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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

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	Provider E	nrollm	ent								^
				New Enrollment	Enroll As A New Provider						
				Track Application	Track Existing Provider Application						
•	lf you	ı aı	re a new	Hawaii Medica	id provider, you	ı will s	elect 'l	New	/ Enrol	lmen	t .'
•				•	edicaid provide						חו

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

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> MyInbox > New Enrollment					
III Enrollment Type					^
Select the Applicable Enrollment Type					
O Individual/Sole Proprietor					
Regular Individual/Sole Proprietor or Rendering/Servicing Provider					
○ Group Practice (Corporation, Partnership, LLC, etc.)					
○ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)					
○ Contractor/MCO					
O 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.)					

To find out which enrollment type your provider type is categorized as, please visit the HOKU webpage at: <u>medquest.hawaii.gov/HOKU</u>. 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.

Submit

Page ID: pgNewEnrollBasicStep(Provider)

Environment: HI_SYSTST R10c-1.1

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Step 1: Provide Basic Information

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Basic Information: Enter required fields and click Finish button.	
III Basic Information	^
First Name: Middle Initial:	
Last Name: *	
Suffix: Gender:	*
SSN: *	
Date of Birth:	Atypical Rendering/Servicing *
III 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: (Enter Street Address or PO Box Only)	
Address Line 3: City/Town:	OTHER V*
StateiProvince: OTHER * County:	OTHER
Country: UNITED STATES 💽 * Zip Code:	* - Validate Address
Page ID: dlgAddBasicInformationStep1(Provider)	☐ View Screening Result ✔ Finish O Cancel

Application ID

ė	Print 😌 Help		
Appl	cation ID: 20200226119723	Name: Individual,Miranda	
	Basic Information		^
You Plea	have successfully completed the basic information on the Enrol r Application ID is: 20200226119723 ise make note of this Application ID. This is the number you will I se to track the status of your enrollment application. Without this	pe required number,	
Plea	will not be able to access your application and your information use make sure to complete your application and submit it for Stat indar days OR your application will be deleted.		
			✔ Ok
Pa	ge ID: dlgAddBasicInformationStep3(Provider)		

Enrollment Steps

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MyInbox New Enrollment Atypical Individual Enrollment							
pplication ID: 20200226119723	Name: Individual, Miranda						
Close							
Enroll Provider - Atypical Individual							^
Enroll Provider - Atypical Individual							
Step	Business Process Wiza Required	start Date	ollment (Atypical In End Date	dividual). Click c		Step Remark	Column.
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete		этер кешатк	
Step 2: Add Locations	Required	02/20/2020	0212072020	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 O Go Page Count SaveToXLS	Viewing Page:	1			K First	Prev Next	» Last

Step 2: Add Locations

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S Mylnbox > New Enrollment > Atypical Individual Enrollment						
Application ID: 20200226119723	Name: Individual, Miranda					
Close Add Pay to address is required for Primary Practice Location. To A	Id/Modify Pay to address, click on Primary Practice Location hyperlink					
III Locations List						^
Filter By) Go			Save Filte	ers 🔻 My	Filters▼
Doing Business As	Location Type Location Details			End Date		
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	No Records Found !					
Page ID: pgLocationListForEnrImnt(Provider)	Environment: HI_SYSTST R10c-1.1			Server Time: 02/20	6/2020 01:2	0:16 MST

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Add Primary Practice Address

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Application ID: 20200226119723		Name: Individual, Miranda		
III Add Provider Location				^
	Location Type: Primary Practice Location			
	Doing Business As:		End Date	
	If a department or drawer number is required enter the information required, please enter the information in Line THREE. (For example		PARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is	
			I Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the 'S. If Address Line 1 and Zip Code combination is not valid, an error will be	
	Address Line 1: * (Enter Street Address or PO Box Only)		Address Line 2	:
	Address Line 3:		City/Town	: OTHER V*
	State/Province: OTHER *		County	: OTHER
	Country: UNITED STATES 💉		Zip Code	: Validate Address
	Web Page:			
	Please enter the hours your	r 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 *
	Monday: * AM PM *	× AM PM *	Friday: * AM PM *	× AM PM *
	Tuesday: * AM PM *	× AM PM *	Saturday: * AM PM *	× AM *
	Wednesday: * AM *	× AM PM *		
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	Language(s) Spoken: Bisayan/Visayan Chinese (which includes Mandarin or Canton	iese)		
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				✓ OK Cancel
Page ID: dlgEnrlAddLocation(Provider)				

Add Pay To Address

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s Mylnbox > New Enrollment > Atypical Individual Enro	oliment						
Application ID: 20200226119723		Name: Individual, Miranda					
	rimary Practice Location. To Add/Modify Pay to add	ress click on Drimary Dractice Location hyperlink					
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III Locations List							^
Filter By	0 G0				💾 Save Fi	Iters V	ly Filters▼
Doing Business As	Location Type	Location Details			End D	ate	
▲▼	A₹				▲ ▼		
	Primary Practice Location	515 E 100 S, Salt Lake City, UTAH 84102			12/31/	2999	
Delete View Page: 1 O 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

Add Pay To Address

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1 ×								hote Pad	🔇 External Links 🕶	★ My Favorites ▼	🚔 Print	? Help
Atypical Inc	dividual Enrollment	> General										
Application ID: 20200226119723				Na	ame: Individual, Mir	anda						
Close Save To add additional add	dresses, click "/	Add Address" but	ton.									
III Location Details												^ ^
Doing Business As: Web Page:		ease enter the ho	urs your office is a	open for each day. I	f you are closed o	n a given day se	elect "Closed" in	the "Open At" di		Type: Primary Practic	e Location	
	Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM		
	Sunday:	Close 🗸 *	AM *	*	AM PM	Thursday:	Close 🗸 *	AM PM *	*	AM *		
	Monday:	02:30 🗸 *	AM PM *	06:30 🗸 *	AM PM *	Friday:	Close 🗸 *	AM PM *	*	AM *		
	Tuesday:	Close 🗸 *	AM *	*	AM PM *	Saturday:	Close 🗸 *	AM PM *	*	AM *		
	Wednesday:	Close 🗸 *	AM PM *	*	AM PM *							
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III Address List												~
Add Address												
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Add Pay To Address

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Application ID: 20200226119723	Name: Individual, Miranda	
III Add Provider Location Address		*
Type of Address:	-SELECT End Date:	
Location Address:	OCopy This Location Address	
	ment or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT	
	VR 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.	
	0595. Il Address Line i and Zip Code combination is not vand, an error will be returned.	
	*	
Address Line 1:	Address Line 2: (Enter Street Address or PO Box Only)	
Address Line 3:	City/Town:	OTHER 🖌 *
Autos Lines.		
	OTHER * County:	
State/Province:	OTHER * County:	
Country:	UNITED STATES 💌 * Zip Code:	* - Validate Address
		✓ OK OC Cancel
Page ID: dlgEnrlLocationAddress(Provider)		

Step 3: Add Correspondence Address

	Provider •								>
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A S MyInbox S New Enrollment S Atypical Individual Enrollment									
Application ID: 20200226119723		Name: Individual, Miranda							
Close									
Enroll Provider - Atypical Individual									^
		Business Process Wiz	ard - Provider Er	nrollment (Atypic	al Individual). Click	on the Step	p # under t	he Step (Solumn.
Step		Required	Start Date	End Date	Status		Step Rema	ark	
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	e			
Step 4: Add Provider Type/Specialties/Subspecialties		Required			Incomplete	е			
Step 5: Associate Billing Provider/Other Associations		Optional			Incomplete	B			
Step 6: Add License/Certification/Other		Optional			Incomplete	в			
Step 7: Add Additional Information		Optional			Incomplete	e			
Step 8: Add Provider Controlling Interest/Ownership Details		Required			Incomplete	Ð			
Step 9: Add Taxonomy Details		Optional			Incomplete	B			
Step 10: Upload Documents		Optional			Incomplete	e			
Step 11: Complete Enrollment Checklist		Required			Incomplete	B			
Step 12: Submit Enrollment Application for Approval		Required			Incomplete	в			
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Page ID: pgBPWAtypicalIndStart(Provider)		Environment: HI_SYSTST R10c-1.1				Server	r Time: 02/26	/2020 01:2	6:53 MST

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Add Correspondence Address

👫 > MyInbox > New Enrollment > Atypical Individual Enrollment > General				
Application ID: 20200226119723	Name: Individual, Miranda			
O Close Add				
III Correspondence Address List				
Address Type	Address	End	d Date	
	۸Ÿ	▲ ▼	,	
	No Records Found !			

Add Correspondence Address

🚔 Print 🙂 Help			
Application ID: 20200226119723	Name: P	ndividual, Miranda	
III Add Correspondence Address			^
Phone Number: Communication Preference:	* Extn:	Fax Number: Email Address:	
End Date: If a depar	rtment or drawer number is required enter the information	on in line TWO.(For example: DEPT 222 or DEPARTMENT	
	WR 1111 or DRAWER 1111) If an attention line is require ATTN: Billing Dept.)	ed, please enter the information in Line THREE. (For	
	ADDRESS button. Once clicked, the re	y requires Address Line 1 and Zip Code, then click the VALIDATE maining address fields will be populated and validated by the 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 Y *	County:	OTHER V
Country:	UNITED STATES V	Zip Code:	* - Validate Address
			✓ OK Scancel
Page ID: dlgEnrlCorrespondenceAddress(Provider)			

Step 4: Add Provider Type/Specialties/Subspecialties

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> MyInbox > New Enrol	lment > Atypi	al Individual E	nrollment										
pplication ID: 2020022	6119723				Name: In	dividual, Miranda							
Close													
Enroll Provide	er - Atypica	Individual											
					Bus	ness Process !	Nizard - Provider Enr	ollment (Atypica	I Individual). Click or	n the Ste	n # unde	er the Sten	Colum
Step						Required	Start Date	End Date	Status			emark	
Step 1: Provider Basic Info	ormation					Required	02/26/2020	02/26/2020	Complete				
Step 2: Add Locations						Required	02/26/2020	02/26/2020	Complete				
tep 3: Add Corresponder	nce Address					Required	02/26/2020	02/26/2020	Complete				
tep 4: Add Provider Type	/Specialties/Su	bspecialties				Required			Incomplete				
tep 5: Associate Billing P	rovider/Other	ssociations				Optional			Incomplete				
tep 6: Add License/Certif	fication/Other					Optional			Incomplete				
tep 7: Add Additional Info	ormation					Optional			Incomplete				
tep 8: Add Provider Cont	trolling Interest	Ownership De	ails			Required			Incomplete				
Step 9: Add Taxonomy De	etails					Optional			Incomplete				
tep 10: Upload Documer	nts					Optional			Incomplete				
Step 11: Complete Enrolln	nent Checklist					Required			Incomplete				
Step 12: Submit Enrollmer	nt Application f	or Approval				Required			Incomplete				
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Step 4: Add Provider Type/Specialties/Subspecialties

	Admin → Provider →								
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> MyInbox > New Enrollment > Atypical Indivi	idual Enrollment								
Application ID: 20200226119723			Name: Indivi	idual, Miranda					ī
Close Add									
Filter By		O Go					💾 Save Fi	ters V	ły
Specialty/Subspecialty				Provider Type		End [Date		
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Provider Type/Specialties/Subspecialties

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Application ID: 20200226119723	Name: Individual, Miranda
III Add Provider Type/Specialty	*
Provider Ty Specia End Da	Ity: Select 'No Specialty' if applicable.
III Add Subspecialty	^
	Available Subspecialties Associated Subspecialties *
Page ID: dlgEnrlAddSpecialties(Provider)	✓ OK ② Cancel

Add Provider Type/Specialties/Subspecialties

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Application ID: 20200226119723	Name: Individual, Miranda						
Close Add							
III Provider Type/Specialty/Subspecialty List							^
Filter By	O Go				💾 Save F	itara 🔽 Mu	Filters▼
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Specialty/Subspecialty	Pr	ovider Type			End Date		
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NO SPECIALTY REQUIRED/No Subspecialty	DH	IS MHS PROVIDER			12/31/2999		
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					K First Prev	• Next	M Last
					K First Prev	Next	W Last
					K First Prev	Next	W Last
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Step 5: Associate Billing Provider

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JyInbox > New Enrollment > Atypical Individual Enrollment								
lication ID: 20200226119723	Name:	Individual, Miranda						
lose								
Enroll Provider - Atypical Individual								~
	Bu	siness Process W	izard - Provider E	nrollment (Atypic	al Individual). Click	on the Step # un	der the Step	Column.
p	Required	Start Date	End Date	Status	Step Remark			
p 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete				
p 2: Add Locations	Required	02/26/2020	02/26/2020	Complete				
p 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete				
p 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete				
p 5: Associate Billing Provider/Other Associations	Optional			Incomplete				
p 6: Add License/Certification/Other	Optional			Incomplete				
p 7: Add Additional Information	Optional			Incomplete				
p 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete				
p 9: Add Taxonomy Details	Optional			Incomplete				
p 10: Upload Documents	Required			Incomplete	Please upload requ	ired documents.		
p 11: Complete Enrollment Checklist	Required			Incomplete				
p 12: Submit Enrollment Application for Approval	Required			Incomplete				
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Associate Billing Provider

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A > MyInbox > New Enroll	ment > Atypical Indiv	idual Enrollment									
Application ID: 20200226	5119723				Name: Individual, Miran	da					
Close Add											
III Billing Provide	er/Other Associa	tions List									^
Filter By				O Go					💾 Save Filte	ers 🔻 My	y Filters▼
NPI/Med-QUEST ID				Provider Name		Start Date		End Date	Status		
						A.A.		▲ ▼	▲ ▼		
Page ID: pgBillingProvid	erListForEnrImnt(Pro	ovider)			Environment HI_SYSTST F	R10c-1.1			Server Time: 02/2	6/2020 01:3	87:29 MST

Associate Billing Provider

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Application ID: 20200226119723	Name: Inc	dividual, Miranda	
Associate Billing Provider/Other Association	ns		
Type: ID:	Enter NPI/Med-QUEST ID of Billing Provider/C	Other Associations and click "Confirm Provider." Provider Name:	
Start Date:	*	End Date:	
			Confirm Provider Vok @ Cancel
Page ID: dlgBillingProviderID(Provider)			

Step 6: Add License/Certification

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> MyInbox > New Enrollment > Atypical Individual Enrollment								
pplication ID: 20200226119723	Name:	Individual, Miranda						
Close								
Enroll Provider - Atypical Individual								^
	Bu	siness Process W	/izard - Provider E	nrollment (Atypic	al Individual). Click	on the Step # unde	r 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 requi	red documents.		
Step 11: Complete Enrollment Checklist	Required			Incomplete				
Step 12: Submit Enrollment Application for Approval	Required			Incomplete				
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Add License/Certification

	Provider -				>
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A > MyInbox > New Enrollment > Atypical Individual Enrollment					
Application ID: 20200226119723	Name: In	dividual, Miranda			
Close Add					
License/Certification/Other List					^
Filter By	O Go			Save Filters	▼ My Filters ▼
License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Date	
▲▼	∆ ⊽	A.	▲ ▼	▲ ▼	
	No R	ecords Found !			
	es and certificates that a the HOKU website at: <u>i</u> 'Reso	•			
Select the link: 'R	equired and Optional Provi	Licenses, Certifica der Type'	tes and Do	ocuments	s by
Page ID: pgLicenseListForEnrImnt(Provider)	Environment	HI_SYSTST R10c-1.1		Server Time: 02/26/20	020 01:41:18 MST

Add License/Certification

🚔 Print 😨 Help		
Application ID: 20200226119723	Name: I	Individual, Miranda
H Add License/Certification/Other		^
License/Certification/Other Type:	*	License/Certification/Other #:
Valid Flag:		
Effective Date:	*	End Date:
		Confirm License/Certification/Other Cancel
Page ID: dlgEnrlmntAddLicense(Provider)		

Add License/Certification

ΔΨ ΔΨ	Name: Individual, Miranda	🔓 Note Pa	ad 🔮 External Links 🕶	★ My Favor	ites 🕶 🚔	Print 🕑 Hel
Dilication ID: 20200226119723 Nose Add License/Certification/Other List Filter By License/Cert_/Other Type Licert A▼						
Close O Add License/Certification/Other List Filter By ♥ ♥ O O o License/Cert./Other Type ▲▼						
License/Certification/Other List	Go					
Filter By	Go					
License/Cert./Other Type Licen	Go					^
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	ense/Cert./Other #	Valid Flag	Effective Date	1	End Date	
HI Board of Social Workers 1254			▲▼		▲ ▼	
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ge ID: pgLicenseListForEnrImnt(Provider)	Environment: HI_SYSTST R10c-1.1			Server T	īme: 02/26/202	20 01:43:57 MST

Step 7: Add Additional Information

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MyInbox > New Enrollment > Atypical Individual Enrollment								
plication ID: 20200226119723	Name:	Individual, Miranda						
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Enroll Provider - Atypical Individual								
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tep	Required	Start Date	End Date	Status	al Individual). Click Step Remark	on the Step # unde	er the step (oiumr
lep 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	otop Romark			
ep 2: Add Locations	Required	02/26/2020	02/26/2020	Complete				
ep 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete				
ep 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete				
ep 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete				
ep 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete				
ep 7: Add Additional Information	Optional			Incomplete				
ep 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete				
ep 9: Add Taxonomy Details	Optional			Incomplete				
ep 10: Upload Documents	Required			Incomplete	Please upload requi	ired documents.		
ep 11: Complete Enrollment Checklist	Required			Incomplete				
tep 12: Submit Enrollment Application for Approval	Required			Incomplete				
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Add Additional Information

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Representative Name		Start Date		End Date			
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Add Additional Information

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Add Authorized Representative			^
First Name:	*	Last Name:	*
Middle Name:			
Start Date:	*	End Date:	
			✓ OK Scancel
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Step 8: Controlling Interest/Ownership Details

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lyInbox > New Enrollment > Atypical Individual Enrollment								
ication ID: 20200226119723	Name:	ndividual, Miranda						
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Enroll Provider - Atypical Individual								^
	Bu	siness Process Wi	zard - Provider E	nrollment (Atypica	al Individual). Click	on the Step # unde	r the Step (Column.
p	Required	Start Date	End Date	Status	Step Remark			
o 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete				
o 2: Add Locations	Required	02/26/2020	02/26/2020	Complete				
p 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete				
o 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete				
5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete				
6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete				
o 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete				
8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete				
9: Add Taxonomy Details	Optional			Incomplete				
o 10: Upload Documents	Required			Incomplete	Please upload requi	red documents.		
o 11: Complete Enrollment Checklist	Required			Incomplete				
o 12: Submit Enrollment Application for Approval	Required			Incomplete				
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innovation@work

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Add Ownership and Disclosure Information

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# > MyInbox > New Enrollment > Atypical Individual Enrollment > General							
Application ID: 20200226119723	Name: Individual, Miranda						
O Close Actions V							
III Per Medicaid Provider Manual							^ ^
PROVIDER OWNERSHIP AND CONTROL DISCLOSURES							
Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers an	nd other disclosed individuals (e.g., owners, managing emplo	vees, agents, etc.).					
REQUIRED DISCLOSURE INFORMATION							
Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and o	control during enrollment, revalidation and within 35 days afte	r any change in ownership:					
 The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate Date of birth and Social Security Number (in the case of an individual). 	e entities must include, as applicable, primary business addre	ss, every business location and P.O. Box addr	355.				
Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in w	hich 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 more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling. 	hip or control interest as a spouse, parent, child or sibling; or	whether the person (individual or corporation) v	ith an ownership or control interest of any	subcontractor in which the	e disclosing entity has a t	five percent or	
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-Publ 	ich Tradad, Carparata Not Publich Tradad, Holding Compan	v Indiract Owner, Limited Liability Company	ubcontractor Foreign Nonresident Alien f	or the keyed Tay ID, then	at least 1 of the following	a 5 owner types	
must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Office		y, marea owner, chines clabinty company, a	ubcontractor, i oreign, Nonresident Allen h	of the keyed Tax 1D, then	at least 1 of the following	g 5 owner types	
If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Inf	formation Officer, Chief Operating Officer, or Chief Financial C	Officer, you must add at least 1 additional owne	rship 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							
III Owners List							^
Filter By And Indicator	O Go				Save Filters	▼ My Filters▼	
Owner SSN/EIN/TIN Owner Information Owner Type	Address Start Date	End Date Relationshi	Status Adverse	Action	Percentage owned		
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innovation@work

Add Owner

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Application ID: 20200226119723			Name: Individual, Min	anda							
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He Add Owner	hnual										^ ^
PROVIDEI Owners Relationships	TROL DISCLOSURES										
Provider E Owners Adverse Action		Social Security Number, is required from providers and	other disclosed individuals (e.g., own	ners, managing employe	es, agents, etc.).						
REQUIRED DISCLOSURE INFORM											
		disclose the following information on ownership and con nership or control interest. The address for corporate et									
	Number (in the case of an individual).	nership or control interest or of any subcontractor in which	the disclosing entity has a five po	cent or more interest							
		trol interest is related to another person with ownership			ether the person (individ	lual or corporation) with an ownership o	or control interest of any	subcontractor in which t	he disclosing entity has	a five percent o	or
		rest as a spouse, parent, child or sibling.									
	ant or manage care entity in which an of and Social Security Number of any ma	wner has an ownership or control interest in an entity than anaging employee.	at is reimbursable by Medicaid and/o	or Medicare.							
REQUIRED OWNERS											
Managing Employee is mandato	ny for all oprollmont hypoc										
	r ownership type in addition to Managin	g Employee.									
		e 501[c]3, Corporate-Non Charitable, Corporate-Publich		ded, Holding Company,	Indirect Owner, Limited	Liability Company, Subcontractor, Fore	ign, Nonresident Alien f	or the keyed Tax ID, the	n at least 1 of the follow	ing 5 owner typ	bes
		fficer, Chief Financial Officer, Chief Information Officer, Board of Directors, Chief Executive Officer, Chief Inform		er, or Chief Financial Off	icer, you must add at lea	ast 1 additional ownership type that is n	ot from among that list				
	ent Type, 3 ownership records must be		······································	-,	, ,		jj				
(1) Agent											
(2) Board of Directors, (3) Managing Employe		I Officer, Chief Information Officer, or Chief Operating O	fficer								
(3) Managing Employe	e										
III Owners List											*
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Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse	Action	Percentage owned		
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Add Ownership

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Application ID: 20200226119723	Name:	Individual, Miranda		
III Provider Controlling Interest/Ownership				
Туре:		Percentage Owned:	*	^
SSN:		EIN/TIN:		
Legal Entity Name:		Entity Business Name:		
	(As shown on the Income Tax Return)		(Doing Business As)	
Owner NPI:				
First Name:		Last Name:		
Suffix:		DOB:		
Phone Number:	* Extn:	Email:		
Start Date:	*	End Date:		
		y requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the ated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will		
Address Line 1:	*	Address Line 2:		
Address Line 3:	(Enter Street Address or PO Box Only)	City/Town:	OTHER 🖌 *	
State/Province:	OTHER *	County:	OTHER	
Country:	UNITED STATES 💌 *	Zip Code:	* - Validate Address	
			✓ 0	K O Cancel
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Add Ownership

plication ID: 20190816091137	Name:		
Provider Controlling Interest/Ownership			
Туј	De: Managing Employee 💙 \star 🌍	Percentage Owned:	12 *
S	SN: 321321321 *	EIN/TIN:	
Legal Entity Nan	ie:	Entity Business Name:	
	(As shown on the Income Tax Return)		(Doing Business As)
Owner N			Teast ded.
First Nan Sufi		Last Name: DOB:	108/16/2000
Phone Numb		Email:	
Start Da		End Date:	
Address Typ	De: Home Address		
	ATTENTION: Address Submission only requires Addre		
	ADDRESS button. Once clicked, the remaining addre Address Line 1 and Zīp Code combination is not vali	ss fields will be populated and validated by the USPS. If d, an error will be returned.	
	Address validation suc	cessful	
Address Line	1: PO Box 2825 *	Address Line 2:	
	(Enter Street Address or PO Box Only)		The Albert
	3:	City/Town:	Ann Arbor 🗸 *
Address Line	MICHIGAN *		Washtenaw
Address Line State/Provinc Count		County: Zip Code:	Washtenaw V 48106 * - 2825 Validate Address

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Add Owners Relationship

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Application ID: 20200226119723			Name: Individ	ual, Miranda							
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Provider (ii Import Owner aar The n Date Owners Relationships U Other Owners Adverse Action in Whethen une person runnowaum of co- more interest is related to another p	n (individual or corporation mber (in the case of an in he case of corporation, w rporation) with an owners erson with ownership or co r manage care entity in w	with an ownership or control interest or of any subcontra- ship or control interest is related to another person with control interest as a spouse, parent, child or sibling, which an owner has an ownership or control interest in a	orporate entities must include, as applic ctor in which the disclosing entity has a ownership or control interest as a spous	able, primary business addr five percent or more interest se, parent, child or sibling; or	ess, every business locatio	n and P.O. Box address.	or control interest of any a	subcontractor in which th	ne disclosing entity has	a five percent o	'n
must also be selected in addition. B • If you select any of the following own • For the Contractor/MCO Enrollment (1) Agent (2) Board of Directors, Chi (3) Managing Employee	nership type in addition to s are selected: Corporate bard of Directors, Chief E: ership types: Managing I Type, 3 ownership record	e-Charitable 501[c]3, Corporate-Non Charitable, Corpora xecutive Officer, Chief Financial Officer, Chief Informati Employee, Board of Directors, Chief Executive Officer, 4	on Officer, or Chief Operating Officer. Chief Information Officer, Chief Operatin					or the keyed Tax ID, the	n at least 1 of the follow	ing 5 owner typ	es
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Add Owners Relationship

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Application ID: 20200226119723			Name: Individual, Miranda			
III Add Relationship						
Do any of the Owners have the follo	lowing relationship (Daughter, Daughter	In Law, Father, Father-In Law, Mother, Mother-I	In Law, Sibling, Son, Son-In Law, Self, Spouse) ? OYes ONo (Click Save to update)			
Owner List						
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✓ Selected Owner:Individual, M	Miranda SSN/EIN/TIN:555556698	Status:Not Completed				
Assoc. Owner	SSN/EIN/TIN	Туре	Relation to Individual, Miranda	Relation to Assoc. Owner	_	
Individual,Miranda	545698563	Individual/Sole Proprietor	Setf	Self		
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bale started bodies Security Number (n hu case of corporation, Number and envolute) or control interest or any started interes													
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				th ownership or control	interest as a spouse, pa	rent, child or sibling; or v	hether the person (individ	ual or corporation) with an ownership	o or control interest of ar	y subcontractor in which	the disclosing entity has	a five percent	or
				n an entity that is reimb	ursable by Medicaid and	/or Medicare							
Maging Employe is mandatory for all estations on workship yees. Har you for following 10 oursers yee is additions to Maging Employee. Har you for following 0 oursers yee yees watched to exploye and o Other costs of the Fixeandia Officer, Chief Infancial Officer, Chief													
Maging Employe is mandatory for all estations on workship yees. Har you for following 10 oursers yee is additions to Maging Employee. Har you for following 0 oursers yee yees watched to exploye and o Other costs of the Fixeandia Officer, Chief Infancial Officer, Chief													
There must be at least one other ownership type in addition to Managing Employee. If any of the following You murry types are selected. Corporate-Anintable 501(53, Corporate-Note Anichael formation Officer, or Chiel Operating Officer. If any of the following ownership types. Managing Employee, Board of Directors, Chiel Financial Officer, or Chiel Operating Officer. If any of the following ownership types. Managing Employee, Board of Directors, Chiel Financial Officer, or Chiel Operating Officer. If any of the following ownership types. Managing Employee, Board of Directors, Chiel Financial Officer, or Chiel Operating Officer. If any of the following ownership types. Managing Employee, Board of Directors, Chiel Information Officer, or Chiel Operating Officer. If any of the following ownership types that againg Employee. If any of the following ownership types. Managing Employee, Board of Directors, Chiel Information Officer, or Chiel Operating Officer. If any of the following ownership types that agains and officer. If any of the following ownership types that agains and officer. If any officer of the following ownership type that is not from anong that list. If any officer of the following ownership type that is not from anong that list. If any officer of the following ownership type that is not from anong that list. If any officer of the following ownership type that is not from anong that list. If any officer of the following ownership type that is not from anong that list. If any officer off		· · · · · · · · · · · · · · · · · · ·											
ti any of the following 10 owner types are selected: Corporate-Non Chairtable 501(3], Corporate-Non Chairtable, Chief Financial Officer, Chief Financial Officer, Chief Financial Officer, or Chief Corporate-Non Chairtable, Corp			mplovee										
If you select any of the following ownership types: Kanaging Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, or Chief Operating Officer, or Chief Pinancial Officer,				orate-Publicly Traded,	Corporate-Not Publicly T	raded, Holding Compan	, Indirect Owner, Limited	Liability Company, Subcontractor, Fo	oreign, Nonresident Alier	for the keyed Tax ID, the	en at least 1 of the follow	ing 5 owner ty	pes
For the Contractor/MCO Enrollment Type, 3 ownership records must be added: (1) Agent (2) Board of Directors, Chief Financial Officer, or Chief Operating Officer (3) Managing Employee													
(1) Agent (2) Board of Directors, Chief Financial Officer, chief Fina				r, Chief Information Off	icer, Chief Operating Off	cer, or Chief Financial C	ifficer, you must add at lea	st 1 additional ownership type that is	not from among that lis	L			
(a) Managing Employee Owners List Iter By Imaging Construction		int Type, o ownersnip records must be de											
Owners List And Indicator Orac Save Filter My Filters Nomer SSNEIN/TIN Ar Owner Information Ar Owner Type Ar Address Ar Sart Date Ar Relationship Status Ar Adverse Action Ar Percentage owned Ar StateS053 Individual/Kinada Individual/Sole Proprietor 515 E 100 S 02/26/202 12/31/299 Compled Not Completed 100 StateS068 Individual/Kinada Individual/Sole Proprietor 515 E 100 S 02/26/202 12/31/299 Completed Not Completed 100	(2) Board of Directors,	Chief Executive Officer, Chief Financial Of	fficer, Chief Information Officer, or Chief	Operating Officer									
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	555556698	Individual,Miranda	Individual/Sole Proprietor		515 E 100 S	02/26/2020	12/31/2999	Completed	Not Cor	npleted	100		

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Disclose Adverse Actions

		Name: Individual, Miranda		
is an indirect ownership interest equal to five (5) percent or more in	a disclosing entity:			
s a combination of direct and indirect ownership interests equal to				
wns an interest of five (5) percent or more in any mortgage, deed of an officer or director of a disclosing entity that is organized as a co a partner in a disclosing entity that is organized as a partnership?		${\rm e}$ disclosing entity if the interest equals at least five (5) percent	nt of the value of the property or assets of the disclosing entity;	
nificant business transaction" means any business transaction or	r series of transactions that, during one fiscal y	year exceed the lesser of \$25,000 and five (5) percent of an o	offeror¿s total operating expenses.	
bcontractor" means:				
ndividual, agency, or organization to which a disclosing entity has ndividual, agency, or organization with which a fiscal agent has e			o its patients; or pplies, equipment, or services provided under the DHS agreement.	
pplier" means an individual, agency, or organization from which a	provider purchases goods and services used	d in carrying out its responsibilities under its DHS agreement ((e.g. a commercial laundry firm, a manufacturer of hospital beds, or a pharma	aceutical firm).
olly owned subsidiary supplier," means a subsidiary or supplier w	vhose total ownership interest is held by the N	Addicaid provider/applicant or by a person, persons, or other ϵ	entity with an ownership or controlling interest in the Medicaid provider/applic	cant.
		Addicaid provider/applicant or by a person, persons, or other e	entity with an ownership or controlling interest in the Medicaid provider/applic	sant.
AL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTOR	RY			cant.
AL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTOR	RY			ant.
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LI ADVERSE LEGAL ACTION/CONVICTION ACTION HISTOR ny of the owners, under any current or former name or business Owners with Adverse Action ter By	RY identity, ever had a final adverse legal action	I listed above imposed against them? Please answer in the 'C	Owners with Adverse Action' section below for each owner.	
L ADVERSE LEGAL ACTION/CONVICTION ACTION HISTOR ny of the owners, under any current or former name or business Owners with Adverse Action ter By	RY identity, ever had a final adverse legal action	listed above imposed against them? Please answer in the 'C	Dwners with Adverse Action' section below for each owner.	
AL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTOR ny of the owners, under any current or former name or business Owners with Adverse Action ter By All rer Name idual,Miranda	XY identity, ever had a final adverse legal action	listed above imposed against them? Please answer in the 'C Response	Dwners with Adverse Action' section below for each owner.	
AL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTOR any of the owners, under any current or former name or business Owners with Adverse Action	XY identity, ever had a final adverse legal action © ©o SSN/EIN/TIN ▲▼ 555556698 545698563	I listed above imposed against them? Please answer in the 'C Response	Dwners with Adverse Action' section below for each owner.	

Step 9: Taxonomy Details

MyInbox > New Enrollment > Atypical Individual Enrollment Application ID: 20200226119723 Name: Individual, Miranda Close Enroll Provider - Atypical Individual Business Process Wizard - Provider Enrollment (Atypical Individual	rnal Links ▼ ★ My Favorites ▼ Jual). Click on the Step # un Remark	
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Step 3: Add Correspondence Address Required 02/26/2020 02/26/2020 Complete		
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Taxonomy Details

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Add Taxonomy

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NUCC Taxonomy Code List

ealth Care Provider Taxonomy Code Set		٥
pand / Collapse All	Health Care Provider Taxonomy Code Set	
pand / Collapse All Introduction National Uniform Claim Committee Website Help Individual or Groups (of Individuals) Group Mult-Speciality Single Speciality Single Speciality Clinical A Laboratory Immunology Allergy Clinical A Laboratory Immunology Allergy Clinical A Laboratory Immunology Clinical Fammacology Clinical A Laboratory Immunology Clinical Fammacology Clinical Clinica Cli	Health Care Provider Taxonomy Code Set Introduction Name Introduction Definition The Health Care Provider Taxonomy code set is an external, nonmedical data code set design the ASC X12M Health Care transactions. This includes the transactions mandated under HIP. The taxonomy code is a unique alphanumeric code, ten characters in length. The code set is Grouping, Classification, and Area of Specialization. • Level I, Provider Grouping A main grouping of service(s) or occupation(s) of health care providers. For example: Hospitals, etc. • Level II, Classification A more specific service or accupation related to the Provider Grouping. For example: Hospitals, etc. • Level II, Classification A more specific service or accupation related to the Provider Grouping. For example: Hospitals, etc. • Level III, Area of Specialization The code set Levels are organized to allow for dilling down to the provider smost specific service for provider grouping Allopathic & Osteopathic Physicians is based upon hospical provider sources are arganized to allow for dilling down to the provider's most specific level services that are readered. Selection of a taxonomy codes are to be use should codes be separated to form new codes, parsed apart, or definition relates of the codes reference in no way implies that providers have an opportunity to incomprove organized the effective do apayers, and vendors an opportunity to incomprove and updage affective for use on Cother 1th. The its between the publication relases and the effective do apayers, and vendors an opportunity to incomprove and exides of thesides referement in no way implies that providers havere	AA. structured into three distinct "Levels" including Provider Allopathic & Osteopathic Physicians, Dental Providers, the Classification for Allopathic & Osteopathic Physicians is ands. The following boards will however, have their general of the code set for Boards that have multiple general y, Surgery, Otolaryngology, Pathology. wr make services available. For example, the Area of in the Subspecialty Certificates as issued by the appropriate ef exactly as they are assigned in the taxonomy list. At no tin thin the code. ased on education and training and are used to define ace any credentilainy or validation process that the ace and creditivity to bords as a source, but this reference dot to identify themselves. In is effective for use on April 1st and the July publication is tate is considered an implementation period to allow provider he National Provider System Workgroup from the Centers for dide code set that would be able to codify provider grouping uvide a single coding structure to support work on the Nation two projects worked independently to some extent until April provide single coding structure to support work on the Nation two projects worked independently to some extent until April provide rest and a coding structure to Work forcours provider some structure and the force of the rest provider some structure and the force of the rest of the force of the rest of the support work of Work Group
Sports Medicine General Practice Hospitalist	The sub-group initially started with the CMS draft taxonomy code set. This list incorporated al ways, e.g. technologists or technicians who support or repair equipment/machinery, contracto offer health services, in concert with others, and do not or cannob lill independent/for their s	ors, physicians, dentists, suppliers. A number of the providers

Step 10: Upload Documents

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tep 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete					
tep 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete					
tep 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete					
tep 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete					
tep 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete					
tep 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete					
tep 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete					
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Step 12: Submit Enrollment Application for Approval	Required			Incomplete					
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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

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Step 11: Enrollment Checklist

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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				
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Enrollment Checklist

Application ID: 20200226119723	Name: Individual, Miranda			
Close Save				
III Provider Checklist				
Question		Answer	Comments	
▲ ▼		▲ ▼		
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requ	ested 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	2	
Are you currently excluded from any Hawaii or other state program? If yes, provide stat	e of exclusion and program in comment field.	Not Completed	2	
Are you currently excluded from any federal program? If yes, provide the program and	date in comment field.	Not Completed	2	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide	type of conviction and date in comment field.	Not Completed	2	
Have you ever had a judgment under any false claims act? If yes, list judgment and dat	e in comments field	Not Completed	2	
Have you been enrolled by another State's Medicaid Program. If yes, provide each stat	e and effective date of enrollment in comments field.	Not Completed	2	
Have you ever had a program exclusion/debarment? If yes, provide program and date in	n comments field.	Not Completed	2	
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	2	
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	2	
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 doll	ar amount and dates in comments field.	Not Completed	2	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a n	ew 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 (and date, also upload fingerprinting documentation.	HCBS) or nonemergency medical transportation provider? Have you had the required fingerprinting completed? If yes, with what state	Not Completed	2	
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Step 12: Submit Application

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Enroll Provider - Atypical Individual							
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ep 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete			
ep 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete			
tep 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete			
tep 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete			
lep 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete			
lep 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete			
tep 10: Upload Documents	Required	02/26/2020	02/26/2020	Complete			
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Submit Application

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III Final Submission								
	Application	D: 20200226119723			EnrollmentT	ype: Atypical Individ	ual Provider	
	, the second					, por rujpicarmania		
		The inf	ormation submitted for enrollment shall be verified a	and reviewed by the State.				
			During this time, any changes to the information sha					
		I agree that the	nformation submitted as a part of the application is	correct (Private and Confid	dential).			
III Application Document	Checklist							
Forms/Documents		Speci	al Instructions		Source		Required	
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Review Provider Participation Agreement

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plication ID: 202002261	119723			Name: Individual, Miran	la					
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PROVIDER AGREEM	IENT AND CONDITIC	ON OF PARTICIPATION	N (PART B)							~
			. ,	aid Program and agree to r	he following terms an	d conditions if	accepted:			
	e are a provider for th	ne 1915© waiver for par		awaii State Medicaid Prog ental Disabilities (DD) or I						
requirements issued purs take any measures nece	suant to the respectivessary to enact this ag nied the benefits of, o	ve title, section and/or a greement, to the effect	act, as promulgated by the that no person shall on the that no person shall on the that no person shall on the	of the Rehabilitation Act of the regulations of the Depa the grounds of the application er any program and/or act	rtment of Health and ble categories such a	Human Servic s race, color, r	es and hereby give a national origin, sex, a	assurance that I/We	e will immed e excluded fr	om
luman Services, the Sec	cretary of Health and	d Human Services, or th	he Medicaid Investigation	care and/or services provio ns Division, such informati as authorized by 42 C.F.I	on from those records					
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copayment required by th	the Hawaii State Med and those established	licaid Program to be pa d by the Hawaii State D	aid by the Medicaid recip Department of Human Se	ne Hawaii State Medicaid ient as stipulated in 42 C.F rvices for services rendere tive Rules.	.R. §447.15. I/We an	n aware that it	is violation of Federa	al law to accept or i	require addit	tional
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Review Provider Participation Agreement

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provider for the period during which the Federal F provider in consideration of and for the purpose o and Human Services, through the Hawaii State D representations and agreements made in this Ass service provider, its successors, transferees, and	f receiving o epartment o surance and	r benefiting from eith f Human Services. T that the United State	ner directly or indirectly or indirect The service provider es and/or the State of	ctly any or all Fede recognizes and ag of Hawaii shall hav	al Financial Assis rees that such Fe the right to seek	stance that is ex deral Financial / judicial enforce	tended after the date Assistance will be ext ment of the Assurance	hereof by the Dep tended in reliance of ce. This Assurance	artment of ⊢ on the	lealth
RETROACTIVE CERTIFICATION:										
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AGREEMENT & ACKNOWLEDGEMENT: I agree and meaning as my handwritten signature. I will n the organization that I am authorized to represent which this documentation is submitted. An electro reproduced for future use. It is also acknowledged	ot, at any tir , consent to onic record w	ne in the future, repu do business electro vill be kept of the door	udiate the meaning on nically. This electror cumentation with wh	of my electronic sig nic signature will fu ich the electronic s	nature or claim th action as acknowl ignature is associ	at my electronic edgement that I ated. This electr	signature is not lega am authorized to rep ronic record will be re	lly binding. Likewis present and bind th	e, I, on beha e organizati	alf of
The undersigned attest that they have entered int this electronic agreement and to maintain enrollm	0				ee an authorized r	representative o	f the enrolling entity I	nas the authority to	sign and su	ıbmit
☐I/We have read all of the Prov	vider Agı	reement and (Participation e to its terms		aii State M	edicaid Progr	am and fully	underst	and
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Mylnbox > New Enrollment > Atypical Individual Enrollment								
plication ID: 20200226119723	Name: Individual, Miranda							
our Application Number 20200226119723 has been successfully	hmitted for State review. Beturn with this application r	umber to track the status o	f your application	n v				
Close	sinded for state review. Retain with this appreadon i		r your uppricute					
Enroll Provider - Atypical Individual								^
	Business Process V	Vizard - Provider Enrollme	nt (Atypical Ind	lividual). Click o	n the Step #	under th	e Step C	olumn
tep	Required	Start Date	End Date	Status		Step Remark		
tep 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete	9			
tep 2: Add Locations	Required	02/26/2020	02/26/2020	Complete	e			
tep 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete	e			
tep 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete	e			
tep 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete	e			
tep 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete	e			
tep 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete	e			
tep 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	e			
tep 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete	e			
tep 10: Upload Documents	Required	02/26/2020	02/26/2020	Complete	e			
	Required	02/26/2020	02/26/2020	Complete	9			
tep 11: Complete Enrollment Checklist			02/20/2020	Complete				
tep 11: Complete Enrollment Checklist tep 12: Submit Enrollment Application for Approval	Required Viewing Pa	02/26/2020	02/26/2020	Complete	-			

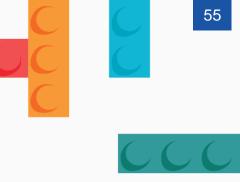
Contact Med-QUEST

https://medquest.hawaii.gov/HOKU

Email: hcsbinquiries@dhs.hawaii.gov Phone: 808-692-8099 Fax: 808-692-8087

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Thank You!

Persistence, Perseverance and Passion as always remains our credo.