

RI Medicaid Provider Enrollment for Home Stabilization

May, 2020

Agenda

- Getting Started
- Completing an Application for Enrollment
- Disclosure Questions
- Agreement Screen
- Signing your Application
- Uploading Required Documents and Submitting Application
- Pausing an Application to complete later
- Resuming an Application
- Checking your Application Status

Getting Started

- Provider enrollment for the RI Medicaid Program is completed electronically through the Enrollment Portal, in the [Healthcare Portal](#).
- Detailed instructions for completing the electronic application are accessible on the homepage of the [Healthcare Portal](#).
- These slides cover the basics of completing the electronic application.

Begin Enrollment Process

<https://www.riproviderportal.org>

Home

Wednesday 09/02/2015 11:47 AM EST

Login ?

*User ID

Log In

[Forgot User ID?](#)
[Register Now](#)
[Where do I enter my password?](#)

Protect Your Privacy!
Always log off and close all of your browser windows

Would you like to enroll as a Provider?

[Provider Enrollment](#)

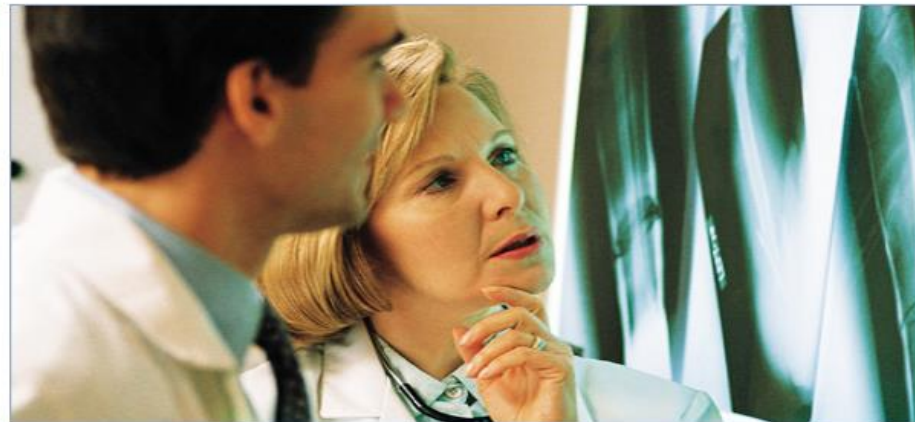
Would you like to enroll as a Trading Partner?

[Click here to Enroll](#)

What can you do in the RI Medicaid Health Care Portal

Through this secure and easy to use internet portal:

- Healthcare providers and Billing Agents can **enroll as a Trading Partner** with RI Medicaid.
- Trading Partners can access eligibility, claim status, file exchange and other Interactive Web Services including the Electronic Health Record (EHR) Incentive Program - **MAPIR** - utilizing their Trading Partner ID as their User ID.



[Provider Enrollment User Guide](#)

[Trading Partner Enrollment User Guide](#)

[Trading Partner Agreement](#)

[Website Requirements](#)

[Rhode Island Medicaid Providers](#)

Click here
for Provider
Enrollment

More information found in
User Guide

Access the Application

Select
Enrollment
Application

[Home](#) > Provider Enrollment

Wednesday 09/02/2015 11:46

Provider Enrollment

[Enrollment Application](#)

Initiate a new provider enrollment application.

[Resume Enrollment](#)

Resume an existing enrollment application that has not been submitted.

[Enrollment Status](#)

Check the current status of an enrollment application.

Customer Links

[National Plan & Provider Numeration System](#)

Apply or Verify your National Provider Identifier (NPI).

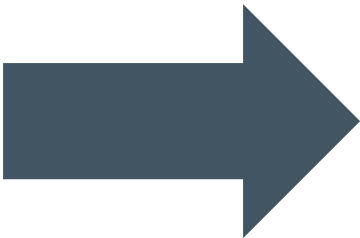
[Trading Partner Enrollment](#)

Enroll as a Trading Partner in the Healthcare Portal.



Welcome Screen

This screen is the starting point. On each of the following screens, you must complete the required information. You cannot advance to the next screen without completing the current one. You can go back by using the menu on the left. Review the list of items you will need to complete the process.





Contact Us | Login

Rhode Island Executive Office of Health and Human Services
Medicaid

Home

Home > Provider Enrollment > Enrollment Application

Friday 04/17/2015 04:19 PM EST

Provider Enrollment: Welcome

?

Welcome

Request Information

Specialties

Provider Identification

Addresses

Languages

Other Information

Disclosures

Agreement

Summary

Welcome to the Rhode Island Medical Assistance Online Provider Enrollment Process

Your suspended application will be presented within the subsequent pages of the enrollment application. Within each page, the data will be presented for review and updates should be applied as appropriate. You will be prompted to navigate through each page and submit "Continue" regardless of the need for any updates. This will validate the application for accuracy prior to submission.

You will need the following information to complete your enrollment request:

National Provider Identifier

Address Information including Postal Code + 4

Taxonomy Codes

Tax ID - either EIN or SSN

License Number

Completed, including signature, W-9 as an attachment

Additional Federally Required Disclosures, as an attachment, if applicable

Please click the "Continue" button to start the enrollment application.

Continue

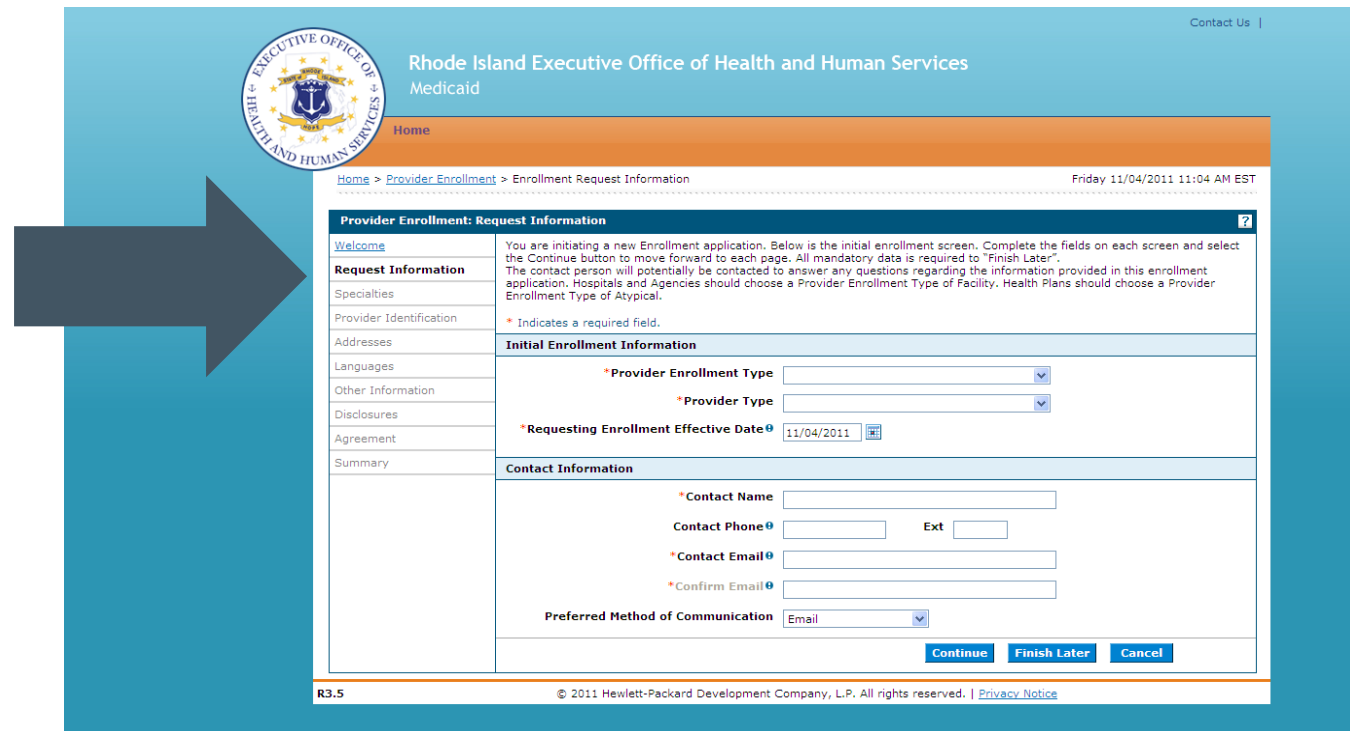
Cancel

R4.2

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Provider Enrollment – Request Information Screen

- **Provider Enrollment Type** – Select the type of enrollment as Facility
- **Provider Type** – Select provider type 107 (Home Stabilization) from the list.
- **Requesting Enrollment Effective Date**
– March 1, 2020
- **Contact information** should be completed with the primary contact information for the provider.
- Select **Continue or Finish Later**.



The screenshot displays the 'Provider Enrollment: Request Information' screen. The header includes the Rhode Island Executive Office of Health and Human Services logo and the text 'Rhode Island Executive Office of Health and Human Services Medicaid'. The breadcrumb trail shows 'Home > Provider Enrollment > Enrollment Request Information'. The date and time are 'Friday 11/04/2011 11:04 AM EST'. The form is divided into several sections: 'Request Information' (with a 'Welcome' message), 'Initial Enrollment Information' (containing fields for 'Provider Enrollment Type', 'Provider Type', and 'Requesting Enrollment Effective Date'), and 'Contact Information' (containing fields for 'Contact Name', 'Contact Phone', 'Contact Email', 'Confirm Email', and 'Preferred Method of Communication'). A large blue arrow points to the 'Request Information' section. The footer includes 'R3.5' and '© 2011 Hewlett-Packard Development Company, L.P. All rights reserved. | Privacy Notice'.

Provider Enrollment: Request Information	
Welcome	You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later". The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application. Hospitals and Agencies should choose a Provider Enrollment Type of Facility. Health Plans should choose a Provider Enrollment Type of Atypical.
Request Information	
Specialties	
Provider Identification	* Indicates a required field.
Addresses	
Languages	
Other Information	
Disclosures	
Agreement	
Summary	
Initial Enrollment Information	
*Provider Enrollment Type	
*Provider Type	
*Requesting Enrollment Effective Date	11/04/2011
Contact Information	
*Contact Name	
Contact Phone	Ext
*Contact Email	
*Confirm Email	
Preferred Method of Communication	Email
Continue Finish Later Cancel	

Enrollment Specialties

- **Specialty** – Select specialty 075 Case Management.
- **Effective Date** – March 1, 2020
- **End Date** – leave blank
- **Taxonomy Code** – Enter the taxonomy from your NPI letter, either 251B00000X or 251K00000X
- **Primary** – Select the checkbox if this specialty is the primary specialty.
- Click **Add** to add the specialty.
- Select continue or finish later to move to next screen.

Rhode Island Executive Office of Health and Human Services
Medicaid

Home

Home > Provider Enrollment > Enrollment Specialties

Friday 11/04/2011 11:08 AM EST

Provider Enrollment: Specialties

[Welcome](#) [Request Information](#) **Specialties**

The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty. The taxonomy code is required for each specialty. If your taxonomy does not display in the drop down list, contact our Provider Enrollment Dept. at (401) 784-8100 for local and long distance calls or 800-964-6211 for in-state toll calls.

* Indicates a required field.
✓ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Specialty	Taxonomy Code	Effective Date	End Date	Action
Click to collapse.				
Type: Dentist				
* Effective Date			* Specialty	
* End Date			* End Date	
* Taxonomy Code			Primary	
☐				
Add Reset				
Continue Finish Later Cancel				

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Provider Identification – Legal Name

[Home](#) > [Provider Enrollment](#) > Enrollment Provider Identification

Friday 03/18/2016 08:49 AM EST

Provider Enrollment: Provider Identification ?	
Welcome	* Indicates a required field.
Request Information	Provider Legal Name
Specialties	The provider legal name and information is provided once for each enrollment. Ownership Information is required.
Provider Identification	* Provider Legal Name
Addresses	* Ownership v
Languages	Business Name
Banking Information	Provider Identification Numbers
Other Information	The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.
Disclosures	* Tax ID * Tax ID Type ☒ EIN ☐ SSN
Agreement	* Effective Date End Date * Fiscal End Date v
Summary	* NPI
	License # Expiration Date
	Medicare #
	DEA #
	CLIA #
	Supplemental NPI
	Supplemental Taxonomy
	Continue Finish Later Cancel

- Enter the provider's **legal name** information.
- **Ownership** – Select the type of ownership as Corporation, Trust/Estate, or Government/Nonprofit Corporation, Individual, Legal Services Corporation, Medical Services Corporation, or Partnership.
- **Business Name** – Enter the business name.

Provider Identification – ID Numbers

[Home](#) > [Provider Enrollment](#) > Enrollment Provider Identification

Friday 03/18/2016 08:49 AM EST

Provider Enrollment: Provider Identification ?	
Welcome	* Indicates a required field.
Request Information	Provider Legal Name
Specialties	The provider legal name and information is provided once for each enrollment. Ownership Information is required.
Provider Identification	* Provider Legal Name
Addresses	* Ownership
Languages	Business Name
Banking Information	Provider Identification Numbers
Other Information	The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.
Disclosures	* Tax ID * Tax ID Type ☒ EIN ☐ SSN
Agreement	* Effective Date Calendar End Date Calendar * Fiscal End Date
Summary	* NPI
	License # Expiration Date Calendar
	Medicare #
	DEA #
	CLIA #
	Supplemental NPI
	Supplemental Taxonomy
	Continue Finish Later Cancel

- **Tax ID** – Enter the provider’s tax ID. If the tax ID is the provider’s Social Security Number, enter the 9-digit number without the dashes (-).
- **Tax ID Type** – Select the tax ID type as Employer Identification Number (EIN) or Social Security Number (SSN).
- **Effective Date** – Enter or select the effective start date for the tax ID.
- **End Date** – Enter or select the end date for the tax ID.
- **Fiscal End Date** – Enter the first letter of the month or select the month the fiscal year ends.
- **NPI** – Enter the provider’s National Provider Identifier (NPI) number.
- **License #** - Enter the provider’s license number.
- **Expiration Date** – Enter or select the date the license expires.
- **Medicare #** - Enter the provider’s Medicare number.
- **DEA # , CLIA #, Supplemental NPI, and Supplemental Taxonomy** – Leave blank

W-9

Form W-9
Rev. December 2011
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)
Donald Green

Business name (disregarded entity name, if different from above)
Blue Y Drywall

Check appropriate box for federal tax classification:
☒ Individual sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (LLC corporation, S-B corporation, Partnership) ☐ Exempt payee
☐ Other (see instructions)

Address (number, street, and apt. or suite no.)
456 Flower Lane

City, state, and ZIP code
Oaktown, AL 00000

Requester's name and address (optional)
J. Builders
123 Maple Avenue
Oaktown, AL 00000

Enter without hyphens here (optional)

Part I Taxpayer Identification Number (TIN)
Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see how to get a TIN on page 3.

Social security number
1 2 3 - 4 5 6 - 7 8 9

Employer identification number
1 - 2 3 4 5 6 7 8 9 0

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

ALL providers must upload a new signed W-9 at the end of the revalidation process.

The business name entered on the W-9 **must match** the provider's legal name.

Addresses

- **Address Type** – Select the provider's address type as Billing Service, Mail To, Pay To, or Service Location.
- **Primary Address** – Select the checkbox if this is the provider's primary address.
 - Service Location must be checked as the primary address.
- **Location Name** – Enter the address' location name.
- **Location Code** – Select the address' location code as In State, Border, or Out of State.
- **Address** – Enter the address.
- **Town Code** – Select the address' town code.
- **City** – Enter the city name.
- **County** – Select the county.
- **State** – Select the state where the address is located.
- **Zip Code** – Enter the address' zip code.
- **Phone and Ext** – Select the phone number type as Phone, Fax, TeleTypewriter, or Telephone Device for Deaf; enter the phone number, and extension. **Mandatory**

Provider Addresses

The provider addresses identify each location where a provider renders services, as well as locations that are used for mail, billing, and payment. Multiple addresses can be added, regardless of the type selected. At least one Service Location and Phone Number is required. To look up your 4 digit zip code extension please go to <http://zip4.usps.com/zip4/welcome.jsp>. For the Location Code field, if you are an out of state provider, please check this [list](#) to determine if you are in a Bordering Community. Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

	Location Name	Type	Address	City	State	Action
	Click to collapse.					
	*Address Type Location Name *Address *Town Code *City *State Phone Primary Address ☐ *Location Code *County *Zip Code Phone					

Service Addresses

If the address selected was a Service Location, enter the service address information:

- **Accepting New Patients** – Select the checkbox if this service address is accepting new patients.
- **ADA Compliant** – Select the checkbox if this service address complies with the Americans with Disabilities Act (ADA).
- **Age Restrictions** – Select the checkbox if this service address has patient age restrictions.
- **Other Restrictions** – Select the checkbox if this service address has other restrictions and enter the restriction.
- **Facility Administrator Last Name, First Name, and License #** - Enter the facility administrator's last name, first name, and license number.
- **Medical Administrator Last Name, First Name, and License #** - Enter the medical administrator's last name, first name, and license number.
- **TDD Capability, Phone, and Ext** – Select the checkbox if the service address has telecommunication devices for the deaf (TDD), and enter the TDD's phone number and extension.
- **TTY Capability, Phone, and Ext** – Select the checkbox if the service address has a teletypewriter (TTY), and enter the TTY's phone number and extension.
- Click **Add** to add the address.

If you have more addresses to add, click + to add another service address.

Service Address Information

If 'Address Type' is changed from 'Service', the service information below will be lost upon Add or Save of address.

Accepting New Patients

ADA Compliant

Age Restrictions

Other Restrictions

Facility Administrator Last Name

First Name

License #

Medical Administrator Last Name

First Name

License #

TDD Capability

Phone

Ext

TTY Capability

Phone

Ext

Add

Reset

Continue

Finish Later

Cancel

Languages

Provider Enrollment: Languages

[Welcome](#)
[Request Information](#)
[Specialties](#)
[Provider Identification](#)
[Addresses](#)
Languages
[Banking Information](#)
[Other Information](#)
[Disclosures](#)
[Agreement](#)
[Summary](#)

Providers that have the ability to interpret multiple languages should select the appropriate ones below.
Click the **Remove** link to remove the row.

Language	Action
Click to collapse.	
*Language	
Add	

Providers that have the ability to interpret multiple languages should select the appropriate languages from the list.
Select the **Add** button after each language.
When finished, select continue.

Banking Information

Bank and Bank Account Information

*ABA Routing Number

*Account Number

*Account Type

*EFT Start Date

EFT End Date

All providers must enroll in EFT for payment.

- Enter the routing number for your bank.
- Enter the account number.
- Select the account type.
- Select today's date on the calendar or enter today's date.
- End date not required.

*Account Type

*EFT Start Date

September, 2015

Su	Mo	Tu	We	Th	Fr	Sa
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	1	2	3
4	5	6	7	8	9	10

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Today: September 2, 2015

served. | [P](#)

Other Information – Group or Facility

Additional information is provided for each enrollment, for group/facility and individual providers.

Certification Information

*Certification

*Effective Date

End Date

Facility Providers

Number of Licensed Beds

Number of Swing Beds

Continue

Finish Later

Cancel

Complete all information on this screen.

Items marked with (*) must have an answer selected.

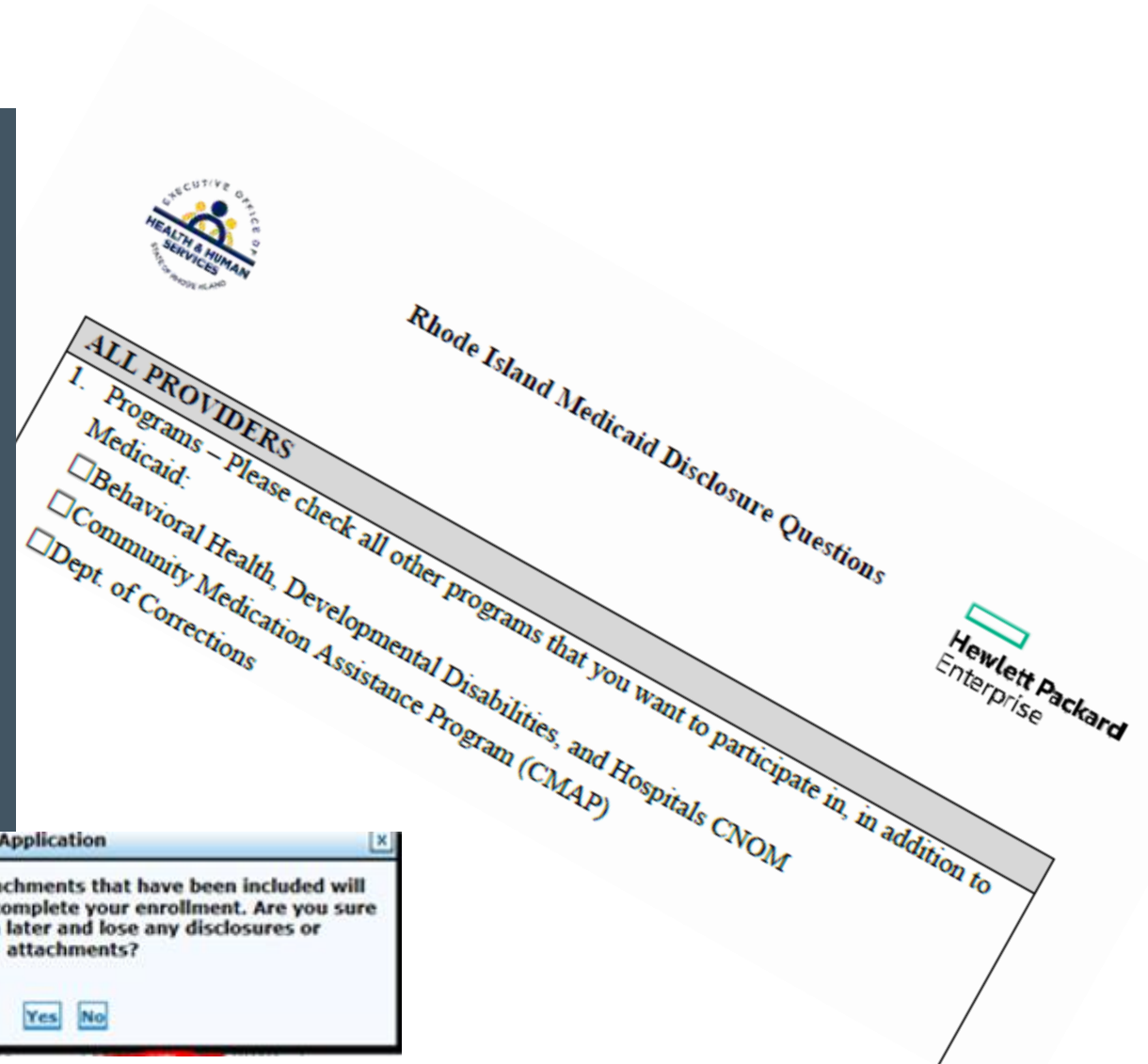
If Not Applicable was selected, today's date should be entered for Effective Date.

Disclosures

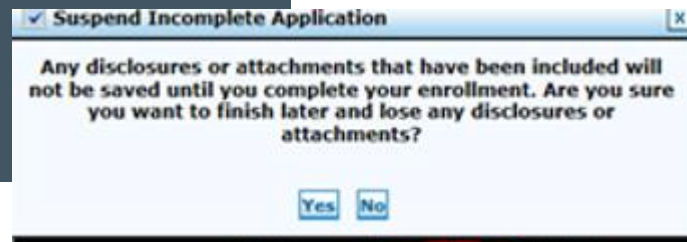
IMPORTANT

Disclosures must be completed all at once. If you save your application, all prior work will be saved **EXCEPT** disclosures.

These must be completed when you are ready to submit.



The image shows a document titled "Rhode Island Medicaid Disclosure Questions" with the logo of the Executive Office of Health & Human Services, State of Rhode Island. The document is tilted and features a section for "ALL PROVIDERS" with the instruction: "1. Programs – Please check all other programs that you want to participate in, in addition to Medicaid:". Below this, there are three checkboxes: ☐ Behavioral Health, Developmental Disabilities, and Hospitals CNOM; ☐ Community Medication Assistance Program (CMAP); and ☐ Dept. of Corrections. The Hewlett Packard Enterprise logo is visible in the bottom right corner of the document.



A screenshot of a Windows dialog box titled "Suspend Incomplete Application". The text inside reads: "Any disclosures or attachments that have been included will not be saved until you complete your enrollment. Are you sure you want to finish later and lose any disclosures or attachments?". At the bottom, there are two buttons: "Yes" and "No".

Disclosures

Answer Yes or No to each question.
If you answer Yes, answer any additional questions and enter an explanation. If the answer is Not Applicable, enter NA without a slash (/).

Remember, if you do not complete and confirm the application, the disclosure question responses will be lost.

The next few slides highlight a few of the disclosure questions.



The image shows a document titled "Rhode Island Medicaid Disclosure Questions" with the logo of the Executive Office of Health & Human Services, State of Rhode Island. The document is a form for providers to disclose participation in various programs. It includes a section for "ALL PROVIDERS" and a list of programs to check for participation. The Hewlett Packard Enterprise logo is visible in the bottom right corner.

Executive Office of Health & Human Services
STATE OF RHODE ISLAND

Rhode Island Medicaid Disclosure Questions

ALL PROVIDERS

1. Programs – Please check all other programs that you want to participate in, in addition to Medicaid:

- ☐ Behavioral Health, Developmental Disabilities, and Hospitals CNOM
- ☐ Community Medication Assistance Program (CMAP)
- ☐ Dept. of Corrections

Hewlett Packard Enterprise

Disclosure Question #4

4. *Is there an Owner/Administrator, Agent of the Provider, Managing Employee or Officer for the Corporation?

☒ Yes ☐ No

*a. Name:

*b. Title:

*c. Legal entity or home address:

*d. Social Security Number or Employer Identification Number

*e. Date of Birth 

Important:
Question 4 requires the owner/administrator's
name, title, and **home address**.

Also, the **Social Security number** and **date of birth** of the owner must be listed.

Disclosure Question #10

Question #10 asks if you have more than one individual to disclose for question 4, 5, 6, 7, and/or 9.

If the answer is yes, you **MUST** complete and upload the Additional Federally Required Disclosures form, found on the Agreement page, following the disclosures.

If controlled by a board of directors, information on all members must be completed.

Ownership and Control				
List the name and address of each person with an ownership or control interest in the disclosing entity and has direct or indirect ownership of 5 percent or more.				
1	Name & Title	Legal Entity or Home Address	Relationship	EIN/ SSN
2	Subcontractor? Y/N	Ownership percentage amount		
3	Name & Title	Legal Entity or Home Address	Relationship	SSN
4	Subcontractor? Y/N			

Disclosing Entity		
List any persons who has an ownership or control interest in another disclosing entity.		
1	Name	Other Disclosing Entity Address
2	Other Disclosing Entity	
3	Other Disclosing Entity	
4	Other Disclosing Entity	
5	Other Disclosing Entity	
6	Other Disclosing Entity	
7	Other Disclosing Entity	
8	Other Disclosing Entity	
9	Other Disclosing Entity	
10	Other Disclosing Entity	
11	Other Disclosing Entity	
12	Other Disclosing Entity	
13	Other Disclosing Entity	
14	Other Disclosing Entity	
15	Other Disclosing Entity	
16	Other Disclosing Entity	
17	Other Disclosing Entity	
18	Other Disclosing Entity	
19	Other Disclosing Entity	
20	Other Disclosing Entity	

Disclosure Question #12

12. List any outstanding balance owed to the RI Executive Office of Health and Human Services Medicaid Program by a previous provider.

If the answer is no outstanding balance, enter 0.
Do not enter decimals or dollar signs.

Agreement Screen – Supporting Documents

The Agreement screen enables you to submit supporting documents as attachments to your application.

Use the browse button to find the file, and then upload to your application.

Documents can be loaded in the following formats:
.jpg or.pdf

Files larger than 2MB should be faxed to 401-784-3892.

Instructions

The terms of enrollment are stated below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.

Access the summary of enrollment [link](#) to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.

The enrollment application terms must be accepted in order to submit the application for approval.

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.

Supporting Documentation

The following actions need to be taken to complete the enrollment process. If you need to submit attachments, please follow the instructions in the Attachments panel below.

Submit as Attachment: [W-9](#)

Submit as Attachment: Additional Federally Required Disclosures [excel](#) [pdf](#) Please complete if you checked Yes to question 10 on the Disclosures page.

Submit as Attachment: License for out of state providers only

Submit as Attachment: Approval Letter from DCYF if you are applying as a Licensed Mental Health Counselor

Attachments

To add an attachment, browse and select the attachment, then select Add.

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click the Remove link to remove the entire row.

	Attachment	Action
	Click to collapse.	
	*Upload File	Browse...
	Add	

Signing your Application

Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Agreement and Addendum have been read.

Read and Print: [Provider Agreement](#)

Read and Print: [Provider Addendum I Glossary](#)

Read and Print: [Exclusion Letter](#)



You will be submitting the Provider Enrollment application electronically. By submitting this application, you acknowledge that you have read and agree to the policies of the Provider Agreement and Provider Addendum I Glossary for all Programs to which you are applying. Therefore, your signature indicates that you have legal authority to submit this application and understand that your electronic signature is binding to the same extent as your written signature.

*I accept ☐ I understand that my electronic signature is equivalent to written signature. The electronic signature should be my legal name (first and last name).

*Your Signature

Title

Agreement Date 09/02/2015

You are unable to sign your document until you open and read each of the document links in blue: Provider Agreement, Provider Addendum and Exclusion Letter. Once you open each, the “I accept” box can be checked and the signature section will open.

Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Agreement and Addendum have been read.

Read and Print: [Provider Agreement](#) ✓

Read and Print: [Provider Addendum I Glossary](#) ✓

Read and Print: [Exclusion Letter](#) ✓

You will be submitting the Provider Enrollment application electronically. By submitting this application, you acknowledge that you have read and agree to the policies of the Provider Agreement and Provider Addendum I Glossary for all Programs to which you are applying. Therefore, your signature indicates that you have legal authority to submit this application and understand that your electronic signature is binding to the same extent as your written signature.

*I accept ☒ I understand that my electronic signature is equivalent to written signature. The electronic signature should be my legal name (first and last name).

*Your Signature

Title

Agreement Date 09/02/2015

Provider Agreements

Read and Print: [Provider Agreement](#)

Read and Print: [Provider Addendum / Glossary](#)

Read and Print: [Exclusion Letter](#)

It is not necessary to sign and fax these documents. Signing the application electronically also signs these three documents.

Completing Application

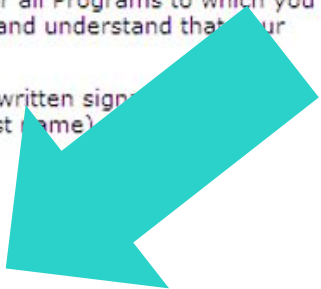
You will be submitting the Provider Enrollment application electronically. By submitting this application, you acknowledge that you have read and agree to the policies of the Provider Agreement and Provider Addendum I Glossary for all Programs to which you are applying. Therefore, your signature indicates that you have legal authority to submit this application and understand that your electronic signature is binding to the same extent as your written signature.

***I accept** ☐ I understand that my electronic signature is equivalent to written signature and my electronic signature should be my legal name (first and last name).

***Your Signature**

Title

Agreement Date 12/01/2011



After checking the “I Accept” box and entering your name and title, you have three choices:
Submit....Finish Later.....Cancel

- Submit – Brings you to your Summary Page. **You must confirm** the information on the Summary to complete application process
- Finish Later – Saves the information **EXCLUDING** Disclosure information
- Cancel – Erases all entered information

Summary Page

Welcome
Request Information
Specialties
Provider Identification
Addresses
Languages
Banking Information
Other Information
Disclosures
Agreement
Summary

Your summary page allows you to print and review all information.

If changes are needed, you must return to the appropriate page, by clicking on the correct section in the table of contents on the left side of the screen.

Confirming Your Application

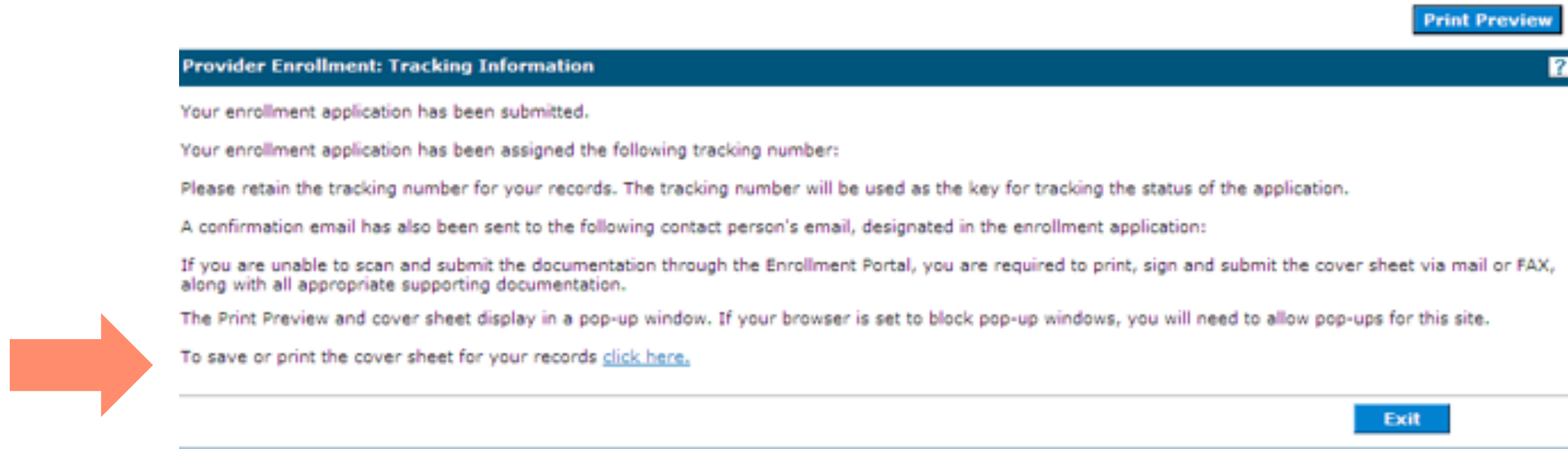


IMPORTANT:
Your enrollment application **WILL NOT** be submitted for processing
until you click the confirm button.

Instructions for Summary Page			
If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields. Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing. Please print a copy of this summary for your records.			
Print Preview		Confirm	Finish Later Cancel



Tracking Information Page and Cover Sheet



Provider Enrollment: Tracking Information Print Preview

Your enrollment application has been submitted.

Your enrollment application has been assigned the following tracking number:

Please retain the tracking number for your records. The tracking number will be used as the key for tracking the status of the application.

A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:

If you are unable to scan and submit the documentation through the Enrollment Portal, you are required to print, sign and submit the cover sheet via mail or FAX, along with all appropriate supporting documentation.

The Print Preview and cover sheet display in a pop-up window. If your browser is set to block pop-up windows, you will need to allow pop-ups for this site.

To save or print the cover sheet for your records [click here.](#)

Exit

After selecting Confirm, you will receive a tracking number.
Make note of this number.
You are also able to print a cover sheet for your records,
or to attach to items you must mail or fax.

Printing the Cover Sheet

[Print](#)

Provider Enrollment: Cover Sheet

Date 2/21/2012

Tracking Number 37652-221-1458-915-3503

Henkel Packard Enterprise

Att: Provider Enrollment
PO Box 2010
Warwick, RI 02887-2010

Enrollment form for the following provider:

Listed below is the additional information necessary (if applicable) to successfully complete your enrollment as a Rhode Island Medical Assistance provider. The information listed below must be sent in order to complete your Provider Enrollment Application. Please check mark the items below that will be included with this cover sheet.

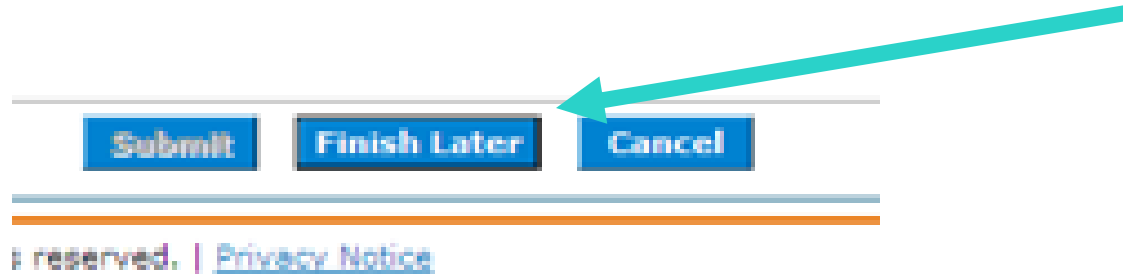
- ☐ Federal W-9 Form, required
- ☐ Additional Federally Required Disclosures, if applicable
- ☐ Copy of DCYF Letter, if applicable
- ☐ Copy of Principal Counselor Certificate, if applicable
- ☐ Copy of Out of State License, if applicable
- ☐ Copy of BHDDH License, if applicable

All of the documents that are checked above must be mailed to HP Enterprise Services (address listed above) or faxed to (401) 784-3892 with this document as a coversheet.

[Print](#) [Close](#)

Use the Print button to print a copy of the Cover Sheet.
Select Close when completed.

Finish Application Later



- Once you have started the provider enrollment application process, you can save the enrollment application and finish it later. You must finish the enrollment process within thirty days or your data will be lost. **Note: the responses to the disclosure questions will need to be re-entered when you resume your application.**
- On any screen, click **Finish Later**. The Suspend Incomplete Application dialog box appears.
 - REMINDER: Any disclosures or attachments that have been included will not be saved until you complete your enrollment.
- Click **Yes** to finish the enrollment application within the next thirty days. The Provider Enrollment: Credentials page appears.

Credentials Page

[Home](#) > [Provider Enrollment](#) > [Enrollment Credentials](#)

Friday 11/04/2011 12:20 PM EST

Provider Enrollment: Credentials 

Your enrollment application will be **suspended for 30 days**, pending completion. Upon expiration, you will need to reinitiate a new enrollment application.

Please provide the following information, which will be required to resume your application at a later date. Your password must be between 8 to 20 characters and must include upper and lower case letters as well as numbers. Please retain your created password as it cannot be reset by Rhode Island Medical Assistance. Your Tax ID is provided, if already contained within your provider enrollment application.

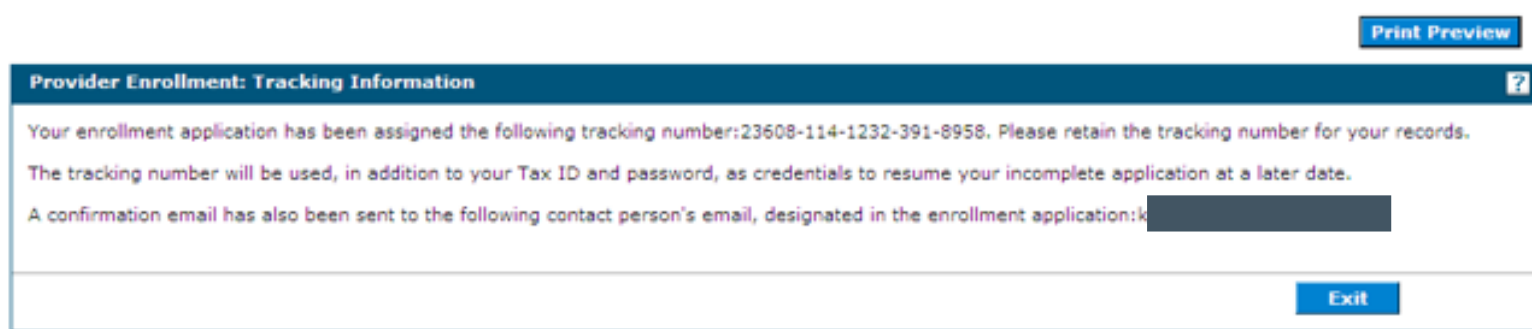
Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number, along with the following information, will be used as your credentials to resume your suspended enrollment application.

* Indicates a required field.

Tax ID 123467898	*Password
	*Confirm Password

- If you have entered your tax ID, it will appear on this screen. If not, enter it here.
- Enter a password. The password must contain 8 characters including upper and lower case letters as well as numbers. This will be the password you will use to resume your application.
- Select SUBMIT to submit the credentials.

Tracking Information – Incomplete Application



Print Preview

Provider Enrollment: Tracking Information ?

Your enrollment application has been assigned the following tracking number: 23608-114-1232-391-8958. Please retain the tracking number for your records.

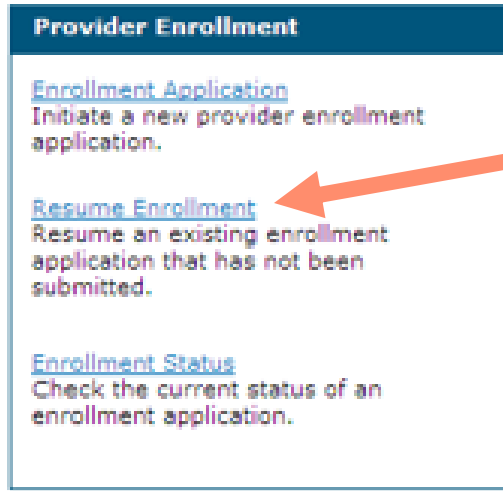
The tracking number will be used, in addition to your Tax ID and password, as credentials to resume your incomplete application at a later date.

A confirmation email has also been sent to the following contact person's email, designated in the enrollment application: k[redacted]

Exit

- You will receive a tracking number. Print or write this number in a secure place.
- This tracking number, with your password will allow you to resume your application.

Resume Enrollment



Provider Enrollment

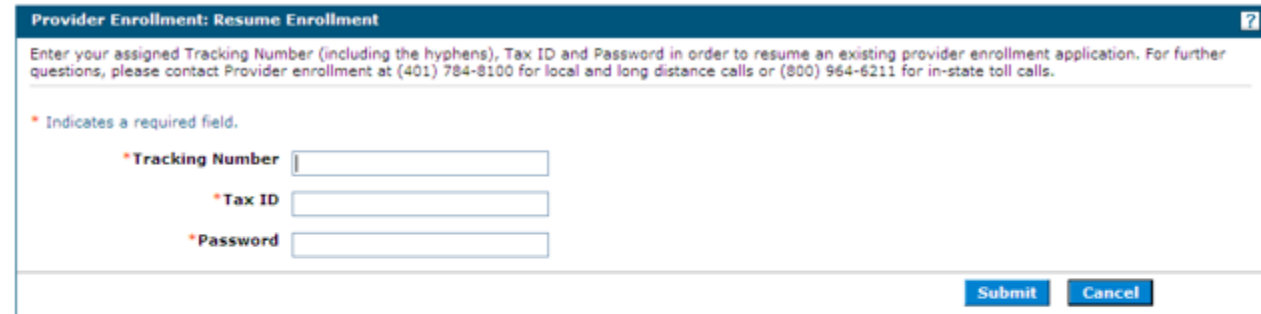
[Enrollment Application](#)
Initiate a new provider enrollment application.

[Resume Enrollment](#)
Resume an existing enrollment application that has not been submitted.

[Enrollment Status](#)
Check the current status of an enrollment application.

To resume an application:

- Enter the Healthcare Portal by clicking on Provider Enrollment (see slide 4)
- **Select Resume Enrollment.**



Provider Enrollment: Resume Enrollment ?

Enter your assigned Tracking Number (including the hyphens), Tax ID and Password in order to resume an existing provider enrollment application. For further questions, please contact Provider enrollment at (401) 784-8100 for local and long distance calls or (800) 964-6211 for in-state toll calls.

* Indicates a required field.

*Tracking Number

*Tax ID

*Password

Enter the Tracking Number, Tax ID and Password to resume your application.
Reminder: Disclosure Question Responses are not saved on incomplete applications.

View Enrollment Status

Provider Enrollment

[Enrollment Application](#)
Initiate a new provider enrollment application.

[Resume Enrollment](#)
Resume an existing enrollment application that has not been submitted.

[Enrollment Status](#)
Check the current status of an enrollment application.

To view enrollment status:

- Enter the Healthcare Portal by clicking on Provider Enrollment (see slide 4)
- **Select Enrollment Status.**

View Enrollment Status

Provider Enrollment - Status

[Back to Home](#)

Enter your assigned Tracking Number (including the hyphens) and Tax ID to verify the current status of your enrollment application. For any further queries, please contact Provider Enrollment at (401) 784-8100 for local and long distance calls or (800) 964-6211 for in-state toll calls.

* Indicates a required field.

*Tracking Number

*Tax ID Number

Search

Cancel

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For any further queries, please contact Provider Enrollment at (401) 784-8100 for local and long distance calls or (800) 964-6211 for in-state toll calls.

Tracking Number
Date Submitted
Status
Status Date

- Enter your Tracking Number and Tax ID. Select Search.
- Any of the following statuses may appear:
 - **Approved** – The enrollment application has been approved for enrollment.
 - **Denied** – The enrollment application has been denied.
 - **Enrolled** – The enrollment application has been enrolled.
 - **Pending** – The enrollment application is waiting to be processed.
 - **Resubmit** – The enrollment application was incomplete, please resubmit

Time Out!

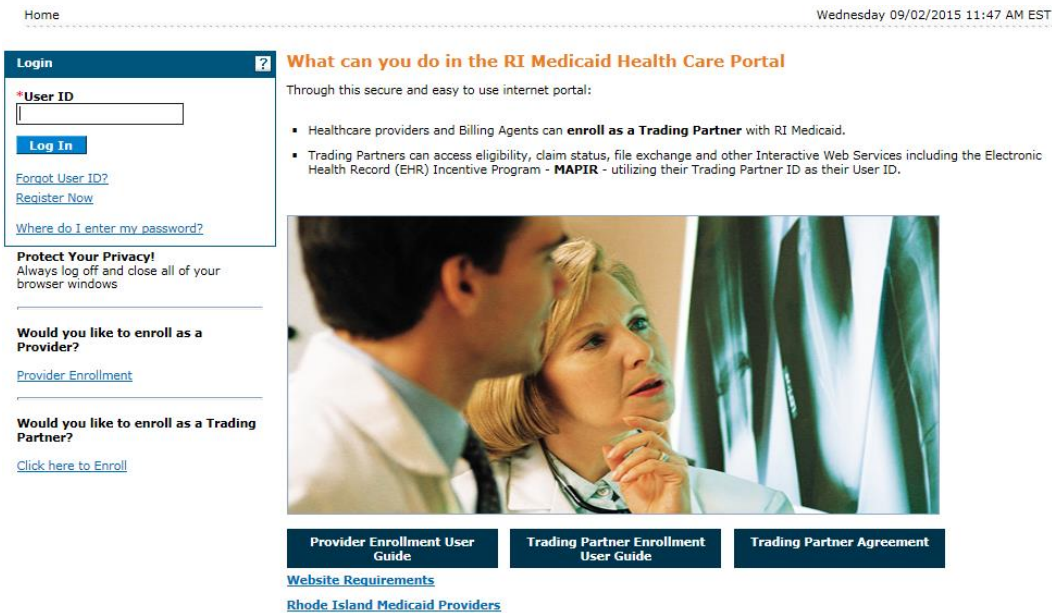
For security purposes, your session will time out after 30 minutes of inactivity. If you anticipate that your application will be idle for more than 30 minutes, save your work, exit, and enter the process again.

Remember: Your disclosure question responses WILL NOT be saved, so you need to allow time to complete these in their entirety and submit, or your responses will be lost.



Next Steps

- After you receive confirmation that you are enrolled as a RI Medicaid provider, you must enroll as a Trading Partner in the Healthcare Portal. This allows you to exchange information electronically with RI Medicaid.
- From the Healthcare Portal homepage, select “Enroll as a Trading Partner” and complete the application.
- For additional help, review the instruction guide at :
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/HCP_Enrolling_as_TP.pdf

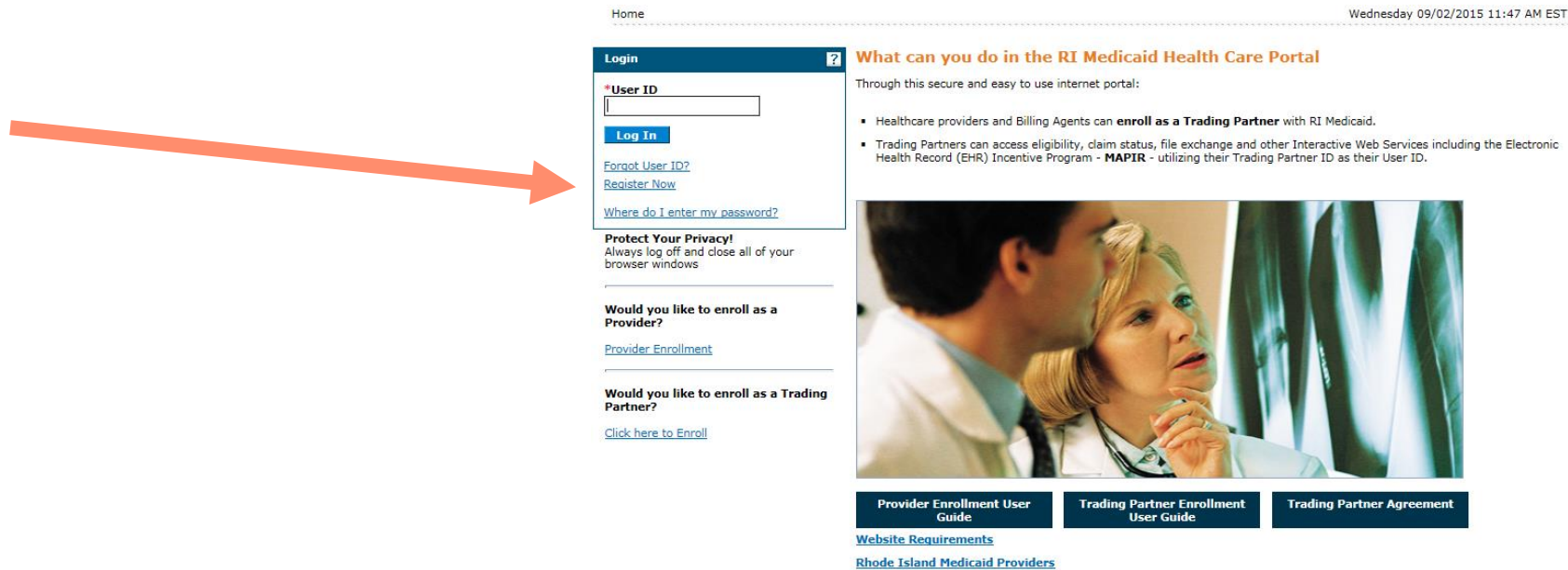


The screenshot shows the RI Medicaid Health Care Portal homepage. At the top, there is a navigation bar with 'Home' on the left and the date 'Wednesday 09/02/2015 11:47 AM EST' on the right. The main content area is divided into two columns. The left column contains a 'Login' section with a 'User ID' input field, a 'Log In' button, and links for 'Forgot User ID?', 'Register Now', and 'Where do I enter my password?'. Below this is a 'Protect Your Privacy!' section with a warning to log off. Further down, there are two enrollment prompts: 'Would you like to enroll as a Provider?' with a 'Provider Enrollment' link, and 'Would you like to enroll as a Trading Partner?' with a 'Click here to Enroll' link. An orange arrow points from the left towards the 'Click here to Enroll' link. The right column features a heading 'What can you do in the RI Medicaid Health Care Portal' followed by a brief description and two bullet points about enrolling as a Trading Partner and accessing services. Below the text is a photograph of a man and a woman looking at a screen. At the bottom, there are three buttons: 'Provider Enrollment User Guide', 'Trading Partner Enrollment User Guide', and 'Trading Partner Agreement'. Below these buttons are links for 'Website Requirements' and 'Rhode Island Medicaid Providers'.

Next Steps

- Once you receive your Trading Partner number, you must register that Trading Partner number in the Healthcare Portal and set up your security credentials.
- From the Healthcare Portal homepage, select “Register Now” and complete the registration process.
- For additional help, review the instruction guide at :

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/HCP_Registering_to_use.pdf



The screenshot displays the RI Medicaid Health Care Portal homepage. At the top, there is a navigation bar with 'Home' on the left and the date 'Wednesday 09/02/2015 11:47 AM EST' on the right. The main content area is divided into two columns. The left column features a 'Login' section with a 'User ID' input field, a 'Log In' button, and links for 'Forgot User ID?', 'Register Now', and 'Where do I enter my password?'. Below this is a 'Protect Your Privacy!' section with a warning to log off. Further down, there are two enrollment prompts: 'Would you like to enroll as a Provider?' with a 'Provider Enrollment' link, and 'Would you like to enroll as a Trading Partner?' with a 'Click here to Enroll' link. The right column has a heading 'What can you do in the RI Medicaid Health Care Portal' followed by a brief description and two bullet points: 'Healthcare providers and Billing Agents can enroll as a Trading Partner with RI Medicaid.' and 'Trading Partners can access eligibility, claim status, file exchange and other Interactive Web Services including the Electronic Health Record (EHR) Incentive Program - MAPIR - utilizing their Trading Partner ID as their User ID.' Below the text is a photograph of a man and a woman in medical attire looking at a screen. At the bottom, there are three buttons: 'Provider Enrollment User Guide', 'Trading Partner Enrollment User Guide', and 'Trading Partner Agreement'. Below these buttons are two links: 'Website Requirements' and 'Rhode Island Medicaid Providers'.

Questions?

Please contact our Customer Service Help Desk at

- (401) 784-8100 for local and long distance calls
- (800) 964-6211 for in-state toll calls.



Thank you