RI Medicaid
Provider Revalidation

June, 2017

PR0094 V1.2 06/30/2017

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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.

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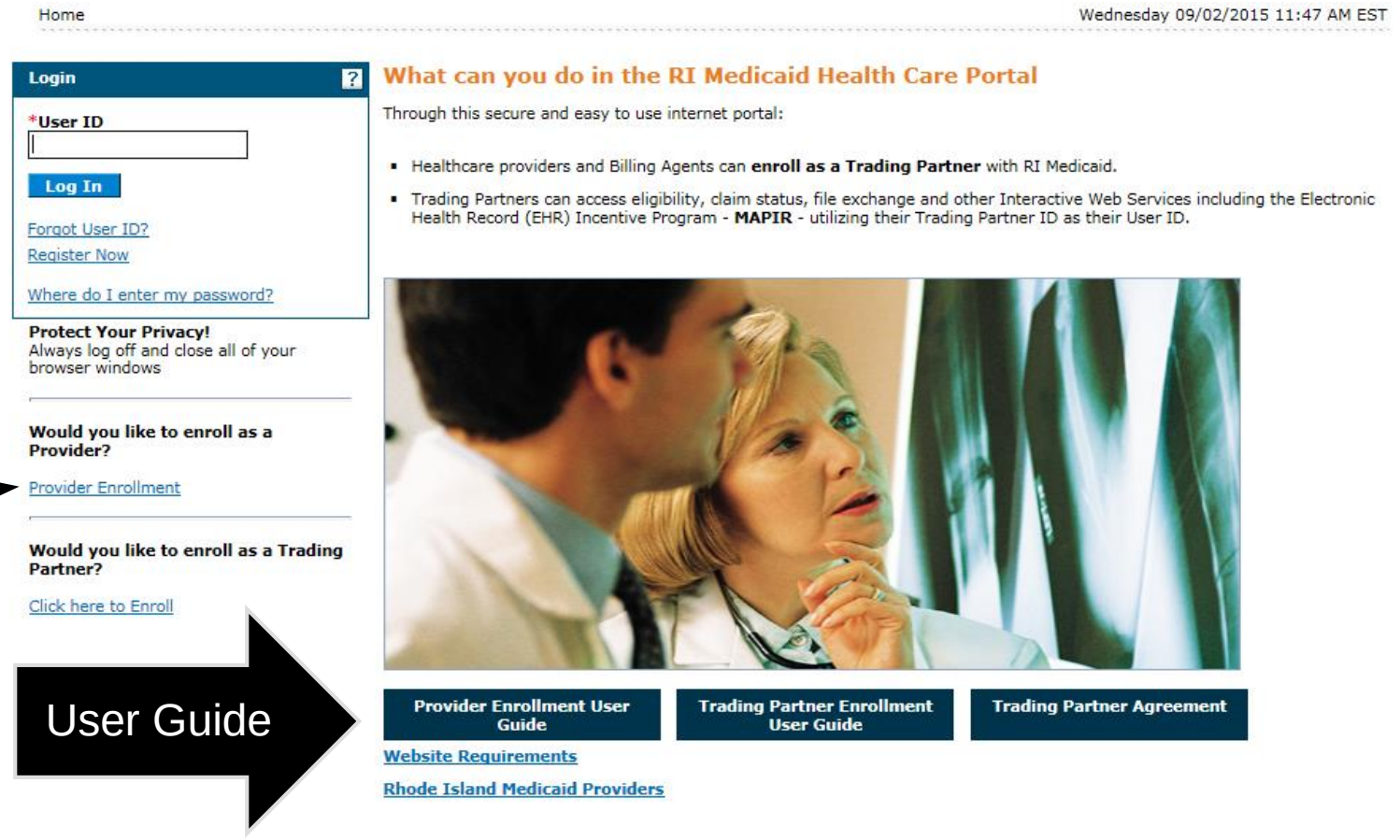
Begin Revalidation Process

https://www.riproviderportal.org

Do NOT login with your User ID.

Click here for Provider Enrollment



User Guide

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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.

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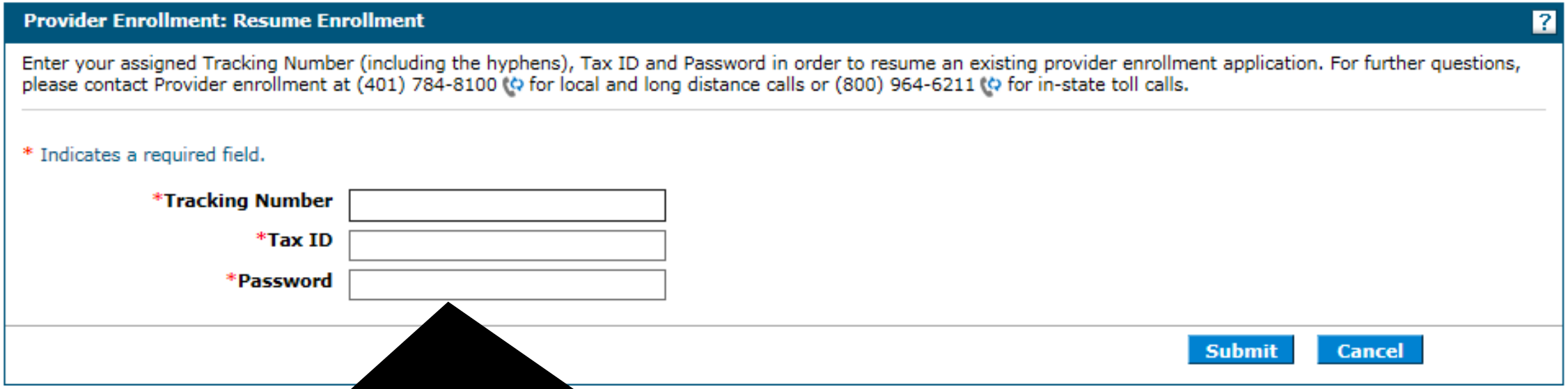
Enter your Tracking Number



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.

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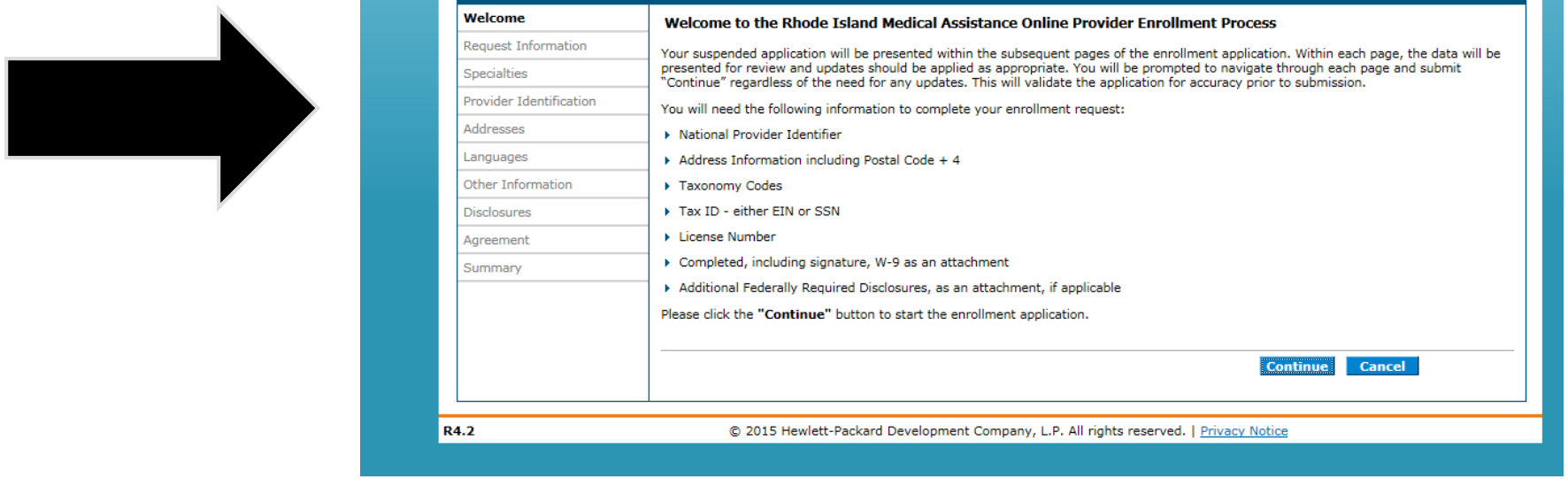
Welcome Screen

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.



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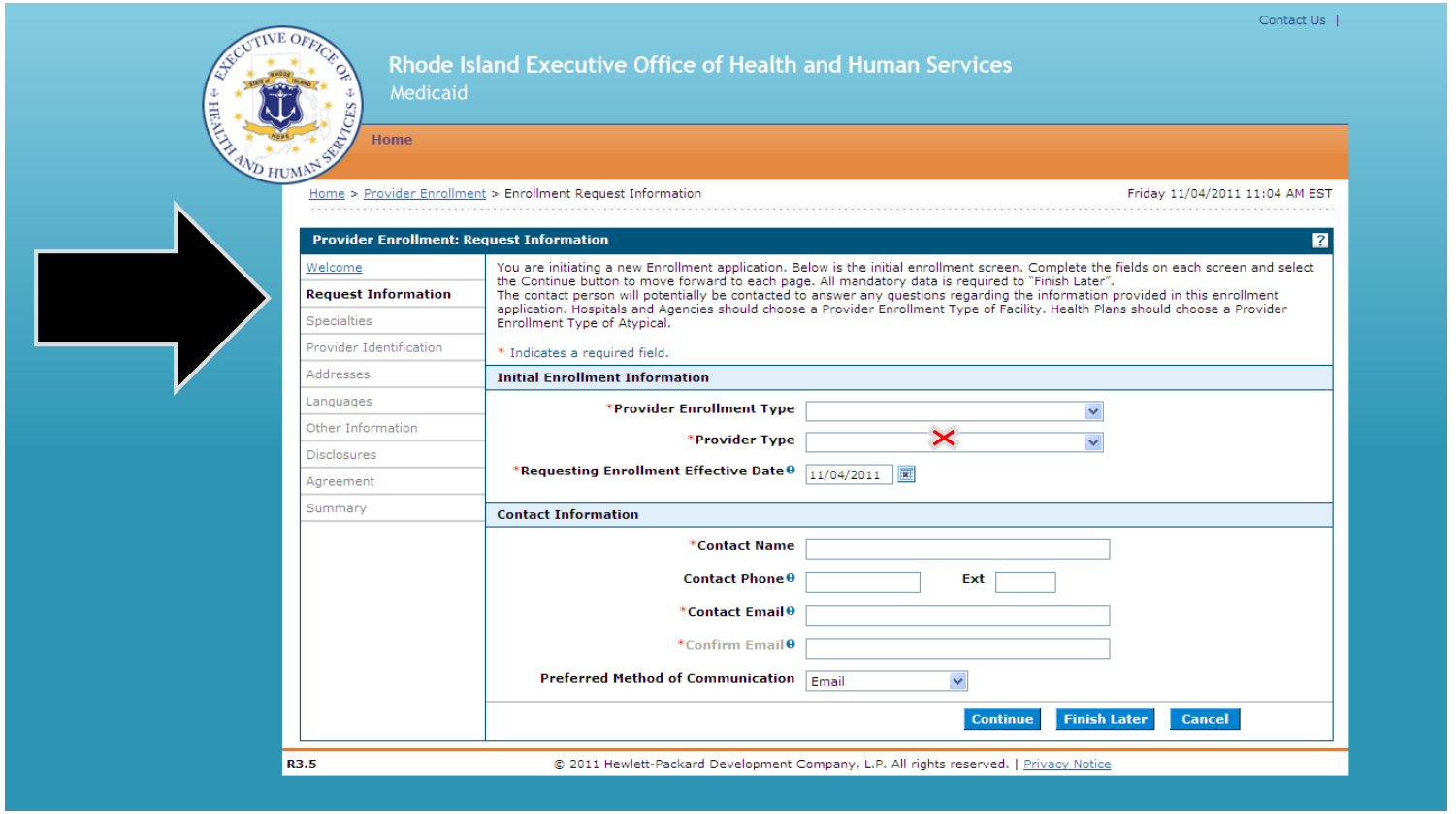
Provider Enrollment – Request Information Screen

- 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.



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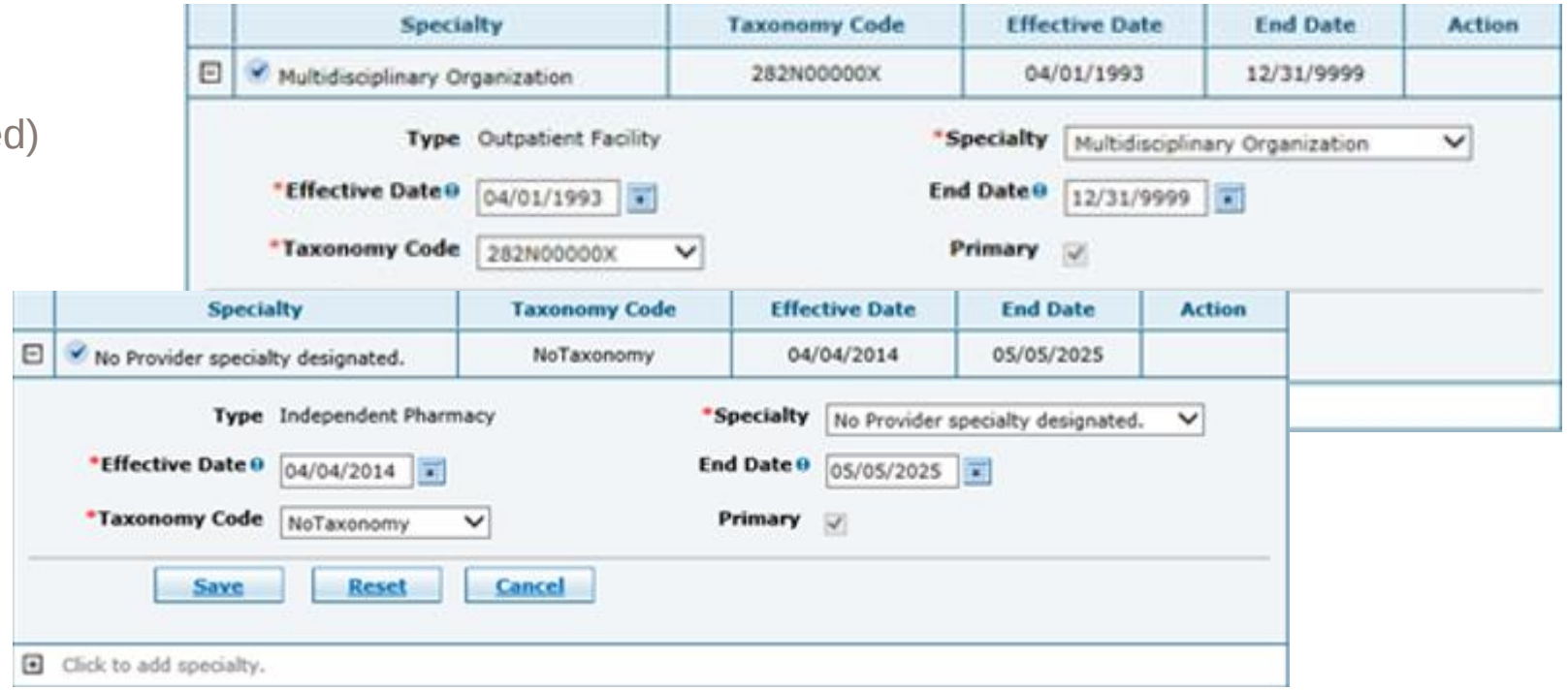
Enrollment Specialties

- 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.

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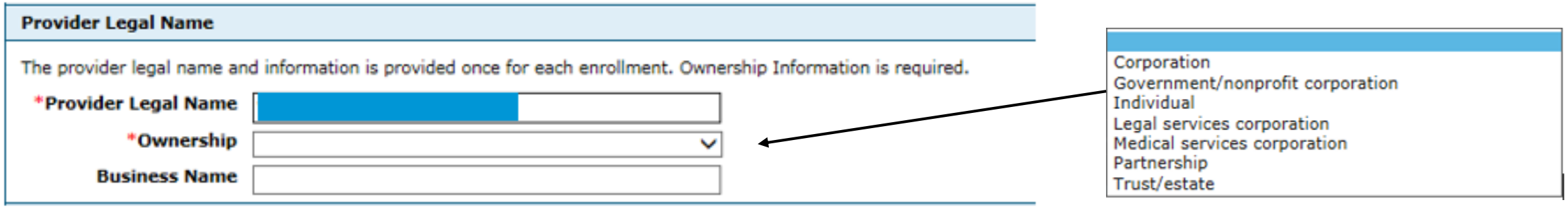
Provider Name



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.

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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.

Print or type
See Specific Instructions on page 2.

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

Business name/disregarded entity name, if different from above
Blue V 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=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
45A Flower Lane

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

City, state, and ZIP code
Oaktown, AL 00000

List account number(s) 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 - 0 0 - 4 7 8 9

Employer identification number
1 -

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.

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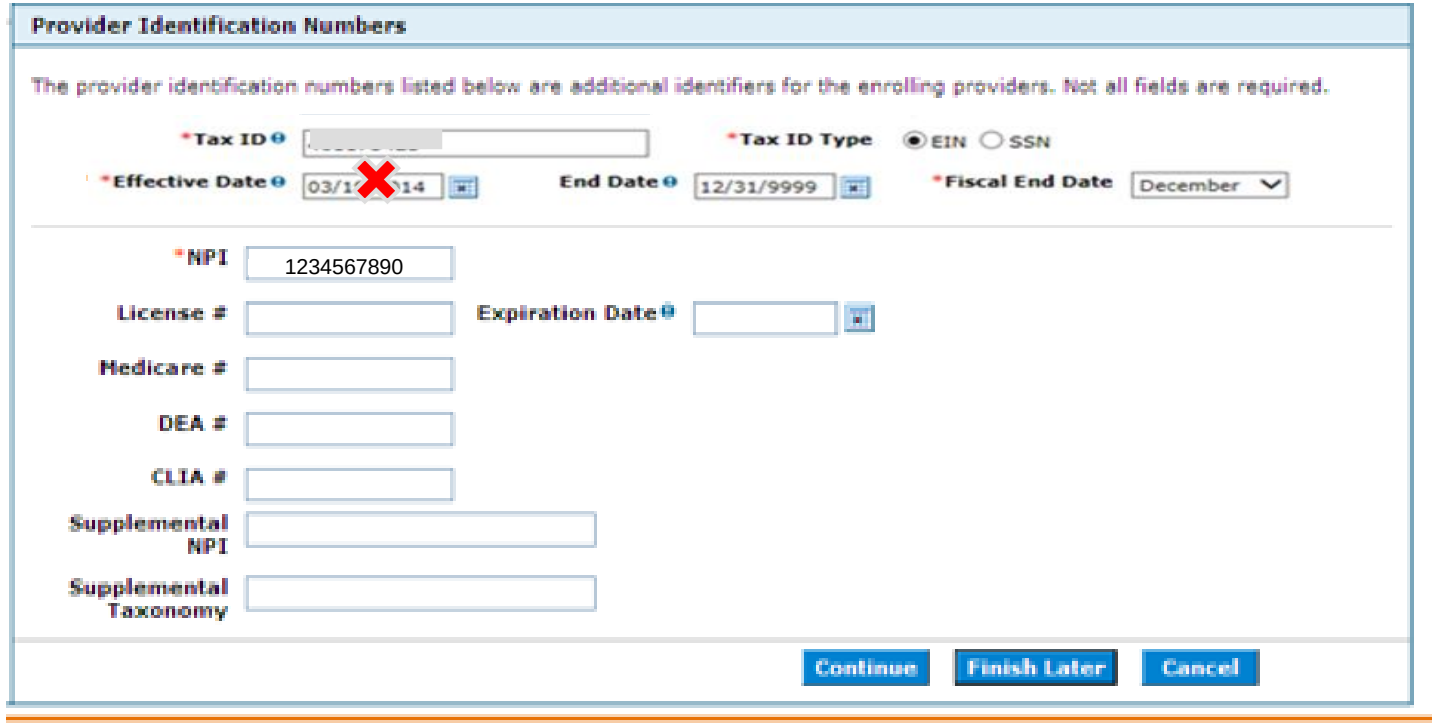
Provider Identification Numbers

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.



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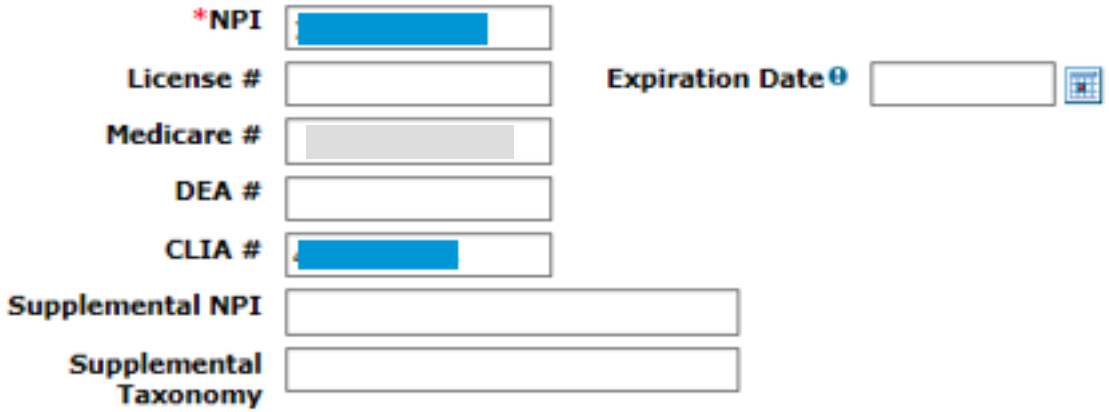
Medicare Number /CLIA



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

Hospitals – enter CLIA# and upload your certificate.

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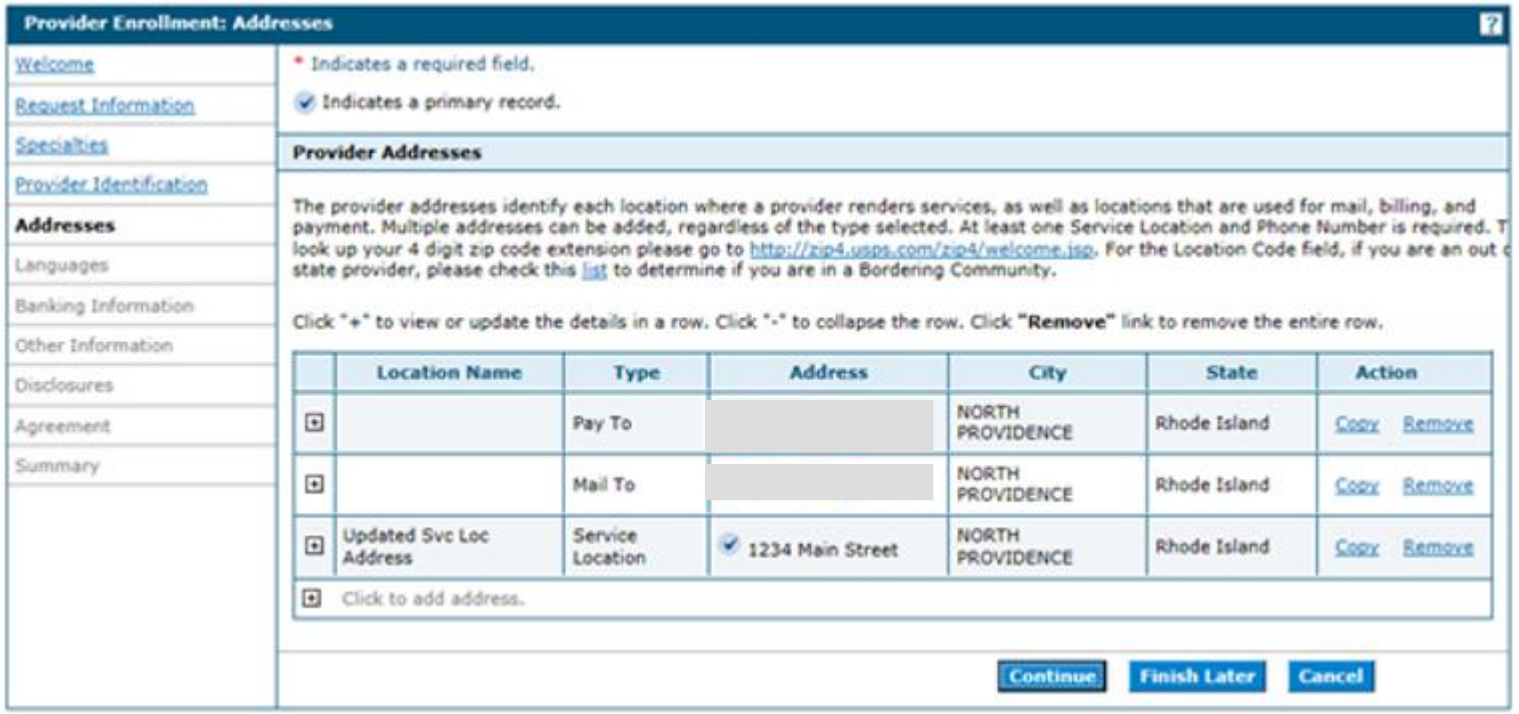
Addresses

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.



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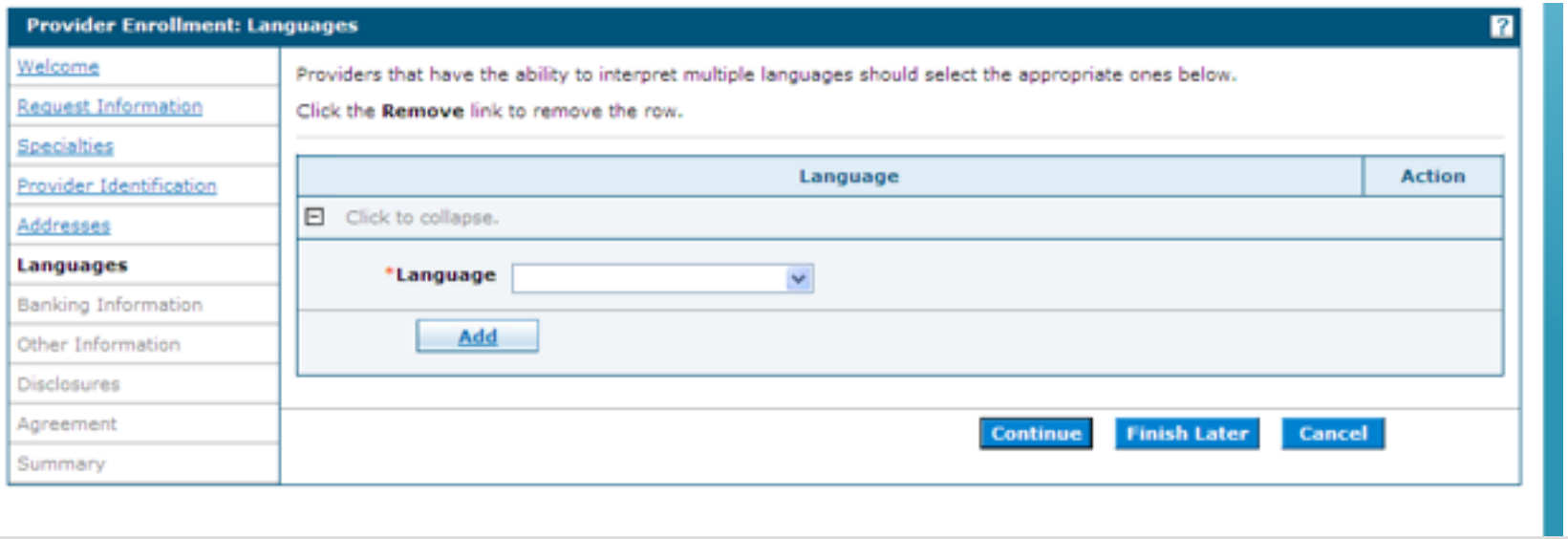
Languages



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.

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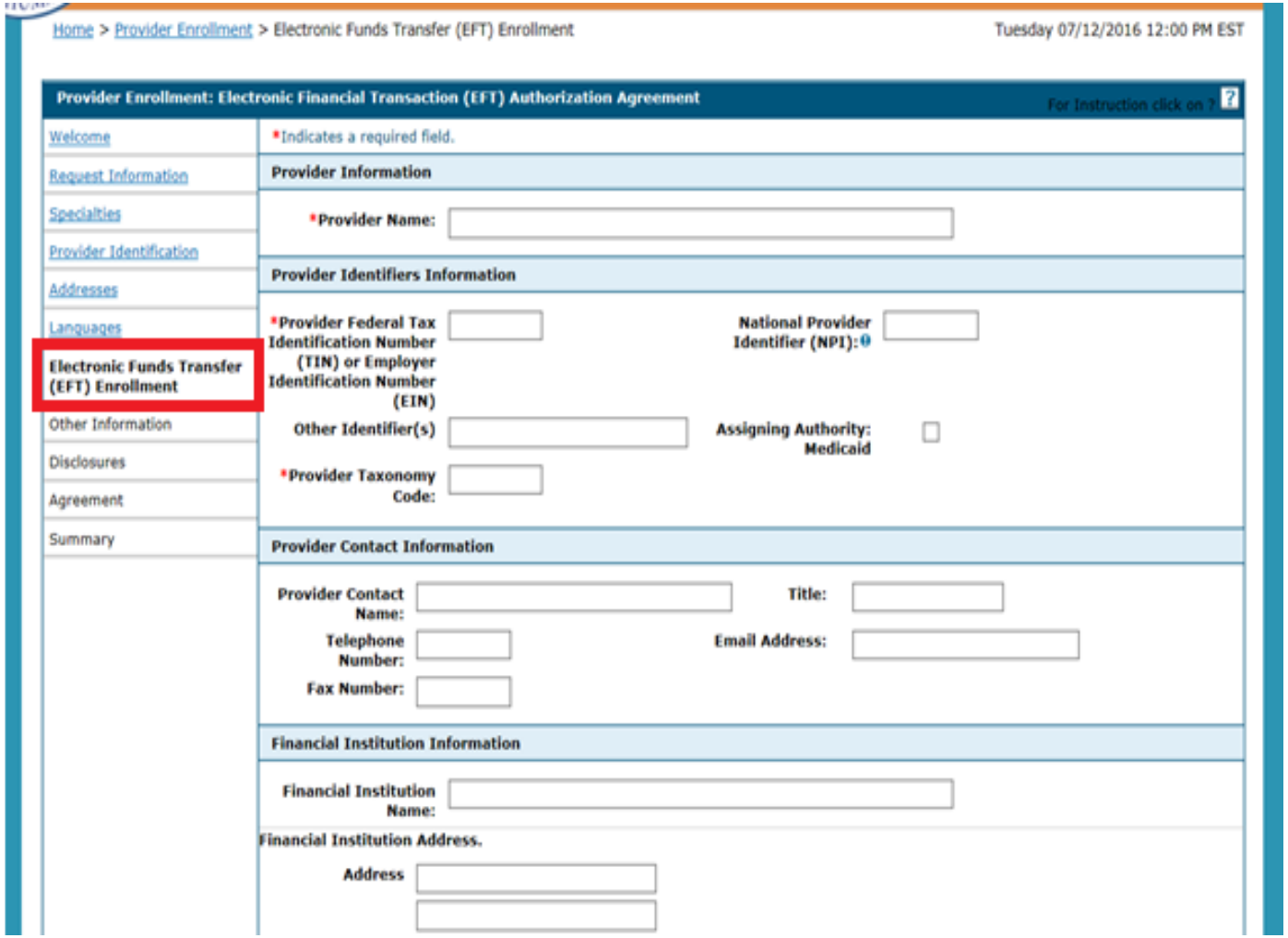
Banking Information

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.



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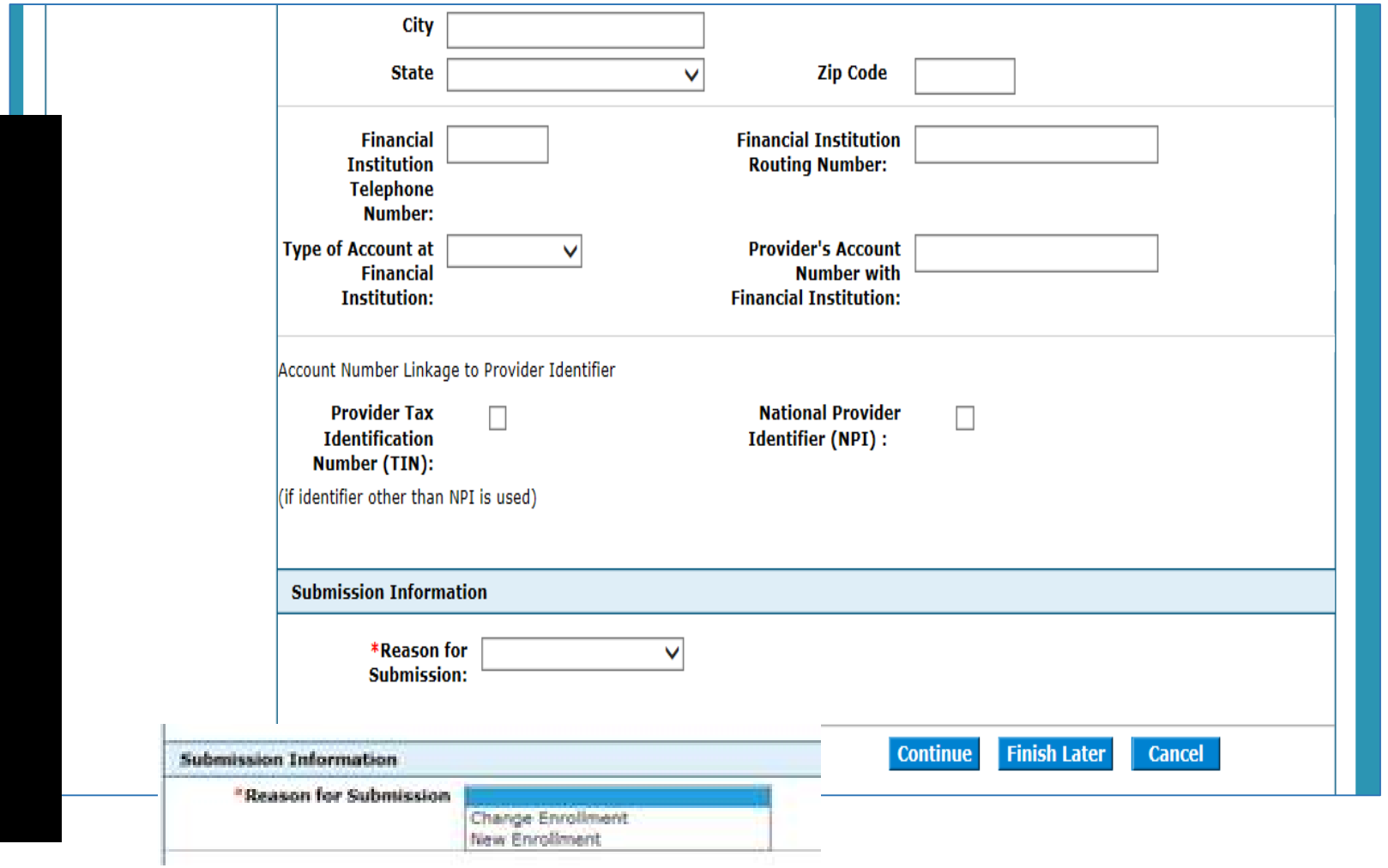
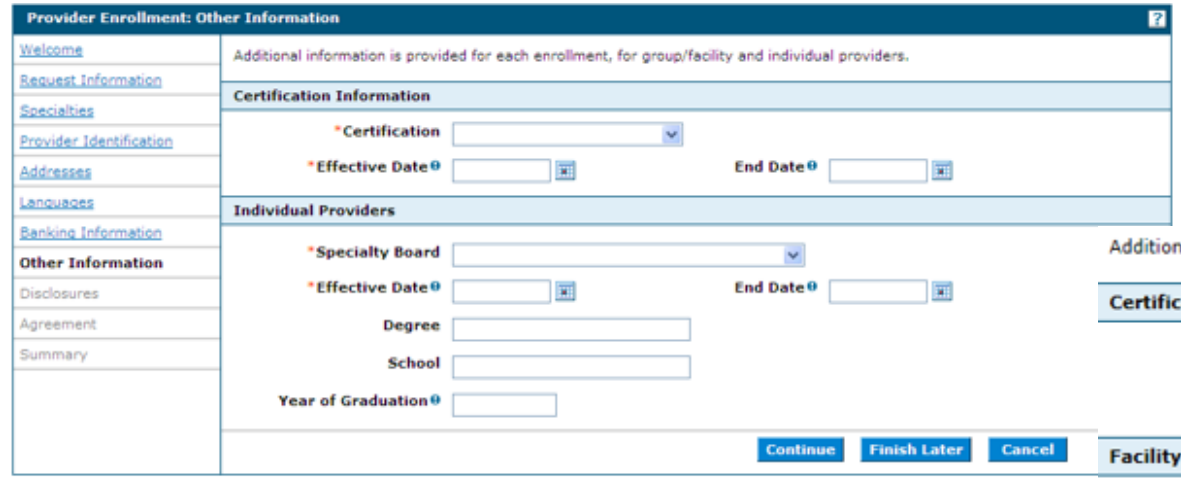
Banking Information

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

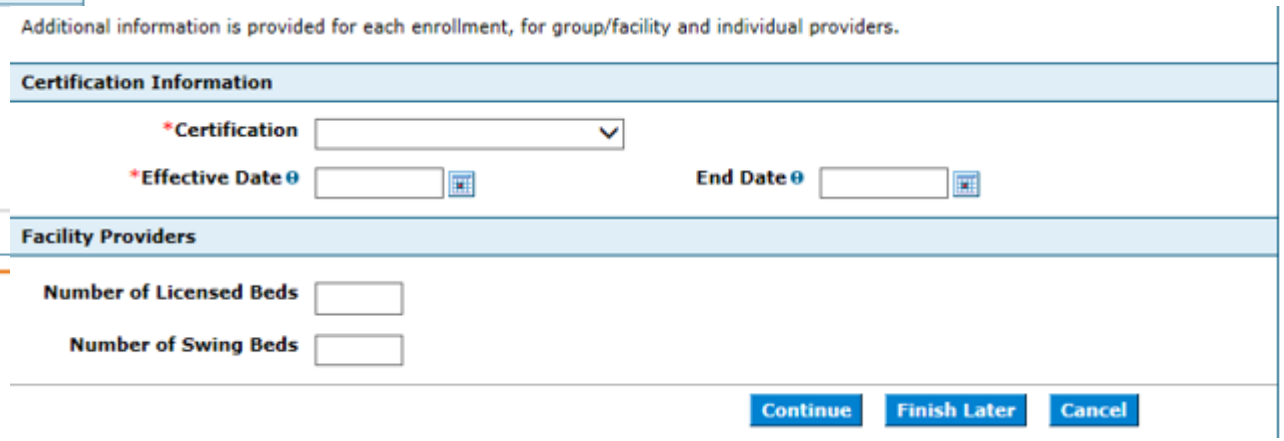


Other Information



Individual Provider

Facility Provider



Select the certification type or select “Not Applicable”. If entering a certification, enter the effective start date. If ‘Not Applicable” enter today’s date.

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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.

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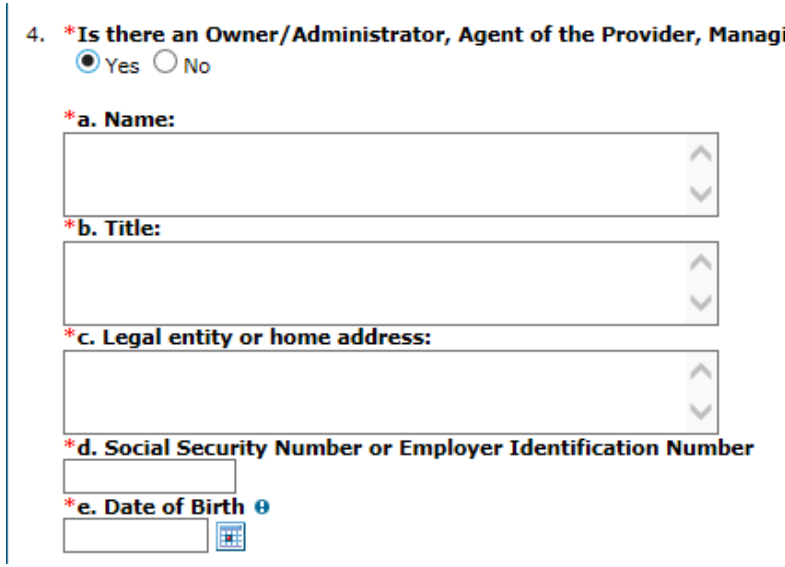
Disclosures

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.

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.

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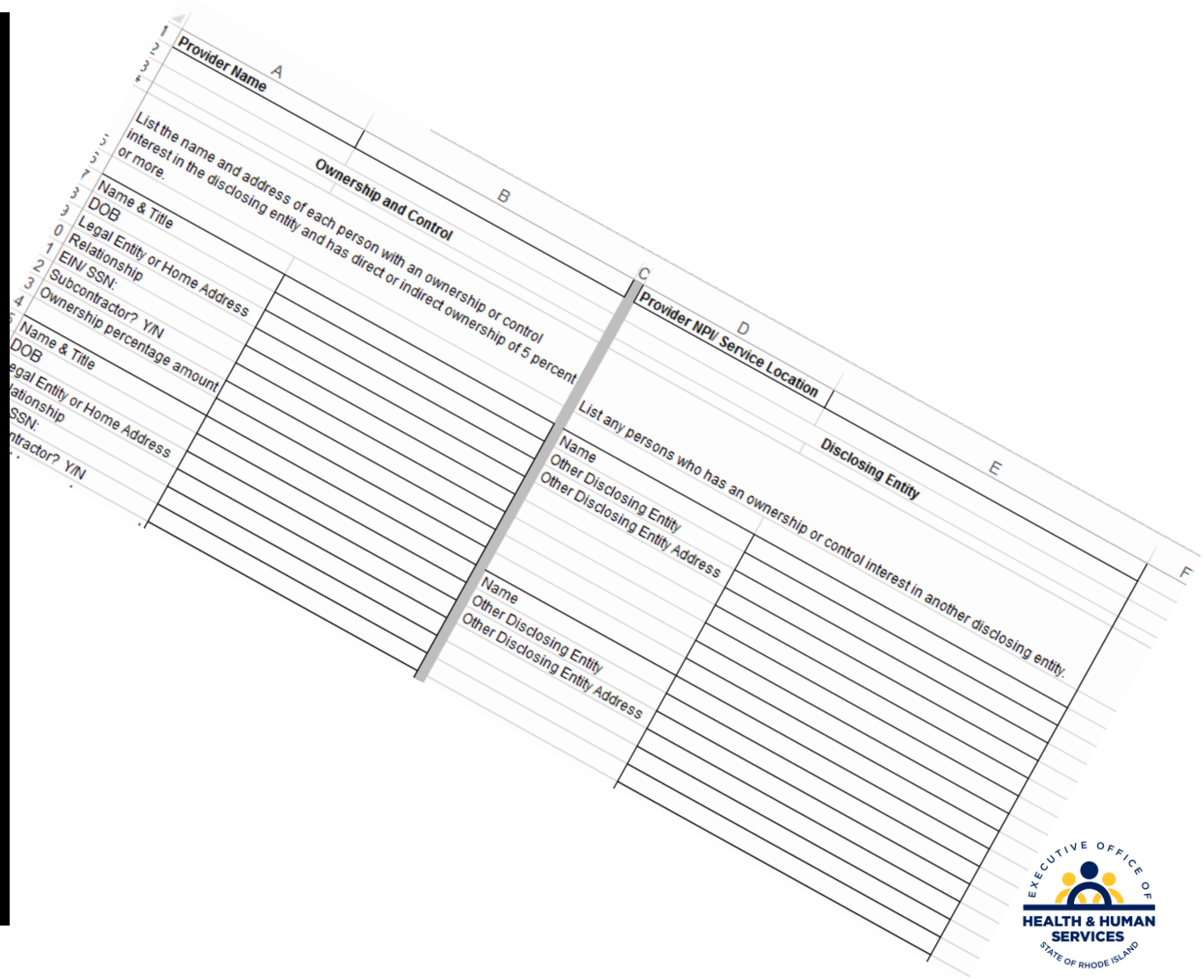
Disclosure Question #10

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.



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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.

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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: ***(Please check all that apply)***
- ☐Anticipating or currently providing services
- ☐Provided services
- ☐ Business expanding
- ☐ Other (please specify) _____

16. Services Provided: ***(Check one)***
- ☐Emergency
- ☐ Urgent
- ☐ 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**
(If yes, complete the following)
   a. Recipient Name: _____
   b. Diagnosis code: _____
   c. Recipient Medicaid Identification Number: _____
   d. Date(s) of Service: _____
   e. Is the reimbursement sought for:
      - ☐ Medicaid Only
      - ☐Medicare Co-pay,
      - ☐Other Insurance Co-pay
   f. Name of Other Insurance: _____

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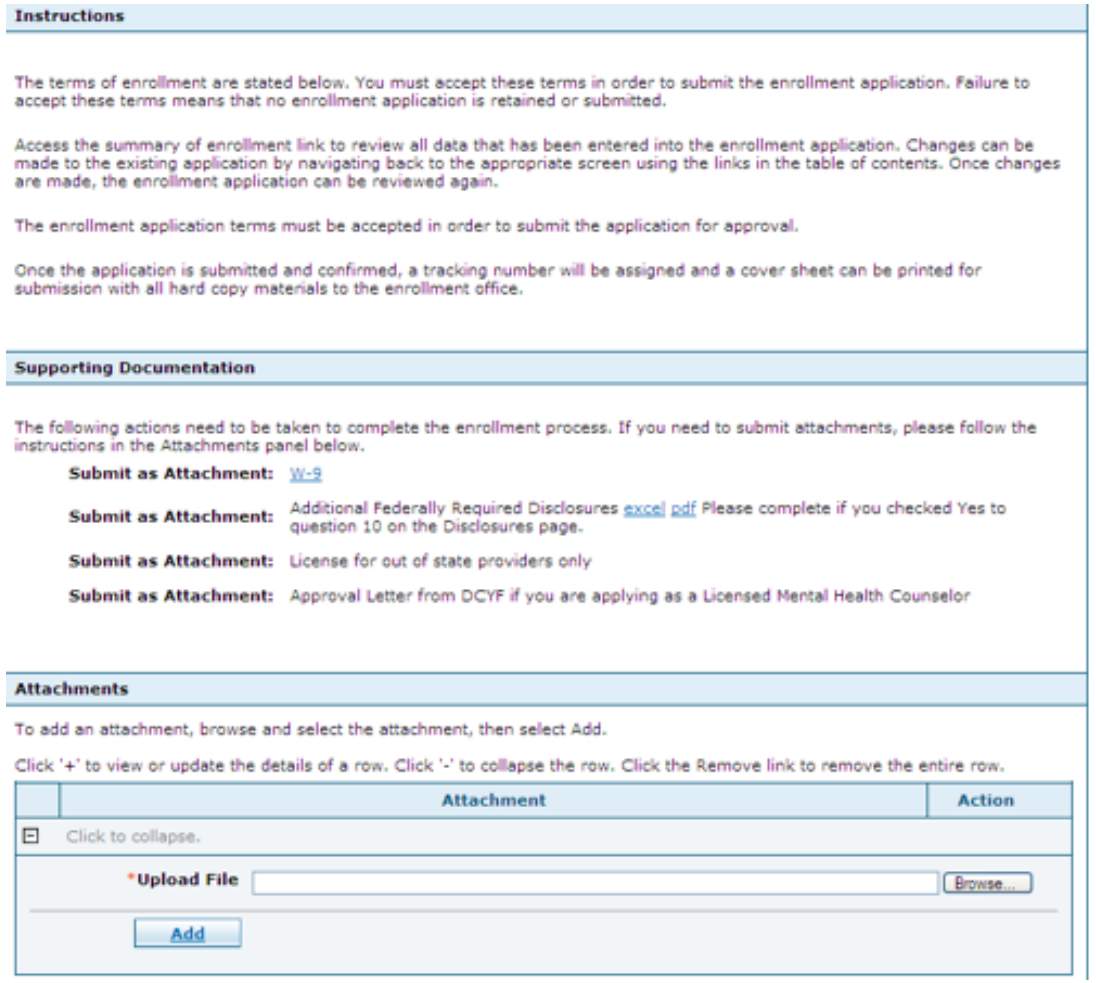
Agreement Screen – Supporting Documents

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.



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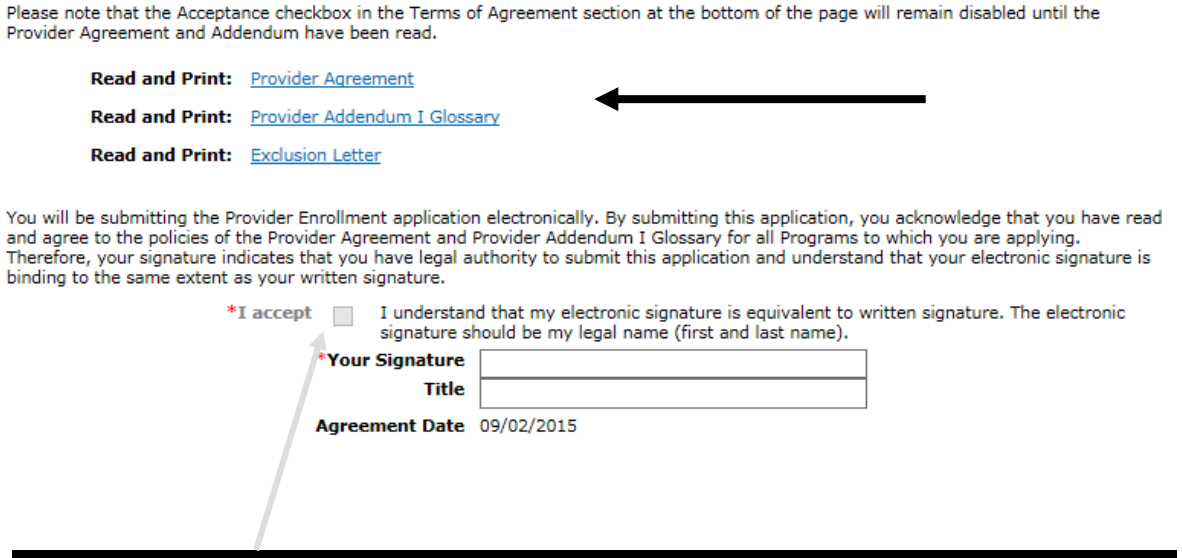
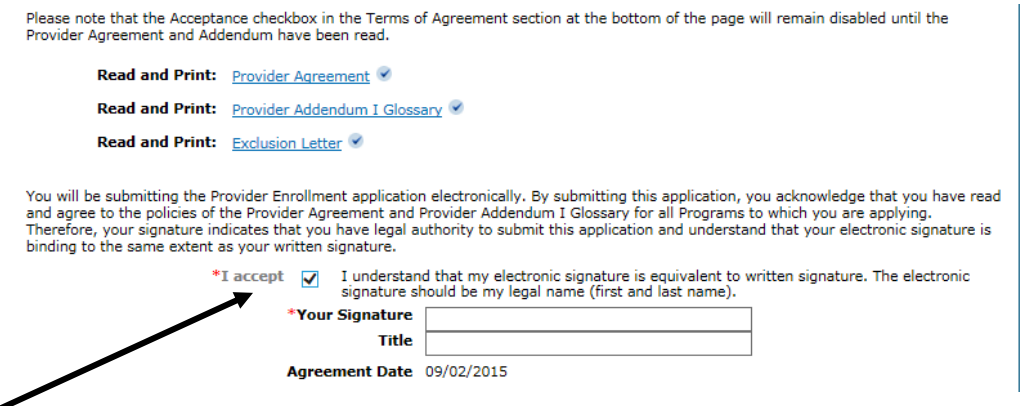
Signing your Application



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.



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Provider Agreements

Read and Print: Provider Agreement

Read and Print: Provider Addendum 1 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.

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Completing Application

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

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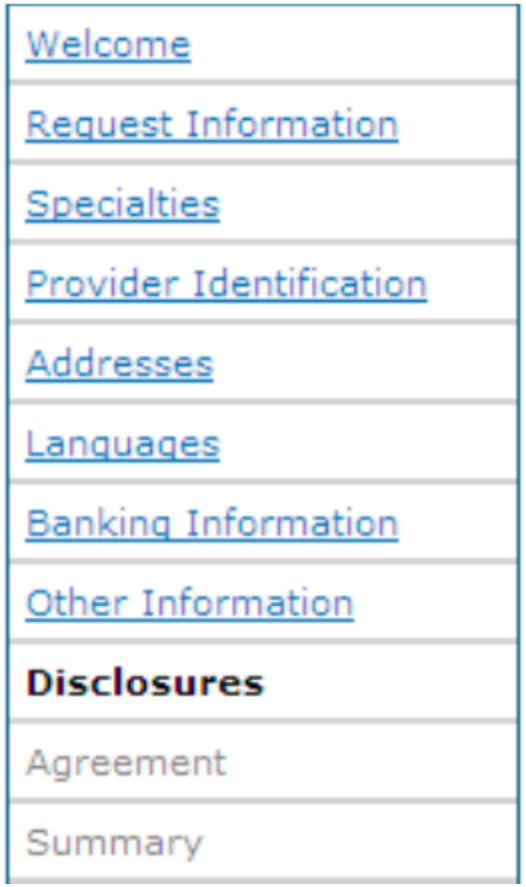
Summary Page



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.

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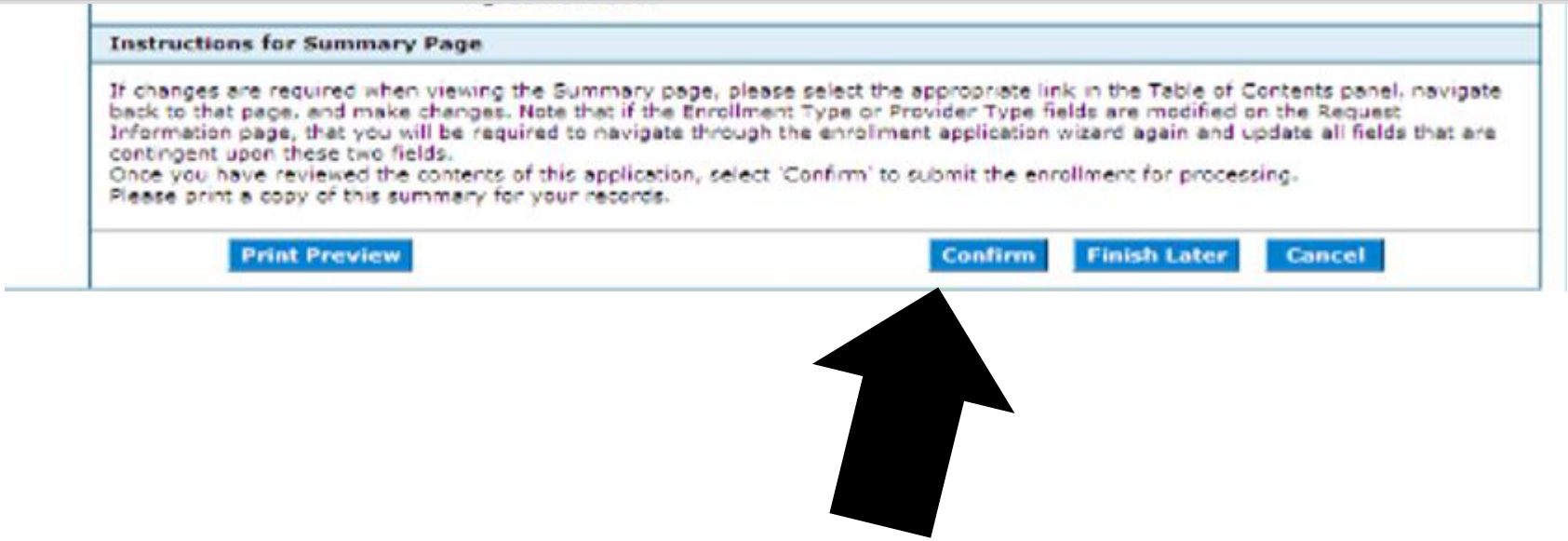
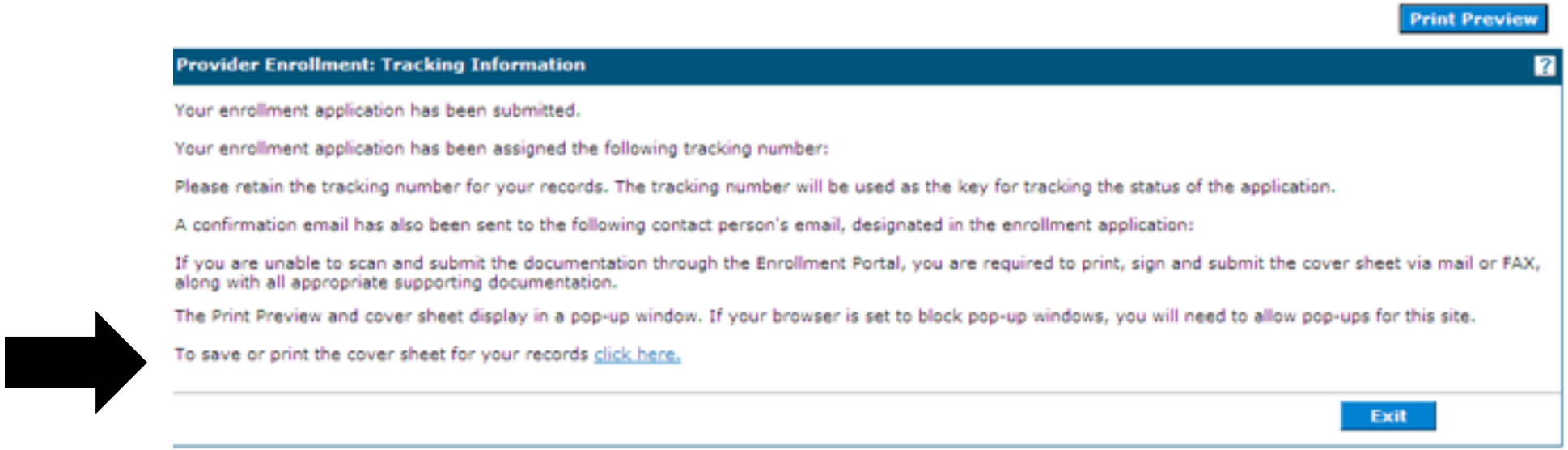
Confirming Your Application

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

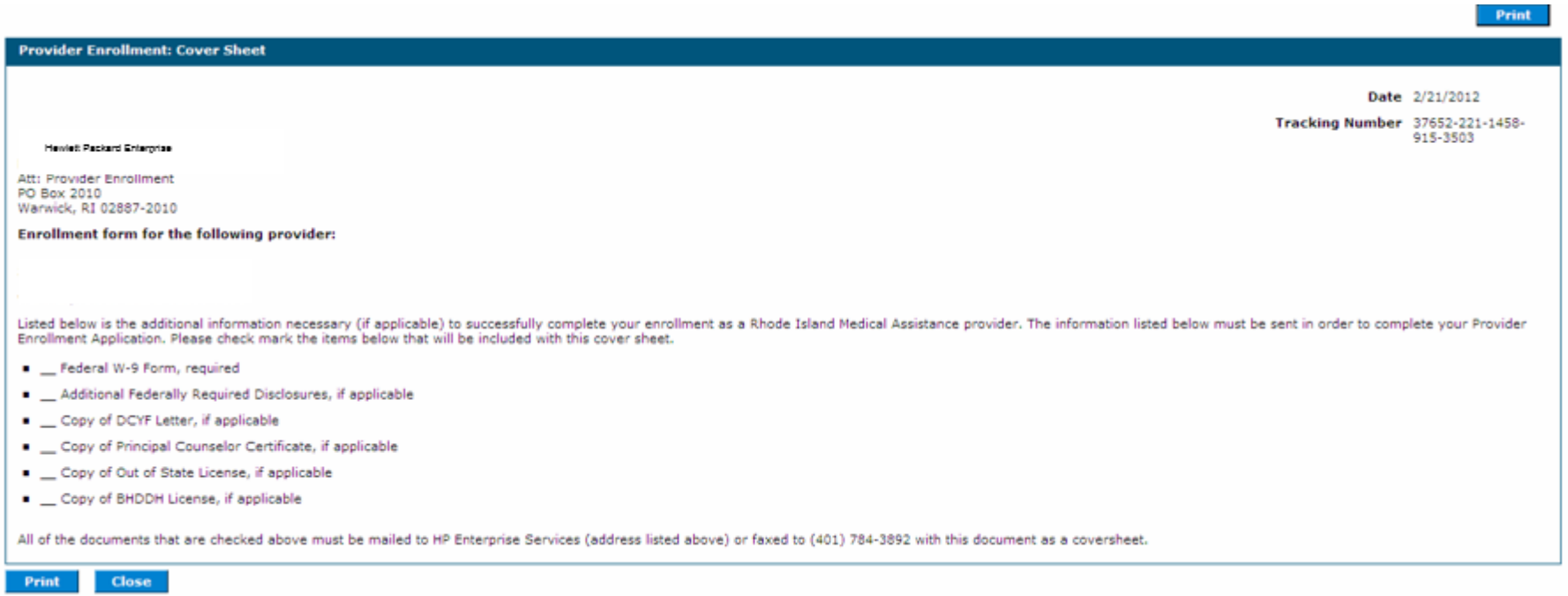


Tracking Information Page and Cover Sheet



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



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

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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