Virginia Medicaid Web Portal
Provider Enrollment

Enrollment Form Instructions

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. **National Provider Identifier - NPI** (Required)

   Enter your organization's 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 for an individual enrolling) **or Organization Name** (Required for Organizations enrolling)

   Enter the individual name enrolling or the organization name which identifies your organization 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.

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

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

9. 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).

10. 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.

11. 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 submitted claim or supporting documentation.

12. License/Certification and Specific Requirements for Provider Type (Required)

- **Specific Requirements for Durable Medical Equipment (DME)**
    - VA Board of Pharmacy or Non-Resident Board of Pharmacy License
    - VA Board of Pharmacy Medical Equipment Supply Permit or Non-Resident Medical Equipment Supply Permit
    - Individual State DME License
    - Business License
    - Contractor's license, permit or certification (for environmental modifications only), or
    - Documentation stating that a license is not required in their area or for services they are rendering.
- **Specific Requirements for Emergency Ambulance and Emergency Air Ambulance**
    - Emergency Medical Services (EMS) certification
    - For Neonatal Specialty EMS certification with Neonatal must be submitted
- **Hearing Aid Specialist**
    - Department of Professional and Occupational Regulations (DPOR)

- **Home Health Agency**
    - Home Care Organization license from VDH or
    - Accreditation Commission for Health Care, Inc. (ACHC) or
    - Community Health Accreditation Program (CHAP) or
    - Centers for Medicare/Medicaid Services (CMS) certification as a Home Health Agency or
    - Joint Commission for Accreditation of Health Care Organizations (JCAHO) certification as a Home Health Agency or
    - Virginia Department of Health (VDH) Centers for Quality Healthcare Services and Consumer Protection as a Home Health Agency
- **Hospice**
    - CMS Certification
- **Independent Laboratory**
    - Clinical Laboratory Improvement Amendments (CLIA) certification
    - CMS Certification
- **Local Education Agency**
    - Department of Education (DOE) approval for services
- **Pharmacy**
    - VA Board of Pharmacy Permit
    - VA Board of Pharmacy Non-Resident Pharmacy Permit
    - Individual State's Pharmacy Permit
- **Prosthetic Orthotic**
    - American Board for Certification on Orthotics and Prosthetics
    - Certificate from the Board for Orthotist/Prosthetist (BOC)
    - Copy of Business License
- **Renal Dialysis**
    - CMS Certification

13. 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.

14. Type of Applicant (Required)

Indicate 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.
- Individual is defined as a single practitioner operating under his/her own SSN or TIN.
- 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.
- 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)".

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.

17. Point-of-Sale (POS)

VA Medicaid Pharmacies have the option to enroll for POS for services rendered to Medicaid Members. Point of Sale (POS) refers to the capturing of data and customer payment information at a physical location when goods or services are bought and sold.

18. Provider Screening (Required for DME, Emergency Air Ambulance, Emergency Ambulance, Home Health Agency, Hospice, Independent Laboratory and Prosthetic Orthotic Applications)

For DME, Emergency Air Ambulance, Emergency Ambulance, Home Health Agency, Hospice, Independent Laboratory and Prosthetic Orthotic applications, if you are enrolling as an out of state provider you are required to be previously screened by CMS or by the Medicaid program that is located in the same state as your servicing address. If you have not been previously screened by one of the entities mentioned above, then you are not eligible to enroll in Virginia Medicaid and your application will be rejected upon receipt.

- If your organization has been screened by Medicare or another state's Medicaid program for the provider type and servicing address on this application, select one of the first two options and enter the state if necessary. This information will be confirmed. No fee is necessary you may continue to Section II.

19. Application Fee (Required for DME, Emergency Air Ambulance, Emergency Ambulance, Home Health Agency, Hospice, Independent Laboratory, Prosthetic Orthotic and Renal Dialysis Applications)

- If your organization has submitted a fee to Medicare or another state's Medicaid agency for the provider type and servicing address on this application, but has not yet been screened, select one of the next two options and to whom the fee was paid. No fee is necessary at this time, but may be required later, depending on the screening outcome where the fee has already been paid. Continue to Section II.
- If you have not been screened by or paid a fee to Medicare or another state's Medicaid agency for the provider type and servicing address on this application, you will be required to select one of the final hour choices.
- Make payment to Virginia Medicaid. During submission of this application you will have an option to choose your method of payment.
- Submit a hardship exception request to Virginia Medicaid. Attach a letter to this application describing the reason for your request. The letter should be on letterhead, signed by an authorized person, dated, and include your NPI. In addition, please submit a copy of your current financial statement, business bank statement, tax return, and a copy of your profit and loss statement for the location where you are claiming the hardship.
- Submitted a Hardship Exception Request to Medicare and it is in-process - attach a copy of your request to this enrollment application.
- Was granted approval for a Hardship Exception Request by Medicare - attach a copy to this enrollment application.

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.

20. 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. Types of ownership may include 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.

21. 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

22. 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

23. 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

24. 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 for 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.

25. 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 for 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.

26. 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 relevant 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.

27. **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 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

28. **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 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

29. 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.

30. Remarks

Please enter any other information to be considered in addition to the information contained within your enrollment application.