Virginia Medicaid Web Portal
Provider Enrollment

Enrollment Form Instructions

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. National Provider Identifier - NPI (Required)

Enter your Individual NPI (Required). To participate as a provider of medical or health services for the Department of Medical Assistance Services (DMAS), you are required to obtain an NPI. DMAS has adopted the NPI as the standard for identifying all providers on all transactions, including paper claims. 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)

Enter your first name, middle initial, last name, suffix, and title. 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.
- For servicing addresses not in Virginia, identify if the servicing address is located farther than 50 miles beyond the Virginia border. If so the provider would be considered an out-of-state provider for licensing purposes.
- 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.
- For providers who are members of a Group Practice, enter the servicing address at which you practice.
- Add the Group NPI of the billing group that bills for your services rendered at this address.
- Use the Add Row button if enrolling provider for more than one Servicing Location.
- If you provide services for more than one Group Practice, enter your servicing address and the Group NPI that is associated with each.

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 want 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. Social Security Number (SSN) and Date of Birth (Required)

Enter the Social Security Number and date of birth of the individual provider. The 9 digits SSN will be entered in with no spaces or hyphens.

8. IRS Name and Taxpayer Identification Number (Optional for Individuals Who Bill and Accept Payments Through a Group Practice)

Required for individual providers who practice as a solo practitioner and will bill under a Taxpayer Identification Number (TIN) other than your SSN, list the IRS registered name and Taxpayer Identification Number (TIN) for your business. This nine digit number may also be called the Employer Identification Number (EIN), Federal Employer Identification Number (FEIN), or Federal Tax Identification number (FTIN).

Optional for individual providers who practice with a group, list the IRS registered name and Taxpayer Identification Number (TIN) for the Group Practice. This nine digit number may also be called the Employer Identification Number (EIN), Federal Employer Identification Number (FEIN), or Federal Tax Identification number (FTIN) for the Group Practice.

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 directory search engine.

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.
- Effective date for an out-of-state provider located farther than 50 miles from the Virginia border will be first date of service on attached claim or supporting documentation.

11. Medical Specialties (Required for all applications with the exception of Physician Assistant)

Select primary and secondary medical specialties.

- Primary specialty is the focus area of services that you render. (Required)

- Secondary specialties are services other than what is listed under your primary specialty. (Optional)
    - For example for Pediatric Cardiology, Cardiology would be primary and Pediatrics secondary.
    - If secondary specialties are not included on your application, you will not be reimbursed for services that require a specialty certification for payment.
    - Secondary specialty of 'Telemedicine' should be included if applicable for physicians.
        - Telemedicine cannot be entered as the primary specialty.
        - All Out of State physicians selecting a Telemedicine specialty require an out of state license to be entered.
        - Out of State physicians (outside of 50 miles of the Virginia border) selecting a Telemedicine specialty also require a Virginia license to be entered.
        - Providers must be enrolled in the Medicaid program in the state in which they are residing to be eligible to enroll in Virginia Medicaid to provide telemedicine services.

12. Licensing Board and Required Documents (Required)

Select from the following Licensing Boards that apply to the individual enrolling.

- State Medical Board
- Virginia Department of Professional and Occupational Regulations (DPOR) (Not applicable for Physician Assistant.)

Enter the license number, effective date and end date from your Licensing Board in the state where the services are being rendered. If your license cannot be validated through an Internet search, attach a copy of your license.

Out of state providers (outside of 50 miles of the Virginia border) selecting a Telemedicine specialty also require a Virginia license to be entered. (Not applicable for Physician Assistant.)

Claim(s) or documentation of a future date of service must be attached for all Providers that are located 50 miles outside the Virginia Border.

13. Specific Requirements for Different Provider Types

Select the service you are applying for. These services require specific licenses. Please read the licensing requirements for each service below. Enter the correct license number, effective date and end date.

Specific Requirements for Baby Care Services (Required)

- Care Coordination (one of the following)
  - Registered Nurse License
  - Copy of Master of Social Work or Bachelor of Social Work license

- Homemaker Services (one of the following)
  - Registered Nurse
  - Licensed Practical Nurse
  - Certified Nurse Aide

- Nutritional Services
  - Registered Dietician Registration Certification.

- Patient Education Service
  - Approval by DMAS. Approval requirements below.
    - Individuals employed by the Virginia Department of Health (VDH) who are approved to provide education in the health department setting. Health Departments should maintain a copy of their employee's approved certification/training in their personnel file at the agency.
    - Other providers who would like to apply for this service that may have certification from programs other than the Health Department. Forward to the address below your course content, a copy of the certificate and a copy of this provider enrollment application to DMAS to be reviewed for approval.
    - Individuals who have certification from programs other than the Health Department. Forward to the address below your course content, a copy of the certificate and a copy of this provider enrollment application to DMAS to be reviewed for approval.
    - Address to mail request for approval with supporting documentation:

      DMAS
      Attention: Baby Care Request for Patient Education Certification Approval
      600 East Broad Street, Suite 1300
      Richmond, Virginia 23219

804-225-3961 (Fax)

Specific Requirements for Chiropractors

Attach a copy of claim(s) for services rendered or supporting documentation indicating services to be rendered.

Specific Requirement for Nurse Practitioners

Select Specialty Nurse Practitioner is licensed and enrolling.

The following specialties only are enrolled

- o Acute Care
- o Adult
- o Certified Nurse Midwife
- o CRNA
- o Family
- o Geriatric
- o Neonatal
- o Pediatric
- o Psychiatry
- o Women's Health (OB/GYN)

Specific Requirements for Psychiatrists

Attach copy of Provider's Three Year Residence Certification of Curriculum Vitae of Three Year Residency in Psychiatry.

14. Mammography Services (Required)

Providers conducting breast cancer screenings or diagnosis through mammography activities must be certified by the FDA under the Mammography Quality Standards Act (MQSA). If you conduct mammography services, attach a copy of your facility's MQSA certificate.

15. Languages Other Than English Spoken at Practice

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

16. 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.

17. 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.

18. Relationships (Required)

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

19. 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

20. 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

21. 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.

22. 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?

- 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.

23. 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.

24. Electronic Funds Transfer (Required for Solo Practitioners, Optional for Individuals Who Bill and Accept Payments through a Group Practice)

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 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

25. Electronic Claims Submission (Required for Solo Practitioners, Optional for Individuals Who Practice with a Group)

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 for more information. 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

26. 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: REASSIGNMENT OF BENEFITS – ROB (Required for Individuals Who Bill and Accept Payments Through a Group Practice)

This section reassigns benefits paid for services rendered as part of your Virginia Medicaid enrollment to be paid to your Group Practice.

- Payment for services rendered will be made to the billing Group Practice NPI and TIN entered on the ROB.
- Make additional entries of the ROB as necessary for enrollment into additional Group Practice NPIs under same TIN.

27. REASSIGNMENT OF BENEFITS (ROB) The completion of this section is required for individuals whom are participating in a Group Practice.

- **Group Practice Legal Business Name**

  Enter Group IRS Name as it is registered with the IRS.

- **Group Practice Taxpayer Identification Number (TIN)**

  Enter the Group Practice's nine-digit Taxpayer Identification Number (TIN). This may also be called the Employer Identification Number (EIN), Federal Employer Identification Number (FEIN), or Federal Tax Identification number (FTIN).

- **Group Practice NPI**

  Enter Group Practice 10-digit NPI

- **Group Authorized Administrator**

  Enter First name, Middle Initial, and Last Name.

  Check Yes to certify that the authorized Administrator listed has validated the information as true, accurate, and complete to the best of their knowledge, and that the business entity (employer, group, or health care delivery system) requesting to receive payment is legally eligible to receive reassigned benefits per all applicable federal and state laws.

- **Individual Provider Signature and Date**

  Check Yes and enter name as signature of individual provider and date applying to authorize the Group Practice to receive Virginia Medicaid payments on Individual Provider's behalf.

28. Remarks

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