



Group Enrollment HOKU New Application Path

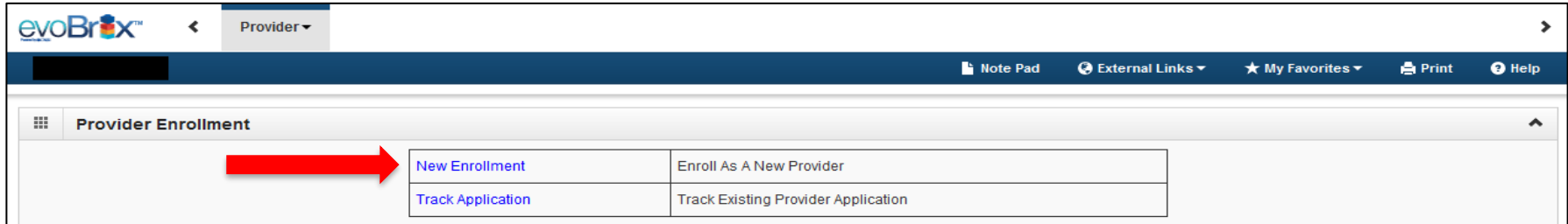
October 21, 2020

Selecting Group Enrollment Type

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

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 Group Enrollment Button

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< My Inbox ▾ Admin ▾ Provider ▾ >

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

🏠 > MyInbox > New Enrollment

☰ Enrollment Type ^

Select the Applicable Enrollment Type

☐ Individual/Sole Proprietor

☐ Regular Individual/Sole Proprietor or Rendering/Service Provider

☒ Group Biller

☐ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

☐ Contractor/MCO

☐ Managed Care Organization

☐ Atypical (non-medical) provider (Choose this option if you do not have a NPI)

☐ Individual (Community Care Foster Family Home CCFFH)

☐ Agency (Adult Day Health, DD/ID, Home Help/Personal Care Agency, Transportation Company etc.)

🕒 Submit

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"/> * <input type="button" value="v"/>
W-9 Entity Type (If Other):	<input type="text"/>
Profit Status:	<input type="text"/> * <input type="button" value="v"/>

Application ID

 Print  Help

Application ID: 20200226291324Name: Hawaii Group


 Basic Information ^

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

Your Application ID is: **20200226291324**

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

 Ok

Page ID: dlgAddBasicInformationStep3(Provider)

Enrollment Steps

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Provider ▾

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External Links ▾
My Favorites ▾
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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
Name: Hawaii Group

Close

Enroll Provider - Group

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

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

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Step 2: Add Locations

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< My Inbox ▾ Admin ▾ Provider ▾

>

👤 ▾

Note Pad External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close Add

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

☰

Locations List

Filter By ▾ Go

Save Filters My Filters ▾

Doing Business As ▲▼	Location Type ▲▼	Location Details ▲▼	End Date ▲▼
No Records Found !			

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

Add Primary Practice Address

PrintHelp

Application ID: 20200226291324Name: Hawaii Group

Add Provider Location

Location Type:Primary Practice Location*

Doing Business As:

End Date:

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

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

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

Address Line 2:

Address Line 3:

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:EnglishBisayan/VisayanChinese (which includes Mandarin or Cantonese)

(For Multiple Selection, use Ctrl Key)

OKCancel

Page ID: dlgEntlAddLocation(Provider)

innovation@work

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Add Pay To Address

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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

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 ▾

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

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innovation@work

Add Pay To Address

Help

Application ID: 20200226291324

Name: Hawaii Group

Add Provider Location Address

Type of Address:

-SELECT-

Pay To

End Date:

Location Address: ☐ Copy This Location Address

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

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

Address Line 1: *

(Enter Street Address or PO Box Only)

Address Line 3:

State/Province:

OTHER

 *

Country:

UNITED STATES

 *

Address Line 2:

City/Town:

OTHER

 *

County:

OTHER

Zip Code: * -

Validate Address

OK

Cancel

Page ID: dlgEnrlLocationAddress(Provider)

Step 3: Add Correspondence Address

My Inbox ▾
Admin ▾
Provider ▾

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External Links ▾
My Favorites ▾
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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
Name: Hawaii Group

Close

Enroll Provider - Group

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

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

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Add Correspondence Address

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾ >

MyInbox > New Enrollment > Group Biller > General

Application ID: 20200226291324 Name: Hawaii Group

Close Add

Correspondence Address List

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

Page ID: pgCorrespondenceListForEnrImnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 03:08:39 MST

Add Correspondence Address

Print
Help

Application ID: 20200226291324
Name: Hawaii Group

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, DRAWER 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

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

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

Address Line 3:
City/Town: *

State/Province: *
County:

Country: *
Zip Code: * -

Validate Address

OK Cancel

Page ID: dlgEnrlCorrespondenceAddress(Provider)

Step 4: Add Provider Type/Specialties/Subspecialties

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My InboxAdminProvider

Note PadExternal LinksMy FavoritesPrintHelp

MyInboxNew EnrollmentGroup Biller

Application ID: 20200226291324Name: Hawaii Group

Close

Enroll Provider - Group

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

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

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Add Provider Type/Specialties/Subspecialties

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>

👤 ▾

Note Pad External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close Add

Provider Type/Specialty/Subspecialty List

Filter By ▾ ▾ ▾ Go Save Filters My Filters ▾

Specialty/Subspecialty	Provider Type	End Date
▢ ▴ ▾	▴ ▾	▴ ▾
No Records Found !		

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Provider Type/Specialties/Subspecialties

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Application ID: 20200226291324 Name: Hawaii Group

Add Provider Type/Specialty

Provider Type: *

Specialty: *

Select 'No Specialty' if applicable.

End Date:

Add Subspecialty

Available Subspecialties

Associated Subspecialties *

»

«

Select 'No Subspecialty' if applicable.

☒ OK

Page ID: dlgEnrlAddSpecialties(Provider)

Add Provider Type/Specialties/Subspecialties

My Inbox ▾
Admin ▾
Provider ▾

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External Links ▾
My Favorites ▾
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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
Name: Hawaii Group

Close
Add

Provider Type/Specialty/Subspecialty List

Filter By ▾

Go
Save Filters
My Filters ▾

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

Delete
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Step 5: Associate Billing Provider

Application ID: 20200226291324 Name: Hawaii Group

[Close](#)

Enroll Provider - Group

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


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

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



Associate Billing Provider


 < My Inbox ▾ Admin ▾ Provider ▾ >




My Inbox ▾ External Links ▾ My Favorites ▾ Print Help

> MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

 Close  Add


 Billing Provider/Other Associations List ^

Filter By ▾  Go  Save Filters  My Filters ▾

NPI/Med-QUEST ID △ ▾	Provider Name ▲ ▾	Start Date ▲ ▾	End Date ▲ ▾	Status ▲ ▾
No Records Found !				

Page ID: pgBillingProviderListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 03:15:41 MST

Step 6: Add Additional Information


My Inbox ▾
Admin ▾
Provider ▾

Note Pad
External Links ▾
My Favorites ▾
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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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 Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Upload Documents	Required			Incomplete	Please upload required documents.
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	

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Add Additional Information

evoBrox™ < My Inbox ▾ Admin ▾ Provider ▾

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close

Authorized Representative List ←

+ Add

Filter By ▾ Go Save Filters My Filters ▾

Representative Name	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼

No Records Found !

NPI List ←

+ Add



Filter By ▾ Go Save Filters My Filters ▾

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

No Records Found !


Page ID: pgAdditionalInfoListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 03:20:06 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 Additional NPIs

 Print  Help

Application ID:


Name:

 Add NPI Details 

NPI:


*

Start Date:



*

End Date:



✓ OK

⊗ Cancel

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Step 7: Controlling Interest/Ownership Details

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My InboxAdminProvider

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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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 Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Upload Documents	Required			Incomplete	Please upload required documents.
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	

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<https://hi-trq-evo.cns-inc.com/evoBrix/CNSIControlServlet>

Add Ownership

Print
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Application ID: 20200226291324
 Name: Hawaii Group

Provider Controlling Interest/Ownership

Type: *

Percentage Owned: *

SSN:

EIN/TIN:

Legal Entity Name:

 (As shown on the Income Tax Return)

Entity Business Name:

 (Doing Business As)

Owner NPI:

First Name:

Last Name:

Suffix:

DOB:

Phone Number: * Extn:

Email:

Start Date: *

End Date:

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

Address Line 1: *

 (Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County:

Country: *

Zip Code: * -

Page ID: dlEnrImntAddOwner(Provider)

Add Ownership

Print
Help

Application ID: 20200226291324
Name: Hawaii Group

Provider Controlling Interest/Ownership

Type:
Managing Employee
*
i

Percentage Owned:
50
*

SSN:
526598566
*

EIN/TIN:

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

Entity Business Name:
(Doing Business As)

Owner NPI:

Last Name:
Owner
*

First Name:
Group
*

DOB:
02/26/1980
*

Suffix:

Email:

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

End Date:

Start 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
*

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: dlgEnrImntAddOwner(Provider)

Add Owners Relationship

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

Actions: Add Owner, Import Owner, **Owners Relationships**, Owners Adverse Action

PROVIDER INFORMATION

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

REQUIRED DISCLOSURE INFORMATION

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

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

REQUIRED OWNERS

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

Owners List

Filter By: [] And Indicator: [] Go: [] Save Filters: [] My Filters: []

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned

Environment: HL_SYSTST R10c-1.1 Server Time: 02/26/2020 03:28:29 MST

Add Owners Relationship

Print Help

Application ID: 20200226291324 Name: Hawaii Group

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

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

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

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

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

Add Owners Relationship

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Help

Application ID: 20200226291324
Name: Hawaii Group

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☒ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

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

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

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

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

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

Complete Adverse Actions

evoBrix™ My Inbox Admin Provider

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MyInbox > New Enrollment > Group Biller > General

Application ID: 20200226291324 Name: Hawaii Group

Close Actions

Pe Add Owner Import Owner

PROVIDER Owners Relationships

Provider E Owners Adverse Action

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

REQUIRED DISCLOSURE INFORMATION

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

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

REQUIRED OWNERS

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

Owners List

Filter By And Indicator Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned

https://hi-trg-evo.cns-inc.com/evoBrix/CNS/ControlServlet Environment: HI_SYSTST R10c-1.1 Server Time: 02/26/2020 03:31:36 MST

innovation@work

Step 8: Taxonomy Details

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Provider ▾

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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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 Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Upload Documents	Required			Incomplete	Please upload required documents.
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	


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Taxonomy Details



My InboxAdminProvider

MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324Name: Hawaii Group

CloseAdd



Taxonomy List

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



Taxonomy Code	Description	Start Date	End Date
No Records Found !			

Page ID: pgTaxonomyListForEnrlmnt(Provider)Environment: HI_SYSTST R10c-1.1Server Time: 02/26/2020 03:34:31 MST

Add Taxonomy




 Print  Help

Application ID: 20200226291324Name: Hawaii Group

 Add Taxonomy 

Taxonomy Code: *

Description:

Start Date:  *  Today's DateEnd Date: 

Page ID: dlgEnrlAddTaxonomy(Provider)

NUCC Taxonomy Code List

The screenshot shows a web browser window with the URL taxonomy.nucc.org. The page title is "Health Care Provider Taxonomy Code Set". On the left, there is a navigation menu with a search bar and a list of links including "Introduction", "National Uniform Claim Committee Website", "Help", and a tree view of "Individual or Groups (of Individuals)" with sub-items like "Group", "Multi-Specialty", "Single Specialty", "Allopathic & Osteopathic Physicians", "Allergy & Immunology", "Anesthesiology", "Dermatology", "Emergency Medicine", "Family Medicine", and "General Practice".

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 9: Upload Documents

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MyInbox > New Enrollment > Group Biller

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Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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 Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 8: Add Taxonomy Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Upload Documents	Required			Incomplete	Please upload required documents.
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	

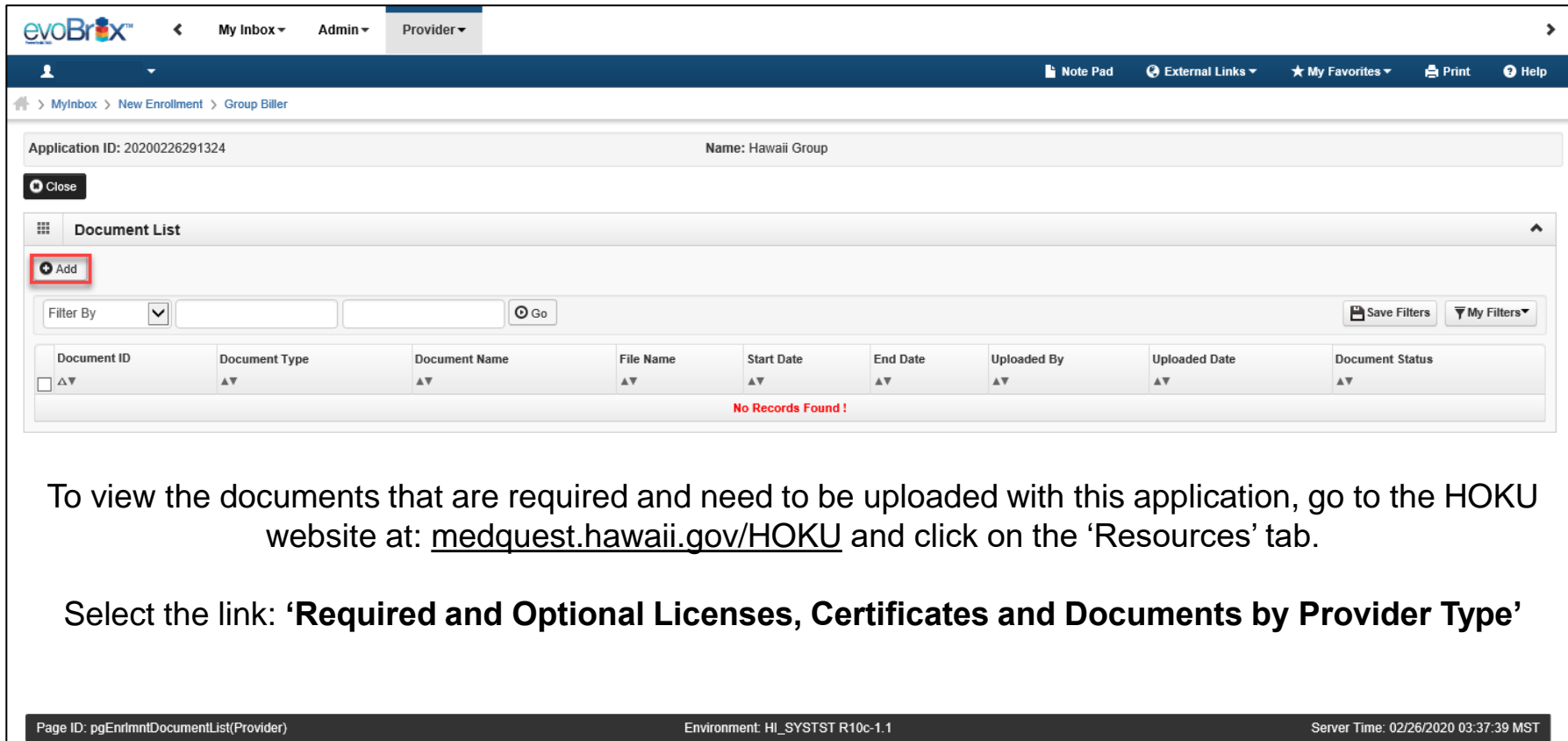
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Upload Documents



Application ID: 20200226291324 Name: Hawaii Group

[Close](#)

Document List

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



Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Document Status
No Records Found !								

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


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


Upload Documents


 Print  Help


Application ID: 20200226291324 Name: Hawaii Group


 Upload Document 

Document Type:  *



Document Name:  *

File Name: 

Start Date: 

End Date: 

Remark:

 OK  Cancel

Page ID: dlgEnrlmntAttachment(Provider)

Upload Documents

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MyInbox > New Enrollment > Group Biller

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Name: Hawaii Group

Close

Document List

Add

Filter By ▾

Go

Save Filters

My Filters ▾

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

Delete

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Step 10: Enrollment Checklist

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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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 Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 8: Add Taxonomy Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	

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Enrollment Checklist

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My Favorites ▾
Print
Help

MyInbox > New Enrollment > Group Biller > Provider Check List

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Name: Hawaii Group

Close Save

Provider Checklist

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

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Step 11: Submit Application

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Name: Hawaii Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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 Additional Information	Optional	02/26/2020	02/26/2020	Complete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete	
Step 8: Add Taxonomy Details	Required	02/26/2020	02/26/2020	Complete	
Step 9: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 10: Complete Enrollment Checklist	Required	02/26/2020	02/26/2020	Complete	
Step 11: Submit Enrollment Application for Approval	Required			Incomplete	


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Submit Application

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⌵

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> MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324 Name: Hawaii Group

Close Next

Final Submission

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

The information submitted for enrollment shall be verified and reviewed by the State.
During this time, any changes to the information shall not be accepted.
I agree that the information submitted as a part of the application is correct (Private and Confidential).

Application Document Checklist

Forms/Documents ▲▼	Special Instructions ▲▼	Source ▲▼	Required ▲▼
No Records Found !			

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Review Group Biller Participation Agreement

My Inbox

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Provider

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MyInbox

New Enrollment

Group Biller

Application ID: 20200226291324

Name: Hawaii Group

Close

Submit Application

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

PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION (PART B)

I/We, Hawaii Group, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

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

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

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

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

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

Page ID: pgEnrTermsAndConditions(Provider)

Environment: HI_SYSTST R10c-1.1

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Complete Group Biller Participation Agreement

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Provider ▾

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My Favorites ▾
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MyInbox > New Enrollment > Group Biller

Application ID: 20200226291324
 Name: Hawaii Group

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

RETROACTIVE CERTIFICATION:

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

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

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

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

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

First Name:
Last Name:
Date:

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Submission Complete

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Application ID: 20200226291324 Name: Hawaii Group

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

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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	
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Step 9: Upload Documents	Required	02/26/2020	02/26/2020	Complete	
Step 10: Complete Enrollment Checklist	Required	02/26/2020	02/26/2020	Complete	
Step 11: Submit Enrollment Application for Approval	Required	02/26/2020	02/26/2020	Complete	

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Thank You!

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