



## Facility/Agency/Organization Enrollment HOKU New Application Path

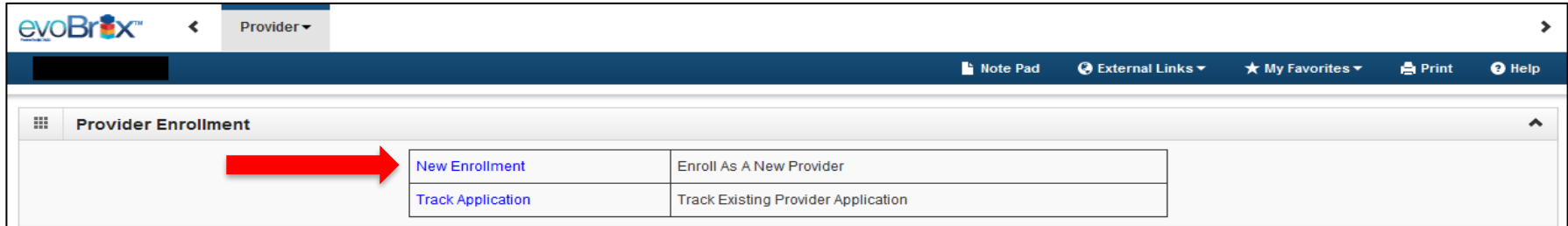
October 21, 2020

# Selecting FAO Enrollment Type

- If the provider being enrolled is a medical or health care Facility, Agency, or Organization (FAO), **that has an NPI**, please select the FAO Enrollment Type.
- FAO providers include:
  - ☐ Hospitals
  - ☐ Nursing Facilities
  - ☐ Assisted Living Facilities
  - ☐ Rural Health Clinics
  - ☐ Federally-Qualified Health Clinics
  - ☐ Laboratories and Imaging Centers
  - ☐ Rehabilitation Centers
  - ☐ Mental Health Facilities
  - ☐ Dialysis Centers
  - ☐ Outpatient Surgical Centers

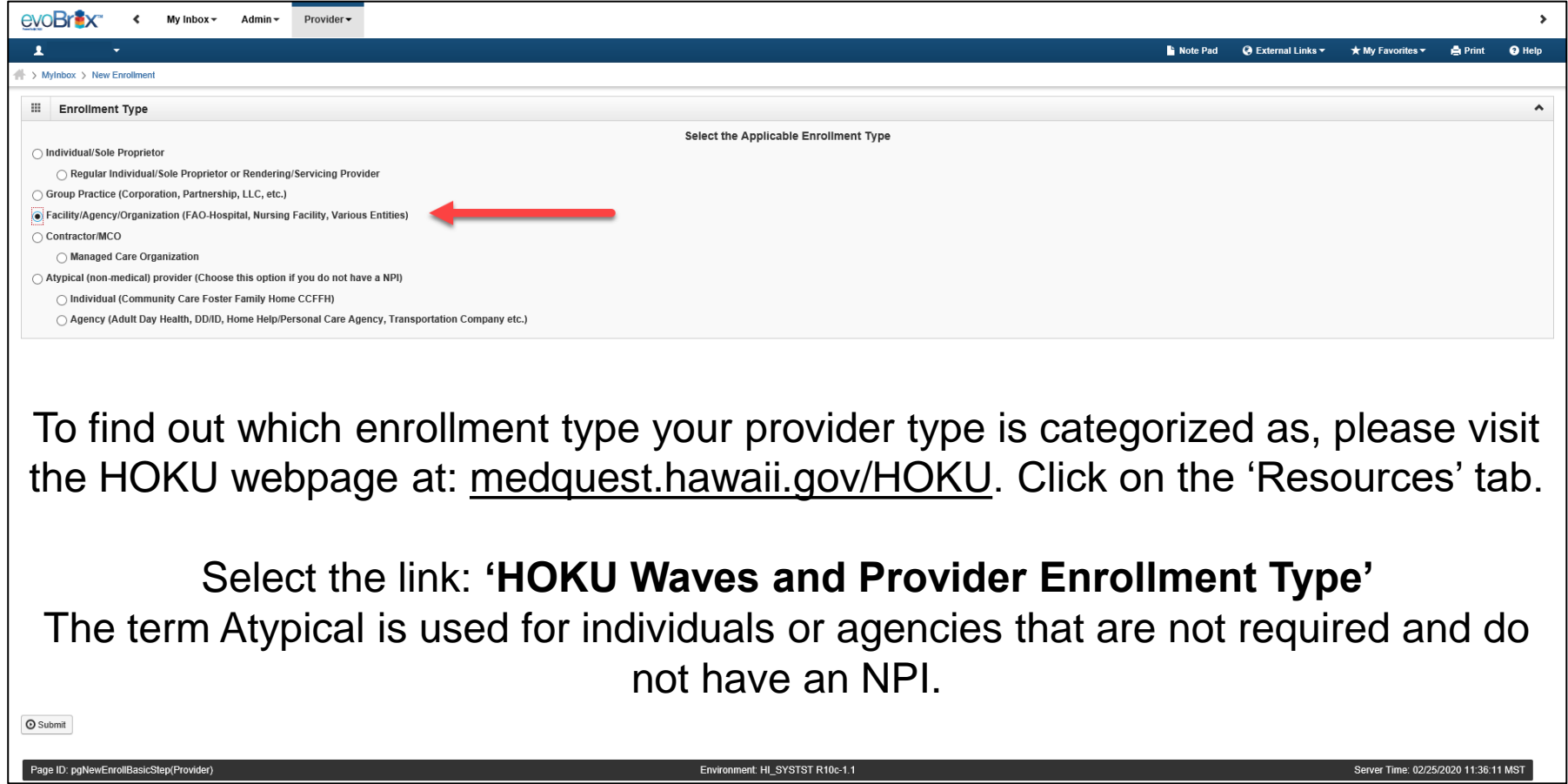
# Provider Enrollment Application Selection

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- 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 FAO Enrollment Button



The screenshot shows the 'evoBrox' web application interface. The top navigation bar includes 'My Inbox', 'Admin', and 'Provider'. The main content area is titled 'Enrollment Type' and contains a section 'Select the Applicable Enrollment Type'. The following options are listed with radio buttons:

- ☐ 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
  - ☐ 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.)

A red arrow points to the 'Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)' option, which is selected. At the bottom left, there is a 'Submit' button. The footer contains the following information:

Page ID: pgNewEnrollBasicStep(Provider)      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/25/2020 11:36:11 MST

To find out which enrollment type your provider type is categorized as, please visit the HOKU webpage at: [medquest.hawaii.gov/HOKU](https://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	
Legal Entity Name:	<input type="text"/> * (As shown on the Income Tax Return)
Entity Business Name:	<input type="text"/> * (Doing Business As)
EIN/TIN:	<input type="text"/> *
NPI:	<input type="text"/> *

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


[View Screening Result](#) [Confirm](#) [Finish](#) [Cancel](#)

Page ID: dlgAddBasicInformationStep1(Provider)

# Application ID

 Print  Help

Application ID: 20200225447257Name: Ohana


 Basic Information ^

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

Your Application ID is: [20200225447257](#)

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: dgAddBasicInformationStep3(Provider)

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# Step 2: Add Locations



My Inbox

Admin

Provider

Person icon

Note Pad

External Links

My Favorites

Print

Help

MyInbox

 > 

New Enrollment

 > 

FAO Enrollment

Application ID: 20200225447257

Name: Ohana

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"/> ▲▼	▲▼	▲▼	▲▼
No Records Found !			

Page ID: pgLocationListForEnrlmnt(Provider)

Environment: HI\_SYSTST R10c-1.1

Server Time: 02/25/2020 12:02:40 MST



# Add Primary Practice Address

PrintHelp

Application ID: 20200225447257Name: Ohana

Add Provider Location

Location Type:Primary Practice Location\*

Doing Business As:

End Date:

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

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

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

Address Line 2:

Address Line 3:

State/Province:OTHER\*

Country:UNITED STATES\*

Web Page:

City/Town:OTHER\*

County:OTHER

Zip Code: \*-Validate Address

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

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

Handicap Accessible:No

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

(For Multiple Selection, use Ctrl Key)

Page ID: digEnrAddLocation(Provider)

OKCancel

innovation@work

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# Add Pay To Address

evoBrx™ < My Inbox ▾ Admin ▾ Provider ▾ >

My Inbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257 Name: Ohana

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

### Locations List

Filter By ▾   Go

Save Filters ▾ My Filters ▾

Doing Business As ▴ ▾	Location Type ▴ ▾	Location Details ▴ ▾	End Date ▴ ▾
<input type="checkbox"/>	Primary Practice Location	515 E 100 S, Salt Lake City, UTAH 84102	12/31/2999

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

Page ID: pg.LocationListForEnrImnt(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:09:20 MST

innovation@work

# Add Pay To Address

Help

Application ID: 20200225447257

Name: Ohana

Add Provider Location Address

Type of Address: Pay To

End Date:

Location Address: ☐ Copy This Location Address

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

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

Address Line 1:  \*

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER \*

State/Province: OTHER \*

County: OTHER

Country: UNITED STATES \*

Zip Code:  \* -

Page ID: digEnrlLocationAddress(Provider)

innovation@work

# Step 3: Add Correspondence Address

evoBrx

My Inbox

Admin

Provider

Farrington,Zak

Note Pad

External Links

My Favorites

Print

Help

MyInbox

New Enrollment

FAO Enrollment

Application ID: 20200225447257

Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required			Incomplete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add 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	Required			Incomplete	
Step 10: Fee Payment	Optional			Incomplete	
Step 11: Upload Documents	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

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Viewing Page: 1

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Next


Last

Page ID: pgBPWOrganizationStart(Provider)

Environment: HI\_SYSTST R10c-1.1

Server Time: 02/25/2020 12:17:25 MST

# Add Correspondence Address

 < My Inbox ▾ Admin ▾ Provider ▾ >

ⓘ Note Pad ↻ External Links ▾ ★ My Favorites ▾ 🖨 Print ⓘ Help

< > MyInbox > New Enrollment > FAO Enrollment > General

Application ID: 20200225447257 Name: Ohana

⊞ Close ⊕ Add

⊞ Correspondence Address List ^

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

Page ID: pgCorrespondenceListForEnrlmnt(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:18:59 MST

# Add Correspondence Address

Print
Help

Application ID: 20200225447257
Name: Ohana

Add Correspondence Address

Phone Number:  \* Extn: 
Fax Number:

Communication Preference:  \*
Email Address:

End Date:

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

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

Address Line 1:  \*  
(Enter Street Address or PO Box Only)
Address Line 2:

Address Line 3: 
City/Town: OTHER  \*

State/Province: OTHER  \*
County: OTHER

Country: UNITED STATES  \*
Zip Code:  \* -

Page ID: dlgEnrCorrespondenceAddress(Provider)



# Add Correspondence Address

evoBrx™ < My Inbox ▾ Admin ▾ Provider ▾ >

MyInbox > New Enrollment > FAO Enrollment > General

Application ID: 20200225447257 Name: Ohana

Close Add

### Correspondence Address List

Address Type ▲▼	Address ▲▼	End Date ▲▼
<input type="checkbox"/> Correspondence	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: pgCorrespondenceListForEnrmtnt(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:23:20 MST

# Step 4: Add Provider Type/Specialties/Subspecialties

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evoBrx™

< My Inbox ▾ Admin ▾ Provider ▾

>

My Inbox ▾ New Enrollment ▾ FAO Enrollment

Application ID: 20200225447257

Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add 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	Required			Incomplete	
Step 10: Fee Payment	Optional			Incomplete	
Step 11: Upload Documents	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

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Viewing Page: 1

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Page ID: pgBPWOrganizationStart(Provider)

Environment: HI\_SYSTST R10c-1.1



Server Time: 02/25/2020 12:25:14 MST

# Add Provider Type/Specialties/Subspecialties

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

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

[Home](#) > [MyInbox](#) > [New Enrollment](#) > [FAO Enrollment](#)

Application ID: 20200225447257Name: Ohana

Close

Add

Provider Type/Specialty/Subspecialty List

Filter By 

Go

Save Filters

My Filters

Specialty/Subspecialty	Provider Type	End Date
<div>▲▼</div>	<div>▲▼</div>	<div>▲▼</div>
No Records Found !		

Page ID: pgLctnSpcltyListForEnrlmnt(Provider)Environment: HI\_SYSTST R10c-1.1Server Time: 02/25/2020 12:30:26 MST

# Add Provider Type/Specialties/Subspecialties

Help

Application ID: 20200225447257      Name: Ohana

Add Provider Type/Specialty

Provider Type:  ▼ \*

Specialty:  ▼ \*

Select 'No Specialty' if applicable.

End Date:

Add Subspecialty

Available Subspecialties

Associated Subspecialties \*

>>

<<

No Subspecialty

Select 'No Subspecialty' if applicable.

✓ OK

Cancel

Page ID: dlgEntAddSpecialties(Provider)

# Add Provider Type/Specialties/Subspecialties

evoBrx™ < My Inbox ▾ Admin ▾ Provider ▾ >

My Inbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257 Name: Ohana

Close Add

### Provider Type/Specialty/Subspecialty List

Filter By ▾   Go Save Filters My Filters ▾

Specialty/Subspecialty ▴ ▾	Provider Type ▴ ▾	End Date ▴ ▾
<input type="checkbox"/> NO SPECIALTY REQUIRED/No Subspecialty	HOSPITAL	12/31/2999

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

Page ID: pgLcInSpcltyListForEnrInmn(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:35:10 MST

# Step 5: Associate Billing Provider

evoBrx™ < My Inbox ▾ Admin ▾ Provider ▾

My Inbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257 Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional			Incomplete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional			Incomplete	
<a href="#">Step 7: Add Additional Information</a>	Optional			Complete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 9: Add Taxonomy Details</a>	Required			Incomplete	
<a href="#">Step 10: Fee Payment</a>	Required			Incomplete	Please add Fee Payments.
<a href="#">Step 11: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 12: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 13: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

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Page ID: pgBPWOrganizationStart(Provider) Environment: HL\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:36:37 MST

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

# Associate Billing Provider

The screenshot shows the evoBrox application interface. At the top, there is a navigation bar with the evoBrox logo and tabs for 'My Inbox', 'Admin', and 'Provider'. Below this is a dark blue header with icons for 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. The main content area shows the breadcrumb 'MyInbox > New Enrollment > FAO Enrollment'. Below this, there is a section for 'Application ID: 20200225447257' and 'Name: Ohana'. A 'Close' button is highlighted with a red box. Below this is a section titled 'Billing Provider/Other Associations List' with a table. The table has columns for 'NPI/Med-QUEST ID', 'Provider Name', 'Start Date', 'End Date', and 'Status'. The table is currently empty, and a red message 'No Records Found!' is displayed below it. At the bottom, there is a footer with 'Page ID: pgBillingProviderListForEnrImnt(Provider)', 'Environment: HI\_SYSTST R10c-1.1', and 'Server Time: 02/25/2020 12:43:55 MST'.

Application ID: 20200225447257 Name: Ohana

Close Add

Billing Provider/Other Associations List

Filter By [dropdown] [input] [input] 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: 02/25/2020 12:43:55 MST


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

# Associate Billing Provider


 Print  Help

Application ID: 20200225447257


Name: Ohana

 Associate Billing Provider/Other Associations


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




Type:   \*

ID:  \*

Start Date:   \*

Provider Name:

End Date:  

 Confirm Provider  Ok  Cancel

Page ID: dlgBillingProviderID(Provider)



# Step 6: Add License/Certification

evoBrx™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required	02/25/2020	02/25/2020	Complete	
Step 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Fee Payment	Required			Incomplete	Please add Fee Payments.
Step 11: Upload Documents	Required			Incomplete	Please upload required documents.
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1GoPage CountSaveToXLS

Viewing Page: 1

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Page ID: pgBPWOrganizationStart(Provider)Environment: HI\_SYSTST R10c-1.1Server Time: 02/25/2020 12:46:18 MST

# Add License/Certification

Application ID: 20200225447257 Name: Ohana

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
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](https://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: pgLicenseListForEnrlmnt(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:47:51 MST

# Add License/Certification

Print Help

Application ID: 20200225447257 Name: Ohana

**Add License/Certification/Other**

License/Certification/Other Type:  \*

License/Certification/Other #:  \*

Valid Flag:

Effective Date:  \*

End Date:

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

**Add License/Certification/Other**

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

License/Certification/Other #:  \*

Valid Flag:

License Classification Type:

Effective Date:

End Date:

Confirm License/Certification/Other OK Cancel

Page ID: dlqEntfmmAddLicense(Provider)

# Add License/Certification

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257
 Name: Ohana

Close
Add

**License/Certification/Other List**

Filter By ▾
 

Go
Save Filters
My Filters ▾

<input type="checkbox"/> ▲▼	License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Date
<input type="checkbox"/>	HI Board of Nursing	123789456	No	02/25/2020	12/31/2999
<input type="checkbox"/>	HCFA/CLIA	456123789	No	02/25/2020	12/31/2999
<input type="checkbox"/>	H&CB Case Management Agency	789456123	No	02/25/2020	12/31/2999

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

Page ID: pgLicenseListForEnrlmnt(Provider)
 Environment: HI\_SYSTST R10c-1.1
 Server Time: 02/25/2020 12:52:13 MST

# Step 7: Add Additional Information

evoBrx™

My Inbox ▾

Admin ▾

Provider ▾

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257

Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/25/2020	02/25/2020	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	02/25/2020	02/25/2020	Complete	
<a href="#">Step 7: Add Additional Information</a>	Optional			Complete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 9: Add Taxonomy Details</a>	Required			Incomplete	
<a href="#">Step 10: Fee Payment</a>	Required			Incomplete	Please add Fee Payments.
<a href="#">Step 11: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 12: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 13: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1

Go

Page Count

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Page ID: pgBPWOrganizationStart(Provider)

Environment: HI\_SYSTST R10c-1.1

Server Time: 02/25/2020 12:53:02 MST

# Add Additional Information

evoBrx™ < My Inbox ▾ Admin ▾ Provider ▾

My Inbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257 Name: Ohana

Close

### Authorized Representative List

Add

Filter By ▾   Go

Save Filters My Filters ▾

Representative Name	Start Date	End Date
No Records Found !		

### Bed Information

Add

Filter By ▾   Go

Save Filters My Filters ▾

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

### NPI List

Add



Filter By ▾   Go

Save Filters My Filters ▾

NPI	Start Date	End Date
No Records Found !		



Page ID: pgAdditionalInfoListForEnrlnmt(Provider) Environment: HL\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:54:19 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: dlglEnrlmntAddAuthorizedRep(Provider)

# Add Bed Information

Print Help

Med-QUEST ID: 000242

Name: Hawaii Cares

NPI: 1558744870



## Add Bed Information



Bed Type:  \*

Bed(s)/Unit(s):  \*

Start Date:  \*

End Date:

OK Cancel



# Add NPI

Print Help

Med-QUEST ID: 000242

Name: Hawaii Cares

NPI: 1558744870



## Add NPI Details



NPI:  \*

Start Date:  \*

End Date:

✓ OK

⊗ Cancel

Page ID: dlgManageNPI(Provider)

# Step 8: Add Controlling Interest/Ownership Details

34

evoBrx™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInboxNew EnrollmentFAO Enrollment

Application ID: 20200225447257Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 2: Add Locations</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 3: Add Correspondence Address</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 4: Add Provider Type/Specialties/Subspecialties</a>	Required	02/25/2020	02/25/2020	Complete	
<a href="#">Step 5: Associate Billing Provider/Other Associations</a>	Optional	02/25/2020	02/25/2020	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	02/25/2020	02/25/2020	Complete	
<a href="#">Step 7: Add Additional Information</a>	Optional	02/25/2020	02/25/2020	Complete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 9: Add Taxonomy Details</a>	Required			Incomplete	
<a href="#">Step 10: Fee Payment</a>	Required			Incomplete	Please add Fee Payments.
<a href="#">Step 11: Upload Documents</a>	Required			Incomplete	Please upload required documents.
<a href="#">Step 12: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 13: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1GoPage CountSaveToXLS

Viewing Page: 1

FirstPrevNextLast

Page ID: pgBPWOrganizationStart(Provider)Environment: HI\_SYSTST R10c-1.1Server Time: 02/25/2020 12:57:32 MST

innovation@work

# Add Owner

evoBrix™ < My Inbox Admin Provider >

Note Pad External Links My Favorites Print Help

MyInbox > New Enrollment > FAO Enrollment > General

Application ID: 20200225447257 Name: Ohana

Close Actions ⓘ

Pe Add Owner Import Owner

PROVIDER Owners Relationships CONTROL DISCLOSURES

Provider E Owners Adverse Action

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

**REQUIRED DISCLOSURE INFORMATION**

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

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

No Records Found !

https://hi-trg-evo.cns-inc.com/evoBrix/CNSiControlServlet Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 12:59:39 MST

# Add Ownership

Print
Help

Application ID: 20200225447257
Name: Ohana

**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: 20200225447257
Name: Ohana

Provider Controlling Interest/Ownership

Type:
Managing Employee
\*

SSN:
126538456
\*

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

Owner NPI:

First Name:
Anne
\*

Suffix:

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

Start Date:
02/25/2020
\*

Percentage Owned:
50
\*

EIN/TIN:

Entity Business Name:
  
(Doing Business As)

Last Name:
Jones
\*

DOB:
02/25/1970
\*

Email:

End Date:

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

Address Type:
Home Address

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

Address validation successful

Address Line 1:
515 E 100 S
\*
  
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town:
Salt Lake City
\*

State/Province:
UTAH
\*

County:
Salt Lake

Country:
UNITED STATES
\*

Zip Code:
84102
\*
4211
Validate Address

OK
Cancel

Page ID: dlgEntInmtAddOwner(Provider)

# Add Owners Relationship

Application ID: 20200225447257      Name: Ohana

Close   **Actions**

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

PROVIDER DISCLOSURES

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

**REQUIRED DISCLOSURE INFORMATION**

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

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

**REQUIRED OWNERS**

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

**Owners List**

Filter By  And Indicator

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 126538456	Jones, Anne	Managing Employee	515 E 100 S	02/25/2020	12/31/2999	Not Completed	Not Completed	50
<input type="checkbox"/> 759856966	Jones, John	Agent	515 E 100 S	02/25/2020	12/31/2999	Not Completed	Not Completed	50

https://hi-trg-evo.cns-inc.com/evoBrix/CNSiControlServlet      Environment: HI\_SYSTST R10c-1.1      Server Time: 02/25/2020 01:07:26 MST

# Add Owners Relationship

Help

Application ID: 20200225447257      Name: Ohana

**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: Jones, John   SSN/EIN/TIN: 759856966   Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Jones, John	Relation to Assoc. Owner
Jones, Anne	126538456	Managing Employee	Spouse	Spouse

View Page: 1 Page Count Save To XLS      Viewing Page: 1      << First   < Prev   Next >   >> Last

▶ Selected Owner: Jones, Anne   SSN/EIN/TIN: 126538456   Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)



# Complete Adverse Actions

Application ID: 20200225447257 Name: Ohana

Close Actions

Pe Add Owner  
Import Owner  
PROVIDER Owners Relationships  
Providers Adverse Action

Annual  
PROVIDER OWNERSHIP DISCLOSURES  
Provider Enrollment: The following home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).  
REQUIRED DISCLOSURE INFORMATION  
Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:  

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

REQUIRED OWNERS

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

Owners List

Filter By  And Indicator  Go

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 126538456	Jones, Anne	Managing Employee	515 E 100 S	02/25/2020	12/31/2999	Completed	Not Completed	50
<input type="checkbox"/> 759856966	Jones, John	Agent	515 E 100 S	02/25/2020	12/31/2999	Completed	Not Completed	50

https://hi-trg-evo.cns-inc.com/evobrix/CNSiControlServlet Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 01:13:27 MST

# Disclose Adverse Actions

Print
Help

Application ID: 20200225447257
Name: Ohana

Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;

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

Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if the interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;

Is an officer or director of a disclosing entity that is organized as a corporation; or

Is a partner in a disclosing entity that is organized as a partnership?

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

"Subcontractor" means:

An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

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

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

**FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY**

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

Owners with Adverse Action

Filter By
All
Go
Save Filters
My Filters

Owner Name ▲▼	SSN/EIN/TIN ▲▼	Response ▲▼	Comments ▲▼
Jones, Anne	126538456	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Jones, John	759856966	<input type="radio"/> Yes <input checked="" type="radio"/> No	

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Go
Page Count
SaveToXLS
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First
Prev
Next
Last

Ok
Cancel

Page ID: pgEnrlmntAdverseAction(Provider)

# Step 9: Taxonomy Details

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My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInboxNew EnrollmentFAO Enrollment

Application ID: 20200225447257Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required	02/25/2020	02/25/2020	Complete	
Step 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete	
Step 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/25/2020	02/25/2020	Complete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Fee Payment	Required			Incomplete	Please add Fee Payments.
Step 11: Upload Documents	Required			Incomplete	Please upload required documents.
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	


View Page: 1GoPage CountSaveToXLS

Viewing Page: 1

FirstPrevNextLast

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# Taxonomy Details

 < My Inbox ▾ Admin ▾ Provider ▾ >

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

< > MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257 Name: Ohana

 Taxonomy List ^

Filter By ▾

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

Page ID: pgTaxonomyListForEnrlmnt(Provider) Environment: HI\_SYSTST R10c-1.1 Server Time: 02/25/2020 01:17:45 MST

# Add Taxonomy

Print Help

Application ID: 20200225447257 Name: Ohana

**Add Taxonomy**

Taxonomy Code:  \* (Click here for Taxonomy List)

Description:

Start Date:  \* End Date:

Today's Date

Confirm Taxonomy Ok Cancel

Page ID: dlgEntAddTaxonomy(Provider)

# NUCC Taxonomy Code List

The screenshot shows a web browser window with the URL [taxonomy.nucc.org](http://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 links including "Introduction", "National Uniform Claim Committee Website", "Help", and a tree view of "Individual or Groups (of Individuals)" with sub-categories like "Group", "Multi-Specialty", "Single Specialty", "Allopathic & Osteopathic Physicians", "Allergy & Immunology", "Anesthesiology", "Dermatology", "Emergency Medicine", and "Family Medicine".

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

**Name**  
Introduction

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

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

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

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

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

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

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

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

# Step 10: Fee Payment

evoBrx™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required	02/25/2020	02/25/2020	Complete	
Step 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete	
Step 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/25/2020	02/25/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/25/2020	02/25/2020	Complete	
Step 10: Fee Payment	Required			Incomplete	Please add Fee Payments.
Step 11: Upload Documents	Required			Incomplete	Please upload required documents.
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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# Fee Payment

My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257
Name: Ohana

Close
Add

Fee Payment List

Filter By ▾

Go
Save Filters
My Filters ▾

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

Page ID: pgEnrlmnFeePaymentList(Provider)
Environment: HI\_SYSTST R10c-1.1
Server Time: 02/25/2020 01:22:35 MST



# Fee Payment

Print Help

Application ID: 20200225447257

Name: Ohana

## Fee Payment

Payment Reason: New Enrollment

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

Fee Paid To:

Payment Date:

Payment Status:

Confirmation Number:

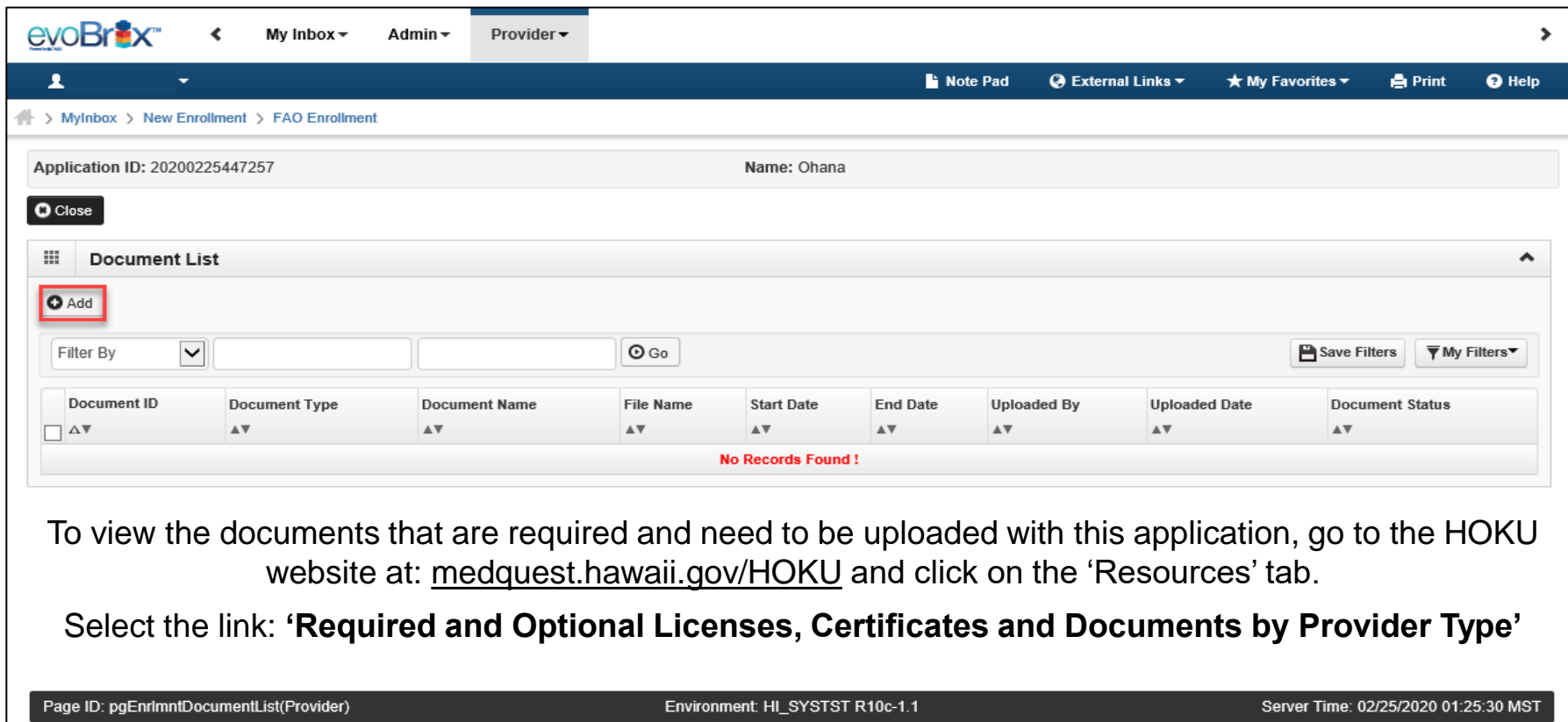
During the COVID-19 Public Health Emergency (PHE), Fee Payments will temporarily be waived. Select 'COVID-19 Waiver.' When the PHE is over, Med-QUEST will send out a correspondence informing providers to mail in their Fee Payment.

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

Ok Cancel

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# Upload Documents



The screenshot shows the evoBrox application interface. At the top, there's a navigation bar with 'My Inbox', 'Admin', and 'Provider' tabs. Below this, a breadcrumb trail reads 'MyInbox > New Enrollment > FAO Enrollment'. The main content area displays 'Application ID: 20200225447257' and 'Name: Ohana'. A 'Close' button is visible. Below this is a 'Document List' section with an 'Add' button highlighted by a red box. The list has columns for Document ID, Document Type, Document Name, File Name, Start Date, End Date, Uploaded By, Uploaded Date, and Document Status. The status 'No Records Found!' is displayed in red. At the bottom, a footer bar contains 'Page ID: pgEnrlmntDocumentList(Provider)', 'Environment: HI\_SYSTST R10c-1.1', and 'Server Time: 02/25/2020 01:25:30 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](https://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

PrintHelp

Application ID: 20200225447257Name: Ohana

Upload Document

Document Type:--SELECT--\*

Document Name:\*

File Name:Browse...

Start Date:

End Date:

Remark:

OKCancel

Page ID: dlgEnrlmntAttachment(Provider)

# Upload Documents

evoBrx™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInboxNew EnrollmentFAO Enrollment

Application ID: 20200225447257Name: Ohana

Close

Document List

Add

Filter ByGoSave FiltersMy Filters

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Document Status
<input type="checkbox"/> 75049141	Certification	DOH Certificate	HOKU Banner_FINAL.png			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049142	Fee Verification	Fee Payment Receipt	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049143	License	HI Board Of Examiners In Naturopathy	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049144	Tax	W9 Indicator	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049145	Form	Acute Hospital Form	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049146	Letter	CMS Approval Letter	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049147	Certification	HCFA/CLIA	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049148	License	H&CB Case Management Agency	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process
<input type="checkbox"/> 75049149	License	HI Board Of Nursing	HI T3 Agenda.docx			Zak Farrington	02/25/2020	In Process

DeleteView Page: 1GoPage CountSaveToXLSViewing Page: 1FirstPrevNextLast

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innovation@work

# Enrollment Checklist

evoBrx

My Inbox

Admin

Provider

Note Pad

External Links

My Favorites

Print

Help

MyInbox

New Enrollment

FAO Enrollment

Provider Check List

Application ID: 20200225447257

Name: Ohana

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 applying as a Private Duty Nurse (LPN/RN) for private duty services?	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: 02/25/2020 01:36:07 MST

# Step 13: Submit Application

evoBrx™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

My Inbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257Name: Ohana

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required	02/25/2020	02/25/2020	Complete	
Step 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete	
Step 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/25/2020	02/25/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/25/2020	02/25/2020	Complete	
Step 10: Fee Payment	Required	02/25/2020	02/25/2020	Complete	
Step 11: Upload Documents	Required	02/25/2020	02/25/2020	Complete	
Step 12: Complete Enrollment Checklist	Required	02/25/2020	02/25/2020	Complete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	


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# Submit Application


My Inbox ▾
Admin ▾
Provider ▾


Note Pad
External Links ▾
My Favorites ▾
Print
Help

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257
Name: Ohana

Close
Next

Final Submission

Application ID: 20200225447257
EnrollmentType: Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

The information submitted for enrollment shall be verified and reviewed by the State.

During this time, any changes to the information shall not be accepted.

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

Application Document Checklist

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

Page ID: pgSubmitEnrlmnt(Provider)
Environment: HI\_SYSTST R10c-1.1
Server Time: 02/25/2020 01:38:38 MST

innovation@work

innovation@work

# Submission Complete

evoBrox™

My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20200225447257Name: Ohana

Your Application Number 20200225447257 has been successfully submitted for State review. Return with this application number to track the status of your application.  
Your Med-QUEST ID is 100041

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required	02/25/2020	02/25/2020	Complete	
Step 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete	
Step 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/25/2020	02/25/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/25/2020	02/25/2020	Complete	
Step 10: Fee Payment	Required	02/25/2020	02/25/2020	Complete	
Step 11: Upload Documents	Required	02/25/2020	02/25/2020	Complete	
Step 12: Complete Enrollment Checklist	Required	02/25/2020	02/25/2020	Complete	
Step 13: Submit Enrollment Application for Approval	Required	02/25/2020	02/25/2020	Complete	

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Page ID: pgBPWOrganizationStart(Provider)Environment: HL\_SYSTST R10c-1.1Server Time: 02/25/2020 01:43:11 MST

# *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.*