



## Group Enrollment

### HOKU New Application Path

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

# Selecting Group Enrollment Type

- If the provider being enrolled is a group biller or group billing organization, please select the Group Enrollment Type.
- These providers include:
  - Group Billers
  - Group Billing Organizations

# Select the Group Enrollment Button

The screenshot shows the evoBrix web application interface. At the top, there is a navigation bar with tabs for 'My Inbox', 'Admin', and 'Provider'. Below this is a dark blue header with utility icons for 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. The main content area is titled 'MyInbox > New Enrollment' and contains a section titled 'Enrollment Type'. Inside this section, the instruction 'Select the Applicable Enrollment Type' is displayed. A list of radio button options is provided, with 'Group Practice (Corporation, Partnership, LLC, etc.)' selected and highlighted by a red arrow. Other options include 'Individual/Sole Proprietor', 'Regular Individual/Sole Proprietor or Rendering/Service Provider', 'Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)', 'Contractor/MCO', 'Managed Care Organization', and 'Atypical (non-medical) provider'. A 'Submit' button is located at the bottom left of the form area. The footer contains technical information: 'Page ID: pgNewEnrollBasicStep(Provider)', 'Environment: HI\_SYSTST R10c-1.1', and 'Server Time: 02/26/2020 02:57:28 MST'.

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾ >

MyInbox > New Enrollment

**Enrollment Type**

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
  - Regular Individual/Sole Proprietor or Rendering/Service 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 CCFHH)
  - Agency (Adult Day Health, DD/ID, Home Help/Personal Care Agency, Transportation Company etc.)

Submit

Page ID: pgNewEnrollBasicStep(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 02:57:28 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:  \*

NPI:  \*

Do you already have a Med-QUEST ID?:  Yes  No

**W9 Information**

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

Profit Status:  \*

Page ID: dlgAddBasicInformationStep1(Provider)

# Application ID

Print Help

Application ID: 20200226291324      Name: Hawaii Group

**Basic Information**

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

Your Application ID is: **20200226291324**

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

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

Home > MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324      Name: Hawaii Group

Close

**Enroll Provider - Group**

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	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 Additional Information	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Upload Documents	Optional			Incomplete	
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider)      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/26/2020 03:01:33 MST

# Step 2: Add Locations

The screenshot shows the evoBrox web 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 the breadcrumb path: MyInbox > New Enrollment > Group Biller. Below the breadcrumb, there are two fields: Application ID: 20200226291324 and Name: Hawaii Group. A message box contains a Close button, an Add button (highlighted with a red box), and the text: "Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink". Below the message is a section titled "Locations List" with a filter bar containing "Filter By" dropdowns, a "Go" button, and "Save Filters" and "My Filters" buttons. A table with the following headers is shown: "Doing Business As", "Location Type", "Location Details", and "End Date". The table body contains the text "No Records Found!". At the bottom of the page, there is a footer with the following information: Page ID: pgLocationListForEnrlnmt(Provider), Environment: HI\_SYSTST R10c-1.1, and Server Time: 02/26/2020 03:02:09 MST.

# Add Primary Practice Address

Print Help

Application ID: 20200226291324 Name: Hawaii Group

**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 \*

County: OTHER

Country: UNITED STATES \*

Zip Code:  \* -

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)

OK Cancel

Page ID: dlqEnrlAddL.location(Provider)



# Add Pay To Address

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

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"/>	Primary Practice Location	515 E 100 S, Salt Lake City, UTAH 84102	12/31/2999

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

Page ID: pgLocationListForEnrlnmt(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:04:09 MST

# Add Pay To Address

evoBrx My Inbox Admin Provider

MyInbox > New Enrollment > Group Biller > General

Application ID: 20200226291324      Name: Hawaii Group

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:	04:00	AM/PM *	07:00	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:    
 Bisayan/Visayan   
 Chinese (which includes Mandarin or Cantonese)

End Date:

**Address List**

Address Type	Address	End Date
<input type="checkbox"/> Location	515 E 100 S, Salt Lake City, UTAH 84102	12/31/2999

     Viewing Page: 1     

Page ID: pgEnrollment.LocationGeneral(Provider)      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/26/2020 03:05:28 MST

# Add Pay To Address

Print Help

Application ID: 20200226291324 Name: Hawaii Group

**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:  \* -

Page ID: dlgEnrlLocationAddress(Provider)

# Step 3: Add Correspondence Address

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required			Incomplete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add Additional Information	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Upload Documents	Optional			Incomplete	
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:07:28 MST

# Add Correspondence Address

The screenshot shows the evoBrix web application interface. At the top, there is a navigation bar with the evoBrix logo and menu items: My Inbox, Admin, and Provider. A secondary navigation bar contains utility icons: Note Pad, External Links, My Favorites, Print, and Help. Below this is a breadcrumb trail: MyInbox > New Enrollment > Group Biller > General.

The main content area displays application information: Application ID: 20200226291324 and Name: Hawaii Group. Below this information are two buttons: Close and Add. The 'Add' button is highlighted with a red box.

Below the buttons is a section titled 'Correspondence Address List'. It contains a table with the following structure:

Address Type	Address	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼

Below the table, the text 'No Records Found!' is displayed in red.

At the bottom of the page, a footer bar contains the following information: Page ID: pgCorrespondenceListForEnrImnt(Provider), Environment: HI\_SYSTST R10c-1.1, and Server Time: 02/26/2020 03:08:39 MST.

# Add Correspondence Address

Print Help

Application ID: 20200226291324
Name: Hawaii Group

☰ Add Correspondence Address
▲

Phone Number: <input style="width: 80%;" type="text"/>	* Extn: <input style="width: 50%;" type="text"/>	Fax Number: <input style="width: 80%;" type="text"/>	
Communication Preference: <input style="width: 80%;" type="text" value="v"/>	*	Email Address: <input style="width: 80%;" type="text"/>	

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 3:

State/Province:  \*

Country:  \*

Address Line 2:

City/Town:  \*

County:  \*

Zip Code:  \* -

Page ID: dlgEnrlCorrespondenceAddress(Provider)

# Step 4: Add Provider Type/Specialties/Subspecialties

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾ >

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add Additional Information	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Upload Documents	Optional			Incomplete	
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:  Go Page Count SaveToXLS

Viewing Page: 1

« First < Prev > Next » Last

Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:10:51 MST

# Add Provider Type/Specialties/Subspecialties

The screenshot shows the evoBrix web 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 links for Note Pad, External Links, My Favorites, Print, and Help. The main content area shows the breadcrumb path: MyInbox > New Enrollment > Group Biller. The application details section displays 'Application ID: 20200226291324' and 'Name: Hawaii Group'. There are 'Close' and 'Add' buttons, with the 'Add' button highlighted in red. Below this is the 'Provider Type/Specialty/Subspecialty List' section, which includes a filter bar with 'Filter By' dropdowns and a 'Go' button. To the right of the filter bar are 'Save Filters' and 'My Filters' buttons. The table below has three 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. The footer of the page contains the page ID 'pgLctnSpcltyListForEnrlmnt(Provider)', the environment 'HI\_SYSTST R10c-1.1', and the server time '02/26/2020 03:12:09 MST'.

Application ID: 20200226291324      Name: Hawaii Group

Close    Add

### Provider Type/Specialty/Subspecialty List

Filter By    Go    Save Filters    My Filters

Specialty/Subspecialty	Provider Type	End Date
No Records Found !		

Page ID: pgLctnSpcltyListForEnrlmnt(Provider)      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/26/2020 03:12:09 MST



# Provider Type/Specialties/Subspecialties

Print Help

Application ID: 20200226291324 Name: Hawaii Group

**Add Provider Type/Specialty**

Provider Type:  \*

Specialty:  \*

Select 'No Specialty' if applicable.

End Date:

**Add Subspecialty**

Available Subspecialties

Associated Subspecialties \*

Select 'No Subspecialty' if applicable.

Page ID: dlgEnrAddSpecialties(Provider)

# Add Provider Type/Specialties/Subspecialties

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close Add

### Provider Type/Specialty/Subspecialty List

Filter By [ ] [ ] Go Save Filters My Filters

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> Δ ▾	<input type="checkbox"/> Δ ▾	<input type="checkbox"/> Δ ▾
<input type="checkbox"/> NO SPECIALTY REQUIRED/No Subspecialty	GROUP-PAYMENT ID	12/31/2999

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

Page ID: pgLcInSpcltyListForEnrlmnt(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:13:40 MST

# Step 5: Associate Billing Provider

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾ >

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional			Incomplete	
<a href="#">Step 6: Add Additional Information</a>	Optional			Incomplete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required			Incomplete	
<a href="#">Step 9: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:14:48 MST

# Associate Billing Provider

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324      Name: Hawaii Group

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 03:15:41 MST

# Associate Billing Provider

Print Help

Application ID: 20200226291324 Name: Hawaii Group

**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:

Confirm Provider Ok Cancel

Page ID: dlgBillingProviderID(Provider)

# Step 6: Add Additional Information

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾ >

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 6: Add Additional Information</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required			Incomplete	
<a href="#">Step 9: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:18:49 MST

# Add Additional Information

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 main content area has a breadcrumb trail: MyInbox > New Enrollment > Group Biller. The application ID is 20200226291324 and the group name is Hawaii Group. There is a Close button. The main section is titled 'Authorized Representative List' and contains an Add button (highlighted with a red box), a filter section with 'Filter By' dropdown and 'Go' button, and 'Save Filters' and 'My Filters' buttons. Below the filter section is a table with columns for Representative Name, Start Date, and End Date. The table is currently empty, displaying the message 'No Records Found!' in red text.

Application ID: 20200226291324      Name: Hawaii Group

Close

Authorized Representative List

Add

Filter By [dropdown] [input] [input] Go      Save Filters      My Filters

Representative Name	Start Date	End Date
No Records Found !		

Page ID: pgAdditionalInfoListForEnrlmnt(Provider)      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/26/2020 03:20:06 MST

# Step 7: Controlling Interest/Ownership Details

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

My InBox > New Enrollment > Group Biller

Application ID: 20200226291324      Name: Hawaii Group

Close

**Enroll Provider - Group**

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 6: Add Additional Information</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required			Incomplete	
<a href="#">Step 9: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider)      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/26/2020 03:20:58 MST



# Ownership and Disclosure Information

evoBrix™
My Inbox ▾ Admin ▾ Provider ▾

Note Pad External Links ▾ My Favorites ▾ Print Help

MyInbox > New Enrollment > Group Biller > General

Application ID: 20200226291324 Name: Hawaii Group

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 manage 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

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

Page ID: pgOwnerListForEnrlmnt(Provider) Environment: HL\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:22:54 MST

# Add Owner

evoBrix My Inbox Admin Provider

Note Pad External Links My Favorites Print Help

MyInbox > New Enrollment > Group Biller > General

Application ID: 20200226291324 Name: Hawaii Group

Close Actions

Pe Add Owner Import Owner

PROVIDER OWNERSHIP CONTROL DISCLOSURES

Provider Enrollment Information  
 Provider Enrollment Information: 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 manage 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"/>								

https://hi-trg-evo.cns-inc.com/evoBrix/CNS/ControlServlet Environment: HL\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:22:54 MST

# Add Ownership

Print Help

Application ID: 20200226291324 Name: Hawaii Group

**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: dlgEnrImntAddOwner(Provider)

# Add Ownership

Application ID: 20200226291324      Name: Hawaii Group

**Provider Controlling Interest/Ownership**

Type:  \* ⓘ      Percentage Owned:  \*

SSN:  \*      EIN/TIN:

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

Owner NPI:

First Name:  \*      Last Name:  \*

Suffix:

Phone Number:  \* Extn:       DOB:  \* 📅

Start Date:  \* 📅      Email:

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:  \*      Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:  \*      State/Province:  \*      County:  \*

Country:  \*      Zip Code:  \* -  \*

Page ID: dIlgEnrImntAddOwner(Provider)

# Add Owners Relationship

Application ID: 20200226291324      Name: Hawaii Group

Close    **Actions**    ?

- Add Owner
- Import Owner
- Owners Relationships**
- Owners Adverse Action

**PROVIDER OWNERSHIP CONTROL DISCLOSURES**

Provider Enrollment Information: 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 manage 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"/>	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

https://hi-trg-evo-cns-inc.com/evoBrix/CNSIControlServlet      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/26/2020 03:28:29 MST

# Add Owners Relationship

Print Help

Application ID: 20200226291324 Name: Hawaii Group

### 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: Agent, Group SSN/EIN/TIN: 555699885 Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Agent, Group	Relation to Assoc. Owner
Owner, Group	526598566	Managing Employee		

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

Selected Owner: Owner, Group SSN/EIN/TIN: 526598566 Status: Not Completed

Save Close

Page ID: dljAddModifyOwnerRelationship(Provider)

# Add Owners Relationship

Print Help

Application ID: 20200226291324 Name: Hawaii Group

### 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: Agent, Group SSN/EIN/TIN: 555699885 Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Agent, Group	Relation to Assoc. Owner
Owner, Group	526598566	Managing Employee	Father	Son

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

Selected Owner: Owner, Group SSN/EIN/TIN: 526598566 Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

# Complete Adverse Actions

evoBrix My Inbox Admin Provider

MyInbox > New Enrollment > Group Biller > General

Application ID: 20200226291324 Name: Hawaii Group

Close **Actions** ?

- Add Owner
- Import Owner
- Owners Relationships
- Owners Adverse Action**

**PROVIDER CONTROL DISCLOSURES**

Provider Enrollment Information: The following 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 manage 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 [ ] 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"/>								

https://hi-trg-evo-cns-inc.com/evoBrix/CNSIControlServlet Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:31:36 MST



# Disclose Adverse Actions

Print Help

Application ID: 20200226291324 Name: Hawaii Group

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 [dropdown] All [dropdown] Go [button] Save Filters [button] My Filters [dropdown]

Owner Name	SSN/EIN/TIN	Response	Comments
Owner,Group	526598566	<input type="radio"/> Yes <input checked="" type="radio"/> No	[text input]
Agent,Group	555699885	<input type="radio"/> Yes <input checked="" type="radio"/> No	[text input]

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

Ok Cancel

Page ID: pgEnrlmntAdverseAction(Provider)

# Step 8: Taxonomy Details

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 6: Add Additional Information</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required			Incomplete	
<a href="#">Step 9: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:33:20 MST

# Taxonomy Details

Application ID: 20200226291324      Name: Hawaii Group

### Taxonomy List

Filter By

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 03:34:31 MST

# Add Taxonomy

Print Help

Application ID: 20200226291324 Name: Hawaii Group

**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 9: Upload Documents

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 6: Add Additional Information</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 9: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:36:32 MST

# Upload Documents

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

My Inbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

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: pgEnrlmnlDocumentList(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:37:39 MST

# Upload Documents

Print Help

Application ID: 20200226291324 Name: Hawaii Group

**Upload Document**

Document Type:  \* Document Name:  \*

File Name:

Start Date:

End Date:

Remark:

Page ID: dlgEnrlmntAttachment(Provider)



# Upload Documents

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

Note Pad External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Document List

Add

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

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Document Status
<input type="checkbox"/> 75049212	Letter	CMS Approval Letter	<a href="#">HI T3 Agenda.docx</a>			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049213	License	GE Tax License	<a href="#">HI T3 Agenda.docx</a>			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049214	Tax	W9 Indicator	<a href="#">HI T3 Agenda.docx</a>			Zak Farrington	02/26/2020	In Process

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

Page ID: pgEnrlmntDocumentList(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:39:34 MST

# Step 10: Enrollment Checklist

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 6: Add Additional Information</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 9: Upload Documents</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:40:27 MST

# Enrollment Checklist

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

My Inbox > New Enrollment > Group Biller > Provider Check List

Application ID: 20200226291324 Name: Hawaii Group

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 ▾	<input type="text"/>
Do you wish to end date your enrollment? If yes, enter date in comment field.	Not Completed ▾	<input type="text"/>
Are you currently excluded from any Hawaii or other state program? If yes, provide state of exclusion and program in comment field.	Not Completed ▾	<input type="text"/>
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	Not Completed ▾	<input type="text"/>
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	Not Completed ▾	<input type="text"/>
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field	Not Completed ▾	<input type="text"/>
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 ▾	<input type="text"/>
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	Not Completed ▾	<input type="text"/>
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 ▾	<input type="text"/>
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 ▾	<input type="text"/>
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 ▾	<input type="text"/>
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	Not Completed ▾	<input type="text"/>
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 ▾	<input type="text"/>

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Page ID: pgProviderCheckList(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:41:12 MST

# Step 11: Submit Application

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 6: Add Additional Information</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 9: Upload Documents</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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Page ID: pgBPWGroupPracticeStart(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/26/2020 03:42:14 MST

# Submit Application

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Note Pad External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close Next

Final Submission

Application ID: 20200226291324 EnrollmentType: Group Practice (Corporation, Partnership, LLC, etc.)

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 03:43:52 MST

# Review Group Biller Participation Agreement

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👤 ▾ | 📄 Note Pad | 🔗 External Links ▾ | ⭐ My Favorites ▾ | 🖨 Print | 🆘 Help

🏠 > MyInbox > New Enrollment > Group Biller

**Application ID:** 20200226291324      **Name:** Hawaii Group

🗑 Close | 📄 Submit Application | 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 Group, 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.

Page ID: pgEnrTermsAndConditions(Provider)      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/26/2020 03:44:24 MST

# Complete Group Biller Participation Agreement

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>

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Provider ▾

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Help

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
Name: Hawaii Group

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

**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:

Page ID: pgEnrTermsAndConditions(Provider)
Environment: HI\_SYSTST R10c-1.1
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# Submission Complete

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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

**Your Application Number 20200226291324 has been successfully submitted for State review. Return with this application number to track the status of your application.** ✕

Close

**Enroll Provider - Group**

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

Step	Required	Start Date	End Date	Status	Step Remark
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<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 6: Add Additional Information</a>	Optional	02/26/2020	02/26/2020	Complete	
<a href="#">Step 7: Add Provider Controlling Interest/Ownership Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 8: Add Taxonomy Details</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 9: Upload Documents</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 10: Complete Enrollment Checklist</a>	Required	02/26/2020	02/26/2020	Complete	
<a href="#">Step 11: Submit Enrollment Application for Approval</a>	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>