Virginia Medicaid Web Portal
Revalidation Instructions

General Instructions

As part of the new Provider Screening Regulations, all billing providers will need to periodically revalidate the information contained with the VA Medicaid Management Information System (MMIS). Please note that servicing providers associated with a group will not need to revalidate. Revalidation for all servicing provider associated to that group will be done by the group administrator.

When it's time for your revalidation, you'll receive a letter 90 days in advance of the revalidation due date. Within that time period, you will be able to utilize the 'Revalidation Submission' option from the Provider Maintenance Menu.

If the 'Revalidation Submission' option is chosen on the Provider Maintenance Menu, this information will begin immediately below the Provider Profile Maintenance information. This way any updates to demographic information can be made at the same time without having to return to the Provider Maintenance menu for another selection option.

Please note that once revalidation information is submitted, it needs to go through a screening process before being applied to the MMIS. This could take up to several days, depending on the information entered. Please be aware that if you go back in to the revalidation information shortly after submitting the updated information, it might not appear.

Ownership and Control Information for the Disclosing Entity

Within this section, please read each question and respond with the appropriate yes/no selection and make any appropriate updates, additions or deletions.

If a 'yes' response is entered and existing information currently housed within the MMIS is displayed, please verify this information and make any necessary changes. If a 'yes' response is entered and no information is currently housed in the MMIS and displayed, then information pertaining to the question will be required before submission.

To update a line, please click the 'Edit' link to enable entry for the associated data line.

To remove an entry, please click the 'Delete' link. This will remove the associated line in its entirety.

To add information, please click the 'Add row' button. This will open up a line and enable entry. The 'Add row' button can be used as much as needed to accommodate all information.

Please note that until the enactment of the Provider Screening Regulations, this information, though previously entered on enrollment applications and kept in your electronic file, was not captured in our system. Therefore the first time this screen is viewed, information will not exist and is required to be entered in order to be captured.

If a ‘no’ response is entered and existing information currently housed within the MMIS is displayed, please confirm that the information can be removed.

1. Does the provider entity have any managing employees and/or any individual(s) or organization(s) with ownership or controlling interests of 5% or more? Yes/No

For a ‘yes’ response, with information displaying, verify the information is correct and go to the next question. For a ‘yes’ response with inaccurate or no existing information, please make any updates, additions or deletions needed.

For any individual entities, please enter the following required fields:

- First Name
- Last Name
- Title
- Date of Birth
- Social Security Number
- Ownership Role
- Street Address
- City
- State
- Zip Code

For individuals who selected ‘Owner’ for the Ownership role, with 5% or more interest, please enter the following field:

- Percent of Ownership (Note: only whole numbers can be entered)

For organizations, please enter the following required fields:

- Organization Name
- Tax Identification Number
- Ownership Role
- Street Address
- City
- State
- Zip Code

For organizations who selected ‘Owner’ for the Ownership role, with 5% or more interest, please enter the following field:

- Percent of Ownership (Note: only whole numbers can be entered)

For a ‘No’ response, continue with the revalidation.

2. Relationships: Are any individuals named above related to each other? (spouse, parent, child or sibling)

This question will only display if two or more entries are made in the first question. If information displayed is accurate, go to the next question. If not, please make any updates, additions or deletions needed.

For any related individuals from question one, please enter the following required fields:

- First Name

- Last Name
- Relationship
- Related to Individual's First Name
- Related to Individual's Last Name

3. Subcontractor: Does any individual have ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more? Yes/No

For a 'yes' response, with information displaying, verify the information is correct and go to the next question. For a 'yes' response with inaccurate or no existing information, please make any updates, additions or deletions needed.

For any individual that has direct or indirect ownership or controlling interest of 5% or more in any subcontractor, please enter the following required fields:

- First name
- Last name
- Title
- Date of Birth
- Social Security Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

For organizations with direct or indirect ownership or controlling interest of 5% or more in any subcontractor, please enter the following required fields:

- Organization name (Last name field)
- Tax Identification Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

4. Other Disclosing Entity: Does any other disclosing entity in which a person, with an ownership or controlling interest in the disclosing entity, have ownership or control interest of at least 5% or more? Yes/No

For a 'yes' response, with information displaying, verify the information is correct and go to the next question. For a 'yes' response with inaccurate or no existing information, please make any updates, additions or deletions needed.

For any individual that has ownership or controlling interest of 5% or more in any other disclosing entity, please enter the following required fields:

- First name
- Last name
- Title
- Date of Birth

- Social Security Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

For organizations with ownership or controlling interest of 5% or more in any other disclosing entity, please enter the following required fields:

- Organization name (Last name field)
- Tax Identification Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

5. Criminal Offenses: Has any individual or organization who has any ownership or controlling interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, or controlled substance violation or any other crime or misconduct? Yes/No

For a 'yes' response, with information displaying, verify the information is correct and go to the next question. For a 'yes' response with inaccurate or no existing information, please make any updates, additions or deletions needed.

For any individual that has ownership or controlling interest of 5% or more that has ever been convicted or assessed fines as indicated above, please enter the following required fields:

- First name
- Last name
- Title
- Date of Birth
- Social Security Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

For any organization that has ownership or controlling interest of 5% or more that has ever been convicted or assessed fines as indicated above, please enter the following required fields:

- Organization name (Last name field)
- Tax Identification Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

For a ‘Yes’ response to this question, you will receive the message “Attach the details listing the final outcome of the offense” along with an ‘Attach’ button.

Clicking the ‘Attach’ button will open up the attachment window to attach an electronic copy of the final disposition. Note: after browsing your computer and selecting the desired document, be sure and hit the ‘Add File’ button. If the document was successfully attached, the file name will display above the ‘Done’ button.

You will be required to submit at least one attachment for every row entered but can attach multiple documents if needed in support of a row.

6. Has any individual or contractor connected with your practice ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct? Yes/No

For a ‘yes’ response, with information displaying, verify the information is correct and go to the next question. For a ‘yes’ response with inaccurate or no existing information, please make any updates, additions or deletions needed.

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For any individual or contractor connected with your practice that has ever been convicted or assessed fines as indicated above, please enter the following required fields:

- First name
- Last name
- Title
- Date of Birth
- Social Security Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

For any organization or contracting entity connected with your practice that has ever been convicted or assessed fines as indicated above, please enter the following required fields:

- Organization name (Last name field)
- Tax Identification Number
- Street Address
- City
- State
- Zip code
- Percent of ownership or controlling interest **(note: only whole numbers can be entered)**

For a ‘Yes’ response to this question, you will receive the message “Attach the details listing the final outcome of the offense” along with an ‘Attach’ button.

Clicking the ‘Attach’ button will open up the attachment window to attach an electronic copy of the final disposition. Note: after browsing your computer and selecting the desired document, be sure and hit the ‘Add File’ button. If the document was successfully attached, the file name will display above the ‘Done’ button.

You will be required to submit at least one attachment for every row entered but can attach multiple documents if needed in support of a row.

7. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any Federal or State agency or program, or any licensing or certification agency? Yes/No

Please select the appropriate radio button, indicating whether the provider has ever had any adverse legal action. For a 'no' response, go to the attestation.

For a 'yes' response, if the answer was previously 'no' (or blank) and changed to 'yes', a message ("A copy of any relevant final disposition documentation must be submitted. Please click here to attach a copy of the document.") will display along with an 'Attach' button.

Clicking the 'Attach' button will open up the attachment window to attach an electronic copy of the final disposition. Note: after browsing your computer and selecting the desired document, be sure and hit the 'Add File' button. If the document was successfully attached, the file name will display above the 'Done' button.

You will be required to submit at least one attachment for every row entered but can attach multiple documents if needed in support of a row.

Prior Screening

Not all providers will require screening. The following provider types will see and need to complete this section.

Provider Types
CORF (Outpatient Rehab Facility)
Hospice
Community Mental Health Centers (CSB)
Home Health Agency - State
Home Health Agency - Private
Durable Medical Equipment/Supplies
Personal Emergency Response System
Prosthetic/Orthotic
Independent Laboratory
Transportation (Emergency Ambulance)
Emergency Air Ambulance
Out-of-State Transportation (Emergency Ambulance)
Out-of-State Emergency Air Ambulance
Out-of-State Laboratory

I have previously been or to be screened by Medicare or a Medicaid Agency.

- **Yes/No –** Radio button
- If 'No' is selected, indicating no previous screening, go to the next section.
- If 'Yes' is selected, indicating a previous screening, the following question(s) displays:
    - **I have been previously screened by:** - A drop down with the following two options:
        - Medicare
        - Medicaid Agency
            - If the 'Medicaid Agency' option is selected, an additional field will be displayed:
                - **State** - followed by the state drop down
    - **Approved** and **In Progress** – radio buttons
        - If the 'Approved' radio button is selected, an additional field will be displayed:
            - **Date Approved** - with an text box for approval date (MM/DD/YYYY)

Revalidation Fee

Not all providers will require submission of a revalidation fee. The following provider types will see and need to complete this section.

Provider Types
Hospital, in-state, General
State Mental Hospital (Aged)
Hospital – EPSDT Psychiatric Hospital
Long Stay Hospital
TB Hospital
SNF-Mental Health
State Mental Hospital (less than age 21)
State Mental Hospital (Med-Surge)
Medical Surgery - Mentally Retarded
SNF-Non Mental Health
SNF - Mentally Retarded
Long Stay Inpatient Hospital - Mental Health
Hospital – Medical Surgery – Mental Health Retardation
Hospital In-State Rehab
Nursing Home - Intensive Care/Nursing Facility (ICF/NF)
ICF - Mental Health
ICF - Mentally Retarded - State Owned

Provider Types
ICF - Mentally Retarded - Community Owned
CORF (Outpatient Rehab Facility)
Hospice
Ambulatory Surgical Center
Renal Unit (Renal Dialysis)
Federally Qualified Health Center
Rural Health Clinic
Community Mental Health Centers (CSB)
Outpatient Rehabilitation
Home Health Agency - State
Home Health Agency - Private
Durable Medical Equipment/Supplies
Personal Emergency Response System
Prosthetic/Orthotic
Independent Laboratory
Residential Psychiatric Treatment
Transportation (Emergency Ambulance)
Emergency Air Ambulance
Out-of-State Transportation (Emergency Ambulance)
Out-of-State Emergency Air Ambulance
Out-of-State Rehab Hospital
Out-of-State Hospital
Out-of-State Laboratory
Out of State ICF Provider

The initial question on this page will be the only one displayed in this section: '**I have paid an application fee**'.

- **Yes/No** radio buttons

- If 'Yes' is selected, the following option(s) displays:

    - **I have previously paid an application fee to:** - A drop down with the following two options:
        - Medicare
        - Medicaid Agency
            - If the 'Medicaid Agency' option is selected, an additional field will be displayed:
                - **State** - followed by the state drop down
        - **Date Paid** – enter date the payment was made in the format MM/DD/YYYY

- After completing this information you will also see a message to “Attach the confirmation of fee payment” along with an ‘Attach’ button.

- Clicking the ‘Attach’ button will open up the attachment window to attach an electronic copy of the final disposition. Note: after browsing your computer and selecting the desired document, be sure and hit the ‘Add File’ button. If the document was successfully attached, the file name will display above the ‘Done’ button.

- If ‘No’ is selected, the following (option)s display:

  - **I wish to pay the application fee to Virginia Medicaid.**
    - If selected, the following message will display in red:
      - Payment instructions will be displayed after completing revalidation
  - **I wish to submit a Hardship Exception Request**
    - Followed by a link to the Hardship Exception Request instructions
    - If selected, the following message will display in red:
      - Please attach your Hardship Exception Request Letter. Refer to instructions for details.
      - ‘Attach’ button will be displayed
  - **I have received an approved Hardship Exception Request letter from CMS.**
    - If selected, the following message will display in red:
      - Please attach copy of the Approval Letter.
      - ‘Attach’ button will be displayed
  - **I have submitted a Hardship Exception Request and it is in-process.**
    - If selected, the following sentence will display:
      - **Please enter the date the Hardship Exception Request was submitted**. – enter the date of the Hardship Exception Request submission in the format MM/DD/YYYY
      - In addition, the following message will display in red:
        - Please attach your Hardship Exception Request Letter
        - ‘Attach’ button will be displayed

  - Note: Clicking the ‘Attach’ button will open up the attachment window to attach an electronic copy of the final disposition. Note: after browsing your computer and selecting the desired document, be sure and hit the ‘Add File’ button. If the document was successfully attached, the file name will display above the ‘Done’ button.

Revalidation Attestation

After revalidation information is reviewed and/or updated, you will need to attest to the accuracy of the existing/updated information in order to submit entries/modifications.

By clicking the box and entering your name below you attest that all information displayed above is correct, accurate and true.

Click the radio button to attest, enter your name and click ‘Submit’ or ‘Make Payment and Submit’ to process the information.

If payment has already been made or no payment is due, the ‘Submit’ button will display. After successful completion of the revalidation, the user will be routed to the Revalidation Status Tracking screen.

If a payment has not been made and is due, the 'Make Payment and Submit' button will display. Clicking this button will route the user to the Financial Menu.

The Financial Menu screen will display the following three options:

- Pay by Check
- Pay by Credit Card Online
- Pay by Credit Card by Mail

A selection from this menu will automatically route the user to the associated function.

Pay by Check

Selection of 'Pay by Check' navigates the user to the screen that can be printed for use as a cover letter to accompany the check.

Providers that wish to make payment via a check can print this coversheet to accompany the payment. Using this coversheet ensures proper credit.

The coversheet contains the NPI, the Last Name or Organization Name, the application tracking number associated with the provider's application, the amount due and a space for the check number.

The check and printed form needs to be mailed to:

Application Fee
Provider Enrollment Services
P. O. Box 26803
Richmond, VA 23261-6803

Pay by Credit Card via Mail

Selection of the 'Pay by Credit Card via Mail' navigates the user to the screen that can be printed for use in submitting credit card information via mail.

Providers that wish to make a credit card payment via the mail can print this coversheet to accompany the payment. Using this coversheet ensures proper credit.

The coversheet contains the NPI, the Last Name or Organization Name and the application tracking number associated with the provider's application.

The provider will need to complete the following information for credit card processing. Note: All information is required:

- Credit Card Type
  - MasterCard, Visa, Discover and American Express are the only forms of credit cards that can be accepted
- Credit Card Number
- Credit Card Expiration Date
- CVV
  - Card verification value
  - For MasterCard, Visa and Discover it's a three digit number located on the back of the card
  - For American Express it's a four digit number located on the front of the card
- Cardholder's Name

    - As it's displayed on the card
- Cardholder's Billing Address
    - Street, City, State and Zip Code
- Cardholder's Phone Number
    - Including Area Code
- Cardholder's Email
    - Used for email receipt once payment has been processed

The completed form needs to be mailed to:

Application Fee
Provider Enrollment Services
P. O. Box 26803
Richmond, VA 23261-6803

Pay by Credit Card Online

Selection of 'Pay by Credit Card Online' navigates the user to the Pay by Credit Card screen. Providers that wish to make a credit card payment online can make their payment immediately through a secured website.

The portal page will display the NPI, the Last Name or Organization Name and the application tracking number associated with the provider's application.

The provider will need to complete the following information for credit card processing:

- Credit Card Type * (required)
    - Select appropriate credit card from drop down options
    - MasterCard, Visa, Discover and American Express are the only forms of credit cards that can be accepted
- Credit Card Number * (required)
- Credit Card Expiration Date * (required)
    - MMYY format
- Amount (not enterable)
    - Populated with the amount due for screening
- CVV * (required)
    - Card verification value
    - For MasterCard, Visa and Discover it's a three digit number located on the back of the card
    - For American Express it's a four digit number located on the front of the card
- Invoice Number (not enterable)
    - Populated with the provider's application tracking number
- Hospital/Facility Name (optional)
- Cardholder's First Name * (required)
    - As it's displayed on the card
- Cardholder's Last Name * (required)
    - As it's displayed on the card
- Cardholder's Address 1 * (required)
    - Building number and street address associated with the cardholder's billing address
- Cardholder's Address 2 (optional)
- City * (required)
    - City associated with cardholder's billing address

- State * (required)
    - State associated with cardholder's billing address
- Postal Code * (required)
    - Zip Code associated with cardholder's billing address
- Country (optional)
- Cardholder's Phone Number * (required)
    - Including Area Code
- Cardholder's Email * (required)
    - Used for email receipt once payment has been processed

After completing the credit card information the transaction will be approved or denied based on the information entered.

If credit card payment online is successful, the user will receive a message indicating so.