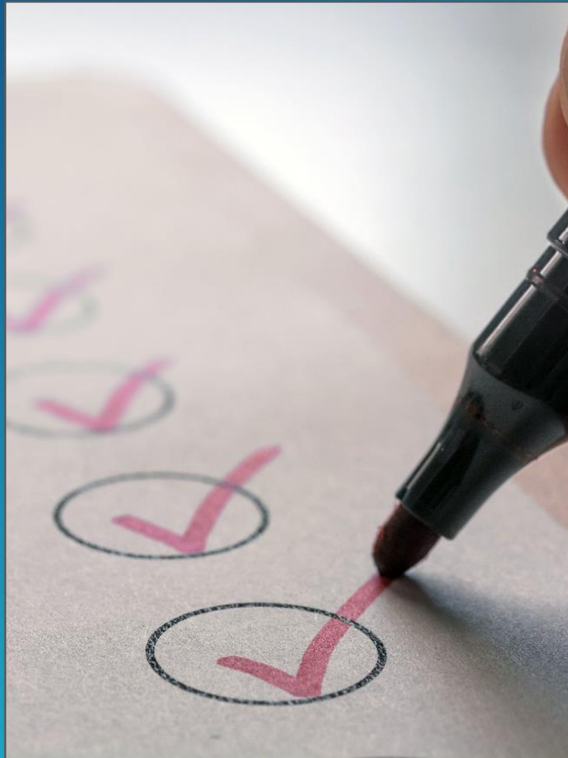
RI Medicaid Provider Revalidation

Jan 2024

PR0094 V1.2 01/2024

Table of Contents

gainwell



- What is Revalidation
- Participation
- Notification Letters
- Time out
- Accessing Information and Log In
- Welcome Screen
- Request Information
- Specialties
- Provider Identification
- Addresses
- Languages
- EFT Enrollment
- Other Information
- Disclosures
- Agreement
- Summary
- Confirmation
- Tracking and Cover Sheet
- Time Out/Errors
- Questions

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

What is Revalidation?

gainwell

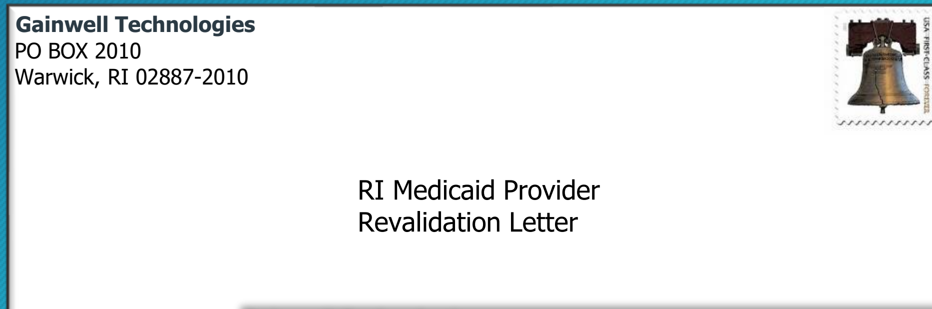
- RI Medicaid Enrollment revalidation is mandated by the Centers for Medicare and Medicaid (CMS) provider screening and program integrity rules.
- EOHHS utilizes the online Healthcare Portal to expedite enrollment revalidation for active providers supporting RI Medicaid.
- Revalidation requires providers to resubmit and recertify the accuracy of their enrollment information.
- Providers will need to review and update their prepopulated provider information on the Healthcare Portal, submit forms, attest online to Disclosure statements and sign electronically.
- Providers have a mandatory 35 days from the date of the revalidation letter received to complete. If providers do not comply, they will be terminated from the program and will have to reapply. Enrollment will not be backdated to termination date.

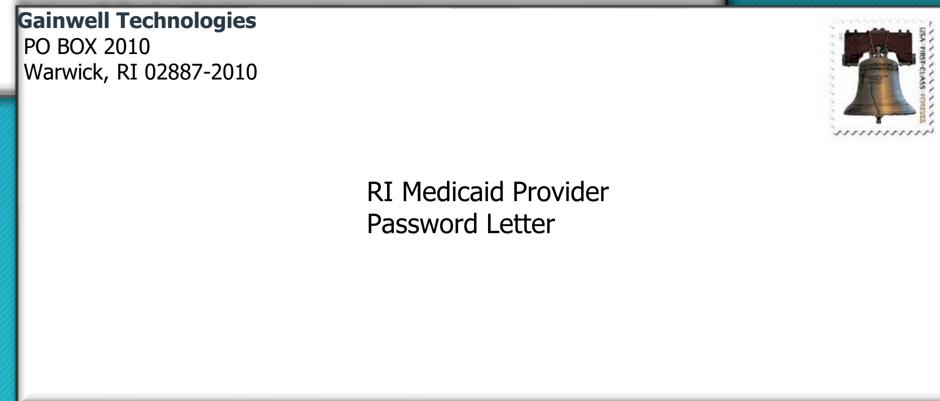
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Notification Letters

gainwell

Providers who are required to revalidate will receive two letters: one will contain a tracking number with directions on how to revalidate and one will contain a password.





EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Participation

If you no longer wish to participate in the Medicaid Program, please fax or email the following information to Provider Enrollment.

Include the following:

- Provider's Name and NPI
- Group Name and NPI (If applicable)
- Term Date

Email - rienrollment@gainwelltechnologies.com

Fax - 401-784-3892

If you would still like to participate in the Medicaid Program, please continue to the next slide.

Time Out!

gainwell

For security purposes, your session will time out after being idle for 45 minutes. If you are not able to finish, we suggest saving your work by clicking “finish later”, exit, and reenter the process again when you are ready.

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

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

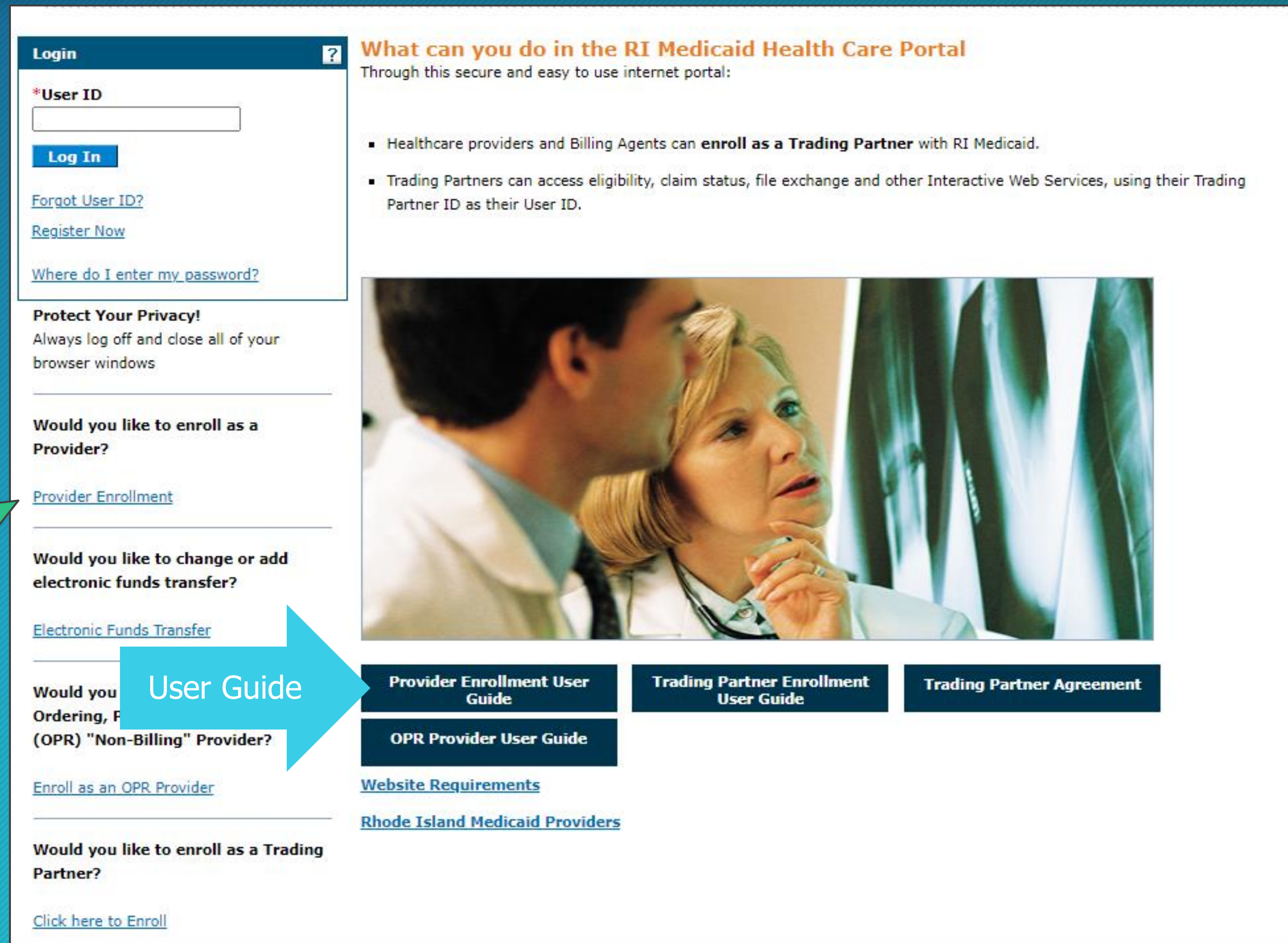
Accessing Information and Login

https://www.riproviderportal.org

gainwell

Do NOT login with your User ID.

Instead, click here for Provider Enrollment



User Guide

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Accessing Information and Login Cont’d

gainwell

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.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Accessing Information and Login Cont'd

gainwell

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

Submit Cancel

- Enter the tracking number as shown on your Revalidation letter, include dashes.
- Enter Tax ID, NO spaces or dashes
- Enter Password as shown in the Password Letter. NO spaces or dashes and capital letters only.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Welcome Screen

This screen is the starting point. On each of the following screens, you must verify or complete the required fields. You cannot advance to the next screen without completing the current one. You can go back by using the menu on the left.

Contact Us | Login

HEALTH & HUMAN SERVICES

Rhode Island Executive Office of Health and Human Services

Medicaid

Home

Home > Provider Enrollment > Enrollment Application

Friday 02/02/2024 04:54 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

Please complete each step in the enrollment process. When you have completed all steps of the application, "submit" and "confirm" the application for further processing by the Rhode Island Medical Assistance Program.

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; not applicable for MCO only Providers
- Additional Federally Required Disclosures, as an attachment, if applicable

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

Continue Cancel

R4.4.02

© 2024 Gainwell Technologies. All rights reserved. | Privacy Notice

HEALTH & HUMAN SERVICES

Request Information

gainwell

- Provider Enrollment type, Provider Type and Effective Date will be pre-populated.
- DO NOT change Provider Enrollment Type, Provider Type, or Effective Date. Changing the Provider Type requires a new application.
- Contact information should be completed by the primary contact. This is the person Provider Enrollment will reach out to if they have questions.
- Select Continue or Finish Later.

Provider Enrollment: Request Information

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

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.

* Indicates a required field.

Type of Provider Enrollment

* **Please select type of Provider Enrollment:**

- (●) RI Medicaid Provider - Billing Claims Directly to RI Medicaid.
- ( ) MCO (Managed Care Organization) Provider - Providing services to RI Medicaid recipients; billing claims through an MCO.
- ( ) MCO & RI Medicaid Provider - Billing Claims Directly to RI Medicaid and through an MCO.

Initial Enrollment Information

***Provider Enrollment Type**
***Provider Type**
***Requesting Enrollment Effective Date** 02/02/2024

Contact Information

***Contact Name**
***Contact Phone** Ext
***Contact Email**
***Confirm Email**
Preferred Method of Communication Email

Continue | Finish Later | Cancel

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Specialties

gainwell

- This screen is prepopulated.
- If no specialty, the field will say "Not Applicable" or "No Provider Specialty Designation"
- Effective date will be original date.
- Leave End Date alone, this doesn't expire
- Taxonomy Code should be verified. DO NOT change the taxonomy code.
- Select continue for next screen or finish later to pause and come back.

Provider Enrollment: Specialties ?

Welcome
Request Information
Specialties
Provider Identification
Addresses
Languages
Electronic Funds Transfer (EFT) Enrollment
Other Information
Disclosures
Agreement
Summary

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
−	Not Applicable	314000000X	04/01/1993	12/31/9999	

Type Nursing Home
*Specialty Not Applicable
*Effective Date 04/01/1993
End Date 12/31/9999
*Taxonomy Code 314000000X
Primary

Save Reset Cancel

+ Click to add specialty.

Continue Finish Later Cancel

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Provider Identification – Legal Name

gainwell

You must enter the LEGAL name associated with NPI listed in Provider Identification Numbers below. Then select the type of ownership from the drop down. If another business name is used, enter this in the Business Name field.

Provider Enrollment: Provider Identification

- Welcome
- Request Information
- Specialties
- Provider Identification
- Addresses
- Languages
- Electronic Funds Transfer (EFT) Enrollment
- Other Information
- Disclosures
- Agreement
- Summary

* Indicates a required field.

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

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: 04/01/1993 | End Date: 12/31/9999 | *Fiscal End Date: December
*NPI: 1013903376
License #: LTC00821 | Expiration Date: 12/31/1995 | License State: Rhode Island
Medicare #
DEA #
CLIA # | Effective Date: 09/01/2022 | CLIA Type: Waiver
Supplemental NPI
Supplemental Taxonomy

Continue | Finish Later | Cancel

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Provider Identification Numbers

gainwell

- 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 and license state is required

Provider Enrollment: Provider Identification

Welcome
Request Information
Specialties
Provider Identification
Addresses
Languages
Electronic Funds Transfer (EFT) Enrollment
Other Information
Disclosures
Agreement
Summary

* Indicates a required field.

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

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 04/01/1993 | End Date 12/31/9999 | *Fiscal End Date December
*NPI
License # | Expiration Date 12/31/1995 | License State Rhode Island
Medicare #
DEA #
CLIA # | Effective Date 09/01/2022 | CLIA Type Waiver
Supplemental NPI
Supplemental Taxonomy

Continue | Finish Later | Cancel

- If your provider type requires a CLIA# please enter and don't forget to upload your certificate.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Addresses

gainwell

- Verify all addresses for the facility. If an address needs to be changed, expand that section.
- A Primary address designation is needed for a Service address, but not for Pay to or Mail to addresses.
- 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
Request Information
Specialties
Provider Identification
Addresses
Languages
Electronic Funds Transfer (EFT) Enrollment
Other Information
Disclosures
Agreement
Summary

* Indicates a required field.

Indicates a primary record.

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		WOONSOCKET	Rhode Island	Copy Remove
+		Mail To		WOONSOCKET	Rhode Island	Copy Remove
+		Service Location	262 POPLAR STREET	WOONSOCKET	Rhode Island	Copy Remove
+	Click to add address.					

Continue Finish Later Cancel

Primary Designation Icon

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Languages

gainwell

Provider Enrollment: Languages

Welcome
Request Information
Specialties
Provider Identification
Addresses
Languages
Electronic Funds Transfer (EFT) Enrollment

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
English	Remove
Click to add language.	

Continue | Finish Later | Cancel

- Providers that can interpret multiple languages should select the appropriate languages from the list.
- Select the **Add** button after each language.
- When finished, select continue or finish later

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

EFT Enrollment

gainwell

- The next screen is to confirm your EFT enrollment for direct deposit of payment from RI Medicaid.
- Enter your Provider name.
- The TIN and NPI will be filled in for you.
- Leave “Other Identifier” field blank and box unchecked if you have an NPI.
- Enter taxonomy.
- Enter Contact Info and Bank Name and Address.

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

- Welcome
- Request Information
- Specialties
- Provider Identification
- Addresses
- Languages
- **Electronic Funds Transfer (EFT) Enrollment**
- Other Information
- Disclosures
- Agreement
- Summary

* Indicates a required field.

Provider Information

*Provider Name

Provider Identifiers Information

*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI): 1013903376

Other Identifier

Assigning Authority: Medicaid

Provider Taxonomy Code

Provider Contact Information

Provider Contact Name

Title: office manage

Phone Number

Email Address

Fax Number

HEALTH & HUMAN SERVICES
EXECUTIVE OFFICE OF
STATE OF RHODE ISLAND

EFT Enrollment – Cont'd

gainwell

- Verify that the Routing Number and Account Number are correct. If not, please put in correct information.
- Check off NPI box only
- Select "Reason for Submission". This should only be "Change Enrollment" when Revalidating

Financial Institution Information

Financial Institution Name

Financial Institution Address

Address

City

State

Zip Code

Financial Institution Telephone Number

Ext

***Financial Institution Routing Number**

***Type of Account at Financial Institution** Checking

***Provider's Account Number with Financial Institution**

Account Number Linkage to Provider Identifier

Provider Tax Identification Number (TIN)

National Provider Identifier (NPI)

(if identifier other than NPI is used)

Submission Information

***Reason for Submission** Change Enrollment

Continue | Finish Later | Cancel

HEALTH & HUMAN SERVICES
EXECUTIVE OFFICE OF
STATE OF RHODE ISLAND

Other Information

gainwell

Provider Enrollment: Other Information

Welcome
Request Information
Specialties
Provider Identification
Addresses
Languages
Electronic Funds Transfer (EFT) Enrollment
Other Information
Disclosures
Agreement
Summary

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

Certification Information

*Certification: Not Applicable
*Effective Date: 01/25/2020 End Date: 12/31/9999

Individual Providers

*Specialty Board: Not Applicable
*Effective Date: 01/25/2020 End Date: 12/31/9999
Degree
School
Year of Graduation

Continue Finish Later Cancel

Individual/Group Provider

Information

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

Certification Information

*Certification: Not Applicable
*Effective Date: 01/01/1995 End Date: 12/31/9999

Facility Providers

Number of Licensed Beds: 0
Number of Swing Beds: 0

Continue Finish Later Cancel

Other Information
Disclosures
Agreement
Summary

Facility Provider

- “Other Information” will display differently for an Individuals, Group, or Facility Provider (note screens above)
- Select the certification type for your company or “Not Applicable” if you do not have one.
- If selecting a certification type, please enter effective date.
- If selecting “Not Applicable” leave the date as is.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Disclosures

gainwell

IMPORTANT

Answering the Disclosure Questions are NOT optional.
CMS requires answers to all questions before revalidation can be accepted.

- Please complete your Disclosure questions all at once. They must be complete when you are ready to submit your application.
- If you do not complete all Disclosure Questions and hit "Finish Later" or "Cancel" all prior work EXCEPT disclosures will be saved. You will have to fill out the disclosure section again when you return.

Suspend Incomplete Application

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?

Yes No

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Rhode Island Medicaid Disclosure Questions

gainwell

INDIVIDUAL PROVIDERS ONLY

1. Are you a Full or Part-time salaried employee of a hospital or institution? **Yes No**
   (If yes, complete the following)
   Name of Facility:

OUT OF STATE PROVIDERS ONLY

2. Reason for Enrollment: ***(Please check all that apply)***
   ☐ Anticipating or currently providing services
   ☐ Provided services
   ☐ Business expanding
   ☐ Other (please specify)

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Disclosures

gainwell

Questions 7-17 are mandatory, answer to the best of your ability. Reach out to Provider Enrollment if you have questions.

All Providers

6. **Programs - Please check all other programs that you want to participate in, in addition to Medical Assistance:**
   - [ ] Behavioral Health, Developmental Disabilities, and Hospitals CNOM
   - [ ] Community Medication Assistance Program (CMAP)
   - [ ] Dept of Corrections
   - [ ] Dept of Health Pharmacy Program
   - [ ] Office of Rehab Services
   - [ ] RI Pharmaceutical Assistance to the Elderly Program (RIPAE)
7. ***Are you currently or have you ever been a provider with Medical Assistance?**
   (●) Yes ( ) No

   Yes or No
8. ***Are you currently enrolled with Medicare? (Please be sure you listed your Medicare number on the Provider Identification panel.)**
   ( ) Yes (●) No

   ***a. If no, have you or will you enroll with Medicare?**
   ( ) Yes ( ) No

   Yes or No with additional info requested

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Disclosure Question #9 and 11

gainwell

9. *Identify any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period.

NA

If you have no business transactions between provider and owned supplier in question #9

- Enter "NA" or "None" and do not add slash(/) or it will error

11. *List any outstanding balance owed to the Rhode Island Executive Office of Health and Human Services by a previous provider.

0

If you have no outstanding balance owed to the RI EOHHS by a previous provider

- Enter "0" with no period

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Disclosure Question #12

gainwell

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

(•) Yes ( ) No

	Last Name	Legal Entity	Address	City	State	Birth Date	Action

* a. Name

Last Name

First Name

* b. Title

* c. Legal entity or home address

Legal Entity

Address

City

State

Zip Code

* d. SSN/EIN

* e. Date of Birth

Add | Reset | Cancel

- Question #12 MUST ALWAYS be "Yes"
- Additional fields will be required to fill out
- Sole proprietors MUST enter personal information
- SSNs are required for all individuals listed as Owner, Administrator, board members and managing employees. (NO EXCEPTIONS)
- If all information is NOT filled out your application will be returned
- For multiple owners, Admins, board members and managing employees the field allows you to add more than one.
- You can also upload (PDF only)/email/fax a copy with everything to Gainwell fax 401-784-3892 or email rienrollment@gainwelltechnologies.com

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Out of State Providers

gainwell

Out of State Providers MUST complete questions 2-5 of the Disclosures.

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

Please be sure to fill out all information pertaining to your recipient.
Recipient is NOT required if you are a bordering community. See Link to verify
Border communities

OUT OF STATE PROVIDERS ONLY

2. Reason for Enrollment: ***(Please check all that apply)***
   ☐Anticipating or currently providing services
   ☐Provided services
   ☐ Business expanding
   ☐ Other (please specify) ________________________

3. Services Provided: ***(Check one)***
   ☐Emergency
   ☐ Urgent
   ☐ Elective

4. Number of RI Medicaid recipients you treat or anticipate treating annually:
   ____

5. 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: ______________________________

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Agreement Screen – Supporting Documents

gainwell

Provider Enrollment: Agreement

Welcome
Request Information
Specialties
Provider Identification
Addresses
Languages
Electronic Funds Transfer (EFT) Enrollment
Other Information
Disclosures
Agreement
Summary

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 (Not required for MCO Only Providers)

Submit as Attachment: Additional Federally Required Disclosures excel pdf Please complete if you have more entities to disclose for questions 12-17 on the Disclosures page.

Submit as Attachment: License for out of state providers only

Submit as Attachment: Behavioral Health, Developmental Disabilities and Hospitals License, if applicable

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 Choose File No file chosen

Add

Please make sure your attachments are no bigger than 5MBs

- Use the "Choose File" button to browse and find your file for upload.
- Documents MUST only be PDF format
- If you receive an error when submitting your application, try removing all files and submit again. If successful fax attachments, you removed to 401-784-3892 instead.

The Agreement screen enables you to upload supporting documents to your application, such as W9, disclosures, licenses, and certifications, etc…

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

W-9 - Attachment

gainwell

Form W-9 (Rev. 3/7/11)

State of Rhode Island
PAYER'S REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

THE IRS REQUIRES THAT YOU FURNISH YOUR TAXPAYER IDENTIFICATION NUMBER TO US. FAILURE TO PROVIDE THIS INFORMATION CAN RESULT IN A $50 PENALTY BY THE IRS. IF YOU ARE AN INDIVIDUAL, PLEASE PROVIDE US WITH YOUR SOCIAL SECURITY NUMBER (SSN) IN THE SPACE INDICATED BELOW. IF YOU ARE A COMPANY OR A CORPORATION, PLEASE PROVIDE US WITH YOUR EMPLOYER IDENTIFICATION NUMBER (EIN) WHERE INDICATED.

Taxpayer Identification Number (T.I.N.)

Enter your taxpayer identification number in the appropriate box. For most individuals, this is your social security number.

Social Security No. (SSN)

Employer ID No. (EIN)

NAME

ADDRESS

(REMITTANCE ADDRESS, IF DIFFERENT) ____________________

CITY, STATE AND ZIP CODE ____________________

CERTIFICATION: Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), **and**
(2) I am not subject to backup withholding because either: (A) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (B) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions -- You must cross out item (2) above if you have been notified by the IRS that you are subject to backup withholding because of under-reporting interest or dividends on your tax return. However, if after being notified by IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross out item (2).

- **ALL** providers must upload a new W9, signed in ink and dated within 30 days of the revalidation application.
- Line 1 of the W9 should never be blank and should include the "Legal" business name. NOT the DBA.
- If you are an individual, please use first and last name.
- DO NOT add both Tax ID and SSN on form. You may use one or the other. Typically for business or group revalidations, use your Tax ID.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Application Fees

gainwell

- Certain Provider Types are subject to an application fee
- To review which Provider Types that must pay a fee, check the EOHHS site https://eohhs.ri.gov under Providers & Partners > Provider Enrollment. Scroll down to "Application Fees for Providers" and click on the link for the document.
- Application fees must be submitted in order to complete your revalidation

gainwell

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Provider Application Fees

Providers who are applying for RI Medicaid enrollment or revalidating enrollment, may be required to pay an application fee.

- Provider types who may be subject to an application fee are:

Inpatient Hospital	Nursing Homes	Indian Health Services
Outpatient Hospital	Outpatient Psych Hospital	Adult Day Care
Free Standing Psych Hospital	Free Standing Ambulatory Surgical Center	Shared Living Agency
Home Health/Skilled Nursing	Federally Qualified Health Center	MRDD Day Habilitation Program
Independent Lab	Hospice	Local Education Agency
Ambulance	ICF-MR Private Facility	Early Intervention
DME Supplier	Assisted Living Facility	Substance Abuse Rehab
DME Emergency Response	Center of Excellence	CMHC- Rehab Option
Habilitation Group Home	Cedar Family Center	BHDDH Behavioral Health Group/BHDDH Agencies
Personal Care/Homemaker	Personal Choice/ Hab Case Mgt	Personal Choice/ Self Directed Community Svs
Lead Center	Hippotherapy	Home Based Therapeutic Svs
MHRH	Meals on Wheels	Recovery Navigation Program
Home Stabilization	Severely Disabled Nursing Home	Peer Recovery Services

- Provider types who are required to pay the fee but are enrolled in Medicare or have paid an enrollment fee to another state Medicaid agency, are exempt. If the fee was paid to another State, proof of payment must be submitted.
- **As of January 1, 2024, the application fee to enroll as a Medicaid provider is $709.00.**
- Payment should be submitted by check, payable to State of Rhode Island. Please include provider name and NPI on the check.
- Payment of fee or proof of payment should be mailed to:
  - **Gainwell Technologies**
    Attn: Enrollment Department
    PO BOX 2010 Warwick, RI 02887

Signing your Application

gainwell

I certify that the foregoing information is true, accurate, and complete with the understanding that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

Please read and print for your records the Provider Agreement and the Provider Addendum I Glossary. The Provider Agreement applies to all Programs (i.e. Medical Assistance, Community Medication Medicare, Department of Health Pharmacy Program, and Rhode Island Pharmaceutical Assistance to the Elderly Program).

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 02/06/2024

Submit | Finish Later | Cancel

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.

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 02/05/2024

Submit | Finish Later | Cancel

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Completing Application

gainwell

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

*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 02/05/2024

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 hit confirm** in order to complete the Revalidation process
- Finish Later – Saves the information, **EXCLUDING** Disclosure information
- Cancel – Erases all entered information

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Summary Page

gainwell

- Welcome
- Request Information
- Specialties
- Provider Identification
- Addresses
- Languages
- Electronic Funds Transfer (EFT) Enrollment
- 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.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Confirming Your Application

IMPORTANT:

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

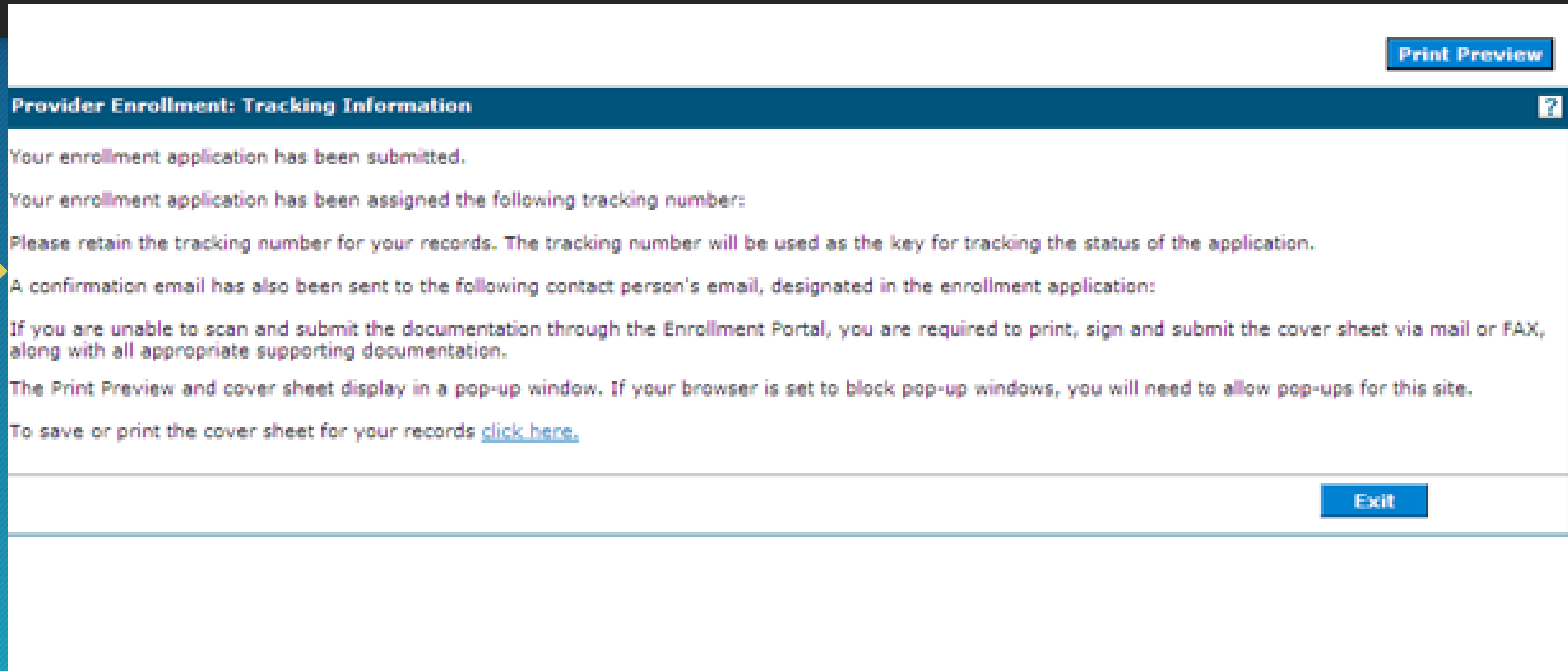
Instructions for Summary Page

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 and Cover Sheet

gainwell



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 documents that MUST be mailed or faxed with your application.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Printing the Cover Sheet

gainwell

Print

Provider Enrollment: Cover Sheet

Date 2/21/2012

Tracking Number 37652-221-1458-915-3503

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.

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Questions?

gainwell

Please either contact our Customer Service Help Desk at

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

Or you can email Provider Enrollment at

- rienrollment@gainwelltechnologies.com

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Thank you