



Atypical Individual Enrollment HOKU New Application Path

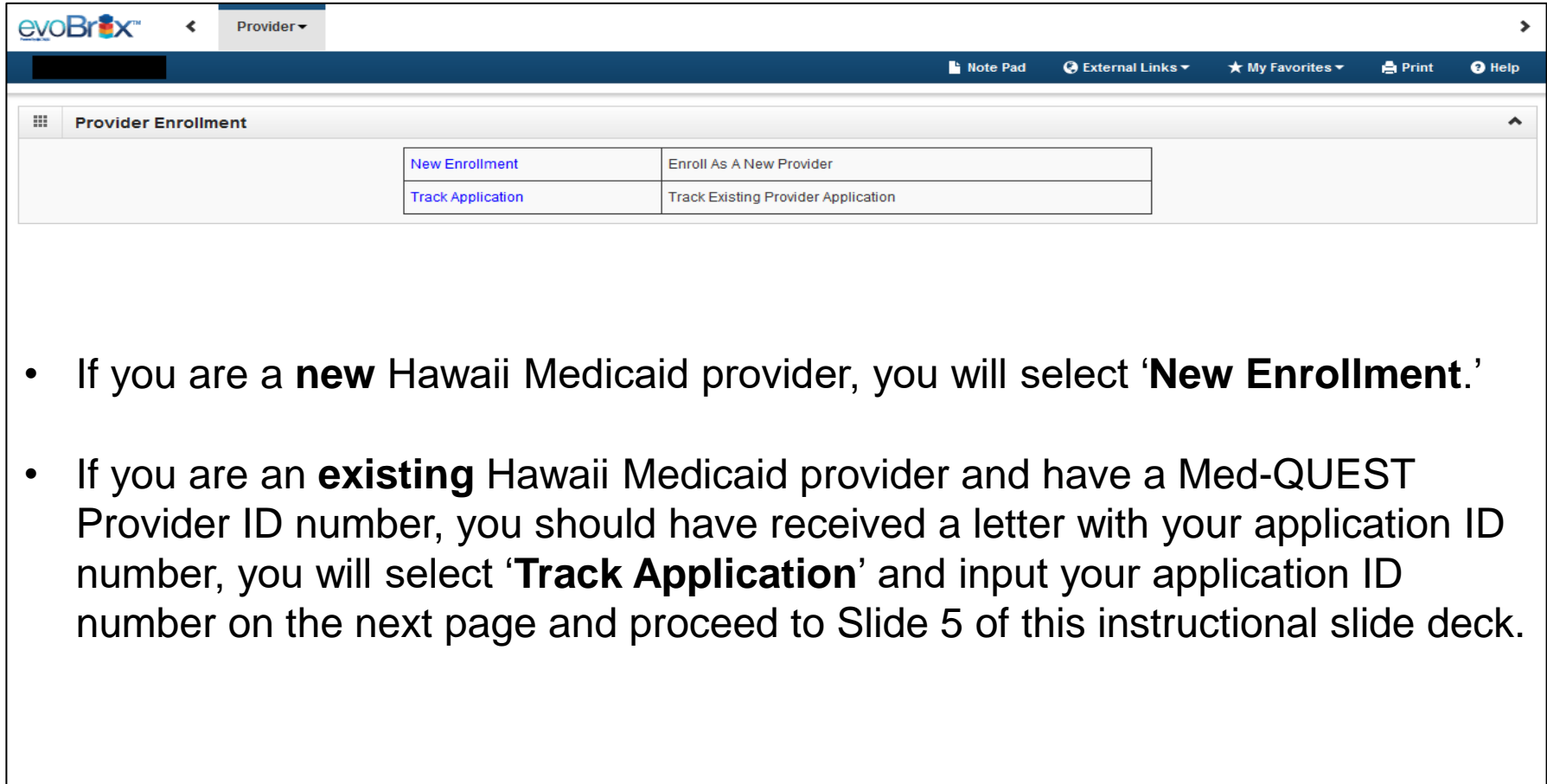
October 21, 2020

Selecting Atypical Individual Enrollment Type

- Select the Atypical Individual Enrollment Type if the provider being enrolled is an individual or sole proprietor operating his/her own health care service and **does not have an NPI**.
- These providers include:
 - ☐ Community Care Foster Family Homes (CCFFH)
 - ☐ Expanded-Adult Residential Care Home (E-ARCH)

Provider Enrollment Application Selection

3



The screenshot shows the evoBrox web application interface. At the top, there is a navigation bar with the evoBrox logo on the left and a 'Provider' dropdown menu. Below the navigation bar is a dark blue header with links for 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. The main content area is titled 'Provider Enrollment' and contains a table with two rows of application selection options.

New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

- 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 Individual Enrollment Button

evoBrox™ < 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 CCFFH)
 - ☐ 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 01:12:19 MST

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.

Step 1: Provide Basic Information

Print
Help

Basic Information: Enter required fields and click Finish button.

Basic Information

First Name:

*

Middle Initial:

Last Name:

*

Suffix:

Gender:

*

SSN:

*

Date of Birth:

*

Applicant Type:

Atypical Rendering/Serviceing

*

W9 Information

W-9 Entity Type:

*

W-9 Entity Type (If Other):

Profit Status:

*

Home Address

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

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:

*

Address Line 2:

Address Line 3:

City/Town:

OTHER

*

State/Province:

OTHER

*

County:

OTHER

Country:

UNITED STATES

*

Zip Code:

*

-

Validate Address

View Screening Result
Finish
Cancel

Application ID

Print Help

Application ID: 20200226119723

Name: Individual,Miranda

Basic Information

^

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

Your Application ID is: **20200226119723**

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

My Inbox

Admin

Provider

Note Pad

External Links

My Favorites

Print

Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723

Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next


Last

Page ID: pgBPWAtypicalIndStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 01:19:10 MST

Step 2: Add Locations

 < My Inbox ▾ Admin ▾ Provider ▾ >

⌵

Note Pad External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723 Name: Individual, Miranda

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: pgLocationListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 01:20:16 MST

Add Primary Practice Address

PrintHelp

Application ID: 20200226119723Name: Individual, Miranda

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: *-Validate Address

Web Page:

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	*	AM	*	AM	Thursday:	*	AM	*	AM
Monday:	*	PM	*	PM	Friday:	*	AM	*	AM
Tuesday:	*	PM	*	PM	Saturday:	*	PM	*	PM
Wednesday:	*	PM	*	PM					

Handicap Accessible:No

Language(s) Spoken:EnglishBisayan/VisayanChinese (which includes Mandarin or Cantonese)

(For Multiple Selection, use Ctrl Key)


OKCancel

Page ID: digEnrAddLocation(Provider)


innovation@work

©2019 CNSI

Add Pay To Address



[My Inbox](#) [Admin](#) [Provider](#)

 [Note Pad](#) [External Links](#) [My Favorites](#) [Print](#) [Help](#)

[MyInbox](#) > [New Enrollment](#) > [Atypical Individual Enrollment](#)

Application ID: 20200226119723 Name: Individual, Miranda

[Close](#) [Add](#) Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink

Locations List

Filter By [Go](#) [Save Filters](#) [My Filters](#)



Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼
<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: pgLocationListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 01:22:51 MST

innovation@work

Add Pay To Address

 Print  Help

Application ID: 20200226119723Name: Individual, Miranda

 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: dlgEnrILocationAddress(Provider)

innovation@work

©2019 CNSI

Step 3: Add Correspondence Address

evoBrox
My Inbox Admin Provider
Note Pad External Links My Favorites Print Help
MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda
Close

Enroll Provider - Atypical Individual


Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	


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

Page ID: pgBPWAtypicalIndStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 01:26:53 MST

Add Correspondence Address



My Inbox ▾Admin ▾Provider ▾



Note PadExternal Links ▾My Favorites ▾PrintHelp

MyInbox > New Enrollment > Atypical Individual Enrollment > General

Application ID: 20200226119723Name: Individual, Miranda

CloseAdd

Correspondence Address List

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

Page ID: pgCorrespondenceListForEnrImnt(Provider)Environment: HI_SYSTST R10c-1.1Server Time: 02/26/2020 01:28:17 MST

Add Correspondence Address

Print
 Help

Application ID: 20200226119723
 Name: Individual, Miranda

Add Correspondence Address

Phone Number: * Extn:
 Fax Number:

Communication Preference: *
 Email Address:

End Date:

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

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

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

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER

Country: UNITED STATES *

Zip Code: * - Validate Address

OK
 Cancel

Page ID: dlgEnrlCorrespondenceAddress(Provider)

innovation@work

Step 4: Add Provider Type/Specialties/Subspecialties

17

evoBrix™

<

My Inbox ▾

Admin ▾

Provider ▾

>

Note Pad

External Links ▾

My Favorites ▾

Print

Help

>

> MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723

Name: Individual, Miranda

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: pgLctnSpcltyListForEnrImnt(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 01:32:32 MST

innovation@work

Add Provider Type/Specialties/Subspecialties

evoBrx™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723Name: Individual, Miranda

CloseAdd

Provider Type/Specialty/Subspecialty List

Filter By

Go

Save FiltersMy Filters

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

DeleteView Page: 1GoPage CountSaveToXLSViewing Page: 1FirstPrevNextLast

Page ID: pgLctnSpcltyListForEnrlmnt(Provider)Environment: HI_SYSTST R10c-1.1Server Time: 02/26/2020 01:35:21 MST

Step 5: Associate Billing Provider

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:
Go
Page Count
SaveToXLS

Viewing Page: 1
First
Prev
Next
Last

Page ID: pgBPWAtypicalIndStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 01:36:11 MST

Associate Billing Provider

evoBrox™

< My Inbox ▾ Admin ▾ Provider ▾

>

👤 ▾

Note Pad External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723 Name: Individual, Miranda

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
<input type="checkbox"/> ▴ ▾	▴ ▾	▴ ▾	▴ ▾	▴ ▾
No Records Found !				

Page ID: pgBillingProviderListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 01:37:29 MST

Associate Billing Provider


 Print  Help

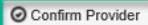


Application ID: 20200226119723 Name: Individual, Miranda

 Associate Billing Provider/Other Associations

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

Type: *
ID: *
Start Date: *
Provider Name:
End Date:



Page ID: dlgBillingProviderID(Provider)

Step 6: Add License/Certification

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

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

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

View Page:
Go
Page Count
SaveToXLS

Viewing Page: 1

First
Prev
Next
Last

Page ID: pgBPWAtypicalIndStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 01:39:45 MST

Add License/Certification

Application ID: 20200226119723 Name: Individual, Miranda

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'**

Page ID: pgLicenseListForEnrlnmt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 01:41:18 MST


Add License/Certification

 Print  Help

Application ID: 20200226119723 Name: Individual, Miranda



Add License/Certification/Other



License/Certification/Other Type: *

License/Certification/Other #: *

Valid Flag:

Effective Date: *

End Date:

Confirm License/Certification/Other

OK

Cancel

Page ID: dlqEnrlmntAddLicense(Provider)

Add License/Certification

evoBrox™
My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

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 Social Workers	125485696	No	02/26/2020	12/31/2999
<input type="checkbox"/> HI Board of Medical Examiners	452152598	No	02/26/2020	12/31/2999
<input type="checkbox"/> HI Board of Psychology	565648596	No	02/26/2020	12/31/2999

Delete
View Page: 1
Go
Page Count
SaveToXLS

Viewing Page: 1
First
Prev
Next
Last

Page ID: pgLicenseListForEnrlnmt(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 01:43:57 MST

Step 7: Add Additional Information

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1
Go
Page Count
SaveToXLS

Viewing Page: 1
First
Prev
Next
Last

Page ID: pgBPWAtypicalIndStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 01:44:30 MST

Add Additional Information

evoBrox™

< My Inbox ▾ Admin ▾ Provider ▾

>

Note Pad External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723 Name: Individual, Miranda

Close

Authorized Representative List

^



Add

Filter By ▾ 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 01:52:17 MST

Add Additional Information


 Print  Help

Application ID:

Name:



Add Authorized Representative



First Name:


*

Last Name:

*


Middle Name:



Start Date:



*

End Date:



 OK  Cancel

Page ID: dlGEnrlmntAddAuthorizedRep(Provider)

Step 8: Controlling Interest/Ownership Details

evoBrox™

<

My Inbox ▾

Admin ▾

Provider ▾

>

Note Pad

External Links ▾

My Favorites ▾

Print

Help

>

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723

Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Page ID: pgBPWAtypicalIndStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 01:53:36 MST

innovation@work

Add Owner

evoBrix™ < My Inbox Admin Provider >

Note Pad External Links My Favorites Print Help

MyInbox > New Enrollment > Atypical Individual Enrollment > General

Application ID: 20200226119723 Name: Individual, Miranda

Close Actions Add Owner Annual

PROVIDER Owners Relationships CONTROL DISCLOSURES

Provider Owners Adverse Action

REQUIRED DISCLOSURE INFORMATION

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

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

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501(c)3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the 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 [v] [] And Indicator [v] [] 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"/> 555556698	Individual, Miranda	Individual/Sole Proprietor	515 E 100 S	02/26/2020	12/31/2999	Completed	Not Completed	100

Viewing Page: 1

First Prev Next Last

https://hi-trg-evo-cns-inc.com/evoBrix/CNSIControlServlet Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 01:55:26 MST

Add Ownership

Print
Help

Application ID: 20200226119723
Name: Individual, Miranda

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: dlqEntfmmAddOwner(Provider)

Add Ownership

Print
Help

Application ID: 20190816091137
Name:

Provider Controlling Interest/Ownership

Type:
Managing Employee
*

Percentage Owned:
12
*

SSN:
321321321
*

EIN/TIN:

Legal Entity Name:

Entity Business Name:

(As shown on the Income Tax Return)

(Doing Business As)

Owner NPI:

First Name:
test cdsd
*

Last Name:
test dsd
*

Suffix:

DOB:
08/16/2000
*

Phone Number:
(321) 321-3323
*
Extn:

Email:

Start Date:
08/16/2019
*

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:
PO Box 2825
*

Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:
Ann Arbor
*

State/Province:
MICHIGAN
*

County:
Washtenaw

Country:
UNITED STATES
*

Zip Code:
48106
*
-
2825
Validate Address

OK
Cancel

Page ID: dlgEnrImntAddOwner(Provider)

innovation@work

Add Owners Relationship

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

Application ID: 20200226119723 Name: Individual, Miranda

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: Individual, Miranda **SSN/EIN/TIN: 555556698** **Status: Not Completed**

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Individual, Miranda	Relation to Assoc. Owner
Individual, Miranda	545698563	Individual/Sole Proprietor	Self	Self

View Page: 1 Go Page Count Save To XLS **Viewing Page:** 1 First Prev Next Last

Selected Owner: Individual, Miranda **SSN/EIN/TIN: 545698563** **Status: Not Completed**

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

innovation@work

innovation@work

Step 9: Taxonomy Details

evoBrix™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInboxNew EnrollmentAtypical Individual Enrollment

Application ID: 20200226119723Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1GoPage CountSaveToXLS

Viewing Page: 1

FirstPrevNextLast

Page ID: pgBPWAtypicalIndStart(Provider)Environment: HL_SYSTST R10c-1.1Server Time: 02/26/2020 02:05:34 MST

Taxonomy Details

evoBrix™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723Name: Individual, Miranda

CloseAdd



Taxonomy List

Filter ByGoSave FiltersMy Filters



Taxonomy Code	Description	Start Date	End Date
No Records Found !			

Page ID: pgTaxonomyListForEnrlnmnt(Provider)Environment: HL_SYSTST R10c-1.1Server Time: 02/26/2020 02:06:51 MST

Add Taxonomy


 Print  Help


Application ID: 20200226119723 Name: Individual, Miranda

 Add Taxonomy 

Taxonomy Code: * [\(Click here for Taxonomy List\)](#)

Description:

Start Date:  *

End Date: 

Confirm Taxonomy

✓ Ok

Cancel

Page ID: dlgEnrlAddTaxonomy(Provider)

NUCC Taxonomy Code List

The screenshot shows a web browser window with the URL taxonomy.nucc.org. The page title is "Health Care Provider Taxonomy Code Set". On the left, there is a navigation menu with a search bar and a list of categories. The main content area is titled "Introduction" and contains a table with two columns: "Name" and "Introduction".

Navigation Menu:

- Introduction
- National Uniform Claim Committee Website
- Help
- Individual or Groups (of Individuals)
 - Group
 - Multi-Specialty
 - Single Specialty
 - Allopathic & Osteopathic Physicians
 - Allergy & Immunology
 - Allergy
 - Clinical & Laboratory Immunology
 - Anesthesiology
 - Addiction Medicine
 - Critical Care Medicine
 - Hospice and Palliative Medicine
 - Pain Medicine
 - Pediatric Anesthesiology
 - Clinical Pharmacology
 - Colon & Rectal Surgery
 - Dermatology
 - Clinical & Laboratory Dermatological Immunology
 - Dermatopathology
 - MOHS-Micrographic Surgery
 - Pediatric Dermatology
 - Procedural 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
 - Addiction Medicine
 - Adolescent Medicine
 - Adult Medicine
 - Geriatric Medicine
 - Hospice and Palliative Medicine
 - Obesity Medicine
 - Sleep Medicine
 - Sports Medicine
 - General Practice
 - Hospitalist
 - Independent Medical Practices

Introduction Table:

Name	Introduction
Definition	<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> 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. <p>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.</p> <p>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.</p> <p>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.</p> <p>Historical Background</p> <p>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.</p> <p>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</p>

Step 10: Upload Documents

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
★ My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:
Go
Page Count
SaveToXLS

Viewing Page: 1

First
Prev
Next
Last

Page ID: pgBPWAtypicalIndStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 02:08:52 MST

Upload Documents

Application ID: 20200226119723 Name: Individual, Miranda

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 02:10:06 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: 20200226119723Name: Individual, Miranda


 Upload Document 

Document Type: ---SELECT---  *



Document Name:  *

File Name: Browse...

Start Date: 

End Date: 

Remark:

 OK  Cancel

Page ID: dlgEnrlmntAttachment(Provider)

Upload Documents List

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

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"/> 75049206	Letter	CMS Approval Letter	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049207	License	GE Tax License	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049208	License	HI Board Of Medical Examiners	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049209	License	HI Board Of Psychology	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049210	Tax	W9 Indicator	HI T3 Agenda.docx			Zak Farrington	02/26/2020	In Process
<input type="checkbox"/> 75049211	License	HI Board Of Social Workers	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 02:13:03 MST

Step 11: Enrollment Checklist

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:
Go
Page Count
SaveToXLS

Viewing Page: 1
First
Prev
Next
Last

Page ID: pgBPWAtypicalIndStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 02:13:38 MST

Enrollment Checklist

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > Atypical Individual Enrollment > Provider Check List

Application ID: 20200226119723
Name: Individual, Miranda

Close Save

Provider Checklist

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

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

Page ID: pgProviderCheckList(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 02:14:53 MST

Step 12: Submit Application

My Inbox
Admin
Provider

Note Pad
External Links
My Favorites
Print
Help

MyInbox
New Enrollment
Atypical Individual Enrollment

Application ID: 20200226119723
Name: Individual, Miranda

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 11: Complete Enrollment Checklist	Required	02/26/2020	02/26/2020	Complete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1
Go
Page Count
SaveToXLS

Viewing Page: 1
First
Prev
Next
Last

Page ID: pgBPWAtypicalIndStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/26/2020 02:15:59 MST

Submit Application

evoBrix

My Inbox

Admin

Provider

Note PadExternal LinksMy FavoritesPrintHelp

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723Name: Individual, Miranda

Close

Next

Final Submission

Application ID: 20200226119723EnrollmentType: Atypical Individual 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-1.1Server Time: 02/26/2020 02:17:03 MST

Review Provider Participation Agreement

My Inbox

Admin

Provider

Note Pad

External Links

My Favorites

Print

Help

MyInbox

New Enrollment

Atypical Individual Enrollment

Application ID: 20200226119723

Name: Individual, Miranda

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, Individual, Miranda, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

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

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

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

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

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

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

Page ID: pgEnrTermsAndConditions(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 02:17:47 MST

Review Provider Participation Agreement

evoBrix™

My Inbox ▾

Admin ▾

Provider ▾

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20200226119723

Name: Individual, Miranda

Close

Submit Application

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

provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services; (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services. The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

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

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

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

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

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

First Name:

Last Name:

Date:

Page ID: pgEnrTermsAndConditions(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 02:17:47 MST

innovation@work

©2019 CNSI

Submission Complete

evoBrox™

<

My Inbox ▾

Admin ▾

Provider ▾

Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

MyInbox >

New Enrollment >

Atypical Individual Enrollment

Application ID: 20200226119723

Name: Individual, Miranda

Your Application Number 20200226119723 has been successfully submitted for State review. Return with this application number to track the status of your application.

×

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 11: Complete Enrollment Checklist	Required	02/26/2020	02/26/2020	Complete	
Step 12: Submit Enrollment Application for Approval	Required	02/26/2020	02/26/2020	Complete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

« First

« Prev

Next »

Last »

Page ID: pgBPWAtypicalIndStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/26/2020 02:20:28 MST

innovation@work

©2019 CNSI

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.*