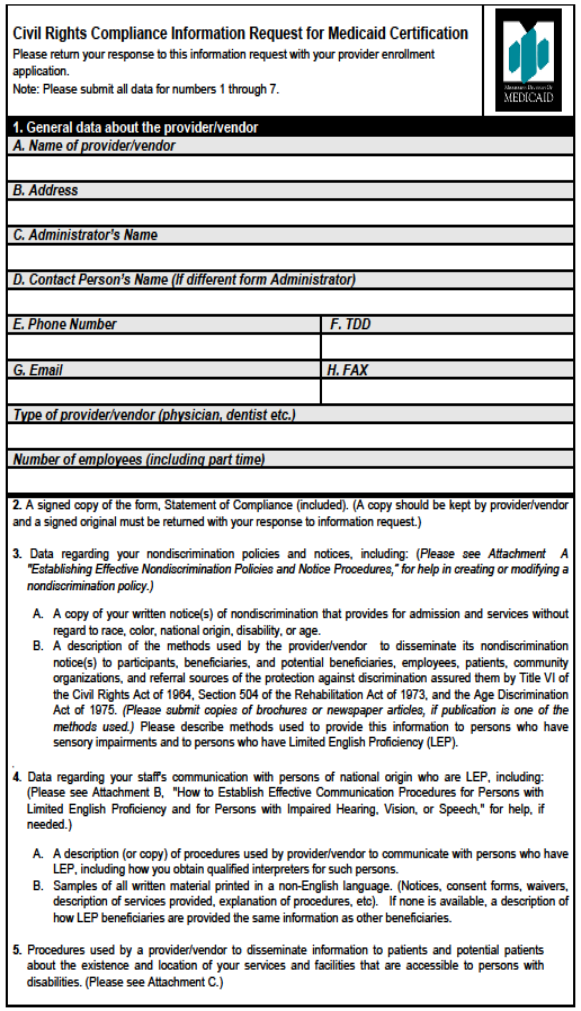
**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

# Forms

## Civil Rights Compliance Package



**Civil Rights Compliance Information Request for Medicaid Certification**

Please return your response to this information request with your provider enrollment application.

Note: Please submit all data for numbers 1 through 7.

**1. General data about the provider/vendor**

*A. Name of provider/vendor*

*B. Address*

*C. Administrator's Name*

*D. Contact Person's Name (If different form Administrator)*

| *E. Phone Number* | *F. TDD* |
|---|---|
| | |
| *G. Email* | *H. FAX* |
| | |

*Type of provider/vendor (physician, dentist etc.)*

*Number of employees (including part time)*

**2.** A signed copy of the form, Statement of Compliance (included). (A copy should be kept by provider/vendor and a signed original must be returned with your response to information request.)

**3.** Data regarding your nondiscrimination policies and notices, including: (*Please see Attachment A "Establishing Effective Nondiscrimination Policies and Notice Procedures," for help in creating or modifying a nondiscrimination policy.)*

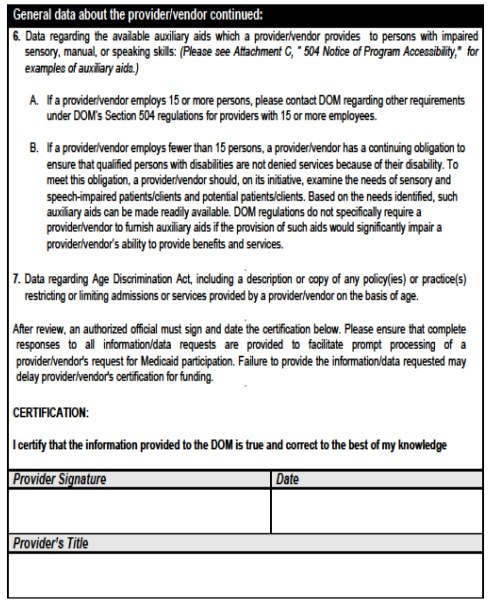
A. A copy of your written notice(s) of nondiscrimination that provides for admission and services without regard to race, color, national origin, disability, or age.
B. A description of the methods used by the provider/vendor to disseminate its nondiscrimination notice(s) to participants, beneficiaries, and potential beneficiaries, employees, patients, community organizations, and referral sources of the protection against discrimination assured them by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. *(Please submit copies of brochures or newspaper articles, if publication is one of the methods used.)* Please describe methods used to provide this information to persons who have sensory impairments and to persons who have Limited English Proficiency (LEP).

**4.** Data regarding your staff's communication with persons of national origin who are LEP, including: (Please see Attachment B, "How to Establish Effective Communication Procedures for Persons with Limited English Proficiency and for Persons with Impaired Hearing, Vision, or Speech," for help, if needed.)

A. A description (or copy) of procedures used by provider/vendor to communicate with persons who have LEP, including how you obtain qualified interpreters for such persons.
B. Samples of all written material printed in a non-English language. (Notices, consent forms, waivers, description of services provided, explanation of procedures, etc). If none is available, a description of how LEP beneficiaries are provided the same information as other beneficiaries.

**5.** Procedures used by a provider/vendor to disseminate information to patients and potential patients about the existence and location of your services and facilities that are accessible to persons with disabilities. (Please see Attachment C.)





**General data about the provider/vendor continued:**

**6.** Data regarding the available auxiliary aids which a provider/vendor provides to persons with impaired sensory, manual, or speaking skills: *(Please see Attachment C, " 504 Notice of Program Accessibility," for examples of auxiliary aids.)*

A. If a provider/vendor employs 15 or more persons, please contact DOM regarding other requirements under DOM's Section 504 regulations for providers with 15 or more employees.

B. If a provider/vendor employs fewer than 15 persons, a provider/vendor has a continuing obligation to ensure that qualified persons with disabilities are not denied services because of their disability. To meet this obligation, a provider/vendor should, on its initiative, examine the needs of sensory and speech-impaired patients/clients and potential patients/clients. Based on the needs identified, such auxiliary aids can be made readily available. DOM regulations do not specifically require a provider/vendor to furnish auxiliary aids if the provision of such aids would significantly impair a provider/vendor's ability to provide benefits and services.

**7.** Data regarding Age Discrimination Act, including a description or copy of any policy(ies) or practice(s) restricting or limiting admissions or services provided by a provider/vendor on the basis of age.

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided to facilitate prompt processing of a provider/vendor's request for Medicaid participation. Failure to provide the information/data requested may delay provider/vendor's certification for funding.

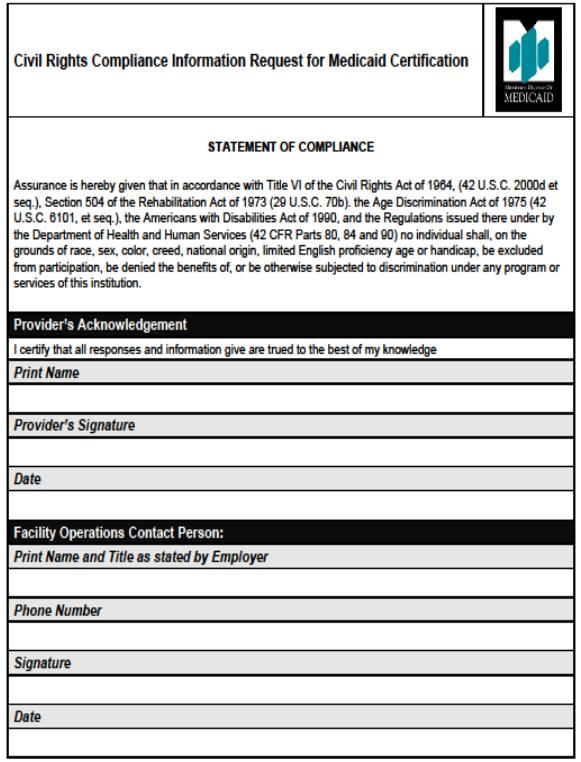
**CERTIFICATION:**

**I certify that the information provided to the DOM is true and correct to the best of my knowledge**

| *Provider Signature* | *Date* |
|---|---|
| | |

*Provider's Title*





**Civil Rights Compliance Information Request for Medicaid Certification**

**STATEMENT OF COMPLIANCE**

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b). the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued there under by the Department of Health and Human Services (42 CFR Parts 80, 84 and 90) no individual shall, on the grounds of race, sex, color, creed, national origin, limited English proficiency age or handicap, be excluded from participation, be denied the benefits of, or be otherwise subjected to discrimination under any program or services of this institution.

**Provider's Acknowledgement**

I certify that all responses and information give are trued to the best of my knowledge

*Print Name*

*Provider's Signature*

*Date*

**Facility Operations Contact Person:**

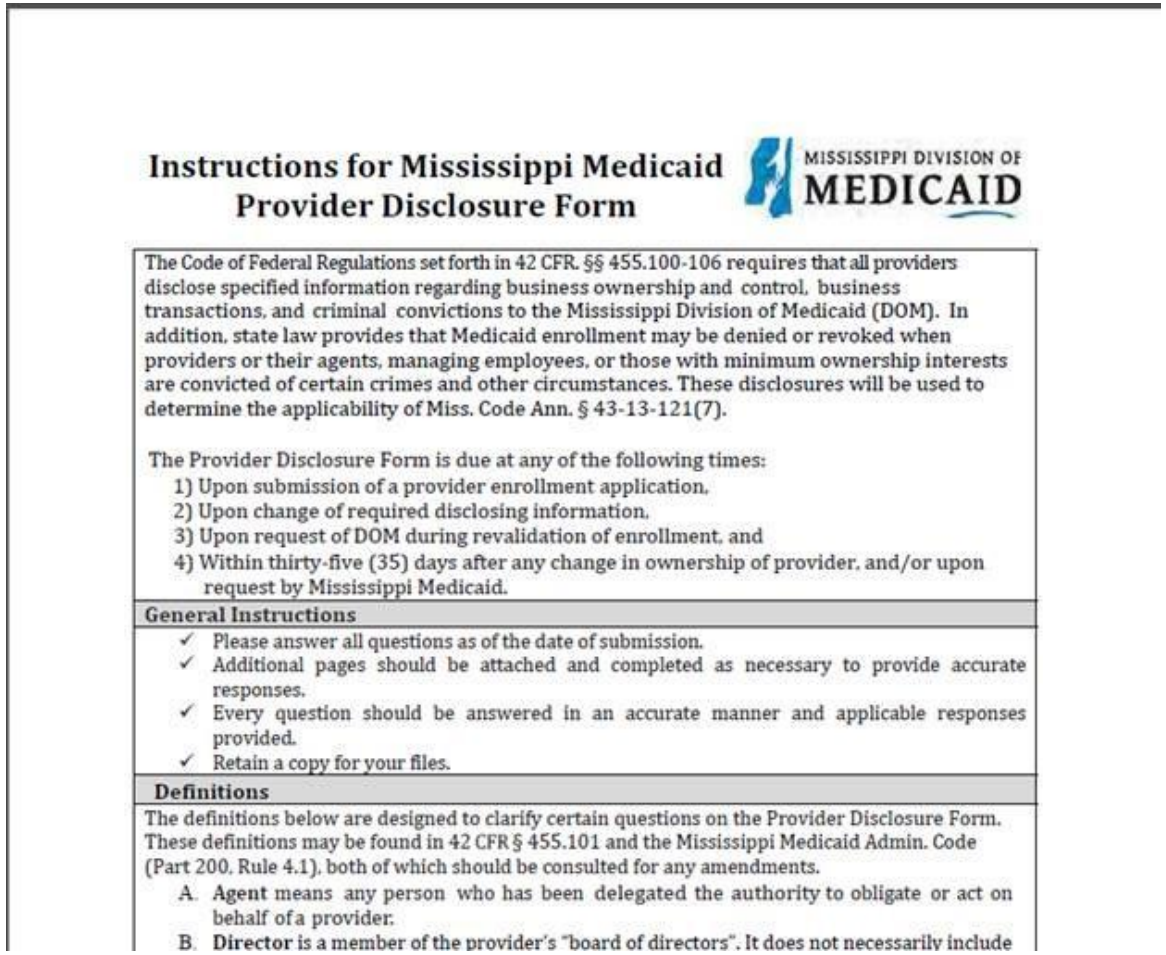
*Print Name and Title as stated by Employer*

*Phone Number*

*Signature*

*Date*

# Provider Disclosure Form



## Instructions for Mississippi Medicaid Provider Disclosure Form

MISSISSIPPI DIVISION OF MEDICAID

The Code of Federal Regulations set forth in 42 CFR. §§ 455.100-106 requires that all providers disclose specified information regarding business ownership and control, business transactions, and criminal convictions to the Mississippi Division of Medicaid (DOM). In addition, state law provides that Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These disclosures will be used to determine the applicability of Miss. Code Ann. § 43-13-121(7).

The Provider Disclosure Form is due at any of the following times:

1) Upon submission of a provider enrollment application,
2) Upon change of required disclosing information,
3) Upon request of DOM during revalidation of enrollment, and
4) Within thirty-five (35) days after any change in ownership of provider, and/or upon request by Mississippi Medicaid.

**General Instructions**

- ✓ Please answer all questions as of the date of submission.
- ✓ Additional pages should be attached and completed as necessary to provide accurate responses.
- ✓ Every question should be answered in an accurate manner and applicable responses provided.
- ✓ Retain a copy for your files.

**Definitions**

The definitions below are designed to clarify certain questions on the Provider Disclosure Form. These definitions may be found in 42 CFR § 455.101 and the Mississippi Medicaid Admin. Code (Part 200, Rule 4.1), both of which should be consulted for any amendments.

A. **Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider.

B. **Director** is a member of the provider's "board of directors". It does not necessarily include

# Provider Disclosure Form Cont.

**Individual Providers**

- Individuals should fill out Section A.  Please review and complete all other applicable sections and sign the document.

**Group Providers**

- Groups should review and complete all applicable sections of the form and have the individual with signature authority sign the document.

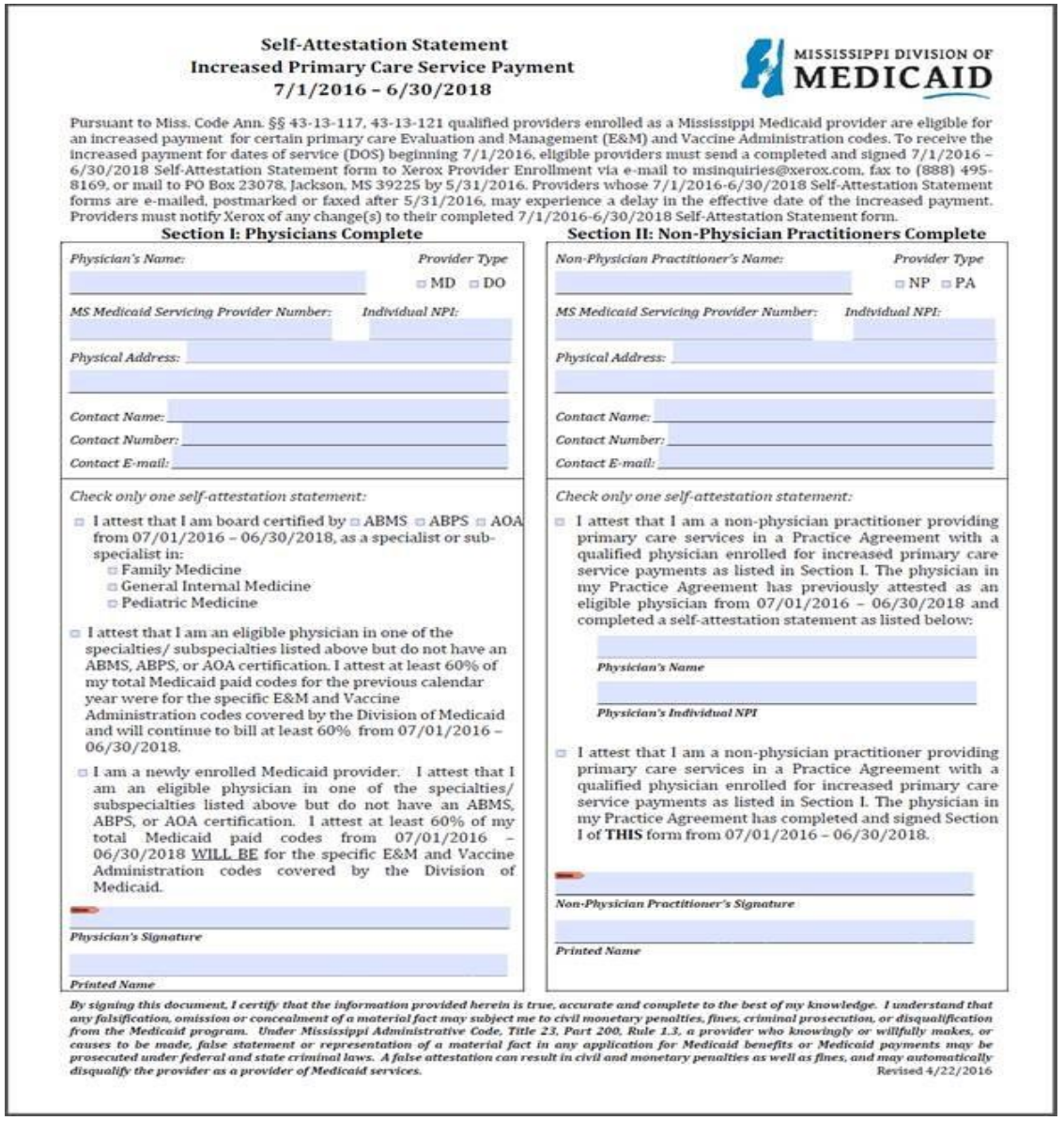
# Provider Attestation

- Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain Evaluation and Management (E&M) and Vaccine Administration codes.

- Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100 percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible providers must send a completed and signed 7/1/2016 – 6/30/2018 Self-Attestation Statement form to Xerox Provider Enrollment by 6/30/2016 through one of the following means:

  - Email: msinquiries@xerox.com
  - Fax: 888-495-8169
  - Postal mail: P. O. Box 23078, Jackson, MS 39225

# Provider Attestation Form



**Self-Attestation Statement**
**Increased Primary Care Service Payment**
**7/1/2016 – 6/30/2018**

MISSISSIPPI DIVISION OF MEDICAID

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121 qualified providers enrolled as a Mississippi Medicaid provider are eligible for an increased payment for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible providers must send a completed and signed 7/1/2016 – 6/30/2018 Self-Attestation Statement form to Xerox Provider Enrollment via e-mail to msinquiries@xerox.com, fax to (888) 495-8169, or mail to PO Box 23078, Jackson, MS 39225 by 5/31/2016. Providers whose 7/1/2016-6/30/2018 Self-Attestation Statement forms are e-mailed, postmarked or faxed after 5/31/2016, may experience a delay in the effective date of the increased payment. Providers must notify Xerox of any change(s) to their completed 7/1/2016-6/30/2018 Self-Attestation Statement form.

**Section I: Physicians Complete**

*Physician's Name:* *Provider Type* ☐ MD ☐ DO

*MS Medicaid Servicing Provider Number:* *Individual NPI:*

*Physical Address:*

*Contact Name:*

*Contact Number:*

*Contact E-mail:*

*Check only one self-attestation statement:*

☐ I attest that I am board certified by ☐ ABMS ☐ ABPS ☐ AOA from 07/01/2016 – 06/30/2018, as a specialist or sub-specialist in:
- ☐ Family Medicine
- ☐ General Internal Medicine
- ☐ Pediatric Medicine

☐ I attest that I am an eligible physician in one of the specialties/ subspecialties listed above but do not have an ABMS, ABPS, or AOA certification. I attest at least 60% of my total Medicaid paid codes for the previous calendar year were for the specific E&M and Vaccine Administration codes covered by the Division of Medicaid and will continue to bill at least 60% from 07/01/2016 – 06/30/2018.

☐ I am a newly enrolled Medicaid provider. I attest that I am an eligible physician in one of the specialties/ subspecialties listed above but do not have an ABMS, ABPS, or AOA certification. I attest at least 60% of my total Medicaid paid codes from 07/01/2016 – 06/30/2018 WILL BE for the specific E&M and Vaccine Administration codes covered by the Division of Medicaid.

*Physician's Signature*

*Printed Name*

**Section II: Non-Physician Practitioners Complete**

*Non-Physician Practitioner's Name:* *Provider Type* ☐ NP ☐ PA

*MS Medicaid Servicing Provider Number:* *Individual NPI:*

*Physical Address:*

*Contact Name:*

*Contact Number:*

*Contact E-mail:*

*Check only one self-attestation statement:*

☐ I attest that I am a non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care service payments as listed in Section I. The physician in my Practice Agreement has previously attested as an eligible physician from 07/01/2016 – 06/30/2018 and completed a self-attestation statement as listed below:

*Physician's Name*

*Physician's Individual NPI*

☐ I attest that I am a non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care service payments as listed in Section I. The physician in my Practice Agreement has completed and signed Section I of **THIS** form from 07/01/2016 – 06/30/2018.

*Non-Physician Practitioner's Signature*

*Printed Name*

***By signing this document, I certify that the information provided herein is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of a material fact may subject me to civil monetary penalties, fines, criminal prosecution, or disqualification from the Medicaid program. Under Mississippi Administrative Code, Title 23, Part 200, Rule 1.3, a provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil and monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.***

Revised 4/22/2016

# Provider Attestation (OBGYN)

- Mississippi Division of Medicaid (DOM) was granted authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Pursuant to HB 1560, effective July 1, 2016 providers who self-attest to a specialty designation in obstetric/gynecologic medicine by the American Congress of Obstetricians and Gynecologists (ACOG) will be eligible for an increased payment for certain primary care services.

- Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The Medicaid Primary Care Provider Fee Schedule is updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year.

- To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible Obstetric/Gynecological providers must send a completed and signed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form to Xerox Provider Enrollment by 6/30/2016 through one of the following means:

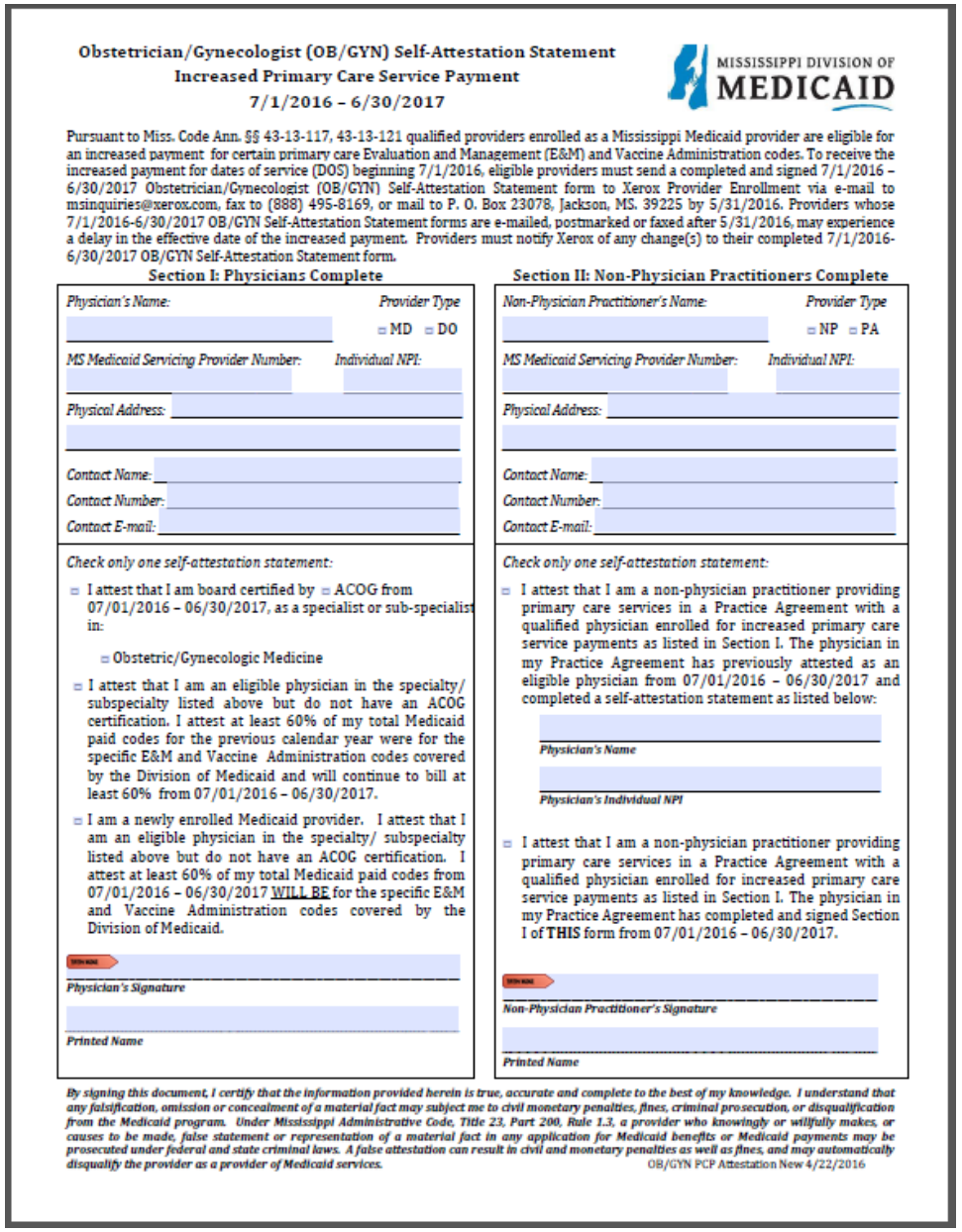
  - Email: msinquiries@xerox.com
  - Fax: 888-495-8169
  - Postal mail: P. O. Box 23078, Jackson, MS 39225

# Provider Attestation (OBGYN) Cont.

- Providers whose 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement forms are e-mailed, postmarked or faxed after 6/30/2016, may experience a delay in the effective date of the increased payment. Providers must notify Xerox of any change(s) to their completed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form.

- Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.msmedicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Xerox Call Center toll-free at 800-884-3222.

# Provider Attestation Form (OBGYN)



**Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement**
**Increased Primary Care Service Payment**
**7/1/2016 – 6/30/2017**

MISSISSIPPI DIVISION OF MEDICAID

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121 qualified providers enrolled as a Mississippi Medicaid provider are eligible for an increased payment for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible providers must send a completed and signed 7/1/2016 – 6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form to Xerox Provider Enrollment via e-mail to msinquiries@xerox.com, fax to (888) 495-8169, or mail to P. O. Box 23078, Jackson, MS. 39225 by 5/31/2016. Providers whose 7/1/2016-6/30/2017 OB/GYN Self-Attestation Statement forms are e-mailed, postmarked or faxed after 5/31/2016, may experience a delay in the effective date of the increased payment. Providers must notify Xerox of any change(s) to their completed 7/1/2016-6/30/2017 OB/GYN Self-Attestation Statement form.

**Section I: Physicians Complete**

*Physician's Name:* *Provider Type* ☐ MD ☐ DO

*MS Medicaid Servicing Provider Number:* *Individual NPI:*

*Physical Address:*

*Contact Name:*
*Contact Number:*
*Contact E-mail:*

*Check only one self-attestation statement:*

☐ I attest that I am board certified by ☐ ACOG from 07/01/2016 – 06/30/2017, as a specialist or sub-specialist in:

☐ Obstetric/Gynecologic Medicine

☐ I attest that I am an eligible physician in the specialty/ subspecialty listed above but do not have an ACOG certification. I attest at least 60% of my total Medicaid paid codes for the previous calendar year were for the specific E&M and Vaccine Administration codes covered by the Division of Medicaid and will continue to bill at least 60% from 07/01/2016 – 06/30/2017.

☐ I am a newly enrolled Medicaid provider. I attest that I am an eligible physician in the specialty/ subspecialty listed above but do not have an ACOG certification. I attest at least 60% of my total Medicaid paid codes from 07/01/2016 – 06/30/2017 WILL BE for the specific E&M and Vaccine Administration codes covered by the Division of Medicaid.

*Physician's Signature*

*Printed Name*

**Section II: Non-Physician Practitioners Complete**

*Non-Physician Practitioner's Name:* *Provider Type* ☐ NP ☐ PA

*MS Medicaid Servicing Provider Number:* *Individual NPI:*

*Physical Address:*

*Contact Name:*
*Contact Number:*
*Contact E-mail:*

*Check only one self-attestation statement:*

☐ I attest that I am a non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care service payments as listed in Section I. The physician in my Practice Agreement has previously attested as an eligible physician from 07/01/2016 – 06/30/2017 and completed a self-attestation statement as listed below:

*Physician's Name*

*Physician's Individual NPI*

☐ I attest that I am a non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care service payments as listed in Section I. The physician in my Practice Agreement has completed and signed Section I of **THIS** form from 07/01/2016 – 06/30/2017.

*Non-Physician Practitioner's Signature*

*Printed Name*

***By signing this document, I certify that the information provided herein is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of a material fact may subject me to civil monetary penalties, fines, criminal prosecution, or disqualification from the Medicaid program. Under Mississippi Administrative Code, Title 23, Part 200, Rule 1.3, a provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil and monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.***

OB/GYN PCP Attestation New 4/22/2016

# Provider License Renewal

- License renewal depends on the provider type. Some provider licenses end on 6-30-2016 where other provider licenses don’t.
- Letters are sent out at the 60 and 30 days prior to your license renewal time. An additional letter is also sent out once the license has been suspended due to non-renewal of license.
- Please contact the call center if you are unsure of the status of your license end date. The number of the call center is 1-800-884-3222.
- Any suspension of  a provider’s license will possibly result in non-payment of claims.

# Effective July 1, 2016

- Waiver Providers will be required to submit a proposal approval letter from the Division of Medicaid, as well as an approval letter from the Department of Health (for some Waiver Provider Types) along with their completed application.

- The Credentialing Checklist will be updated to include new requirements for Waiver Providers, such as the Medicaid Approval Proposal Letter.

- The Provider Disclosure Form will be required on all applications submitted on or after 7/1/2016.

# Frequently Asked Questions

**Q. How long does it take to process an enrollment application?**

A. Generally, complete applications will take 6-8 weeks to be processed. Incomplete applications are returned. To avoid delays, please ensure all applications are complete with the required forms and attachments.

**Q. Should I hold claims until I receive a provider number?**

A. For initial enrollment, **Yes.** For providers re-enrolling, **No.**

**Q. Do I have to participate in Direct Deposit?**

A. Yes, all providers must participate in direct deposit.

# Frequently Asked Questions Cont.

**Q. Why must we complete and submit a W-9?**

A. The W-9 is required by the IRS.

**Q. Why do we have to submit verification of social security and/or federal tax-ID numbers?**

A. DOM must verify this information to comply with IRS requirements.

**Note:**

**In accordance with CMS regulations, in January 2014, the Mississippi Division of Medicaid began requiring all Ordering, Referring, Prescribing, and Medicare-cost sharing physicians to be enrolled with Mississippi Medicaid. There is a separate application available.**

# Questions