# **Provider Enrollment**

U.S. State & Local Human Services

g**z**ınwell



# Agenda

Revalidations

**Expired Credentials** 

**EFT Requirements** 

Top 5 reasons update request get denied

Top 5 reasons applications get RTP'd

Submitting Updates and Applications

**Updated Provider Enrollment Documents** 





# **Revalidations**

- Providers due for revalidation will receive a 30-, 60-, and 90-day letter.
- Revalidation due dates can be viewed on the portal login.
- Pre-filled revalidation applications will be available on the portal with a hyperlink below their due date.
- Providers who don't submit their revalidation application by the deadline will be terminated.

g<sub>7</sub>inwell





# **Expired Credentials**

- Providers with an expired License/Cert/DEA will be sent a 30-day notification.
- Current License/Cert dates can be viewed on the portal login.
- Providers who don't submit their expired credentials by the deadline will be terminated.
- If the provider is terminated for expired credentials, they can submit the Lic/Cert credentials requested within 6 months of their termination and be reactivated with no gap in coverage.
- Recommend to submit the updated documents through the portal.







# **Requirements for submitting EFT**

Submitting EFT doesn't change who the claim is paid to Individual VS Group. The claim will pay to the provider listed as the biller on the claim.

### Individual Providers:

- Completed EFT Form
- Must submit voided check or bank letter with EFT form.
  - Voided Check: Voided check must match the individual's name on the application or must submit a bank letter.
  - o Bank Letter:
    - Must be signed by the bank.
    - Needs to include the following information: account holder name, account number, routing number.
    - If the account name doesn't match the individual providers, then the letter needs to detail the individual has depositing rights into the account.
- It's often easier to submit the individual's EFT information under their personal account rather than submitting the group's.

## **Group/Facility Providers**:

- Completed EFT Form
- Must submit voided check or bank letter with EFT form.
  - Voided Check: Voided check must match the group's legal name or DBA on the application or must submit a bank letter.
  - o Bank Letter:
    - Must be signed by the bank.
    - Needs to include the following information: account holder name, account number, routing number.
    - If the account name doesn't match the group's legal name or DBA name listed on the application, then the letter needs to detail the individual has depositing rights into the account.





# Top 5 reasons applications get RTP'd

## **EFT** information

- EFT form not being submitted with the voided check or bank letter.
- Voided Check not matching enrolling provider name.
- Bank Letter not signed by the bank or the bank letter not listing the individual provider as having depositing rights if the account holder doesn't match the enrolling provider.

# **Individual Providers W9**

 W9 submitted for individual providers with the group name and FEIN tax ID instead of the enrolling provider name and SSN.

# Submitting Individual providers under the wrong SSN or TAX ID

• Providers with the incorrect SSN or providers listing their groups FEIN for their SSN.

### **IRS** letters for groups submitted to be enrolled.

 IRS letter is required for all FEIN TAX IDs submitted and any FEIN listed on the ownership disclosure. For example, any business FEIN tax ID listed as the enrolling provider or an owner on the application.

## **Section IV Forms**

• Section IV form missing for applicable group enrollments.





# Top 5 reasons update request get denied

## **EFT information**

- EFT form not being submitted with the voided check or bank letter.
- Voided Check not matching enrolling provider name.
- Bank Letter not signed by the bank or the bank letter not listing the individual provider as having depositing rights if the account holder doesn't match the enrolling provider.

## **Request Types**

Submitting a request under the incorrect request type.

## Listing incorrect Medicaid ID on documents or request ticket (Groups)

 Groups submitting their individual provider updates not listing the correct Medicaid ID for each provider they are submitting the same request for.

# Missing Signatures Incomplete forms for requested change





# **Benefit of using Portal for applications & update requests**

The portal is the most efficient way to submit applications or update request.

## Submissions can be tracked online

- Search previous submissions on update request online to see if they are approved or denied.
- Review the status of your application and see any request for corrections/documentation pending for the application.

## **Reduction of errors on submitted applications**

 The online wizard will help guide you through the required information and provide a list of supporting documents needed based on the provider type and specialty being applied.





Tuesday 08/23/2022 07:53 AM CST

## **Applications submitted on portal**

You can **check the status** of any application submitted and see any notes for corrections or documents needed to complete your application.

**If corrections are needed**, you can click the "Resume Enrollment" to access the previously submitted application and upload any document or make changes need for your application and resubmit.

# **AR**Medicaid

ome

### Home > Provider Enrollment

### Provider Enrollment

Enrollment Application Initiate a New Enrollment application.

<u>Re-Enrollment</u> Initiate a Re-enrollment application.

### Resume Enrollment Resume an existing application that you previously started.

Enrollment Status Check the current status of an enrollment application.

#### Completing an Online Application

Watch this video to see step by step instructions on how to complete an online Enrollment Application.

#### Customer Links

Print an Application for Mailing Pay Application Fee (new window) Provider User Manual







# Submitting update requests through the portal.

# 24 Request Types

| Provider Name                                      | Role IDs  |                                      |                  |
|--|---|--------------------------------------|------------------|
| Submit an Update Re                                | equest  |                                      | ?                |
| Select the Request type<br>allow your request to b | e that is being made and add any necessary attachments before submitting. Once the do<br>e processed. | cuments have been uploaded, dick the | submit button to |
| • •  | Request Type ADDRESS CHANGE FORM  |                                      |                  |
| Attachments  |   |                                      |                  |
| Fill out all required fi                           | elds before submitting.   | Attachment Status                    | Action           |
| Collapse   |   |                                      |                  |
| Upload File: O Test                                | Page.pdf r ID: 100011101  |                                      |                  |
|  |   |                                      |                  |
|  |   | Colorit C                            |                  |





| * Re                                      | equest Type ADDRESS CHANGE FORM |                              |        |
|---|---------------------------------|------------------------------|--------|
| Attachments<br>Fill out all required fiel | de before submitting            |                              | E      |
|   | File Name                       | Attachment Status            | Action |
| ŧ   | TEST PAGE.PDF                   | Uploaded, Pending Submission | Remove |
| Ð   | TEST PAGE.PDF                   | Uploaded, Pending Submission | Remove |
| ŧ   | TEST PAGE.PDF                   | Uploaded, Pending Submission | Remove |
| +   | TEST PAGE.PDF                   | Uploaded, Pending Submission | Remove |
| t   | TEST PAGE.PDF                   | Uploaded, Pending Submission | Remove |
| Upload File:<br>Individual Provider       | Select<br>ID:                   |                              |        |





Searching previously submitted updates on the portal

| Provider Name   |   |                                       |  | 1 |
|---|---|---------------------------------------|--|---|
| riorider manie  | Rol is  |                                       |  |   |
|   |   |                                       |  |   |
| Soarch Horfate Poouests   | c   |                                       | 2  | - |
| Search Optione Requests   |   |                                       |  | 4 |
| Enter your search criteria and click t  | he Search button. The default search will return request<br>the are required.   | s from the last 7 days, plus any In I | Process requests.  |   |
| Entier macking to or more and to be   | are required.   |                                       |  |   |
| Tracking ID   |   |                                       |  |   |
| Request Type  | ~   |                                       |  |   |
| Status  | ×   |                                       |  |   |
| From Date   | To Date o   |                                       |  |   |
|   |   |                                       |  |   |
|   |   |                                       |  |   |
|   |   | New Reque                             | st Search Clear  | - |
|   |   | New Reque                             | st Search Clear  | - |
| Search Results  |   | New Reques                            | st Search Clear  |   |
| Search Results<br>Click the Tracking ID to view more  | e detail about the update request.  | New Reques                            | st Search Clear  | - |
| Search Results<br>Click the Tracking ID to view mo<br>Tracking ID   | re detail about the update request.   | New Reques<br>Submit Date             | st Search Clear  |   |
| Search Results<br>Click the Tracking ID to view mod<br>Tracking ID<br>10953                                     | e detail about the update request.           Request Type           ADDRESS CHANGE FORM                               | New Reques                            | st Search Clear Status IN PROCESS                                    |   |
| Search Results<br>Click the Tracking ID to view mod<br>Tracking ID<br>10953<br>10915                            | e detail about the update request.           Request Type           ADDRESS CHANGE FORM           ADDRESS CHANGE FORM | New Reques                            | st Search Clear Status IN PROCESS PARTIALLY DENIED                   |   |
| Search Results<br>Click the Tracking ID to view mod<br>Tracking ID<br>10953<br>10915<br>10952                   | e detail about the update request.  | New Request                           | Status IN PROCESS PARTIALLY DENIED APPROVED                          |   |
| Search Results<br>Click the Tracking ID to view more<br>Tracking ID<br>10953<br>10915<br>10952<br>10603         | e detail about the update request.  | New Request                           | Status Status IN PROCESS PARTIALLY DENIED APPROVED APPROVED          |   |
| Search Results<br>Click the Tracking ID to view mod<br>Tracking ID<br>10953<br>10915<br>10952<br>10603<br>10633 | e detail about the update request.  | New Reques                            | Status Status IN PROCESS PARTIALLY DENIED APPROVED APPROVED APPROVED |   |





# Reviewing previous portal submissions

| Information      |   |                                       |
|------------------|---|---------------------------------------|
| ovider Functions | Provider LTC Census   Search Update Requests   Submit an Update Request | st<br>Tuesday 12/01/2020 10:01 AM CST |
|                  | 2-1- 10-  |                                       |
| Provider Nam     | Role IDs  |                                       |
|                  |   |                                       |
| View Update      | Request   | Back to Search Results ?              |
| This request h   | s been partially denied. No updates can be made at this time.           |                                       |
|                  | Tracking ID 10915   |                                       |
|                  | Submit Date 11/30/2020  |                                       |
|                  | Request Type ADDRESS CHANGE FORM  |                                       |
|                  | Status PARTIALLY DENIED   |                                       |
| Attachmen        | s   |                                       |
|                  | File Name   | Attachment Status                     |
| •                | TEST PAGE.PDF   | APPROVED                              |
| ÷                | TEST PAGE.PDF   | DENIED                                |
| ŧ                | TEST PAGE.PDF   | APPROVED                              |
|                  | TEST PAGE.PDF   | APPROVED                              |
| •                |   | DENIED                                |
| +                | TEST PAGE.PDF   | DENIED                                |
| •                | TEST PAGE.PDF   | DENIED                                |





(...continued) Reviewing previous portal submissions

|                 | > Search opdate Kednests > Should all c | pdate Request            |   | Tuesday 12/01/2020 10:01 AM CST |
|-----------------|---|--------------------------|---|---------------------------------|
| Provider Name   | Role 1                                  | De                       |   | <br>                            |
|                 |   |                          |   |                                 |
| View Update I   | Request                                 |                          |   | Back to Search Results 💡        |
| This request ha | s been partially denied. No updates c   | an be made at this time. |   |                                 |
|                 | Tracking ID 10915                       |                          |   |                                 |
|                 | Submit Date 11/30/2020                  |                          |   |                                 |
|                 | Request Type ADDRESS CH                 | ANGE FORM                |   |                                 |
|                 | Status PARTIALLY DE                     | NIED                     |   |                                 |
| Attachment      | 5                                       |                          |   |                                 |
|                 |   | File Name                |   | Attachment Status               |
| E               |   | TEST PAGE.PDF            |   | APPROVED                        |
| Individual Pro  | ovider ID: 100011101                    |                          |   |                                 |
| E               |   | TEST PAGE.PDF            |   | DENIED                          |
| Individual Pro  | wider ID: 100011201                     | STED IS NOT VALID        | _ |                                 |
| E               |   | TEST PAGE.PDF            |   | APPROVED                        |
| Individual Pro  | wider ID: 100011301                     |                          |   |                                 |
| E               |   | TEST PAGE.PDF            |   | APPROVED                        |
|                 |   |                          |   |                                 |





# PDF Fillable Provider Enrollment Forms/Documents.

Provider enrollment forms are now a PDF fillable format with an digital signature built into the form.

Using the new PDF editable forms will help reduce errors from handwriting and be more efficient to submit without having to print the form.

Please make sure you are using the most current version when submitting applications or updated.

To use the digital signature the document must be saved on the computer or device first.



Division of Medical Services Gainwell Technologies Provider Enrollment Unit P.O. Box 8105, Little Rock, AR 72203-8105 P: (501) 376-2211 WATS: (800) 457-4454 F: (501) 374-0746

#### SECTION IV: PROVIDER GROUP AFFILIATIONS

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

| Brickey                                     | Tyler                               |          | DO    |
|---|-------------------------------------|----------|-------|
| Last Name                                   | First Name                          | M.I.     | Title |
| Arkansas Department of Health               |                                     |          |       |
| Group Organization Name                     |                                     |          |       |
| 100050002                                   |                                     |          |       |
| Group Provider ID Number                    |                                     |          |       |
| 05/01/23                                    |                                     |          |       |
| Effective Date (Date Provider Joined Group) | Expiration Date (Date Provider Left | t Group) | _     |

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original or approved electronic signature of the individual provider is mandatory. (No stamped or copied signature is allowed; "approved electronic signature" is described as those which comply with Arkansas Code § 25-31-103 et seq.)

| Tyler Brickey Digitally signed by Tyler Brickey<br>Date: 2023.08.15 13:18:50 -05'00' | MD                  |          | 06/01/23 |
|--|---------------------|----------|----------|
| Provider Signature   | Title               |          | Date     |
| Tyler Brickey  |                     | 10010030 | 1        |
| Typed or Printed Name  | Provider Medicaid I | D        |          |

Primary Care Physicians must complete the Primary Care Physician Agreement to have their managed care fees paid to a new group Provider ID Number.







gainwell



# Thank you!



