Virginia Medicaid Web Portal
Provider Enrollment
(Group 4)

Enrollment Form Instructions

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. National Provider Identifier (NPI) or Atypical Provider Identifier (API)

Atypical Provider Identifier (API) Consumer Directed Services Coordination provider category has been identified as an Atypical provider category. As such you will be assigned a ten-digit Atypical Provider Identifier (API) for you to use when your application is approved. Your new ten-digit API number is to be used on all Medicaid business transactions including electronic and paper claims, Automated Response System telephone service (ARS) and Prior Authorizations (PA).

National Provider Identifier (NPI) Some Consumer Directed Services Coordination providers may have successfully obtained a National Provider Identifier (NPI) because they provide other services that qualify them as a healthcare provider according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules. If this is the case enter your ten-digit NPI. If you are a business, enter your organization's NPI. More information about the NPI and how to obtain one can be found at http://www.cms.gov under Regulations and Guidance, HIPAA Administrative Simplification, National Provider Identifier Standard (NPI).

2. Individual Provider Name (Required for Individuals) or Organization Name (Required for Organizations)

Enter the individual name or organization which identifies you to the public. This name will be used on the Virginia Medicaid Provider Search Directory.

3. Primary Servicing Address (Required)

Enter your Primary Servicing Address in this section.

- A Post Office Box address is not acceptable as a service location.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- Consumer-Directed Service Coordinator providers must be located within the Commonwealth of Virginia.
- Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

4. Correspondence Address (Required)

Enter the address to which you would like correspondence (Medicaid Manual updates, Medicaid memos, etc.) sent.

- A Post Office Box is acceptable for this type of address.
- Only one Correspondence Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Correspondence Address is the same as the Primary Servicing Address, enter SAME on the Attention line.

Indicate if you wish to receive mailed Medicaid correspondence at this address. If you select 'No' then all mailed Medicaid correspondence associated with your enrollment will be suppressed.

5. Pay To Address

Enter the address to which you would like payments sent for services rendered.

- Only one Pay To Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Pay To Address is the same as the Correspondence Address, enter SAME on the Attention line.

6. Remittance Advice Address

Enter the address to which you would like Remittance Advice sent for services rendered.

- Only one Remittance Advice Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Remittance Address is the same as the Pay To Address, enter SAME on the Attention line.

7. IRS Name (Required)

Enter IRS name associated with the tax ID registered with the IRS.

8. Taxpayer Identification Number (TIN) (Required)

Enter your nine-digit Taxpayer Identification Number (TIN). This may also be called your Employer Identification Number (EIN), Federal Employer Identification Number (FEIN), or Federal Tax Identification Number (FTIN).

9. Doing Business as (DBA) Name

Enter the name under which the business or operation is conducted and presented to the community. This name will be used on the Virginia Medicaid Provider Search Directory.

10. Requested Effective Date of Enrollment (Required)

Enter the date that you are requesting your enrollment to begin.

- Effective date cannot be more than one year past the current date.
- Effective date will never be before the effective date of your license.

11. Type of Applicant (Required)

Select the Type of Applicant: Corporation, Individual, Limited Liability Company, Partnership or Government Entity.

- Corporation is defined as a legal entity or structure under the authority of the laws of a state consisting of a person or group of persons who become shareholders.
- Limited Liability Company is defined as a business structure allowed by state statute whose owners have limited personal liability for the debts and actions of the Limited Liability Company.
- Partnership is defined as the relationship existing between two or more persons who join and carry on a trade or business.
- Individual is defined as a single practitioner operating under his/her own SSN or TIN. Requires SSN and Date of Birth.
- Government Entity is defined as a “legally authorized or recognized agency, instrumentality, or other entity of Federal, State, or local government (including multijurisdictional agencies, instrumentalities, and entities)”.

12. Languages Other Than English Spoken at Practice

Please check all that apply for languages that are spoken at your organization. If no language is selected, English only will be recorded.

13. Signature Waiver (Required)

Signature waiver allows for the submission of claim(s) which will contain the provider's computer generated, stamped, or typed signature instead of a hand written signature.

SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104 AND 42 C.F.R. §455.106

This section must be completed by an authorized representative. An authorized representative is defined as an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity.

14. Ownership and Control Information for Disclosing Entity (Required)

Does any managing employee and/or any individual(s) or organization(s) have any ownership or controlling interest in this provider entity or in any subcontractor? The term "managing employee" means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

If yes include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual
- Tax ID (TIN) for an organization
- Type of ownership (Board of Directors, Controlling Interest, Managing Employee, Owner or Other)
- Address
- Percentage of ownership (Owners with 5% or greater ownership only)

If your organization is a non-profit or not-for-profit organization in accordance with Section 501(c)(3)

- Enter each member of your board of directors, including first name, last name or organization name, title (i.e. CEO, Pres.), and date of birth, SSN for individuals or Tax ID (TIN) for organizations, and address.

15. Relationships (Required if applicable)

Are any of the individuals named in the previous question related to each other?

If yes include:

- Name from previous question
- Relationship (spouse, parent, child, or sibling)
- Name of the person from previous question to whom they are related

16. Subcontractor (Required)

Does any individuals with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more?

If yes include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

17. Other Disclosing Entity (Required)

Does the name, title, SSN/TIN, address and percentage of ownership of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more?

If yes include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

18. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)

Does any individual or organization listed previously have any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

Criminal offenses that must be included are:

- Convictions for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
    - Fraud
    - Obstruction of an investigation
    - Controlled substance violation
    - Any other crime or misconduct

If yes include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

Attach a copy of the final disposition.

19. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)

Has any individual or contractor connected with your practice that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

Criminal offenses that must be included are:

- Convictions for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
    - Fraud
    - Obstruction of an investigation
    - Controlled substance violation
    - Any other crime or misconduct

If yes include:

- First and last name or organization name
- Date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

Attach a copy of the final disposition.

20. Adverse Legal Actions (Required)

Check Yes if the applicant has had any adverse legal actions imposed by:

- Medicare
- Medicaid
- Federal agency or program
- Any state's agency or program
- Any licensing or certification agency

If Yes is checked, attach a copy of the final disposition.

SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION

All Virginia Medicaid providers that enroll must submit all claims electronically by Electronic Data Interchange (EDI) through a clearing house, or Direct Data Entry (DDE) through the Virginia Medicaid web portal (www.virginiamedicaid.dmas.virginia.gov). Providers must also enroll to receive their payments via Electronic Funds Transfer (EFT) for payment of those services. Any provider who cannot comply with these requirements for good cause must request an exemption describing why they cannot comply.

21. Electronic Funds Transfer (Required)

If you select to participate in the Electronic Funds Transfer (EFT) of payments directly deposited into your account, you must provide:

- Account Type – The account type of the financial institution that will receive your EFT deposits.
- Financial Institution – The name of the financial institution that will receive your EFT deposits.
- Routing or ABA Number – The routing or ABA number of the financial institution above. Your banking institution's 9-digit routing number is sometimes called the ABA number. The routing number must begin with numbers that fall in the ranges 01-12, 21-32 or 61-72 (for example 079986597). Note the number on your deposit slip is not a valid routing number.
- Account Number - The Account Number is a code identifying the account that will be accepting your direct deposit.

If you select not to participate in EFT you must apply for an exemption and show good cause.

- Good cause may include, but is not limited to the unavailability of a banking institution capable of transacting business via EFT.
- To apply for an exemption, attach to this application either a letter from the financial institution or a letter from the applicant for consideration. The letter must:
    - Be on letterhead, either a financial institutions or the applicants
    - Be signed
    - Be dated
    - Include the applicant's NPI
    - Include a description of the good cause

22. Electronic Claims Submission (Required)

For more information on how to submit claims through Electronic Data Interchange (EDI) through a clearing house or through Direct Data Entry (DDE) at no cost on the Virginia Medicaid Web Portal, visit www.virginiamedicaid.dmas.virginia.gov. This information is located in the Quick Links menu, Provider Services, EDI Support.

Check if you will submit claims using (EDI) through a clearing house or DDE through the Virginia Medicaid Web Portal, www.virginiamedicaid.dmas.virginia.gov .

If you select to apply for an exemption you must show good cause.

- Good cause may include, but is not limited to:
  - Unavailability of necessary infrastructure in the geographic region
  - No mechanism to electronically submit for a particular claim type
  - Financial hardship

- To apply for an exemption, attach a letter to this application for consideration. The letter must:
  - Be on the applicant's letterhead
  - Be signed
  - Be dated
  - Include the applicant's NPI
  - Include a description of the good cause

23. Electronic Remittance Advice (ERA)

Check to request participation in electronic remittance advices as part of your enrollment with Virginia Medicaid and FAMIS and enter the Service Center Name and ID Number.

SECTION IV: HOME AND COMMUNITY BASED CARE SERVICES DEMOGRAPHICS

In accordance with Federal requirements, all providers of Home and Community Based Care services must submit the following information to DMAS.

24. Additional Provider Types Enrolled (Required)

If organization is currently a Medicaid enrolled provider, select type of provider and API or NPI number.

25. Administrators Name (Required)

Enter name of the Administrator for the organization.

26. Administrative Personnel (Required)

Name, title, and telephone for all persons responsible for general management of your organization's program to include:

- Person responsible for signing contract (Required)
- Chief administrator on-site
- Other on-site contact person
- Chief corporate officer
- Other corporate contact person

27. Geographical Areas to be Served (Required)

List cities and counties in which you intend to service Medicaid eligible members.

28. Ownership Name and Percentage (Must Equal 100%)

Enter the name and address of all owners of organization and percent of ownership. Percent of ownership must equal 100 percent. If your organization is a not-for-profit or non-profit organization in accordance with IRS Section 501(c)(3), a list of your organization board of director must be submitted.

29. Criminal Offense Disclosure (Required)

Federal requirements stipulate that disclosure must be made of any person (not limited to but including owner, operator, manager and/or employee) associated with the organization who has been convicted of a criminal offense (misdemeanor and/or felony). This disclosure must be made upon each submission of the provider agreement, or upon the provider receiving notice of the criminal offense, whichever is sooner. It is the duty of the provider organization to make inquiry and screen individuals at the point of application for employment to comply with this section.

List anyone associated with your organization (owner, operators, manager or employees) who have been convicted of a criminal offense.

30. Consumer Directed Service Coordination Staffing Credentials (Required)

- As a Consumer-Directed Service Coordinator you are responsible for assuring that all Service Facilitator (SF) staff meet the qualifications detailed

in Chapter II of the Elderly or Disabled with Consumer Direction Waiver Services Provider Manual.

- All SF staff that performs supervisory activities must be familiar with all definitions for the completion of the functional status assessments and all program requirements, regardless of whether they perform these activities on a full time or part time basis.

- It is the provider's responsibility to assure that any new staff for the Consumer-Directed Service Coordinator Program is oriented to the program and have complied by all policies, procedures and forms necessary to comply with DMAS requirements.

- The provider is responsible for instructing all Medicaid Members of Consumer-Directed Service Coordinator program requirements related to their performance of duties as employers.

- For each Consumer-Directed Service Coordinator program staff
    - Enter name
    - Full or part-time status
    - License number (if applicable)
    - Degree type, (if applicable)
    - Amount and type of clinical experience (if applicable)

Service Facilitators Attestation

- Both attestation statements should be read and the checkbox checked afterwards.
- Attach one copy of each of the 4 modules (to include certificates from parts a & b of modules 2, 3, & 4) for the Consumer Directed Service Facilitation Certificate along with this application. All 7 certificates must be submitted in order to be enrolled.

31. Compliance with Federal Regulations Regarding Rates (Required)

An authorized administrator and signee of the Provider Participation Agreement attests that that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community Based Care Services than is charged the private sector for the same services.

32. Insolvency or Bankruptcy Verification (Required)

An authorized administrator and signee of the Provider Participation Agreement attests that there is neither a judgment or pending action of insolvency or bankruptcy in a state or federal court. Further, the provider of services agrees to inform DMAS immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

33. Validation of Program Description and Accurate Completion of Enrollment Application (Required)

An authorized administrator and signee of Provider Participation Agreement attests that the chief administrative agent and professional staff have received and reviewed the program description materials of Home and Community Based Care services, and that all information within this application is accurate, truthful, and complete.

34. Remarks

Enter any additional information you would like to be considered as part of your enrollment application.