

RI Medicaid Revalidation Tips and Reminders



Agenda

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

Begin Revalidation Process

Do NOT login
with your User
ID.

Click here for
Provider
Enrollment

gainwell

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](#)



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

[Submit](#) [Cancel](#)

The tracking number and password 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.

Verify Information

Verify or complete the information on each screen. You cannot advance to the next screen without completing the current one. You can go back by using the menu on the left.

The following pages in this guide highlight some of the more common “errors” made.



Provider Name

Provider Legal Name	
The provider legal name and information is provided once for each enrollment. Ownership Information is required.	
*Provider Legal Name	<input type="text"/>
*Ownership	<input type="text" value="▼"/>
Business Name	<input type="text"/>

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.

Electronic Funds Transfer

Bank and Bank Account Information

*ABA Routing Number

*Account Number

*Account Type

*EFT Start Date

EFT End Date

After verifying your banking information, you MUST change the EFT start date to today's date. If you save your application and complete later, you must change again. Select the date from the calendar (see image at right)

*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



W-9

W-9
Form (Rev. December 2015)
Department of the Treasury
Internal Revenue Service

**Request for Taxpayer
Identification Number and Certification**

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

Name (as shown on your books for 2015)
Donald Green

Business name/disregarded entity name, if different from above
Donald V Drysdale

Check appropriate box for federal tax classification:
 Individual proprietor C Corporation S Corporation Partnership Trust/estate
 Limited liability company. Enter the tax classification (i.e., C corporation, S-B corporation, Partnership) Foreign person
 Other (see instructions)

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

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

City, state, and ZIP code
Oaktown, AL 00000

Use account numbers here (optional)

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.

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

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

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 W-9 at the end of the revalidation process.

Medicare Number /CLIA

*NPI	<input type="text"/>	
License #	<input type="text"/>	Expiration Date 
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, enter the number and upload a copy of your Medicare letter

Hospitals – enter CLIA# and upload your certificate.

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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The image shows a tilted document titled "Rhode Island Medicaid Disclosure Questions". At the top left is a small circular logo with a person icon and the text "Rhode Island Medicaid". The main heading is "Rhode Island Medicaid Disclosure Questions". Below this is a section titled "ALL PROVIDERS" with a sub-heading "1. Programs - Please check all other programs that you want to participate in, in addition to Medicaid." followed by three checkboxes: Behavioral Health, Developmental Disabilities, and Hospitals CNOM; Community Medication Assistance Program (CMAP); and Dept. of Corrections.



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

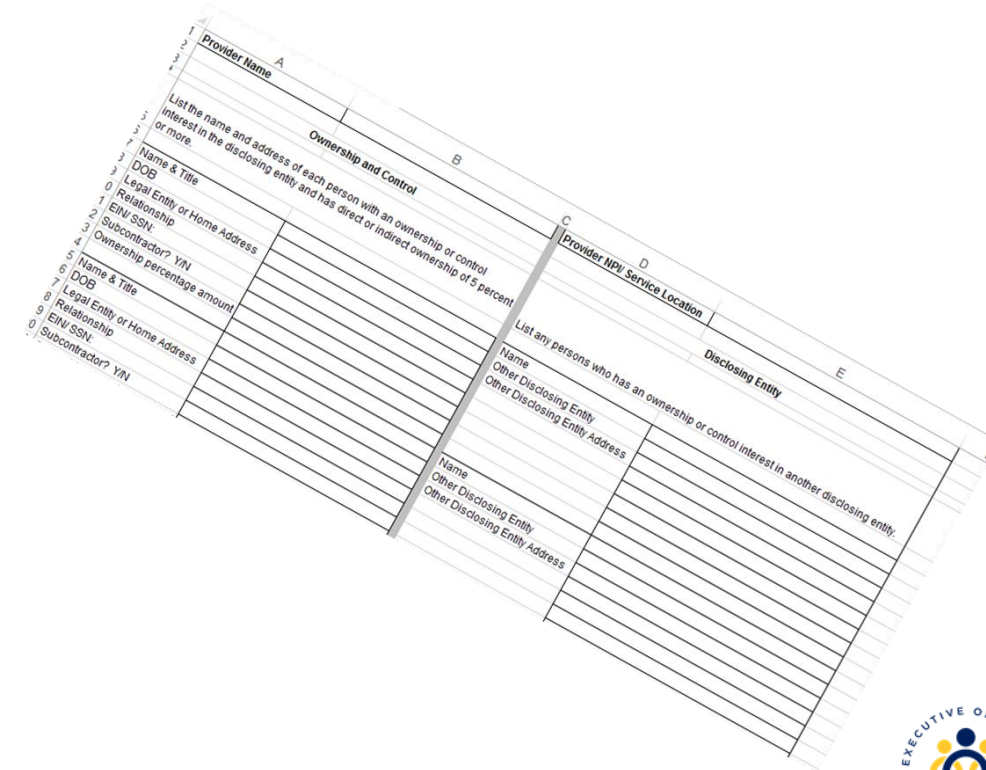
*e. Date of Birth 

Question 4 asks for the owner/administrator's name, title, and home address.

Also, the **Social Security** number 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, complete the Additional Federally Required Disclosures form, found on the Agreement page, following the disclosures.



The form is titled "Additional Federally Required Disclosures" and is divided into several sections. Section A is for "Provider Name". Section B is for "Ownership and Control" and includes a table with columns for Name & Title, DOB, Legal Entity or Home Address, Relationship, EIN/SSN, and Subcontractor? Y/N. Section C is for "Provider NPI Service Location". Section D is for "Disclosing Entity" and includes a table with columns for Name, Other Disclosing Entity, and Other Disclosing Entity Address. Section E is for "List any persons who has an ownership or control interest in another disclosing entity." and includes a table with columns for Name, Other Disclosing Entity, and Other Disclosing Entity Address. Section F is for "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." and includes a table with columns for Name & Title, DOB, Legal Entity or Home Address, Relationship, EIN/SSN, and Subcontractor? Y/N.

Attachments

The following attachments are required:

- W-9
- License for out of state providers only
- Approval letter from DCYF if you are applying as a Licensed Mental Health Counselor

To prevent error messages due to file size, please only upload the W-9 form through the portal and email or fax the remaining documents. Documents should be emailed to: rienrollment@gainwelltechnologies.com or faxed to 401-784-3892.



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 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](#)

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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

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.

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:

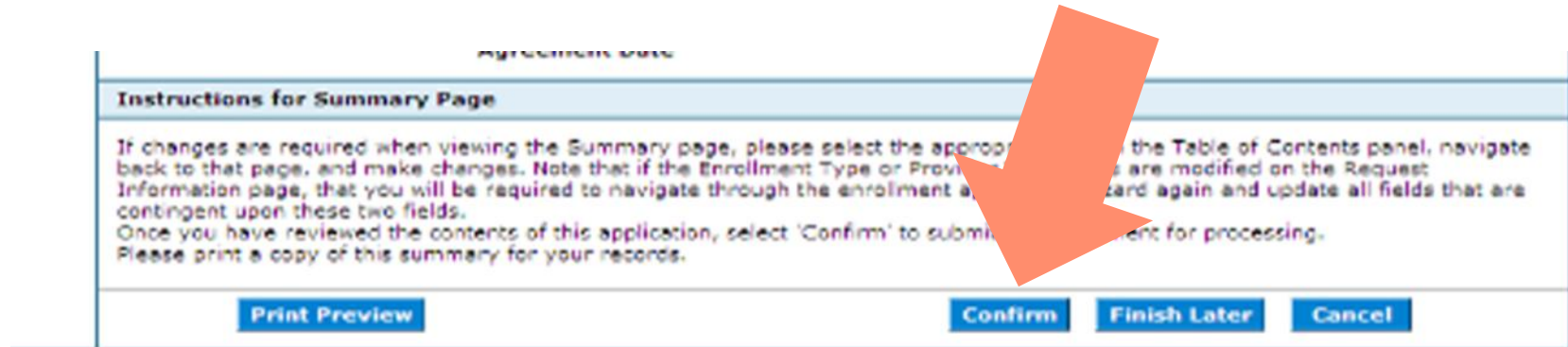
Submit...Finish Later...Cancel

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

Summary Page

Your summary page appears for you to review all information.

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



The screenshot shows a web interface for a summary page. At the top, there is a header with the text "agreement state". Below this is a section titled "Instructions for Summary Page". The text in this section reads: "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 Information 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 this application for processing. Please print a copy of this summary for your records." Below the text are four buttons: "Print Preview", "Confirm", "Finish Later", and "Cancel". A large orange arrow points from the top right towards the "Confirm" button.

Time Out!

For security purposes, your session will time out after 30 minutes. If it will take more than 30 minutes for you to complete, 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.



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!

