Enrolling as a Health First Colorado Home and Community Based Services Provider

Presented by:
Colorado Department of Health Care Policy & Financing

June 2019

Our Mission

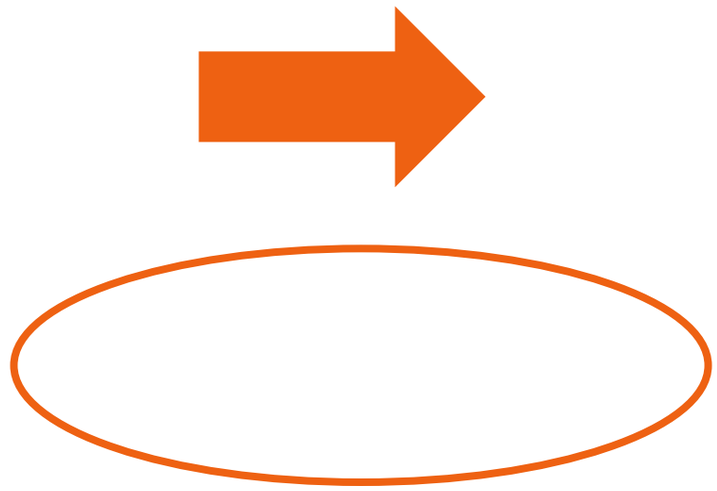
Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**.

Purpose of This Training

The purpose of this training is to provide a hands-on tool and reference guide to be used during the enrollment and revalidation process for Home and Community Based Providers (HCBS).

Providers should pay special attention to areas that are called out as potentially confusing or refer to website references.

Pay special attention to the information called out in Orange.



Provider Survey, Licensure, and Enrollment Structure Overview

Colorado Department of Public Health and Environment (CDPHE)

Colorado Department of Health Care Policy and Financing (HCPF)

CDPHE Responsibilities

- First point of contact for providers requiring CDPHE approval.
- Providers may be required to do a separate application for CDPHE.
- Provide onsite review of policies and procedures.
- Ensure health, safety, and welfare of members.
- License providers where necessary.
- Recommend to HCPF that providers be enrolled as Health First Colorado Providers.
- While CDPHE reviews and provides recommendations for approval to HCPF/Gainwell Technologies (GWT), it is the provider's responsibility to enroll with HCPF/GWT separately.

Providers who are required to go through the CDPHE process may receive ongoing surveys and oversight from CDPHE.

HCPF Responsibilities

- First point of contact for providers not requiring CDPHE approval.
- Accepts CDPHE recommendations for enrollment.
- Oversight agency for Gainwell Technologies (GWT), the fiscal agent that pays Health First Colorado claims.
- Enrolls providers as Health First Colorado providers.
- Oversight agency for rules that govern HCBS providers.

Colorado Department of Public Health and Environment (CDPHE) Portal

- Visit the CDPHE website
- Health Facilities regulated by CDPHE
- Submit a Letter of Intent (LOI)

CDPHE Overview

Once a provider receives the initial survey from CDPHE, a portal account will be set up. The following are some of the actions that can be accomplished in that portal:

- Manage licensure, survey, and provider contact information
- Submit an electronic plan of correction
- Access to submit changes to CDPHE
- Change address, name, ownership, or administrator
- Add CCBs (Community Centered Boards)
- Add additional HCBS services

Enrolled with CDPHE:

Now What?

A provider must now enroll with Health First Colorado in order to PROVIDE and BILL for services.

CDPHE cannot approve a provider to provide or bill for services.

This can only be done by Health First Colorado.

CDPHE and Health First Colorado systems do not share information, so any changes a provider makes with one entity they will need to make with the other.

Selecting Your Provider Specialty: HCPF

Selecting a provider specialty is very important.

A list of waivers and their respective provider specialties is available on the HCPF website.

https://www.colorado.gov/pacific/hcpf/information-hcbs-service-provided

Some provider specialties require review and approval with CDPHE, and some do not. Only register for the provider specialties for the services a provider will provide.

Any specialties requiring CDPHE review will only be approved by HCPF/GWT after CDPHE has made a recommendation for approval.

Selecting Your Provider Specialty

Example of a Provider that requires CDPHE registration.

Select → Personal Care SLS

Then it will open additional information about the provider specialty.

Personal Care SLS

Specialty Code: 664

Additional Requirements:

- If you are planning to include this service in your application and plan to enroll using your SSN rather than an EIN, please do not pay the application fee (you can just continue on to the next page of the application).
- Copy of one of the following IRS documents for EIN enrollments only
  - SS-4 Employer Identification Number Assignment
  - IRS 147c EIN Verification letter
- Copy of the Affidavit of Lawful Presence for SSN enrollments only
  - Photocopy of government issued photo ID (i.e. Driver License) must be attached to application
  - Affidavit of Lawful Presence can be found on the HCPF Provider Services website under "Provider Forms"
- Malpractice/Liability insurance information must be entered on the application. However, proof of insurance is not a required attachment.
- Copy of W-9 signed within last six months.
  - Address must match one address listed on the application
  - DBA (Trade Name) must be listed on Line 2 if included on the application.
- Voided check or signed bank letter
  - Voided check or bank letter address must match an address on the application
  - If bank letter is submitted, the letter must be signed by the bank within the last six months.
    - Must include account and routing numbers
- Electronic Visit Verification is required for some services billed under this specialty code and will be automatically added with an approved application for Health First Colorado (Colorado's Medicaid Program). For additional information visit the EVV web page.

Required Certifications and/or Licenses:

- A copy of an approved Program Approved Service Agency (PASA) application from the Colorado Department of Public Health and Environment.
- Certification from the Colorado Department of Public Health and Environment
- Home Care Agency Class A or Class B license issued by the Colorado Department of Public Health and Environment

OR

- If CDPHE does not require a provider to obtain a Home Care Agency license for this specialty, a signed attestation on letterhead must be submitted that states one of the following:
  - Provider is an SSN provider that only has one employee
  - Provider is an EIN provider that only has one employee who provides hands-on assistance
  - Provider is an EIN provider that does not provide hands-on assistance

Selecting Your Provider Specialty

Example of a Provider that Does Not Require CDPHE registration.

Select → Non-Medical Transportation BI/EBD/SCI/CMHS

Then it will open additional information about the provider specialty.

Non-Medical Transportation BI/EBD/SCI/CMHS

SPECIALTY CODE: 660

ADDITIONAL REQUIREMENTS:

- Letter of Intent (for Colorado Choice Transitions providers only).
- List of counties served (please upload this on the "Attachments and Fees" page of the application)

REQUIRED CERTIFICATIONS AND/OR LICENSES:

- PUC license, if applicable. To obtain a Medicaid Transportation Permit (MCT) follow the directions outlined here.

RISK LEVEL: Moderate	FEE REQ'D? No	NPI REQ'D? No
TAX ID REQ'D: SSN or EIN	OOS ALLOWED? No	BT ALLOWED? Yes

HCPF/GWT Enrollment

HCPF Portal

- Provider Enrollment application
- Application Tracking Number (ATN)
- Look up the status of a Medicaid application
- Contact information can be updated

If required, providers must complete the CDPHE process before enrolling with HCPF/GWT.

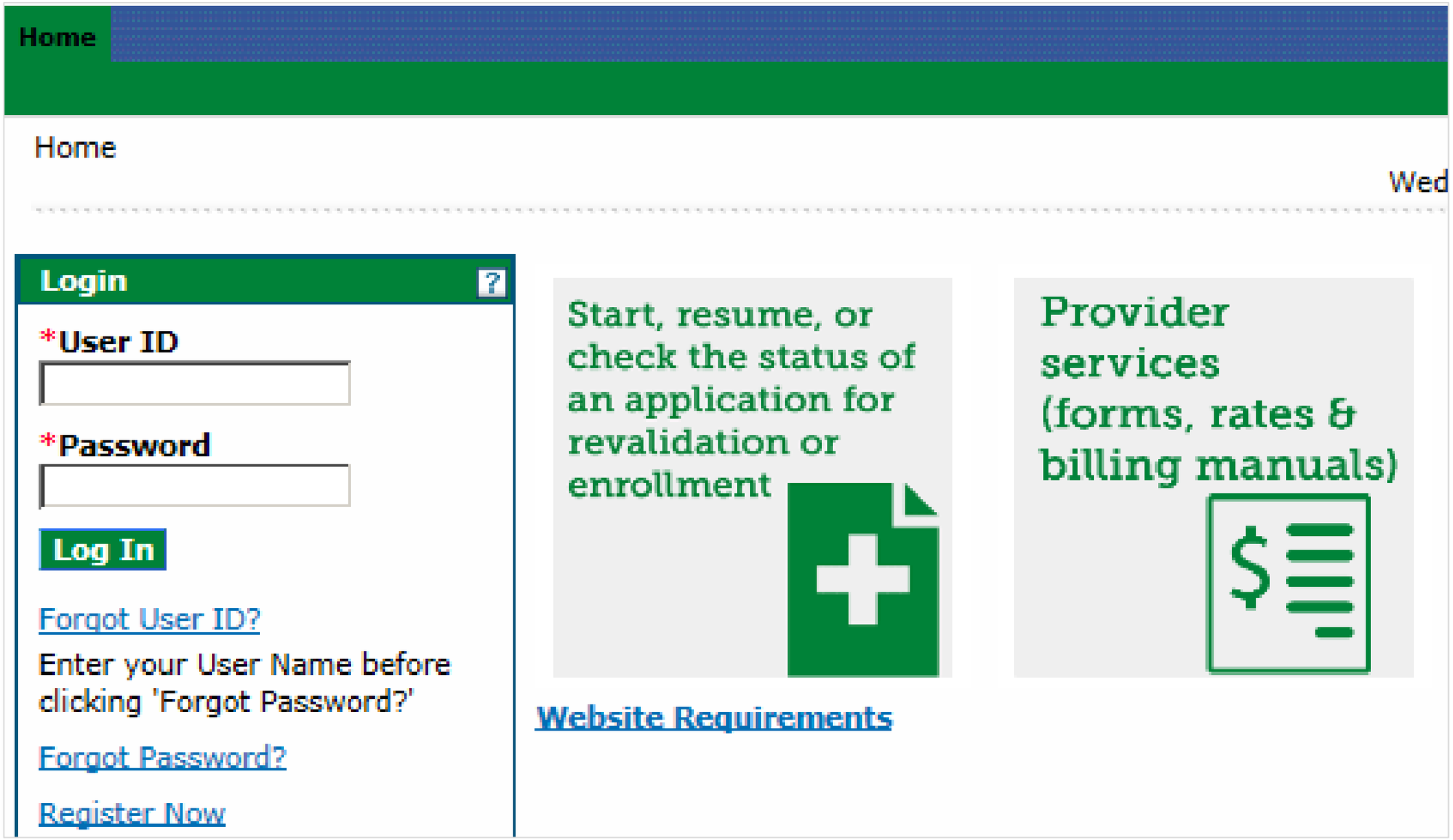
Providers should access the HCPF/GWT portal after completing this training and ensuring all required information is available.

HCPF/GWT Portal

- Update billing and ownership contact and address information.
- Manage and update information about locations where member care is provided.
- Submit billing for reimbursement.
- Maintain and update Health First Colorado provider enrollment information.

Enrollment Application

Navigate to the provider enrollment page



Information needed for the HCPF/GWT Enrollment Process

- Verify good standing with the Secretary of State.
- Obtain an NPI number and taxonomy code. A taxonomy code is required prior to applying for an NPI.
- An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number and is used to identify a business entity.
- Visit the Provider Enrollment web page for enrollment resources and updates.

Information needed for the GWT/HCPF Enrollment Process

- A National Provider Identifier is a unique 10-digit identification number issued to U.S. health care providers by the Centers for Medicare & Medicaid Services (CMS). NPIs are required for some Health First Colorado HCBS provider specialties, however it is STRONGLY encouraged for all providers to have a unique NPI by location to assist in eliminating billing issues. The Colorado NPI Law (HB 18-1282) will require a unique NPI by provider and location for new Organization Health Care Providers beginning January 1, 2020. The NPPES website can be accessed from the link above.

Important: If the provider is an individual, then an individual NPI must be requested. If the provider is a business, then an organizational NPI must be requested.

Information needed for the GWT enrollment process

- Enrollment Checklist is available on the Provider Enrollment Type web page under "Atypical - HCBS".

- **Address Information**
  - **Service Address** – This is the location at which the provider provides care. *(Each service address requires a separate application.)*
  - **Mailing Address** – This is the location at which the provider receives physical mail.
  - **Billing Address** – This is the location from which the provider submits their claims.

- Does the provider have a zip code + 4? The zip code + 4 is required when completing the application.

Enrollment Application

Home

Home > Provider Enrollment > Enrollment Application

Wednesday 06/12/2019 03:50 PM MST

Provider Enrollment: Welcome

- **Welcome**
- Request Information
- Change of Ownership
- Specialties
- Addresses
- Provider Identification
- Network Participation
- Languages
- EFT Enrollment
- Other Information
- Addendums
- Disclosures
- Attachments and

Welcome to the Online Provider Enrollment Process

Please complete each step in the enrollment process. Required fields are noted. You will be able to save the information and return using the tracking number assigned by the system. When you have completed all steps of the application, print a copy of the information for your records, "submit" and "confirm' the application for processing.

Please click the **"Continue"** button to start the enrollment process.

Want to make sure your application is processed as quickly as possible?

Please do NOT begin your application before reviewing all of the training resources available. Starting an application prior to reviewing the training materials will likely result in an incomplete or incorrect application. An incorrect or incomplete application requires additional review, which may add weeks of additional processing time. Please visit our Revalidation and Enrollment Instructions page at: www.Colorado.gov/HCPF/revalidation-and-enrollment-instructions. Be sure to review the **Information by Provider Type (link)** before you begin the online trainings – it will help you select the correct training, right from the start.

Continue Cancel

Enrollment Application

Provider Enrollment: Request Information

- Welcome
- **Request Information**
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- Other Information

You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to the next page. All mandatory data is required to "Finish Later".
The contact person listed on this page may be contacted to answer any questions regarding the information provided in this enrollment application.

* Indicates a required field.

Initial Enrollment Information

Atypical providers are those who are not required to have a National Provider Identifier or taxonomy code and may include, but not limited to, Home and Community Based Waiver Services and Managed Care Organizations.

- Enrollment requirements vary

*Enrollment Type: Atypical

*Provider Type: 36-Home & Community Based Services

*Requesting Enrollment Effective Date: 06/12/2019

Atypical is always selected for an HCBS enrollment.

36-HCBS is always the provider type for an HCBS enrollment.

Effective date of license, if applicable.
Effective date of program approval form, if applicable.
Current date, if applicable.

Home & Community Based Services (HCBS)

PROVIDER TYPE: 36

SPECIAL INSTRUCTIONS:

- Click here for Information by HCBS Service Provided (Step 1.5)

Completing the Application

Provider Information

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

NPI | **NPI Zip + 4** | **Taxonomy**

***Tax ID Number** | ***Tax ID Type** ○ EIN ○ SSN

Effective Date

***Do you have a current CO Medicaid ID?** ○ Yes ◉ No

If "Yes" a box will appear for the current CO Medicaid ID

***Were you previously enrolled as a provider?** ○ Yes ◉ No

If "Yes" a field will open for the previous ID number to be entered

Contact Information

***Last Name**

***First Name**

Suffix

***Phone** | **Ext**

Fax Number

***Contact Email**

***Confirm Email**

***Email For Provider Publications**

***Confirm Email**

Preferred Method of Communication Email

This section should be completed with the information of the individual responsible for completing and managing the application.

Continue | Finish Later | Cancel

Selecting Finish Later

Provider Enrollment: Credentials

Your enrollment application will be suspended for 60 days, pending completion. Upon expiration, you will need to reinitiate a new enrollment application.

Please provide the following information, which will be required to resume your application at a later date. Your password must be between 8 to 20 alphanumeric characters. Your tax id is provided, if already contained within your provider enrollment application.

Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number along with the following information, will be used as your credentials to resume your suspended enrollment application.

* Indicates a required field.

Tax ID 123456789

*Password

*Confirm Password

*What is your mother's maiden name?

*What is your high school mascot?

*What is your father's middle name?

Submit Cancel

Suspend Incomplete Application

Do you want to suspend this application and resume later?

Yes No

Print Preview

Provider Enrollment: Tracking Information

Your enrollment application has been assigned the following tracking number:1546. Please retain the tracking number for your records.

The tracking number will be used, in addition to your Tax ID and password, as credentials to resume/revise your application at a later date.

A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:qwerty@email.com.

Exit

Change of Ownership (CHOW)

Provider Enrollment: Change Of Ownership or Change of Federal Employer Identification Number (EIN) ?

- Welcome
- Request Information
- **Change of Ownership**
- Specialties
- Addresses
- Provider Identification
- Network Participation
- Languages
- EFT Enrollment
- Other Information
- Addendums
- Disclosures
- Attachments and Fees
- Agreement
- Summary

* Indicates a required field.

Change Of Ownership or EIN

Change of ownership or a change of EIN terminates the Colorado Medicaid Provider Participation Agreement. New owners and providers with a new EIN must re-apply and complete a new Colorado Medicaid Provider Participation Agreement in order to participate in Colorado Medicaid.
If this is a change of ownership, you must attach a verfication statement from the closing (selling) provider including:

- The name of the opening (purchasing) entity,
- The future effective date of the change of ownership, and
- A forwarding address (for the selling provider).

If this information is not provided, your application will not be processed.
You may not submit claims for dates of service before your application is activated.
In addition, while your application is in process, you may not submit claims using:

- The closing provider's Colorado Medicaid provider ID/NPI or
- The Colorado Medicaid provider ID/NPI associated with your old EIN.

Change Of Ownership or EIN

***Is this application due to a change of ownership or change of EIN?** ○ Yes ◉ No

Continue | Finish Later | Cancel

Specialties

Provider Enrollment: Specialties

- Welcome
- Request Information
- Change of Ownership
- **Specialties**
- Addresses
- Provider Identification
- Network Participation
- Languages
- EFT Enrollment
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- Addendums
- Disclosures
- Attachments and

Specialties

The provider type is established on the Request Information screen. All specialties available for the selected provider type can be added on this screen.

* Indicates a required field.

Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

	Specialty	Taxonomy	Effective Date	End Date	Action
⊟	Click to collapse.				

*Specialty: Supported Living Program B

Provider Type: Home & Community Based Services (HCBS)

*Specialty Effective Date: 05/24/2019

End Date: 12/31/2299

Primary

Add | Reset

Select add

This is the correct end date for all specialties.

Specialty effective date:
Date of licensure and certification.

End Date:
12/31/2299 - is the correct end date for all specialties.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

	Specialty	Taxonomy	Effective Date	End Date	Action
⊞	Supported Living Program BI		05/24/2019		
⊞	Click to add additional specialties.				

Multiple specialties can be added at this time as needed.

Additional Taxonomies

Additional Taxonomies (if applicable)

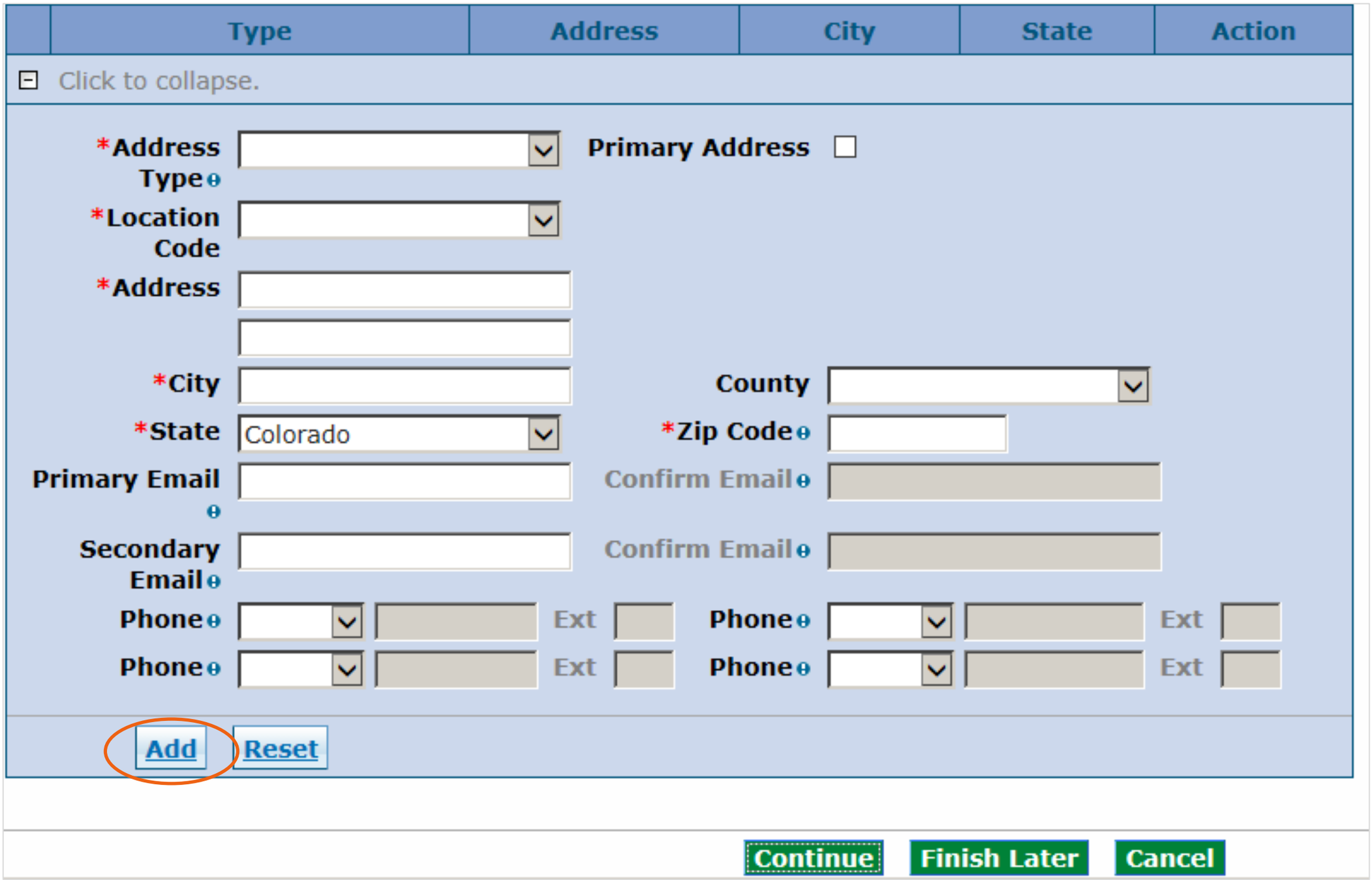
Fields marked required in this section are only required if any information is entered in this section.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Taxonomy	Action
⊟ Click to collapse.	
Taxonomy	
Add	

Continue Finish Later Cancel

This section is not required. The provider may select continue if they only have one taxonomy code.

Provider Addresses



Service Address Information

Service Address Information

If 'Address Type' is changed from 'Service', the service information below will be lost upon Add or Save of address.

Opt Out of Provider Directory ☐

Accepting New Members ☐ **ADA Compliant** ☐ **Accepting New Members with Special Needs** ☐

TDD Capability ☐ **Phone** ⓘ Ext

TTY Capability ☐ **Phone** ⓘ Ext

Add Reset

Continue Finish Later Cancel

Additional Addresses

* Indicates a required field.

Indicates a primary record.

Provider Addresses

The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

The service location address must be a physical location. A post office box is not a valid service location address.

The service location address must include an **office** phone number and at least one **email** address. It is desired that the service location address provide a **fax** phone number.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

	Type	Address	City	State	Action
⊞	Service Location	55555 5th	denver	Colorado	Copy Remove
⊞	Click to add address.				

Be sure to add all address types prior to selecting the continue button.

Provider Identification

* Indicates a required field.

Provider Legal Name

The provider legal name and information is provided once for each enrollment.

*Provider Legal Name

Doing Business As

Organizational Structure

Select the applicable type of business.

*Organization Type

License

Fields marked required in this section are only required if any information is entered in this section.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

	License #	Effective Date	End Date	License State	Action

Click to collapse.

*License # *Effective Date *End Date

*License State

Add Reset

Medicare Participation:
Not required for HCBS

Medicare Participation

To receive Medical Assistance Program payments for services provided to individuals who have Medicare and Medical Assistance Program benefits, providers must accept assignment of their Medicare claims.

Automatic crossover is an exchange of claim information between Medicare and the Medical Assistance Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Medical Assistance Program. The Colorado Medical Assistance Program obtains crossover claim information from Colorado Medicare carriers and intermediaries. For automatic crossover to occur, providers must identify their NPI number.

Automatic crossovers should occur when the participant has registered their NPI with Medicare Part A and/or Part B and in the Colorado interChange.

Medicare numbers are no longer used for automatic crossover from Medicare Part A and Part B to the Medical Assistance Program.

Medicare # **Effective Date** **Medicare Type**

Other Identifier

The provider identification number listed below is an additional identifier used by Managed Care Organizations only.

Health Plan Identifier (HPID)

Continue Finish Later Cancel

MCO/BHO Network Participation:

Not required for HCBS

MCO/BHO Network Participation

* Indicates a required field.

Documentation confirming your participation in a MCO/BHO network will be required on the Attachments and Fees step of enrollment.
Fields marked required in this section are only required if any information is entered in this section.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

	MCO/BHO Network Participation	Effective Date	Action
⊟	Click to collapse.		

*MCO/BHO Network

*Effective Date

Add

Continue | Finish Later | Cancel

Leave blank and select continue, not applicable for HCBS enrollment.

Languages

Provider Enrollment: Languages

- Welcome
- Request Information
- Change of Ownership
- Specialties
- Addresses
- Provider Identification
- Network Participation
- **Languages**

Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Language	Action
⊟ Click to collapse.	
*Language: English	
Add	

Add all languages that are spoken by provider staff.

Continue | Finish Later | Cancel

Provider Enrollment: Languages

- Welcome
- Request Information
- Change of Ownership
- Specialties
- Addresses
- Provider Identification
- Network

Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Language	Action
English	Remove
⊞ Click to add language.	

Continue | Finish Later | Cancel

Electronic Funds Transfer (EFT)

Provider Enrollment: EFT Information ?

- Welcome
- Request Information
- Change of Ownership
- Specialties
- Addresses
- Provider Identification
- Network Participation
- Languages
- **EFT Enrollment**
- Other Information
- Addendums

In order to have payments electronically deposited, Providers must enter all applicable fields within the Financial Institution Information section below. Financial Institution Address is optional and can be added by clicking the checkbox next to Financial Institution Address. For further explanation on EFT Enrollment, please refer to the Help page by clicking the question mark near the top of the screen.

* Indicates a required field.

Provider Information

Provider Name Bob Jones
Business Name XYZ Provider

Provider 'Pay To' address is optional. If you wish to include provider address, return to addresses page to enter. It will be auto-populated here.

Provider 'Pay To' Address

Address 5555555
City denver
State Colorado
Zip Code/Postal Code 80234-1005
Country _

Provider Identification

Provider Identification Numbers

Tax ID 560697164

*NPI must be provided if one has been issued.

Provider National Provider Identifier (NPI) _

Other Identifier [ ] **Assigning Authority** [ ]

Trading Partner ID [ ]

Provider License Number _ **License Issuer** _

Provider Type 36-Home & Community Based Services (HCBS)

Taxonomy _

Provider Contact Information

Provider Contact Name Shannon Miller **Suffix** _

Phone 1-515-555-5555 **Ext** _

Email srmiller1981@gmail.com **Fax Number** _

Provider Agent Information is optional. If you wish to include provider agent information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

Provider Identification

Provider Agent Information

Federal Agency Information is optional. If you wish to provide federal agency information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

Federal Agency Information

Retail Pharmacy Information is optional. If you wish to include retail pharmacy information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

Retail Pharmacy Information

Financial Institution Information

Financial Institution Information

Financial Institution Address is optional. If you wish to include financial institution address with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

☐ **Financial Institution Address**

***Financial Institution Name**

Financial Institution Telephone Number **Ext**

***ABA Routing Number**

***Type of Account at Financial Institution**

***Provider's Account Number with Financial Institution**

***Confirm Provider's Account Number with Financial Institution**

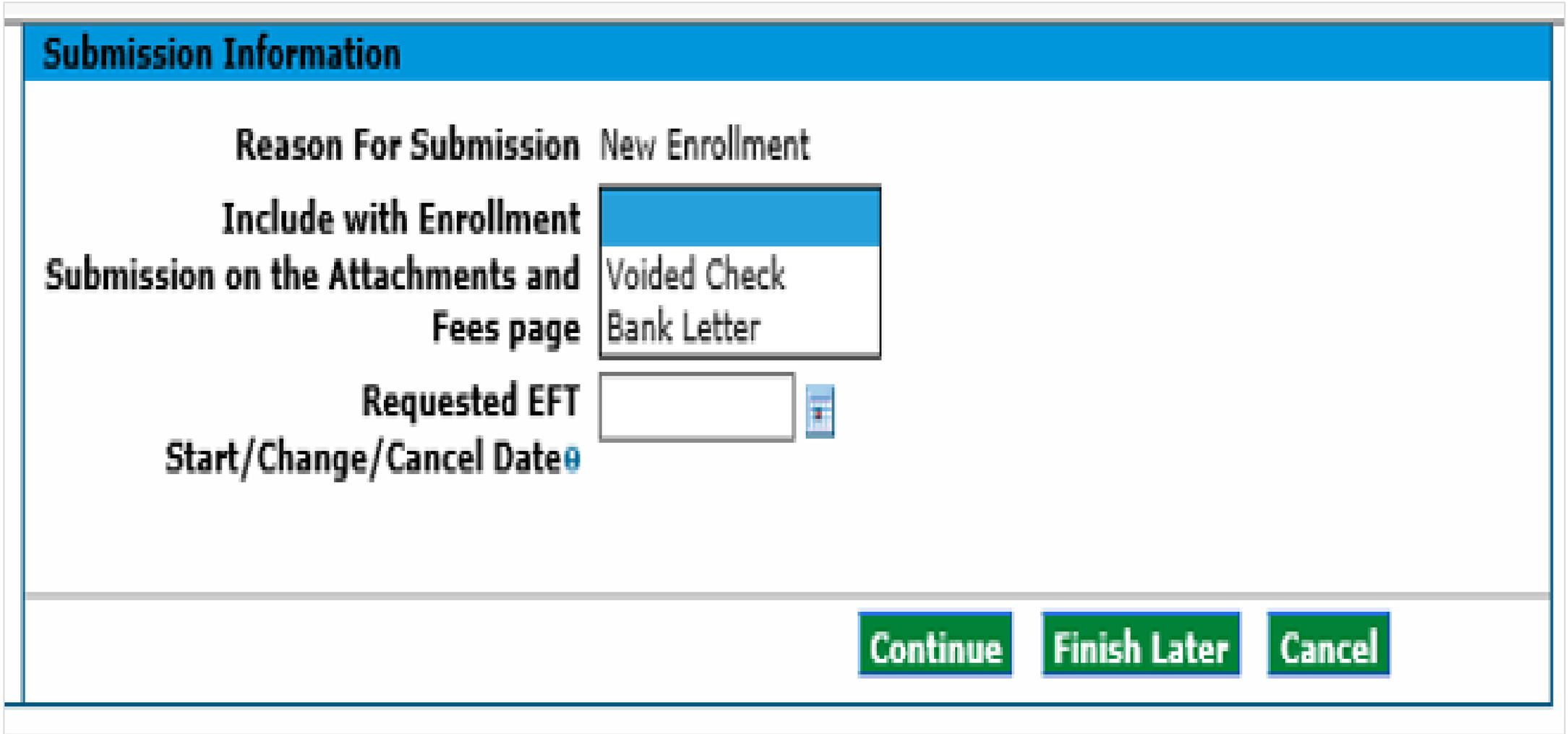
Account Number Linkage to Provider Identifier

Enter either a Provider Tax Identification Number (TIN) or Provider National Provider Identifier (NPI). Provider preference for grouping (bulking) claim payments - must match preference for v5010 X12 835 remittance advice.

Provider Tax Identification Number (TIN)

Provider National Provider Identifier (NPI)

Submission Information



Atypical Supplemental Questions

Supplemental Questions

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE

Medicaid Participation

Medicaid Participation

1. ***Are you currently enrolled in the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   ○ Yes ◉ No

2. ***Are you currently applying for enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   ◉ Yes ○ No

   ***Which states?**

   Texas, Nevada, New Mexico

3. ***Have you ever been denied enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   ○ Yes ○ No

4. ***Has your enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated?**
   ○ Yes ○ No

Disclosures

- Disclosure A – Ownership or Control Interest
- Disclosure B – Subcontractor Ownership
- Disclosure C – Individual Relationships
- Disclosure D - Managing Employees
- Disclosure E - Business Relationships
- Disclosure F - Convictions of Criminal Offense

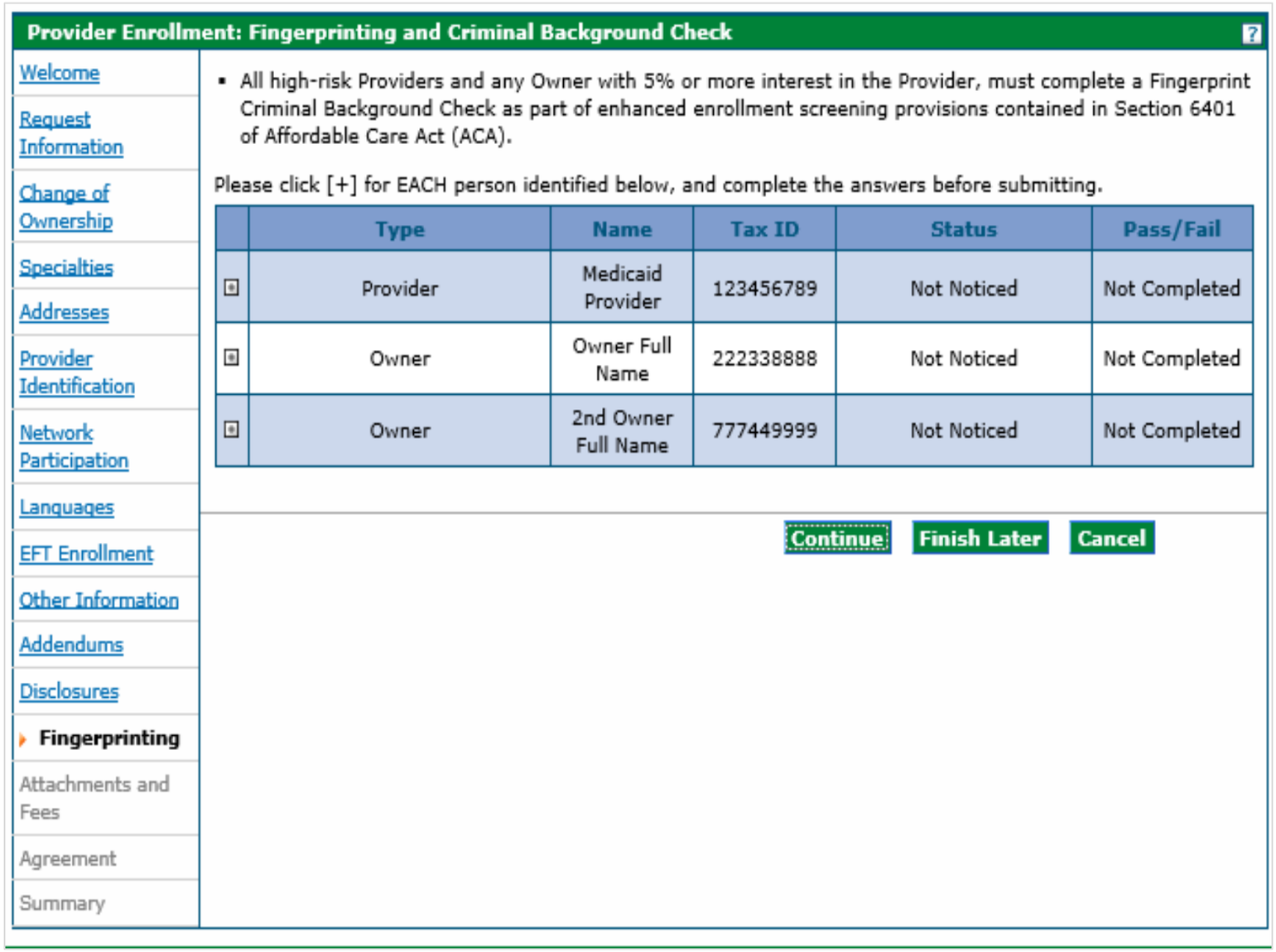
Completion of Disclosures

Available Enrollment Disclosures

Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

Disclosure Name	Description	Status
A. OWNERSHIP OR CONTROL INTEREST	Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more.	Completed
B. SUBCONTRACTOR OWNERSHIP	Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.	Completed
C. INDIVIDUAL RELATIONSHIPS	Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.	Completed
D. MANAGING EMPLOYEES	Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.	Completed
E. BUSINESS RELATIONSHIPS	Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.	Completed
F. CONVICTIONS OF CRIMINAL OFFENSE	Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Childrens Health Insurance Program or the Title XX services since the inception of these programs.	Completed

Fingerprint Background Checks



- Medicaid – Department of Health Care Policy and Financing Code 25YQGp*
- Contact IdentoGO to schedule background check https://identogo.com/contact

Supporting Documentation

Provider Enrollment: Attachments And Fees

- Welcome
- Request Information
- Specialties
- Addresses
- Provider Identification
- Network Participation
- Languages
- EFT Enrollment
- ERA Enrollment
- Other Information
- Addendums
- Disclosures
- Attachments and Fees
- Agreement
- Summary

Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit attachments, please follow the instructions in the Attachments panel below.

Read: Reference Information For Services Identification

Submit as Attachment: Completed W-9 Form

Submit as Attachment: Completed Proof of Lawful Presence

Submit as Attachment: Completed Supervising Physician Signature Form

Submit as Attachment: License

* Indicates a required field.

Attachments

To add an attachment, complete the required fields and click the **Add** button.
Use the 'Other' selection to upload attachments not in the list.

Note: if you choose to "Upload" attachments by "File Transfer", a maximum of 10 MBs of information can be uploaded.
The allowable file types are: bmp, doc, docx, gif, jpg, jpeg, pdf, ppt, tif, tiff, txt, xls, xlsx.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action

Click to collapse.

*Transmission Method: FT-File Transfer

*Upload File: Choose File — No file chosen

*Attachment Type:

Add | Cancel

Make sure the provider clicks "Add" to attach each document.

Application Fee

No Application Fee Required

Continue | Finish Later | Cancel

Application Fee

Application Fee

The Affordable Care Act requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment an[illegible] as required, and is assessed in full for each service location enrolled in CO Medicaid.

Please answer all questions. If you answer "NO" to all of the following questions, you must pay a[illegible] you answer "Yes" to any of the following questions, do not pay a fee, and click the [illegible]ontinue b[illegible]

This panel will only show if a fee is required for the provider type.

Application Fee Questions

Medicare Enrollment - if the service location has enrolled or re-validated with Me[illegible] approved, no fee is required.

1. *Are you an approved Medicare provider at this service location?
   ◎ Yes ◎ No

Medicaid Enrollment - if the service location has enrolled or re-validated with another States Medicaid or Childrens Health Insurance Program and paid an application fee in the last 12 months, no fee is required. (Upload proof of payment in the Attachments section, above.)

2. *Have you enrolled or re-validated in another States Medicaid or Childrens Health Insurance Program within the last 12 months?
   ◎ Yes ◎ No

Financial Hardship - if you are requesting a waiver for financial hardship, include a letter describing the financial hardship and why the hardship justifies an exception, as well as any additional documentation that you believe may aide CMS in its determination. If you choose to apply for an application fee waiver, your enrollment will be delayed while CMS makes its determination. (Upload letter and documentation in the Attachments section, above.)

3. *Are you requesting a waiver of the application fee because of financial hardship?
   ◎ Yes ◎ NO

One Service Location with Multiple National Provider Identifiers (NPI) - if this service location enrolled with Colorado Medicaid with a different NPI, only one application fee is required.

4. *Has this service location address enrolled with a different NPI (or awaiting an enrollment decision) and paid the application fee with that enrollment?
   ◎ Yes ◎ No

Amount Due 553.00

- To make a payment, click the link below.
  Online Bill Pay

W-9

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Affidavit

Please refer to the Department of Revenue's website at Colorado.gov/revenue (Evidence of Lawful Presence: HB06S-1023) for further information.

Each individual applicant who is 18 years of age or older and requesting to receive direct reimbursement must attach a photocopy of one of the following documentation types AND sign the following affidavit.

Pursuant to C.R.S. § 24-76.5-103, on or after August 1, 2006, each agency or political subdivision of the State shall verify the lawful presence in the United States of each natural person eighteen years of age or older who applies for state or local public benefits or for federal public benefits by requiring the applicant to produce one of the following:

1) A valid Colorado driver's license or a Colorado identification card; or
2) A United States military card or a military dependent's identification card; or
3) A United States Coast Guard Merchant Mariner card; or
4) A Native American Tribal Document

AND
Execute the affidavit below.

AFFIDAVIT

For the Colorado Department of Health Care Policy and Financing as Proof of Lawful Presence in the United States.

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

- ☐ I am a United States citizen.
- ☐ I am not a United States citizen but I am a Permanent Resident of the United States.
- ☐ I am not a United States citizen but I am lawfully present in the United States pursuant to Federal law.
- ☐ I am a foreign national not physically present in the United States.

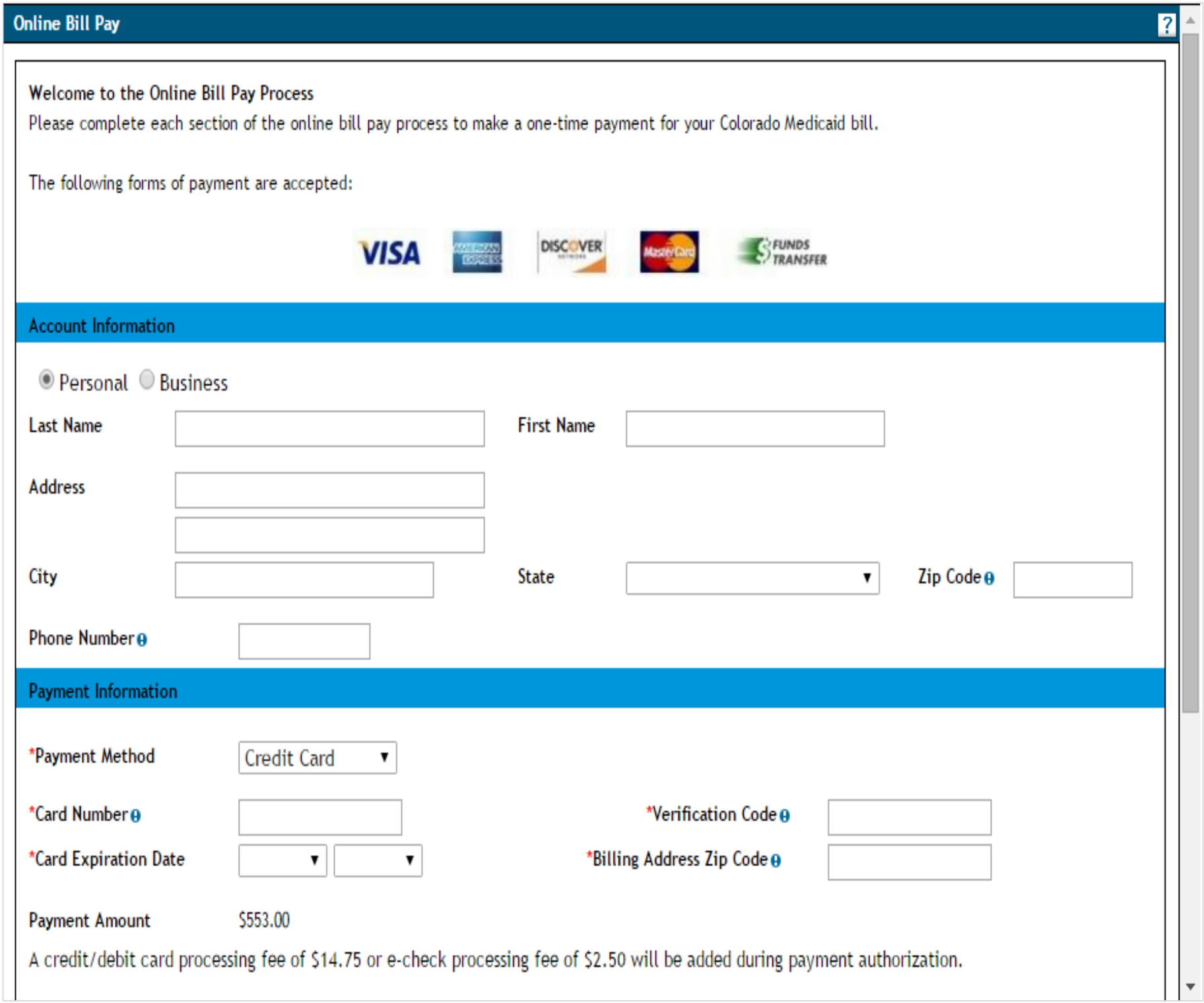
I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature _____ Date _____

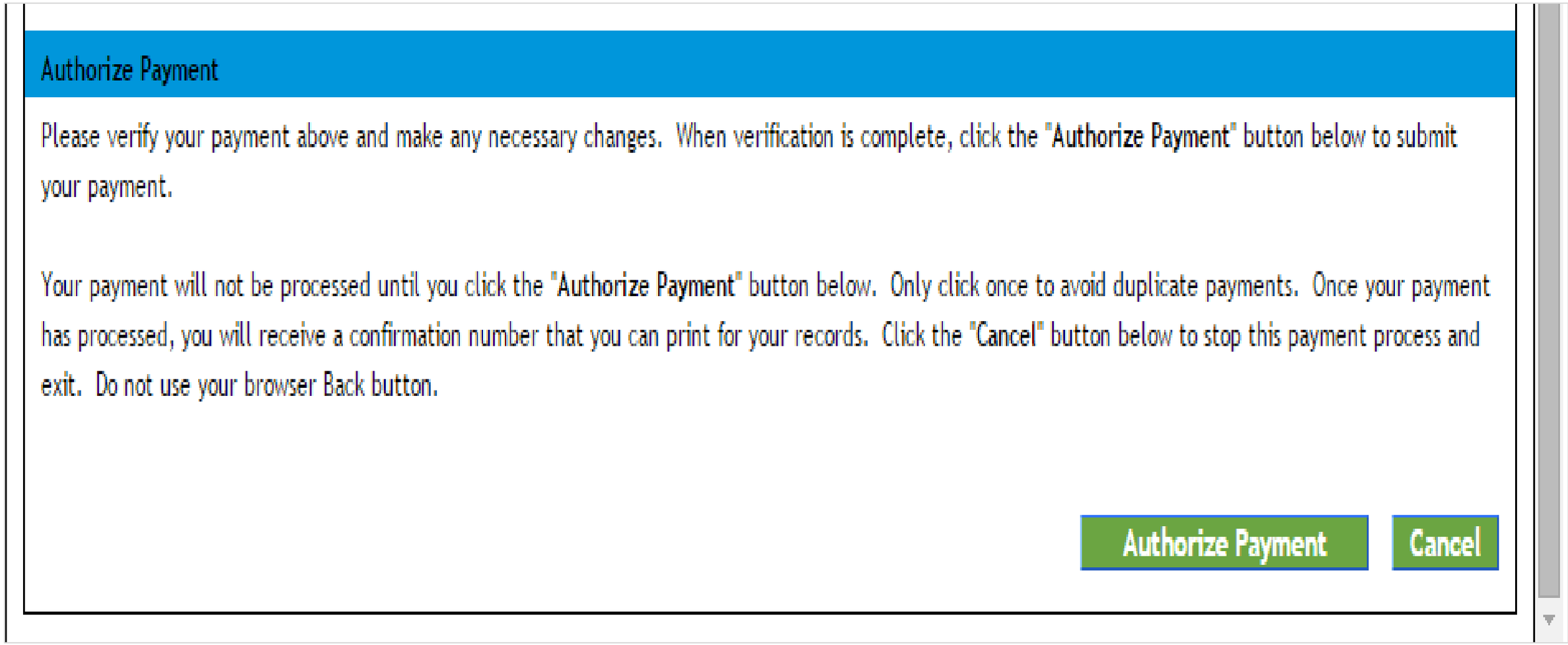
Name (please print) _____ Social Security Number _____

Print Reset

Application Fee Payment



Application Fee Payment



Terms of Agreement

Terms of Agreement

Provider Name	Medicaid Provider
Address	1234 Your Street Denver Colorado, 80202-1515
Tax ID	123456789
NPI	_
Contact Name	Medicaid Contact
Contact Email	M.Contact@business.com

NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE.

Please read and print for your records the Provider Participation Agreement. The Provider Participation Agreement applies to all Programs.

Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Participation Agreement has been read.

Read and Print: Provider Participation Agreement

(You must review the Provider Participation Agreement prior to signing below)

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

*I accept ☐ I understand that my electronic signature is equivalent to written signature.

*Your Signature (Entering your name in the box to the right will constitute your electronic signature.)

Suffix

Submission Date 06/13/2019

Review Finish Later Cancel

Provider Enrollment Agreement

Instructions

The terms of enrollment are stated below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.

Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.

Once the application is submitted and confirmed, a tracking number will be assigned. Please print a copy of your tracking number and application for your records.

Terms of Agreement

Provider Name Medicaid Provider
Address 1234 Your Street
Denver
Colorado, 80202-1515
Tax ID 123456789
NPI _
Contact Name Medicaid Contact
Contact Email M.Contact@business.com

NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE.

Please read and print for your records the Provider Participation Agreement. The Provider Participation Agreement applies to all Programs.

Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Participation Agreement has been read.

Read and Print: Provider Participation Agreement

(You must review the Provider Participation Agreement prior to signing below)

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

*I accept ☐ I understand that my electronic signature is equivalent to written signature.

*Your Signature
(Entering your name in the box to the right will constitute your electronic signature.)

Suffix

Submission Date 06/13/2019

Review | Finish Later | Cancel

Overview Provider Information

Provider Identification

Last Name Provider
First Name Medicaid
Middle _ Suffix _
Gender Male Birth Date 08/20/1973

Degree	School	Year of Graduation
MD	University of Medicaid	2000

License #	Effective Date	End Date	License State
HH45675600	07/20/2015	07/23/2015	CO-Colorado

Medicare # 123456789 Effective Date 07/20/2015 Medicare Type Medicare A & B
DEA # _ Effective Date _

Health Plan Identifier (HPID) 123456789

Languages

Language English

Other Information

Malpractice/General Liability Insurance

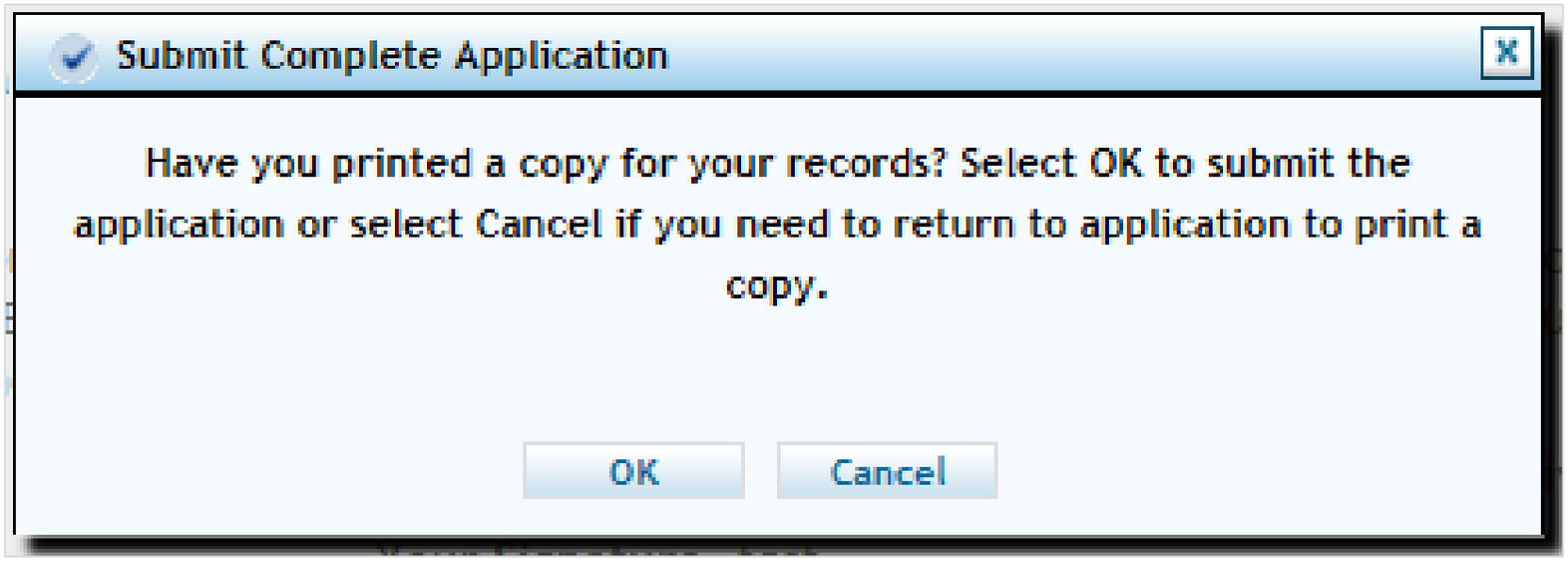
Name	Policy ID	Effective Date	End Date
Medicaid Insurance	010101010101	07/20/2015	07/20/2015

Board Certification

Medicaid Participation

1. Are you currently enrolled in the Title XIX (Medicaid) program or CHIP of any other state(s)?
   No
2. Are you currently applying for enrollment in the Tile XIX (Medicaid) program or CHIP of any other states(s)?
   No
3. Have you ever been denied enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s)?
   No
4. Has your enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated?
   No

Submitting Your Application

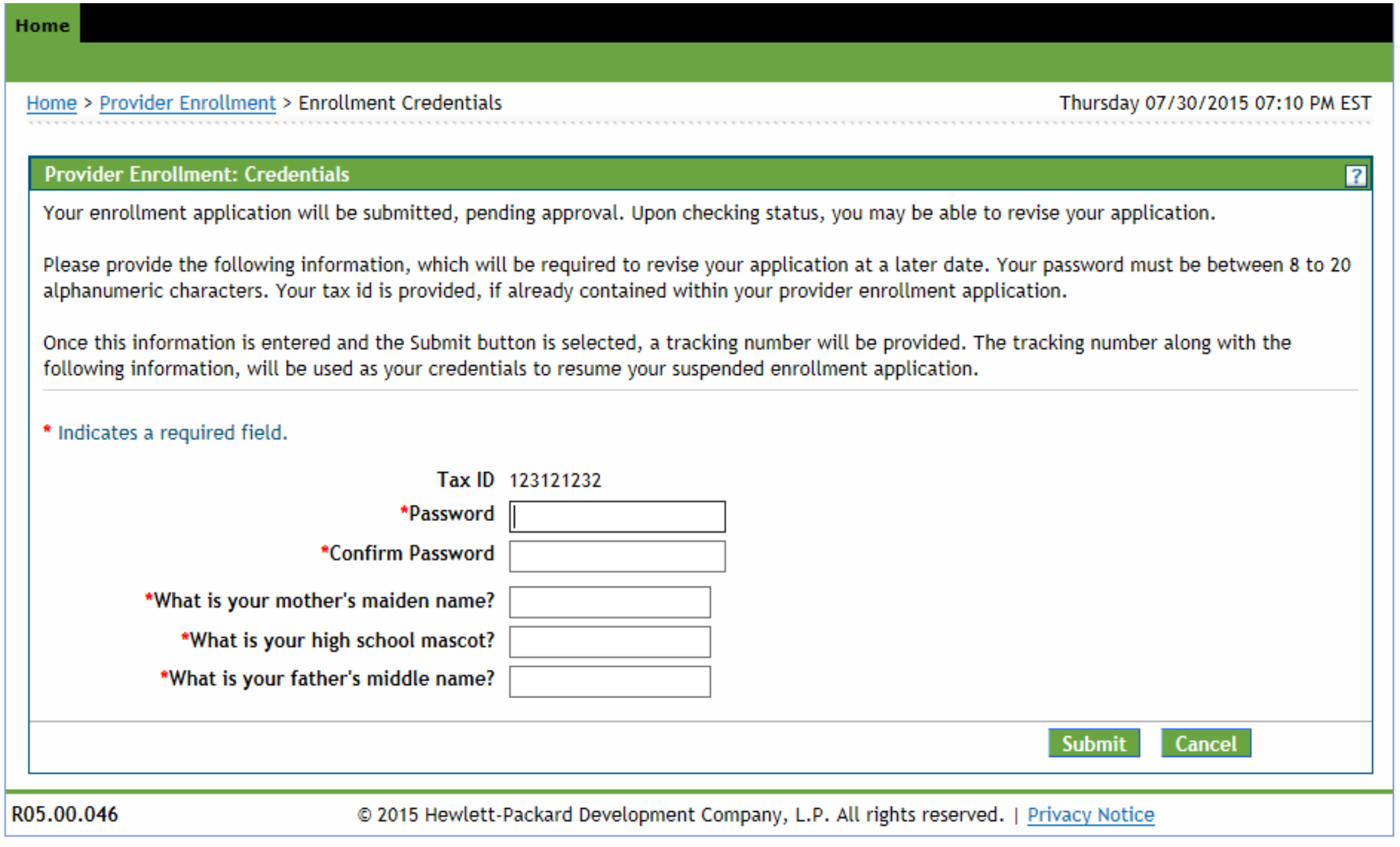


Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.
Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing.
Please print a copy of this summary for your records.

Print Preview Confirm Finish Later Cancel

Creating Enrollment Credentials



Confirmation of Submission

Print Preview

Provider Enrollment: Tracking Information

Your enrollment application has been submitted. Your enrollment application has been assigned the following tracking number: 1977

Please retain the tracking number for your records. The tracking number will be used, in addition to your Tax ID and password, as credentials to revise your submitted application at a later date.

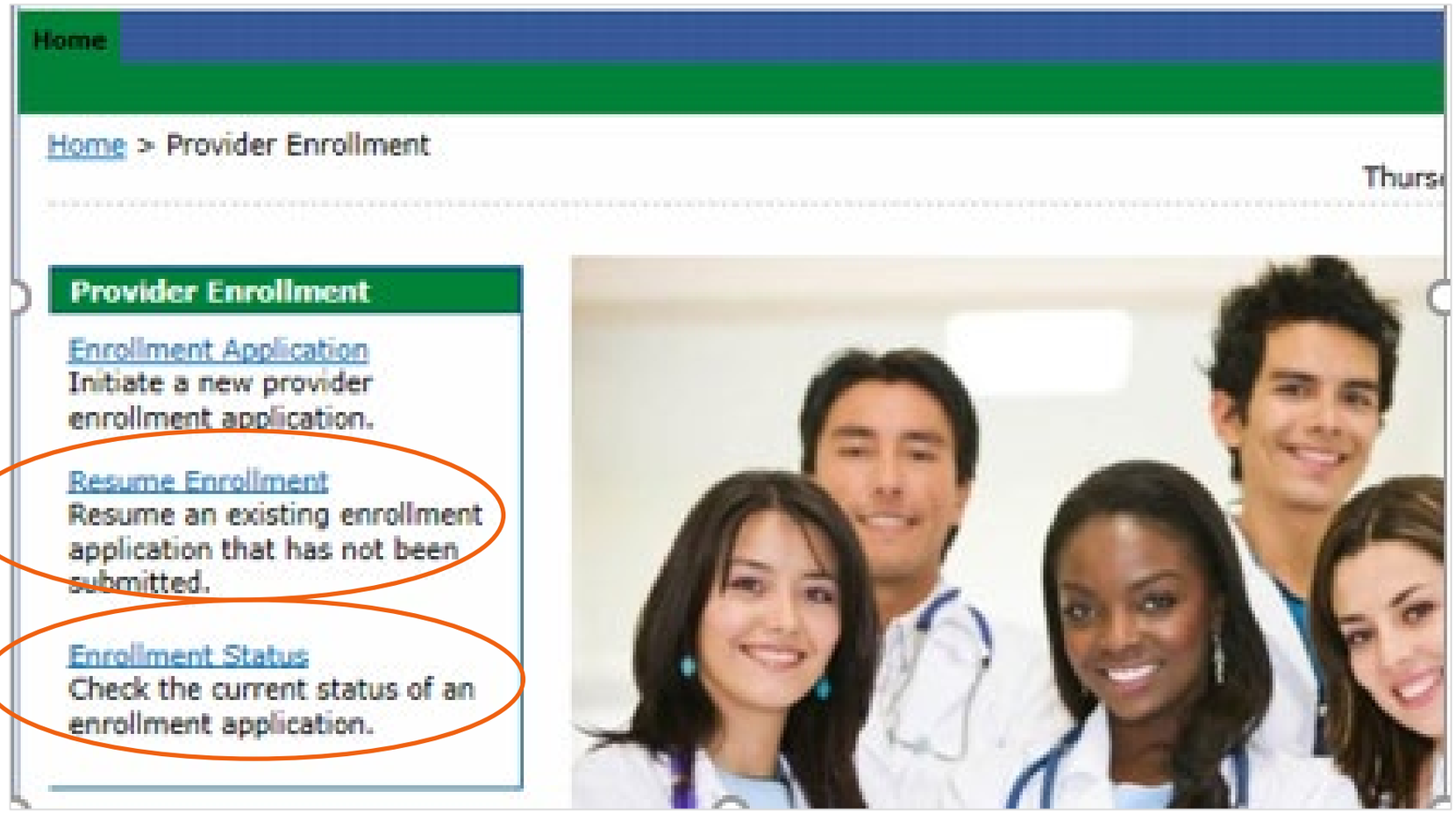
A confirmation email has also been sent to the following contact person's email, designated in the enrollment application: test.test@test.com.

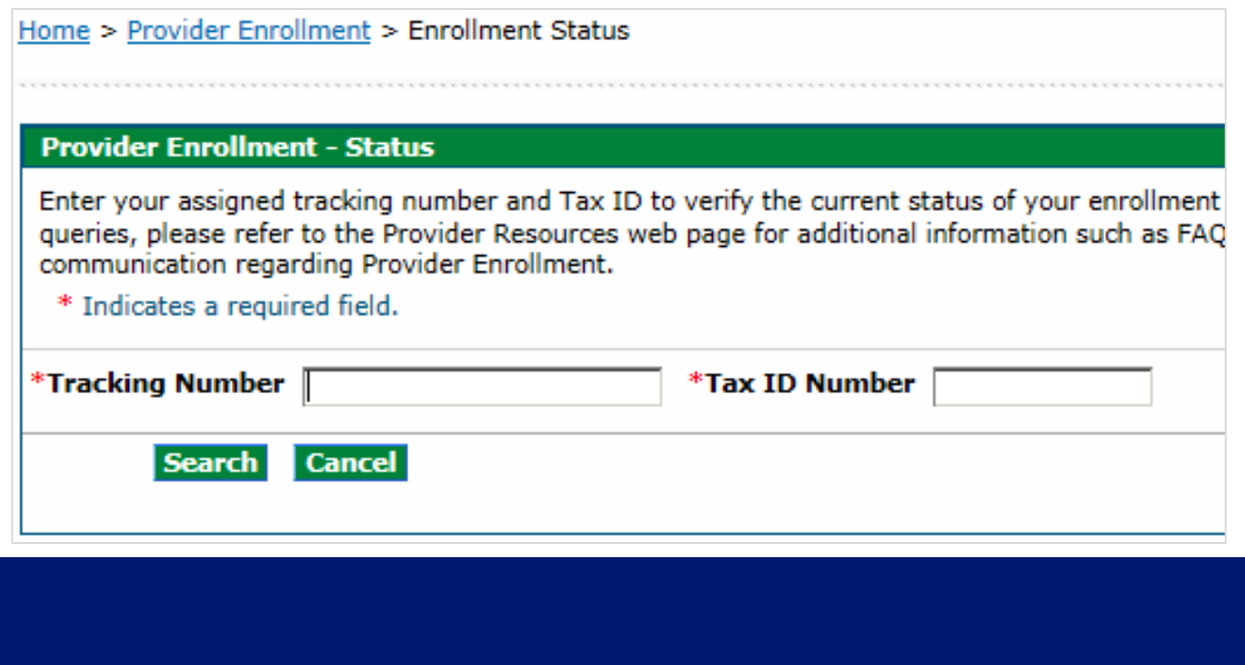
Exit

R05.00.051

Privacy Notice

Provider Enrollment Status





Provider Enrollment Status

Home

Home > Provider Enrollment > Enrollment Status

Saturday 08/29/2015 10:40 AM EST

Provider Enrollment - Status Back to Home

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

* Indicates a required field.

*Tracking Number 1611 *Tax ID Number 123456789

Search Cancel

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

Tracking Number	1611
Date Submitted	_
Status	Incomplete
Status Date	08/28/2015

R05.00.055

Privacy Notice

What is the Process after an Application is Submitted?

- The application must be approved by GWT and/or HCPF.
- The application is either denied, rejected, returned to provider (RTP), approved, etc.
- RTP is when the application is returned to the provider for additional information. A provider will receive emails periodically that will notify them of their status in the enrollment process.
- These emails may require a provider to send in additional information for their application, inform them of a denial and their rights to file a grievance.
- Providers should follow the instructions given in the email and contact GWT at 1-844-235-2387, regarding any questions about their enrollment.

What is the Process after Enrollment?

Once the application has been approved, a notification is sent. Register for the Provider Web Portal.

How long will it take to get my screening results?

- Provider Enrollment responses may take up to 2 weeks.

Please note: This timeline might be affected by application complexity and accuracy.

Please review the Provider Enrollment Manual for:

- ➢ Steps to check your enrollment status
- ➢ Sample Notifications

Site Visits by GWT

- Per federal requirement 42CFR 455.432, pre-enrollment site visits are required for providers who are designated as “moderate” or “high” categorical risks to the Medicaid program.
- The purpose is to verify that the information submitted to the Department of Health Care Policy and Financing by a provider is accurate and to determine compliance with federal and state enrollment requirements. In the event a provider specialty falls into one of these risk categories, the provider will be contacted for the required site visit. A representative will visit the provider’s service location to verify certain aspects of your enrollment. Providers that refuse a site visit may be excluded from the Colorado Medicaid Program.
- For further information about risk categories by provider type, please refer to the Federal Provider Screening Regulation.

Sample Enrollment Email:

Approved Application

Dear Provider:

The Department of Health Care Policy & Financing (the Department) is pleased to welcome <ABC HCBS> to the Health First Colorado (Colorado's Medicaid Program) and/or Child Health Plans *Plus* (CHP+) Provider Network.

The Department is committed to partnering with providers to ensure members receive the highest quality care possible. Please visit the Provider Services web page for more information about policies and procedures, instructions for accessing the Provider Web Portal, and more. Providers are encouraged to learn about the Accountable Care Collaborative (ACC), Health First Colorado's delivery system, by visiting the Accountable Care Collaborative (ACC) web page.

The enrollment effective date is <6/01/2030>.

As required by the Affordable Care Act, the current risk level assignment is <moderate>.

Contact the Provider Services Call Center at 1-844-235-2387 with any questions regarding this letter.

Thank you,
Provider Enrollment

Adjusting an Existing Enrollment

- Changes to an existing enrollment may be necessary as providers' models change or there are changes to Health First Colorado benefits. Please contact GWT for further guidance on how to make those changes.

Training Completion

All HCBS providers are required to complete the enrollment/revalidation training.

Under the “HCBS Provider Enrollment Training” tab on the Long-Term Services and Support Web Page, providers will find the following:

- The recorded webinar training
- A PDF copy of the training with active web links
- The enrollment quiz

Save a copy of the results of the HCPF HCBS Enrollment Training quiz as a PDF and upload it to the supporting documents of the application. Failure to do so could result in delays in application processing.

GWT Contact Information

For questions about provider enrollment please call the Gainwell Technologies (GWT) Provider Services Line

1-844-235-2387

Providers are advised to request and record a call tracking number (CTN) as record of all interactions with GWT.