



Atypical Agency Enrollment HOKU New Application Path

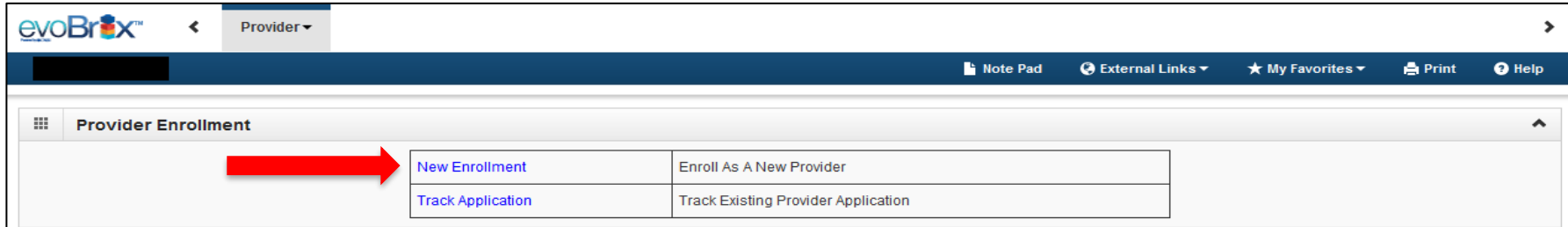
October 21, 2020

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
 - ☐ 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

Provider Enrollment Application Selection

3



- If you are a **new** Hawaii Medicaid provider, you will select '**New Enrollment.**'
- If you are an **existing** Hawaii Medicaid provider and have a Med-QUEST Provider ID number, you should have received a letter with your application ID number, you will select '**Track Application**' and input your application ID number on the next page and proceed to Slide 5 of this instructional slide deck.

Select the Atypical Agency Enrollment Button

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾ >

My Inbox ▾ Enrollment Task List ▾ 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 CCFFH)
- ☒ Agency (Adult Day Health, DD/ID, Home Help/Personal Care Agency, Transportation Company etc.) ←

Submit

To find out which enrollment type your provider type is categorized as, please visit the HOKU webpage at: medquest.hawaii.gov/HOKU. Click on the 'Resources' tab.

Select the link: **'HOKU Waves and Provider Enrollment Type'**

The term Atypical is used for individuals or agencies that are not required and do not have an NPI.

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:	<input type="text"/>	* (As shown on the Income Tax Return)
Entity Business Name:	<input type="text"/>	* (Doing Business As)
	EIN/TIN:	<input type="text"/> *

W9 Information		
W-9 Entity Type:	<input type="text"/>	▼ *
Profit Status:	<input type="text"/>	▼ *
	W-9 Entity Type (If Other):	<input type="text"/>

[✓ Finish](#) [⊗ Cancel](#)



Page ID: dlgAddBasicInformationStep1(Provider)

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 ▾ >

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

*Note – Step 11: Employee Details was removed from HOKU

Step 2: Add Locations

 < 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 ⬆
No Records Found !			

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

Add Primary Practice Address

PrintHelp

Application ID: 20200226110177Name: 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:

State/Province:OTHER*

Country:UNITED STATES*

Web Page:

City/Town:OTHER*

County:OTHER

Zip Code: *-Validate Address

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:	*	AM PM	*	AM PM	Thursday:	*	AM PM	*	AM PM
Monday:	*	AM PM	*	AM PM	Friday:	*	AM PM	*	AM PM
Tuesday:	*	AM PM	*	AM PM	Saturday:	*	AM PM	*	AM PM
Wednesday:	*	AM PM	*	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: digEnrAddLocation(Provider)OKCancel

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Add Pay To Address

 < 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"/>	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: pgLocationListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 09:40:43 MST

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Add Pay To Address

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

✓ OK

⊗ Cancel

Page ID: dlgEnrlLocationAddress(Provider)

Step 3: Add Correspondence Address

evoBrx

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInboxEnrollment Task ListNew EnrollmentAtypical Agency Enrollment

Application ID: 20200226110177Name: 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	

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Page ID: pgBPWAtypicalAgencyStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 09:45:06 MST

*Note – Step 11: Employee Details was removed from HOKU

Add Correspondence Address

 < 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 ⊞ Add

☰ Correspondence Address List ^

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

Page ID: pgCorrespondenceListForEnrImnt(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: *

State/Province: *
County:

Country: *
Zip Code: * -

Page ID: dlqEmtCorrespondenceAddress(Provider)

Step 4: Add Provider Type/Specialties/Subspecialties

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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			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

*Note – Step 11: Employee Details was removed from HOKU

Add Provider Type/Specialties/Subspecialties


 < 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**



 **Provider Type/Specialty/Subspecialty List** ^

Filter By ▾ ⌂ Go Save Filters ▾ My Filters ▾

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



Page ID: pgLctnSpcltyListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 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 *

»

«

Select 'No Subspecialty' if applicable.

 OK  Cancel

Page ID: dlgEnrAddSpecialties(Provider)

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Add Provider Type/Specialties/Subspecialties

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

Provider Type/Specialty/Subspecialty List

Filter By ▾

Go
Save Filters
My Filters ▾

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

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

Step 5: Associate Billing Provider

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	

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Associated Biller is an optional step. To complete the step, click on the Step 5 hyperlink and then click Close.

*Note – Step 11: Employee Details was removed from HOKU

Associate Billing Provider

The screenshot shows the evoBlox application interface. At the top, there is a navigation bar with the evoBlox logo and tabs for '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 displays the 'Application ID: 20200226110177' and 'Name: Hawaii Atypical'. Below this, there are 'Close' and 'Add' buttons, with the 'Add' button highlighted by a red box. The 'Billing Provider/Other Associations List' section features a filter bar with a 'Filter By' dropdown, input fields, and a 'Go' button. To the right of the filter bar are 'Save Filters' and 'My Filters' buttons. Below the filter bar is a table with columns: 'NPI/Med-QUEST ID', 'Provider Name', 'Start Date', 'End Date', and 'Status'. Each column has a small triangle icon for sorting. The table is currently empty, and a red message 'No Records Found!' is displayed at the bottom of the table area.

Application ID: 20200226110177 Name: Hawaii Atypical

Billing Provider/Other Associations List



Filter By

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

Click Close if you are using your Type 2-Organization NPI to bill.


Associate Billing Provider

 Print  Help


Application ID: 20200226110177Name: 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: 

 Confirm Provider  Ok  Cancel

Page ID: dlgBillingProviderID(Provider)

*Note – Step 11: Employee Details was removed from HOKU

Add License/Certification

Application ID: 20200226110177 Name: Hawaii Atypical

Close **Add**

License/Certification/Other List



Filter By

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


To view the licenses and certificates that are required and need to be included with this application, go to the HOKU website at: medquest.hawaii.gov/HOKU and click on the 'Resources' tab.

Select the link: **'Required and Optional Licenses, Certificates and Documents by Provider Type'**


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: 

Note: The License Classification Type may be displayed if a specific DCCA License/Certification Type is selected.




Add License/Certification/Other


License/Certification/Other Type: HI Board of Medical Examiners *


License/Certification/Other #: *


Valid Flag:


License Classification Type :
-SELECT-
DOS-OSTEOPATHIC PHYSICIAN AND SURGEON
DOSR-OSTEOPATHIC RESIDENT
MD-PHYSICIAN
MDR-PHYSICIAN-RESIDENT

Effective Date: 

End Date: 

 Confirm License/Certification/Other

 OK

 Cancel

Page ID: dlqEnrlmntAddLicense(Provider)

Add License/Certification

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

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Add Additional Information

evoBrx™ < My Inbox ▾ Admin ▾ Provider ▾

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

Application ID: 20200226110177 Name: Hawaii Atypical

Close

Authorized Representative List

Add

Filter By ▾ Go

Save Filters My Filters ▾

Representative Name	Start Date	End Date
No Records Found !		

Bed Information

Add



Filter By ▾ Go

Save Filters My Filters ▾

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



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

Add Authorized R

 Print  Help


Application ID:

Name:


 Add Authorized Representative 



First Name: *

Middle Name:

Start Date:  *

Last Name: *

End Date: 

 OK  Cancel

Page ID: dlGEnrlmntAddAuthorizedRep(Provider)

Add Bed Information

Print Help

Med-QUEST ID: 000242

Name: Hawaii Cares

NPI: 1558744870



Add Bed Information



Bed Type: *

Bed(s)/Unit(s): *

Start Date: *

End Date:

OK

Cancel

Step 8: Add Controlling Interest/Ownership Details

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My Inbox

Admin

Provider

Note Pad

External Links

My Favorites

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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			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	

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Page ID: pgBPWAtypicalAgencyStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 11:47:52 MST

*Note – Step 11: Employee Details was removed from HOKU

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Add Owner

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 E Owners Adverse Action

ing 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:
 - (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
▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴

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: * ⓘ

SSN:

Legal Entity Name:

(As shown on the Income Tax Return)

Owner NPI:

First Name:

Suffix:

Phone Number: * Extn:

Start Date: *

Percentage Owned: *

EIN/TIN:

Entity Business Name:

(Doing Business As)

Last Name:

DOB:

Email:

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: dlqEntfmmntAddOwner(Provider)

Add Ownership

Print
Help

Application ID: 20200226110177
Name: Hawaii Atypical

Provider Controlling Interest/Ownership

Type:
Managing Employee
*

SSN:
569696325
*

Legal Entity Name:

(As shown on the Income Tax Return)

Owner NPI:

First Name:
Joe
*

Suffix:

Phone Number:
(555) 555-5555
*
Extn:

Start Date:

Percentage Owned:
50
*

EIN/TIN:

Entity Business Name:

(Doing Business As)

Last Name:
Atypical
*

DOB:
02/26/1980
*

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:
121 N Davis Blvd
*

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town:
Bountiful
*

State/Province:
UTAH
*

County:
Davis

Country:
UNITED STATES
*

Zip Code:
84010
*
-
1806
Validate Address

OK
Cancel

Page ID: dlqEntfmmntAddOwner(Provider)

Add Owners Relationship

evoBrix™ < My Inbox ▾ Admin ▾ Provider ▾

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

Application ID: 20200226110177 Name: Hawaii Atypical

Close Actions ⓘ

Pe Add Owner
Import Owner
Owners Relationships
Owners Adverse Action

PROVIDER DISCLOSURES

Provider Enrollment: 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

- 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:
 - (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	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: pgOwnerListForEnrlnmt(Provider) Environment: HL_SYSTST R10c-1.1 Server Time: 02/26/2020 12:27:57 MST

Add Owners Relationship

[Print](#) [Help](#)

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 Save To XLS 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
Owners Relationships
Owners Adverse Action

PROVIDER: Owners Relationships CONTROL DISCLOSURES

Provider Enrollment: 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

- 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:
 - (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

Help

Application ID: 20200226110177Name: 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	<div><input type="radio"/> Yes <input type="radio"/> No</div>	<input type="text"/>
Atypical, Joe	569696325	<div><input type="radio"/> Yes <input type="radio"/> No</div>	<input type="text"/>

View Page:

Page Count

Save To XLS

Viewing Page: 1

First Prev Next Last

Ok

Cancel

Page ID: pgEnfrmtAdverseAction(Provider)

Step 9: Taxonomy Details

evoBrx

My Inbox

Admin

Provider

Note Pad

External Links

My Favorites

Print

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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			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

*Note – Step 11: Employee Details was removed from HOKU

Add Taxonomy Details

 < 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



☰ Taxonomy List ^

Filter By ▾ ⌂ Go Save Filters ▾ My Filters ▾



Taxonomy Code	Description	Start Date	End Date
⊞ ▲▼	▲▼	▲▼	▲▼
No Records Found !			


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

Add Taxonomy


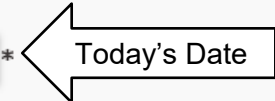
 Print  Help


Application ID: 20200226110177 Name: Hawaii Atypical




 **Add Taxonomy** 

Taxonomy Code: * 
(Click here for Taxonomy List)

Description:

Start Date:  *  Today's Date

End Date: 

 Confirm Taxonomy  Ok  Cancel

Page ID: dlgEnrlAddTaxonomy(Provider)

NUCC Taxonomy Code List

The screenshot displays the 'Health Care Provider Taxonomy Code Set' website. The left sidebar contains a navigation menu with the following items: Introduction, National Uniform Claim Committee Website, Help, Individual or Groups (of Individuals), Multi-Specialty, Single Specialty, Allopathic & Osteopathic Physicians, Allergy & Immunology, Anesthesiology, Addiction Medicine, Critical Care Medicine, Hospice and Palliative Medicine, Pain Medicine, Pediatric Anesthesiology, Clinical Pharmacology, Colon & Rectal Surgery, Dermatology, Electrodiagnostic Medicine, Emergency Medicine, Emergency Medical Services, Hospice and Palliative Medicine, Medical Toxicology, Pediatric Emergency Medicine, Sports Medicine, Undersea and Hyperbaric Medicine, Family Medicine, Adolescent Medicine, Adult Medicine, Geriatric Medicine, Hospice and Palliative Medicine, Obesity Medicine, Sleep Medicine, Sports Medicine, General Practice, and Hospitalist.

The main content area is titled 'Introduction' and contains the following text:

Name
Introduction

Definition
The Health Care Provider Taxonomy code set is an external, nonmedical data code set designed for use in an electronic environment, specifically within the ASC X12N Health Care transactions. This includes the transactions mandated under HIPAA.

The taxonomy code is a unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Grouping, Classification, and Area of Specialization.

- Level I, Provider Grouping**
A major grouping of service(s) or occupation(s) of health care providers. For example: Allopathic & Osteopathic Physicians, Dental Providers, Hospitals, etc.
- Level II, Classification**
A more specific service or occupation related to the Provider Grouping. For example, the Classification for Allopathic & Osteopathic Physicians is based upon the General Specialty Certificates as issued by the appropriate national boards. The following boards will however, have their general certificates appear as Level III areas of specialization strictly due to display limitations of the code set for Boards that have multiple general certificates: Medical Genetics, Preventive Medicine, Psychiatry & Neurology, Radiology, Surgery, Otolaryngology, Pathology.
- Level III, Area of Specialization**
A more specialized area of the Classification in which a provider chooses to practice or make services available. For example, the Area of Specialization for provider grouping Allopathic & Osteopathic Physicians is based upon the Subspecialty Certificates as issued by the appropriate national boards.

The code set Levels are organized to allow for drilling down to the provider's most specific level of specialization. The ten digit codes for each provider category are unique and contain no embedded logic. The codes and categories are to be used exactly as they are assigned in the taxonomy list. At no time should codes be separated to form new codes, parsed apart, or edited on any one position within the code.

The taxonomy codes are self-selected by the provider. The taxonomy codes are organized based on education and training and are used to define specialty, not specific services that are rendered. Selection of a taxonomy code does not replace any credentialing or validation process that the organization requesting the code should complete. Definitions for some of the codes reference specialty or certifying boards as a source, but this reference in no way implies that providers have met the requirements of that board if they choose the code to identify themselves.

The code set is published (released) twice a year in January and July. The January publication is effective for use on April 1st and the July publication is effective for use on October 1st. The time between the publication release and the effective date is considered an implementation period to allow providers, payers, and vendors an opportunity to incorporate any changes into their systems.

Historical Background
In the absence of an all-encompassing Provider Classification System, both ASC X12N and the National Provider System Workgroup from the Centers for Medicare & Medicaid Services (CMS) began work on identifying and coding an external provider code set that would be able to codify provider grouping and provider area of specialization for all health care related providers. CMS' intent was to provide a single coding structure to support work on the National Provider System, while X12N needed a single common code set for trading partner use. The two projects worked independently to some extent until April 1996 when the lists were coordinated and a single taxonomy code set was proposed. A sub-group of X12N TG2 WG15 (Provider Information Work Group) was charged with resolving differences in the two proposed taxonomy code sets. Their work resulted in a single taxonomy code set that both CMS and members of X12N found meaningful, easy to use, and functional for electronic transactions.

The sub-group initially started with the CMS draft taxonomy code set. This list incorporated all types of providers associated with health care in various ways, e.g. technologists or technicians who support or repair equipment/machinery, contractors, physicians, dentists, suppliers. A number of the providers offer health services, in concert with others, and do not or cannot bill independently for their services. The amount of research to validate and classify all

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

*Note – Step 11: Employee Details was removed from HOKU

Step 10: Fee Payment


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

Fee Payment

[Print](#) [Help](#)

Application ID: 20200225447257

Name: Ohana

Fee Payment

Payment Reason: New Enrollment

Options	Description
<input type="radio"/> Pay Fee	Select this option in order to pay the fee to Med-QUEST. Once the Med-QUEST ID is received via correspondence or if there is an existing Med-QUEST ID, please submit a cashier's check payable to: State Director of Finance, c/o Med-QUEST Division, Health Care Services Branch, Provider Enrollment, 601 Kamokila Boulevard, Room 506A Kapolei, HI 96707. Mail check to: Med-QUEST Division, Health Care Services Branch, Provider Enrollment, 601 Kamokila Blvd., Room 506A, Kapolei, HI 96707.
<input type="radio"/> Fee Paid to Medicare	Select this option if you have paid the enrollment fee to the Centers for Medicare Services. This is subject to federal and state approval.
<input type="radio"/> Fee Paid to Medicaid in Another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below. Upload your receipt or documentation of payment in the "Upload Documents" step. This is subject to federal and state approval.
<input type="radio"/> Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit. A "Hardship Letter" must be written and uploaded in the "Upload Documents" step. You can continue submitting the enrollment application/modification request. This is subject to federal and state approval.
<input type="radio"/> Med-QUEST Prior Payment	Select this option if you have paid the fee to Med-QUEST within the last 12 months.

Fee Paid To: Payment Date:

Payment Status:

Confirmation Number:

During the COVID-19 Public Health Emergency (PHE), Fee Payments will temporarily be waived. Select 'COVID-19 Waiver.' When the PHE is over, Med-QUEST will send out a correspondence informing providers to mail in their Fee Payment.

<input checked="" type="radio"/>	COVID-19 Waiver	Provider Fee Payment has been waived for the duration of the COVID-19 emergency. It may be required when the emergency passes.
----------------------------------	-----------------	--

 Ok Cancel

Step 11: 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

*Note – Step 11: Employee Details was removed from HOKU. Upload Documents Step will be Step 11.

Step 11: Upload Documents

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

To view the documents that are required and need to be uploaded with this application, go to the HOKU website at: medquest.hawaii.gov/HOKU and click on the 'Resources' tab.



Select the link: **'Required and Optional Licenses, Certificates and Documents by Provider Type'**


Fingerprint-Based Criminal Background Check (FCBC) Determination Letter will be 'Optional' and temporarily waived during the COVID-19 Public Health Emergency (PHE). Once the PHE is over, Med-QUEST will send out a correspondence to providers that need to submit their FCBC Determination Letter.


Upload Documents

 Print  Help


Application ID: 20200226110177 Name: Hawaii Atypical


 Upload Document 

Document Type: ---SELECT---  *


Document Name:  *


File Name:

Start Date: 

End Date: 

Remark:



 OK

Page ID: dlEnrlmntAttachment(Provider)

Upload Documents

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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

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 ▲▼
<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

Delete
View Page:
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 12:51:03 MST

*Note – Step 11: Employee Details was removed from HOKU. Enrollment Checklist will be Step 12.


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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

Close

Next

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

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Submission Complete

evoBrox

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Note PadExternal LinksMy FavoritesPrintHelp

MyInboxEnrollment Task ListNew EnrollmentAtypical Agency Enrollment

Application ID: 20200226110177Name: 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
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	02/26/2020	02/26/2020	Complete	

View Page: 1GoPage CountSaveToXLS

Viewing Page: 1

FirstPrevNextLast

Page ID: pgBPWAtypicalAgencyStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 01:01:34 MST

*Note – Step 11: Employee Details was removed from HOKU

Contact Med-QUEST

<https://medquest.hawaii.gov/HOKU>

Email: hcsbinquiries@dhs.hawaii.gov

Phone: 808-692-8099

Fax: 808-692-8087

Office Address:

601 Kamokila Boulevard, Room 506A
Kapolei, HI 96707



Thank You!

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