



Atypical Agency
Enrollment
HOKU New Application Path

Hawaii Train-the-Trainer Materials
Created February 28, 2020

Selecting Atypical Agency Enrollment Type

- If the provider being enrolled is a Facility, Agency, or Organization (FAO) providing health care or support services, and **does NOT have an NPI**, please select the Atypical Agency enrollment type.
- Atypical Agencies include:
 - Adult Day Health Centers
 - Adult Foster Care Providers
 - Home and Community-Based Services Providers
 - Home Help Agencies
 - Residential Treatment Facilities
 - Habilitation Providers
 - Mental Health Providers
 - Developmentally Disabled Day Cares
 - Personal Care Attendant Agencies
 - Blood Banks
 - Respite Care or Specialized Services

Select the Atypical Agency Enrollment Button

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > Enrollment Task List > New Enrollment

Enrollment Type

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
 - Regular Individual/Sole Proprietor or Rendering/Serviceing Provider
- Group Practice (Corporation, Partnership, LLC, etc.)
- Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- Contractor/MCO
 - Managed Care Organization
- Atypical (non-medical) provider (Choose this option if you do not have a NPI)
- Individual (Community Care Foster Family Home CCFH)
- Agency (Adult Day Health, DD/ID, Home Help/Personal Care Agency, Transportation Company etc.)

Page ID: pgNewEnrollBasicStep(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:22:08 MST

Step 1: Provide Basic Information

Print Help

Basic Information: Enter required fields and click Finish button.

Basic Information

Legal Entity Name: * (As shown on the Income Tax Return)

Entity Business Name: * (Doing Business As) EIN/TIN: *

W9 Information

W-9 Entity Type: * W-9 Entity Type (If Other):

Profit Status: *

Application ID

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Basic Information

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: **20200226110177**

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

Ok

Page ID: dlgAddBasicInformationStep3(Provider)

Enrollment Steps

evoBrx My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Correspondence Address	Required			Incomplete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Incomplete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:35:01 MST

Step 2: Add Locations

Application ID: 20200226110177 Name: Hawaii Atypical

Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink

Locations List

Filter By

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
No Records Found !			

Page ID: pg_LocationListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:38:09 MST

Add Primary Practice Address

Application ID: 20200226110177 Name: Hawaii Atypical

Add Provider Location

Location Type: Primary Practice Location *
 Doing Business As: End Date:

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: *
 (Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

Country: UNITED STATES *

Zip Code: * - Validate Address

Web Page:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	<input type="text"/> *	AM PM *	<input type="text"/> *	AM PM *	Thursday:	<input type="text"/> *	AM PM *	<input type="text"/> *	AM PM *
Monday:	<input type="text"/> *	AM PM *	<input type="text"/> *	AM PM *	Friday:	<input type="text"/> *	AM PM *	<input type="text"/> *	AM PM *
Tuesday:	<input type="text"/> *	AM PM *	<input type="text"/> *	AM PM *	Saturday:	<input type="text"/> *	AM PM *	<input type="text"/> *	AM PM *
Wednesday:	<input type="text"/> *	AM PM *	<input type="text"/> *	AM PM *					

Handicap Accessible: No

Language(s) Spoken: English
 Bisayan/Visayan
 Chinese (which includes Mandarin or Cantonese)

(For Multiple Selection, use Ctrl Key)

Page ID: dijEnrAddLocation(Provider)

Add Pay To Address

evoBrix™ < My Inbox ▾ Admin ▾ **Provider ▾** >

👤 ▾ 📄 Note Pad 🌐 External Links ▾ ★ My Favorites ▾ 🖨 Print ? Help

🏠 > MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

⊕ Close ⊕ Add Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink

Locations List ⬆

Filter By ▾ 🔄 Go 📄 Save Filters ▾ My Filters

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>	Primary Practice Location	89 S 750 E, Bountiful, UTAH 84010	12/31/2999

🗑 Delete View Page: 1 🔄 Go 📄 Page Count 📄 SaveToXLS Viewing Page: 1 ⏪ First ⏪ Prev Next ⏩ ⏩ Last

Page ID: pg_LocationListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:40:43 MST

Add Pay To Address

evoBrx My Inbox Admin Provider

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20200226110177 Name: Hawaii Atypical

To add additional addresses, click "Add Address" button.

Location Details

Doing Business As: Location Type: Primary Practice Location

Web Page:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close	AM/PM		AM/PM	Thursday:	Close	AM/PM		AM/PM
Monday:	03:30	AM/PM	05:30	AM/PM	Friday:	Close	AM/PM		AM/PM
Tuesday:	Close	AM/PM		AM/PM	Saturday:	Close	AM/PM		AM/PM
Wednesday:	Close	AM/PM		AM/PM					

Handicap Accessible:

Language(s) Spoken: English
 Bisayan/Visayan
 Chinese (which includes Mandarin or Cantonese)

End Date: 12/31/2999

Address List

Address Type	Address	End Date
Location	89 S 750 E, Bountiful, UTAH 84010	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

Page ID: pgEnrollment.LocationGeneral(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:41:58 MST

Add Pay To Address

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Add Provider Location Address

Type of Address: **-SELECT-**
Pay To

End Date:

Location Address: Copy This Location Address

If a department or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER

Country: UNITED STATES *

Zip Code: * - **Validate Address**

Page ID: dlqEnrlLocationAddress(Provider)

Step 3: Add Correspondence Address

evoBrx My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required			Incomplete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Incomplete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Page Count Viewing Page: 1

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:45:06 MST

Add Correspondence Address

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾ >

My Inbox ▾ Note Pad External Links ▾ My Favorites ▾ Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20200226110177 Name: Hawaii Atypical

Close Add

Correspondence Address List

Address Type	Address	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼
No Records Found !		

Page ID: pgCorrespondenceListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:47:40 MST

Add Correspondence Address

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Add Correspondence Address

Phone Number: * Extn: Fax Number:

Communication Preference: * Email Address:

End Date:

If a department or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER

Country: UNITED STATES *

Zip Code: * -

Page ID: dlqEmtCorrespondenceAddress(Provider)

Step 4: Add Provider Type/Specialties/Subspecialties

evoBrx My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Incomplete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

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Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:50:58 MST

Add Provider Type/Specialties/Subspecialties

The screenshot shows the evoBrox application interface. At the top, there is a navigation bar with the evoBrox logo and menu items: My Inbox, Admin, and Provider. Below this is a secondary navigation bar with icons for Note Pad, External Links, My Favorites, Print, and Help. The main content area shows a breadcrumb trail: MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment. Below the breadcrumb, there is a header section with 'Application ID: 20200226110177' and 'Name: Hawaii Atypical'. A toolbar contains 'Close' and 'Add' buttons, with the 'Add' button highlighted by a red box. Below the toolbar is a section titled 'Provider Type/Specialty/Subspecialty List' with a grid icon and an expand/collapse arrow. This section includes a filter area with 'Filter By' dropdown, two input fields, a 'Go' button, 'Save Filters', and 'My Filters' buttons. Below the filter area is a table with columns: 'Specialty/Subspecialty', 'Provider Type', and 'End Date'. The table is currently empty, and a red message 'No Records Found!' is displayed at the bottom of the table area. At the very bottom of the page, there is a footer with 'Page ID: pgLcnSpcltyListForEnrlmnt(Provider)', 'Environment: HI_SYSTST R10c-1.1', and 'Server Time: 02/26/2020 09:52:51 MST'.

Add Provider Type/Specialties/Subspecialties

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Add Provider Type/Specialty

Provider Type: *

Specialty: *

Select 'No Specialty' if applicable.

End Date:

Add Subspecialty

Available Subspecialties		Associated Subspecialties *
<input type="text"/>	<input type="button" value="»"/> <input type="button" value="«"/>	<input type="text"/>

Select 'No Subspecialty' if applicable.

OK Cancel

Page ID: dlgEnrAddSpecialties(Provider)

Add Provider Type/Specialties/Subspecialties

evoBrox™ < My Inbox ▾ Admin ▾ **Provider ▾** >

My InBox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close Add

Provider Type/Specialty/Subspecialty List

Filter By [v] [] [] Go Save Filters My Filters ▾

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼
<input type="checkbox"/> NO SPECIALTY REQUIRED/No Subspecialty	DHS MHS PROVIDER	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev Next > >> Last

Page ID: pgLcnSpcltyListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:30:54 MST

Step 5: Associate Billing Provider

evoBrx My Inbox Admin Provider

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev Next > >> Last

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:32:12 MST

Associate Billing Provider

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

My Inbox ▾ External Links ▾ My Favorites ▾ Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close Add

Billing Provider/Other Associations List

Filter By [] [] [Go] Save Filters My Filters ▾

NPI/Med-QUEST ID	Provider Name	Start Date	End Date	Status
No Records Found !				

Page ID: pgBillingProviderListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:34:20 MST

Associate Billing Provider

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Associate Billing Provider/Other Associations

Enter NPI/Med-QUEST ID of Billing Provider/Other Associations and click "Confirm Provider."

Type: *

ID: *

Start Date: *

Provider Name:

End Date:

Page ID: dlgBillingProviderID(Provider)

Step 6: Add License/Certification

evoBrx My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:36:09 MST

Add License/Certification

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

My Inbox ▾ Note Pad External Links ▾ My Favorites ▾ Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close Add

License/Certification/Other List

Filter By [v] [] [] Go Save Filters My Filters ▾

License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Date
No Records Found !				

Page ID: pgLicenseListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:39:27 MST

Add License/Certification

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Add License/Certification/Other

License/Certification/Other Type: * License/Certification/Other #: *

Valid Flag:

Effective Date: * End Date:

Page ID: dlgEnrlmntAddLicense(Provider)

Add License/Certification

evoBrex™ < My Inbox ▾ Admin ▾ **Provider ▾** >

👤 ▾ 📄 Note Pad 🔗 External Links ▾ ★ My Favorites ▾ 🖨 Print ⓘ Help

🏠 > MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

⊕ Close ⊕ Add

☰ License/Certification/Other List ⤴

Filter By ▾ ⌂ Go 📄 Save Filters ▾ My Filters ▾

License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Date
▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> HI Board of Psychology	125478569	No	02/26/2020	12/31/2999
<input type="checkbox"/> HI Board of Medical Examiners	459862353	No	02/26/2020	12/31/2999

🗑 Delete View Page: 1 ⌂ Go 📄 Page Count 📄 SaveToXLS Viewing Page: 1 ⏪ First ⏩ Prev ⏪ Next ⏩ Last

Page ID: pgLicenseListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:42:47 MST

Step 7: Add Additional Information

evoBrx My Inbox Admin Provider

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Additional Information	Optional			Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:43:51 MST


Add Additional Information

evoBrx My Inbox Admin Provider

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical


Authorized Representative List



Filter By

Representative Name	Start Date	End Date
No Records Found!		

Bed Information



Filter By

Bed Type	Bed(s)/Unit(s)	Start Date	End Date
No Records Found!			

Page ID: pgAdditionalInfoListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:45:23 MST

Step 8: Add Controlling Interest/Ownership Details

evoBrx My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 11:47:52 MST

Add Controlling Interest/Ownership Details

evoBrx My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20200226110177 Name: Hawaii Atypical

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501(c)3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
 - Agent
 - Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
 - Managing Employee

Owners List

Filter By [] And Indicator [] Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !

Page ID: pgOwnerListForEnrInmt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:21:10 MST

Add Owner

evoBrix My Inbox Admin Provider

My Inbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20200226110177 Name: Hawaii Atypical

Close **Actions** ?

- Add Owner**
- Import Owner

PROVIDER OWNERSHIP DISCLOSURES

Provider Information: Providing home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

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- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501(c)3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the key Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
 - Agent
 - Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
 - Managing Employee

Owners List

Filter By [] And Indicator []

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/>	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !

https://hi-trg-evo.cns-inc.com/evoBrix/CNSIControlServlet Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:21:10 MST

Add Ownership

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Provider Controlling Interest/Ownership

Type: * ⓘ

Percentage Owned: *

SSN:

EIN/TIN:

Legal Entity Name:
(As shown on the Income Tax Return)

Entity Business Name:
(Doing Business As)

Owner NPI:

First Name:

Last Name:

Suffix:

DOB: ⓘ

Phone Number: * Extn:

Email:

Start Date: ⓘ *

End Date: ⓘ

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: * -

Page ID: dlqEnfImntAddOwner(Provider)

OK Cancel

Add Ownership

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Provider Controlling Interest/Ownership

Type: * ⓘ

Percentage Owned: *

SSN: *

EIN/TIN:

Legal Entity Name:
(As shown on the Income Tax Return)

Entity Business Name:
(Doing Business As)

Owner NPI:

First Name: *

Last Name: *

Suffix:

DOB: *

Phone Number: * Extn:

Email:

Start Date: *

End Date:

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

Address Type: Home Address

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address validation successful

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: * -

OK Cancel

Page ID: dlqEnrImntAddOwner(Provider)

Add Owners Relationship

evoBrox
My Inbox Admin Provider
Note Pad External Links My Favorites Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Close Actions

Add Owner
Import Owner
Owners Relationships
Owners Adverse Action

PROVIDER DISCLOSURE INFORMATION

Provider Enrollment Information: The following home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501(c)3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the key Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
 - Agent
 - Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
 - Managing Employee

Owners List

Filter By And Indicator

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 565474858	Atypical,Sally	Agent	121 N Davis Blvd	02/26/2020	12/31/2999	Not Completed	Not Completed	50
<input type="checkbox"/> 569696325	Atypical,Joe	Managing Employee	121 N Davis Blvd	02/26/2020	12/31/2999	Not Completed	Not Completed	50

Page ID: pgOwnerListForEnrInmt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:27:57 MST

Add Owners Relationship

Application ID: 20200226110177 Name: Hawaii Atypical

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? Yes No (Click Save to update)

Owner List

Show Owners: All [Go] Save Filters My Filters

Selected Owner: Atypical, Joe SSN/EIN/TIN: 569696325 Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Atypical, Joe	Relation to Assoc. Owner
Atypical, Sally	565474858	Agent	Spouse	Spouse

View Page: 1 [Go] Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Selected Owner: Atypical, Sally SSN/EIN/TIN: 565474858 Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

Complete Adverse Actions

evoBrix
My Inbox ▾ Admin ▾ Provider ▾
Note Pad External Links ▾ My Favorites ▾ Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20200226110177 Name: Hawaii Atypical

Close Actions ▾

- Add Owner
- Import Owner
- PROVIDER Owners Relationships CONTROL DISCLOSURES
- Provider Enrollment Information: Home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).
- Owners Adverse Action

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501(c)3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the key Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
 - (1) Agent
 - (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
 - (3) Managing Employee

Owners List

Filter By And Indicator Go Save Filters My Filters ▾

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 565474858	Atypical,Sally	Agent	121 N Davis Blvd	02/26/2020	12/31/2999	Completed	Not Completed	50
<input type="checkbox"/> 569696325	Atypical,Joe	Managing Employee	121 N Davis Blvd	02/26/2020	12/31/2999	Completed	Not Completed	50

https://hi-trg-evo.cns-inc.com/evoBrix/CNSIControlServlet
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 12:32:36 MST

Disclose Adverse Actions

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;
 Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if the interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
 Is an officer or director of a disclosing entity that is organized as a corporation; or
 Is a partner in a disclosing entity that is organized as a partnership?

"Significant business transaction" means any business transaction or series of transactions that, during one fiscal year exceed the lesser of \$25,000 and five (5) percent of an offeror's total operating expenses.

"Subcontractor" means:
 An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
 An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

"Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under its DHS agreement (e.g. a commercial laundry firm, a manufacturer of hospital beds, or a pharmaceutical firm).

"Wholly owned subsidiary supplier," means a subsidiary or supplier whose total ownership interest is held by the Medicaid provider/applicant or by a person, persons, or other entity with an ownership or controlling interest in the Medicaid provider/applicant.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owners with Adverse Action

Filter By [] All [] Go [] Save Filters [] My Filters []

Owner Name	SSN/EIN/TIN	Response	Comments
Atypical,Sally	565474858	<input type="radio"/> Yes <input type="radio"/> No	[]
Atypical,Joe	569696325	<input type="radio"/> Yes <input type="radio"/> No	[]

View Page: 1 [] Go [] Page Count [] SaveToXLS [] Viewing Page: 1 [] [] First [] Prev [] Next [] Last []

Ok [] Cancel []

Page ID: pgEnrImntAdverseAction(Provider)

Step 9: Taxonomy Details

evoBrx
My Inbox ▾ Admin ▾ Provider ▾
⌵

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment
Note Pad External Links ▾ My Favorites ▾ Print Help

Application ID: 20200226110177
Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency
⌵

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: Go Page Count SaveToXLS

Viewing Page: 1

⏪ First ⏩ Prev Next ⏪ Last

Page ID: pgBPWAtypicalAgencyStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 12:34:49 MST

Add Taxonomy Details

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

My Inbox ▾ External Links ▾ My Favorites ▾ Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close Add

Taxonomy List

Filter By [] [] Go Save Filters My Filters ▾

Taxonomy Code	Description	Start Date	End Date
No Records Found !			

Page ID: pgTaxonomyListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:36:30 MST

Add Taxonomy

Print Help

Application ID: 20200226110177 Name: Hawaii Atypical

Add Taxonomy

Taxonomy Code: *
(Click here for Taxonomy List)

Description:

Start Date: * End Date:

Page ID: dlgEnrAddTaxonomy(Provider)

NUCC Taxonomy Code List

Use the browser's find feature (Ctrl-F) to search for values. Taxonomy codes are self-selected. Choose the code that best identifies you as a provider.

- ⊕ Individual or Groups (of Individuals)
 - ⊕ Group [\[definition\]](#)
 - Multi-Specialty - **193200000X** [\[definition\]](#)
 - Single Specialty - **193400000X** [\[definition\]](#)
 - ⊕ Allopathic & Osteopathic Physicians [\[definition\]](#)
 - ⊕ Allergy & Immunology - **207K00000X** [\[definition\]](#)
 - Allergy - **207KA0200X** [\[definition\]](#)
 - Clinical & Laboratory Immunology - **207KI0005X** [\[definition\]](#)
 - ⊕ Anesthesiology - **207L00000X** [\[definition\]](#)
 - Addiction Medicine - **207LA0401X** [\[definition\]](#)
 - Critical Care Medicine - **207LC0200X** [\[definition\]](#)
 - Hospice and Palliative Medicine - **207LH0002X** [\[definition\]](#)
 - Pain Medicine - **207LP2900X** [\[definition\]](#)
 - Pediatric Anesthesiology - **207LP3000X** [\[definition\]](#)
 - Clinical Pharmacology - **208U00000X** [\[definition\]](#)
 - Colon & Rectal Surgery - **208C00000X** [\[definition\]](#)
 - ⊕ Dermatology - **207N00000X** [\[definition\]](#)
 - Clinical & Laboratory Dermatological Immunology - **207NI0002X** [\[definition\]](#)
 - Dermatopathology - **207ND0900X** [\[definition\]](#)
 - MOHS-Micrographic Surgery - **207ND0101X** [\[definition\]](#)
 - Pediatric Dermatology - **207NP0225X** [\[definition\]](#)
 - Procedural Dermatology - **207NS0135X** [\[definition\]](#)
 - Electrodiagnostic Medicine - **204R00000X** [\[definition\]](#)
 - ⊕ Emergency Medicine - **207P00000X** [\[definition\]](#)

Clicking a [\[definition\]](#) link to the left displays code value definitions, when available, and additional information about the selected code in this space.

If you are unable to find a code to meet your need:

- [Submit a Question](#)
- [More Information](#)

85%

Step 10: Fee Payment

evoBrx My Inbox Admin Provider

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete	
Step 10: Fee Payment	Optional			Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:38:58 MST

Step 10: Fee Payment

evoBrox™ < My Inbox ▾ Admin ▾ **Provider ▾** >

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

Myinbox > Track Application > Individual Enrollment > New Enrollment > FAO Enrollment > FAO Enrollment > FAO Enrollment > FAO Enrollment > FAO Enrollment

Application ID: 20190816104773 Name:

Close **Add**

Fee Payment List

Filter By Go Save Filters My Filters ▾

Payment Id	Payment Reason	Payment Amount	Fee Option	Payment Made To	Payment Status	Confirmation Number	Payment Date
No Records Found !							

Page ID: pgEnrImnFeePaymentList(Provider) Environment: Development R10c-1.1 Server Time: 08/16/2019 05:01:27 MST

Upload Documents

evoBrx My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete	
Step 10: Fee Payment	Optional	02/26/2020	02/26/2020	Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:41:05 MST

Step 11: Upload Documents

The screenshot shows the EvoBrix application interface. At the top, there is a navigation bar with the EvoBrix logo and menu items: My Inbox, Admin, and Provider. Below this is a secondary navigation bar with icons for Note Pad, External Links, My Favorites, Print, and Help. The breadcrumb trail indicates the current location: MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment. The main content area displays the application details: Application ID: 20200226110177 and Name: Hawaii Atypical. A Close button is visible. Below this is a 'Document List' section with an 'Add' button highlighted in a red box. There is a filter section with 'Filter By' dropdowns, a 'Go' button, and 'Save Filters' and 'My Filters' buttons. A table with columns for Document ID, Document Type, Document Name, File Name, Start Date, End Date, Uploaded By, Uploaded Date, and Document Status is shown, but it contains no data. A red message 'No Records Found!' is displayed below the table. The footer contains page ID, environment, and server time information.

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Document List

Add

Filter By [] [] Go Save Filters My Filters

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Document Status
No Records Found!								

Page ID: pgEnrlmntDocumentList(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:46:57 MST


Upload Documents


Print Help


Application ID: 20200226110177 Name: Hawaii Atypical

Upload Document

Document Type: * Document Name: *

File Name: Browse... 

Start Date: 

End Date: 

Remark:

Page ID: dlgEnrlmntAttachment(Provider)

Upload Documents

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🏠 > MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

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Document List

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Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Document Status
<input type="checkbox"/> 75049201	Fee Verification	Fee Payment Receipt	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049202	Letter	CMS Approval Letter	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049203	License	HI Board Of Medical Examiners	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049204	Tax	W9 Indicator	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049205	License	HI Board Of Psychology	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process

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Step 13: Enrollment Checklist

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MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

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Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete	
Step 10: Fee Payment	Optional	02/26/2020	02/26/2020	Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

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Enrollment Checklist

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> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > Provider Check List

Application ID: 20200226110177 Name: Hawaii Atypical

Close Save

Provider Checklist

Question	Answer	Comments
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	Not Completed	
Do you wish to end date your enrollment? If yes, enter date in comment field.	Not Completed	
Are you currently excluded from any Hawaii or other state program? If yes, provide state of exclusion and program in comment field.	Not Completed	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	Not Completed	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	Not Completed	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field	Not Completed	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	Not Completed	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	Not Completed	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	Not Completed	
Are you trying to reactivate a provider previously active with Med-QUEST whose status became inactive or lapsed for any reason? If yes, please add the previous Med-QUEST ID in the comments field again.	Not Completed	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	Not Completed	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	Not Completed	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	Not Completed	
Are you a Home Health Agency, DME provider, home and community based provider (HCBS) or nonemergency medical transportation provider? Have you had the required fingerprinting completed? If yes, with what state and date, also upload fingerprinting documentation.	Not Completed	

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Page ID: pgProviderCheckList(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:53:56 MST

Last Step: Submit Application

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MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete	
Step 10: Fee Payment	Optional	02/26/2020	02/26/2020	Complete	
Step 11: Employee Details	Optional			Incomplete	
Step 12: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 13: Complete Enrollment Checklist	Required	02/26/2020	02/26/2020	Complete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

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Submit Application

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> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

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Final Submission

Application ID: 20200226110177 EnrollmentType: Atypical Agency Provider

The information submitted for enrollment shall be verified and reviewed by the State.
 During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).

Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
△ ▾	△ ▾	△ ▾	△ ▾
No Records Found!			

Page ID: pgSubmitEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 12:57:28 MST

Review Provider Participation Agreement

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Application ID: 20200226110177 **Name:** Hawaii Atypical

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION (PART B)

I/We, Hawaii Atypical, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

I/We agree to abide by the applicable provisions of the Hawaii State Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations (C.F.R.) related to the Medical Assistance Program. Upon certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual. If I/We are a provider for the 1915© waiver for participants with Developmental Disabilities (DD) or Intellectual Disabilities (ID), I/We agree to abide by the policies and procedures contained in the Medicaid Waiver Provider Standards Manual.

I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L. 94-135), and all the requirements issued pursuant to the respective title, section and/or act, as promulgated by the regulations of the Department of Health and Human Services and hereby give assurance that I/We will immediately take any measures necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excluded from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program and/or activity of the service provider that is funded in its entirety or in part directly or indirectly by Federal Financial Assistance.

I/We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by me/we to eligible Medicaid beneficiaries and to furnish the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division, such information from those records regarding any payments that have been claimed by me/we under the program as the Hawaii State Department of Human Services may, from time to time, require as authorized by 42 C.F.R. §431.107(b)(2).

I/We agree to disclose full and complete information regarding ownership information as described in 42 C.F.R. §455 Subpart B. This includes but is not limited to disclosure of information on ownership and control (42 C.F.R. §455.104), information related to business transactions (42 C.F.R. §455.105), and information on persons convicted of crimes (42 C.F.R. §455.106) upon execution of this provider agreement during re-validation of the enrollment process, within thirty-five (35) days of any change in ownership of the disclosing entity and at the request of the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division in the Department of Attorney General.

I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an agreement with me/we if any person, who has an ownership or control interest in the provider, or who is an agency or managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare and Medicaid Program (Title XIX) as stipulated in 42 C.F.R. §455.106.

I/We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative Rules, plus any deductible, coinsurance, or copayment required by the Hawaii State Medicaid Program to be paid by the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Federal law to accept or require additional payments over and beyond those established by the Hawaii State Department of Human Services for services rendered under the Hawaii State Medicaid Program. I/We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.

I/We understand that when changes in Hawaii State Department of Human Services and Hawaii State Medicaid Program policies and procedures become necessary due to changes in State or Federal laws or regulations, that such change will take effect within thirty (30) days of receipt of written notice from the Hawaii State Department of Human Services or the Hawaii State Medicaid Program to me/we.

I/We understand that (1) Any information provided by the Hawaii State Department of Human Services and the Hawaii State Medicaid Program to a provider and by a provider to the Department or Medicaid Program, shall be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient except in accordance with Subtitle 12, Chapter 17- 1702 of the Hawaii Administrative Rules; (2) Any information about Medicaid Providers and recipients shall be confidential and shall not be disclosed except in accordance with Subtitle 12, Chapter 1702-5 of the Hawaii Administrative Rules. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the individual; (3) The records of any person, including all communications or specific medical or epidemiological information contained therein, that indicates that a person has or has been tested for HIV/AIDS shall be strictly confidential and shall only be released in accordance with Chapter 325-101, Hawaii Revised Statutes; (4) Information regarding an individual's records and reports with respect to mental health and substance abuse services are confidential and may only be disclosed in accordance with Chapter 334-5, Hawaii Revised Statutes; (5) Any information pertaining to the provision of services related to pregnancy, family planning or venereal disease shall be treated as confidential and may be released in accordance with Chapter 577A-3, Hawaii Revised Statutes.

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Review Provider Participation Agreement

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MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOSPITALS, CORPORATIONS OR OTHER ENTITIES:

(1) I/We and each of us agree that all services for which our organization makes a claim against the Hawaii State Medicaid Program (Title XIX) shall be only for services rendered by persons who are properly licensed and/or qualified for the service they provide for which the claims are submitted; (2) If any real property or structure thereon is provided or improved either directly or indirectly by Federal

Financial Assistance from the Department of Health and Human Services, this Assurance shall obligate the service provider, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal Financial Assistance is extended or for another purpose involving the provision of similar services and/or benefits. If any personal property is so provided, this Assurance shall obligate the service provider for the period during which it retains ownership or possession of the property. In all other cases this Assurance shall obligate the service provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services; (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services. The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

I/We agree that retroactive provider certification shall be limited to no more than twelve (12) months back to the date on which the application was received in the Hawaii State Department of Human Services/Med-QUEST Division/Health Care Services Branch office subject to the discretion of the Med-QUEST Division Administration. The month in which the application was received shall be counted as the first month.

ELECTRONIC SIGNATURE: This Acknowledgement is to let you know that by submitting an electronic signature, you are providing an electronic mark, that is held to the same standard as a legally binding equivalent of a handwritten signature provided by you on behalf of your organization. For purposes of the acknowledgement, a digital mark is considered a typed legal First and Last name (legal name may include middle name, initial or suffix) followed by the typed date. Any document requiring an electronic signature may contain a signature acknowledgment statement provided in the same area requiring the electronic signature.

AGREEMENT & ACKNOWLEDGEMENT: I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding. Likewise, I, on behalf of the organization that I am authorized to represent, consent to do business electronically. This electronic signature will function as acknowledgement that I am authorized to represent and bind the organization for which this documentation is submitted. An electronic record will be kept of the documentation with which the electronic signature is associated. This electronic record will be retained and capable of being reproduced for future use. It is also acknowledged that this electronic signature meets the standard identified for uniqueness, verification, sole control, and record linkage.

The undersigned attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the enrolling entity has the authority to sign and submit this electronic agreement and to maintain enrollment information through Med-QUEST Provider Enrollment.

I/We have read all of the Provider Agreement and Condition of Participation in the Hawaii State Medicaid Program and fully understand and agree to its terms.

First Name: **Last Name:** **Date:**

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Submission Complete

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MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment

Application ID: 20200226110177 Name: Hawaii Atypical

Your Application Number 20200226110177 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
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Step 14: Submit Enrollment Application for Approval	Required	02/26/2020	02/26/2020	Complete	

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Thank You!

*Persistence, Perseverance and Passion
as always remains our credo.*

Contact Med-QUEST

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<https://medquest.hawaii.gov/en/plans-providers/Provider-Management-System-Upgrade.html>