

RI Medicaid Provider Revalidation

June, 2017

PR0094 V1.2 06/30/2017



Agenda

- How to begin
- Access your information
- Verifying your information for revalidation
- Important reminders
- Disclosures
- Uploading supporting documents
- Signature page

What is Revalidation?

- Revalidation of enrollment in the RI Medicaid Program is mandated by the Centers for Medicare and Medicaid (CMS) provider screening and program integrity rules.
- EOHHS requires revalidation for all active providers.
- Revalidation requires providers to resubmit and recertify the accuracy of enrollment information.
- Revalidation is completed electronically through the new Provider Enrollment Portal, accessed through the Healthcare Portal.
- Providers have 35 days from the date of the revalidation notification letter to complete the process.
- If the process is not completed, providers will be terminated from enrollment in the RI Medicaid program and will be required to re-apply.

Notification Letters

Providers who are required to revalidate will receive two letters: one containing a tracking number and one with a password.

DXC Technology
PO Box 2010
Warwick, RI 02887-2010



RI Medicaid Provider

DXC Technology
PO Box 2010
Warwick, RI 02887-2010



RI Medicaid Provider

Begin Revalidation Process

<https://www.riproviderportal.org>

Do NOT login with your User ID.

Click here for Provider Enrollment

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](#)

User Guide

Access Your Information

Select
Resume
Enrollment

[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.



Enter your Tracking Number

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

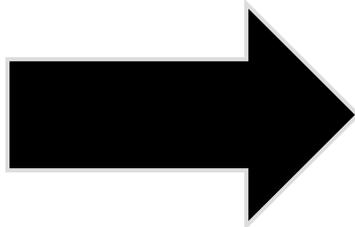
*Tax ID

*Password

Use the tracking number and password that were sent in two separate letters.
Enter tracking number exactly as typed, **including dashes**.
Then enter Tax ID and Password that was sent to you by mail.
This is **not** your Healthcare Portal password.

Welcome Screen

This screen is the starting point. On each of the following screens, you must verify or 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.



EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
Rhode Island Executive Office of Health and Human Services
Medicaid

Contact Us | Login

Home

Home > Provider Enrollment > Enrollment Application

Friday 04/17/2015 04:19 PM EST

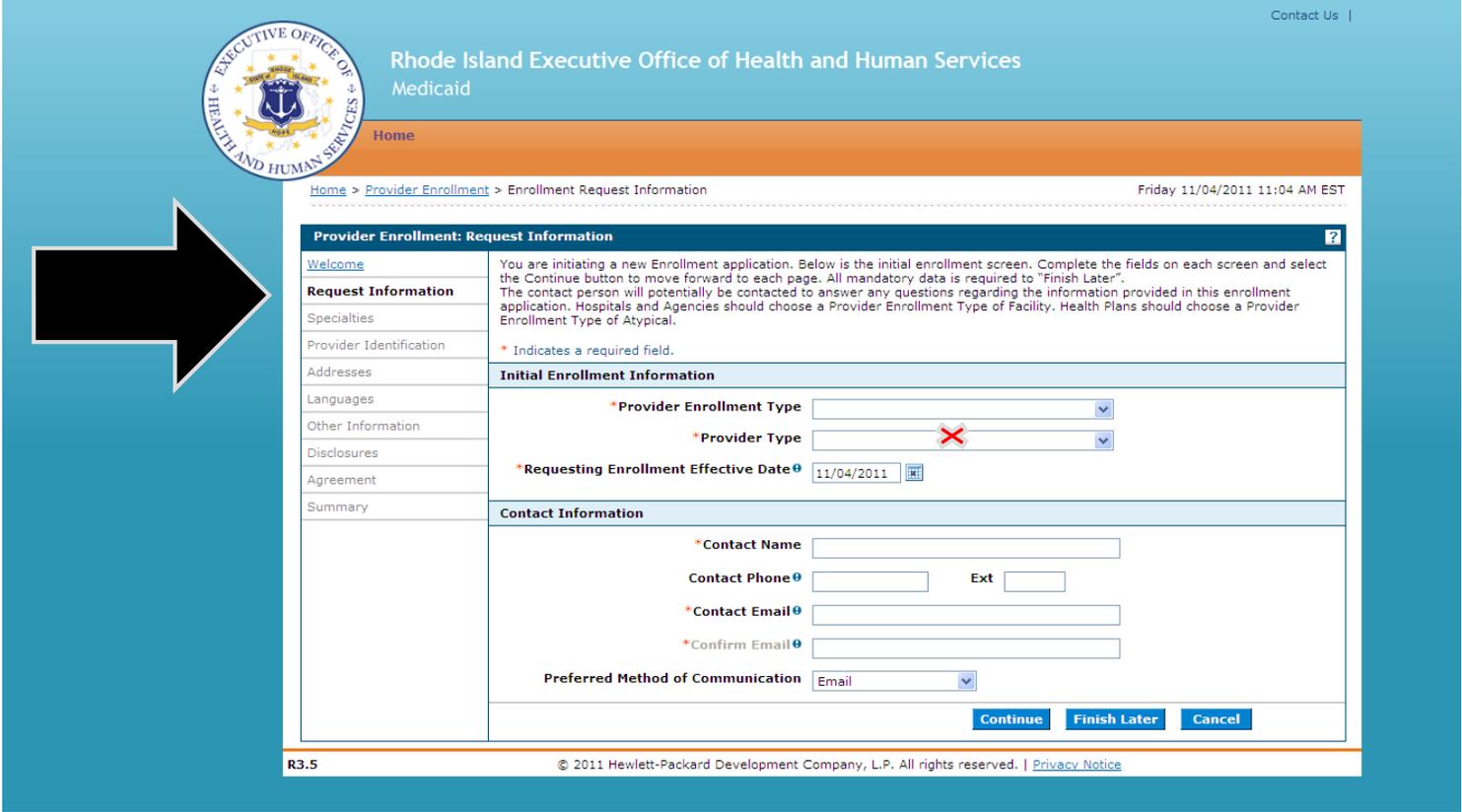
Provider Enrollment: Welcome

Welcome	Welcome to the Rhode Island Medical Assistance Online Provider Enrollment Process
Request Information	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.
Specialties	
Provider Identification	You will need the following information to complete your enrollment request:
Addresses	▶ National Provider Identifier
Languages	▶ Address Information including Postal Code + 4
Other Information	▶ Taxonomy Codes
Disclosures	▶ Tax ID - either EIN or SSN
Agreement	▶ License Number
Summary	▶ 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.
	<input type="button" value="Continue"/> <input type="button" value="Cancel"/>

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Provider Enrollment – Request Information Screen

- Provider Enrollment type, Provider Type and Effective Date will be pre-populated.
- Provider Type should not be changed. Changing the Provider Type requires a new application.
- Contact information should be completed with the primary contact information for the provider.
- Select Continue or Finish Later.



The screenshot shows the 'Provider Enrollment: Request Information' screen. The page 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 is 'Home > Provider Enrollment > Enrollment Request Information'. The date and time are 'Friday 11/04/2011 11:04 AM EST'. The main content area is titled 'Provider Enrollment: Request Information' and contains a 'Welcome' message and a 'Request Information' section. The 'Request Information' section is divided into 'Initial Enrollment Information' and 'Contact Information'. The 'Initial Enrollment Information' section includes fields for 'Provider Enrollment Type', 'Provider Type', and 'Requesting Enrollment Effective Date'. The 'Provider Type' field has a red 'X' next to it, indicating an error. The 'Contact Information' section includes fields for 'Contact Name', 'Contact Phone', 'Contact Email', and 'Confirm Email'. The 'Preferred Method of Communication' is set to 'Email'. At the bottom of the form are buttons for 'Continue', 'Finish Later', and 'Cancel'. The footer of the page includes the text 'R3.5 © 2011 Hewlett-Packard Development Company, L.P. All rights reserved. | Privacy Notice'.

Enrollment Specialties

- This screen is prepopulated.
- If no specialty, the field will say Not Applicable or No Provider Specialty Designation
- Effective date will be original date.
- To expand, click the plus (+) sign.
(Images shown have been expanded)
- Taxonomy Code should be verified. Do not change the taxonomy code.
- To add a taxonomy, select the plus sign (+) to add. Click save after adding.
- Select continue or finish later to move to next screen.

Specialty	Taxonomy Code	Effective Date	End Date	Action
<input checked="" type="checkbox"/> Multidisciplinary Organization	282N00000X	04/01/1993	12/31/9999	
<p>Type Outpatient Facility</p> <p>*Specialty Multidisciplinary Organization</p> <p>*Effective Date 04/01/1993</p> <p>End Date 12/31/9999</p> <p>*Taxonomy Code 282N00000X</p> <p>Primary <input checked="" type="checkbox"/></p>				
<input checked="" type="checkbox"/> No Provider specialty designated.	NoTaxonomy	04/04/2014	05/05/2025	
<p>Type Independent Pharmacy</p> <p>*Specialty No Provider specialty designated.</p> <p>*Effective Date 04/04/2014</p> <p>End Date 05/05/2025</p> <p>*Taxonomy Code NoTaxonomy</p> <p>Primary <input checked="" type="checkbox"/></p> <p><input type="button" value="Save"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/></p>				
<p><input checked="" type="checkbox"/> Click to add specialty.</p>				

Provider Name

Provider Legal Name

The provider legal name and information is provided once for each enrollment. Ownership Information is required.

*Provider Legal Name

*Ownership

Business Name

- Corporation
- Government/nonprofit corporation
- Individual
- Legal services corporation
- Medical services corporation
- Partnership
- Trust/estate



You must enter the LEGAL name for your facility. Then select the type of ownership from the drop down. If another business name is used, enter in the Business Name field.

Note: The character “&” is not allowed in the name.

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 (C-Corporation, S-C Corporation, Partnership) Exempt payee
 Other (see instructions)

Address (number, street, and apt. or suite no.)
154 Flower Lane
City, state, and ZIP code
Oakman, AL 36000

Requester's name and address (optional)
J Builders
123 Maple Avenue
Oakman, AL 36000

Part 1 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 1 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.
Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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

Employer identification number
1 - - - - -

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.

Provider Identification Numbers

Verify the Tax ID.
DO NOT change the tax effective date. This will cause an error in your application.
The NPI will be pre-populated.
Enter any of the other information below the NPI as applicable.
If License # is added, expiration date is required.

Provider Identification Numbers

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

*Tax ID *Tax ID Type EIN SSN

*Effective Date End Date *Fiscal End Date

*NPI

License # Expiration Date

Medicare #

DEA #

CLIA #

Supplemental NPI

Supplemental Taxonomy

Medicare Number /CLIA

*NPI	<input type="text"/>	
License #	<input type="text"/>	Expiration Date ⓘ <input type="text"/>
Medicare #	<input type="text"/>	
DEA #	<input type="text"/>	
CLIA #	<input type="text"/>	
Supplemental NPI	<input type="text"/>	
Supplemental Taxonomy	<input type="text"/>	

If also a Medicare provider, you must enter your Medicare number.

Hospitals – enter CLIA# and upload your certificate.

Addresses

Verify all addresses for the facility. If an address needs to be changed, expand that section.

To expand any section, click on the plus sign (+) on the left, or click the bottom plus sign to add another service address.

Note: Phone number is a required field for the service address.

Provider Enrollment: Addresses

[Welcome](#) * Indicates a required field.
[Request Information](#) ☑ Indicates a primary record.
[Specialties](#)
[Provider Identification](#)
Addresses
[Languages](#)
[Banking Information](#)
[Other Information](#)
[Disclosures](#)
[Agreement](#)
[Summary](#)

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
☑		Pay To		NORTH PROVIDENCE	Rhode Island	Copy Remove
☑		Mail To		NORTH PROVIDENCE	Rhode Island	Copy Remove
☑	Updated Svc Loc Address	Service Location	☑ 1234 Main Street	NORTH PROVIDENCE	Rhode Island	Copy Remove
☑	Click to add address.					

[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 <input type="text"/>	
<input type="button" value="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

The next screen is to confirm your EFT enrollment for direct deposit of payment from RI Medicaid. Enter Provider name. TIN and NPI will be filled in for you. Leave *other identifier* blank if you have an NPI and do not check box. Enter taxonomy. Enter contact information and bank name and address.

Home > [Provider Enrollment](#) > Electronic Funds Transfer (EFT) Enrollment Tuesday 07/12/2016 12:00 PM EST

Provider Enrollment: Electronic Financial Transaction (EFT) Authorization Agreement For instruction click on ?

Welcome	*Indicates a required field.
Request Information	Provider Information
Specialties	*Provider Name: <input type="text"/>
Provider Identification	Provider Identifiers Information
Addresses	*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) <input type="text"/>
Languages	National Provider Identifier (NPI): <input type="text"/>
Electronic Funds Transfer (EFT) Enrollment	Other Identifier(s) <input type="text"/> Assigning Authority: Medicaid <input type="checkbox"/>
Other Information	*Provider Taxonomy Code: <input type="text"/>
Disclosures	Provider Contact Information
Agreement	Provider Contact Name: <input type="text"/> Title: <input type="text"/>
Summary	Telephone Number: <input type="text"/> Email Address: <input type="text"/>
	Fax Number: <input type="text"/>
	Financial Institution Information
	Financial Institution Name: <input type="text"/>
	Financial Institution Address:
	Address <input type="text"/>
	<input type="text"/>

Banking Information

Enter the remaining information for the bank.
Check the NPI box only.
Select a reason for submission.
For revalidation it is “change enrollment”
Select continue

City	<input type="text"/>	State	<input type="text" value="v"/>	Zip Code	<input type="text"/>
Financial Institution Telephone Number:	<input type="text"/>	Financial Institution Routing Number:	<input type="text"/>		
Type of Account at Financial Institution:	<input type="text" value="v"/>	Provider's Account Number with Financial Institution:	<input type="text"/>		
Account Number Linkage to Provider Identifier					
Provider Tax Identification Number (TIN):	<input type="checkbox"/>	National Provider Identifier (NPI):	<input type="checkbox"/>		
(if identifier other than NPI is used)					
Submission Information					
*Reason for Submission:	<input type="text" value="v"/>				
Submission Information					
*Reason for Submission	<input type="text" value="v"/>				
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>					

Submission Information

*Reason for Submission

- Change Enrollment
- New Enrollment

Other Information

Provider Enrollment: Other Information ?

Welcome
Request Information
Specialties
Provider Identification
Addresses
Languages
Billing Information

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

Certification Information

* Certification

* Effective Date End Date

Individual Providers

* Specialty Board

* Effective Date End Date

Degree

School

Year of Graduation

Individual Provider

Facility Provider

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

Select the certification type or select "Not Applicable". If entering a certification, enter the effective start date. If "Not Applicable" enter today's date.

Disclosures

IMPORTANT

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

These must be completed when you are ready to submit.

Executive Office of Health & Human Services
STATE OF RHODE ISLAND

Rhode Island Medicaid Disclosure Questions

Hewlett Packard Enterprise

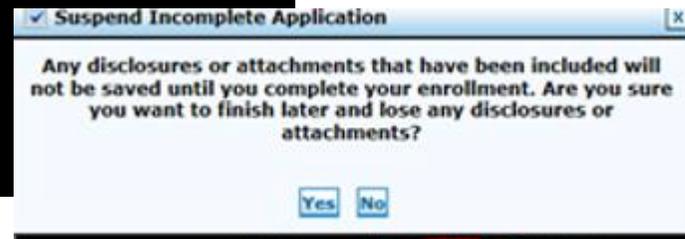
ALL PROVIDERS

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



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 screenshot shows a survey form titled "Rhode Island Medicaid Disclosure Questions" from the Executive Office of Health & Human Services, State of Rhode Island. The form includes the Hewlett Packard Enterprise logo. A grey header bar contains the text "ALL PROVIDERS" and "1. Programs – Please check all other programs that you want to participate in, in addition to". Below this, there are three checkboxes: "Medicaid:", "Behavioral Health, Developmental Disabilities, and Hospitals CNOM", and "Community Medication Assistance Program (CMAP)". A fourth checkbox, "Dept. of Corrections", is partially visible at the bottom of the list.

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				
A	B	C	D	E
1	2	3	4	5
6	7	8	9	10
Provider Name		Provider NPI/ Service Location		Disclosing Entity
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.				
Name & Title		List any persons who has an ownership or control interest in another disclosing entity.		
DOB		Name		
Legal Entity or Home Address		Other Disclosing Entity		
Relationship		Other Disclosing Entity Address		
EIN/SSN				
Subcontractor? Y/N				
Ownership percentage amount				
Name & Title		Name		
DOB		Other Disclosing Entity		
Legal Entity or Home Address		Other Disclosing Entity Address		
Relationship				
SSN				
Subcontractor? Y/N				

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.

Out of State Providers

Out of State Providers MUST complete questions 15-18 of the Disclosures.

You must be providing services to at least one RI Medicaid recipient to revalidate your enrollment.

OUT OF STATE PROVIDERS ONLY		
15.	Reason for Enrollment: <i>(Please check all that apply)</i>	
	<input type="checkbox"/> Anticipating or currently providing services	
	<input type="checkbox"/> Provided services	
	<input type="checkbox"/> Business expanding	
	<input type="checkbox"/> Other (please specify) _____	
16.	Services Provided: <i>(Check one)</i>	
	<input type="checkbox"/> Emergency	
	<input type="checkbox"/> Urgent	
	<input type="checkbox"/> Elective	
17.	Number of RI Medicaid recipients you treat or anticipate treating annually:	

18.	Is enrollment based on a contact with a specific recipient?	Yes No
	<i>(If yes, complete the following)</i>	
	a. Recipient Name: _____	
	b. Diagnosis code: _____	
	c. Recipient Medicaid Identification Number: _____	
	d. Date(s) of Service: _____	
	e. Is the reimbursement sought for:	
	<input type="checkbox"/> Medicaid Only	
	<input type="checkbox"/> Medicare Co-pay,	
	<input type="checkbox"/> Other Insurance Co-pay	
	f. Name of Other Insurance: _____	

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
<input type="checkbox"/> Click to collapse.	
*Upload File <input type="text"/>	<input type="button" value="Browse..."/>
<input type="button" value="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

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](#) ✓

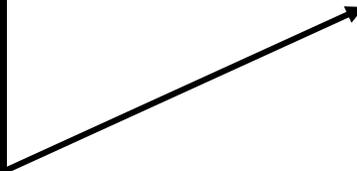
You will be submitting the Provider Enrollment application electronically. By submitting this application, you acknowledge that you have read and agree to the policies of the Provider Agreement and Provider Addendum I Glossary for all Programs to which you are applying. Therefore, your signature indicates 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 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.

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.

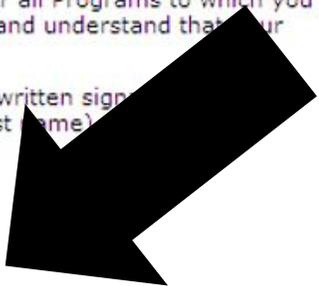
*I accept I understand that my electronic signature is equivalent to written signature and my electronic signature should be my legal name (first and last name)

*Your Signature

Title

Agreement Date 12/01/2011

[Submit](#) [Finish Later](#) [Cancel](#)



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 revalidation 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 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 revalidation application **WILL NOT** be submitted for processing until you click the confirm button.

Instructions for Summary Page

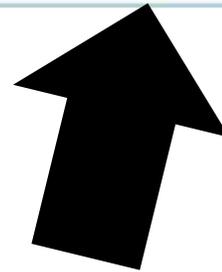
If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate 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

Print Preview

Provider Enrollment: Tracking Information

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 view your tracking 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

Navitel 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.

Time Out!

For security purposes, your session will time out after being idle for 2 hours. If you will not finish, save your work by clicking “finish later”, exit, and enter the process again.

Remember: If the application times out, all of your responses will be lost and you will need to begin again.



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

