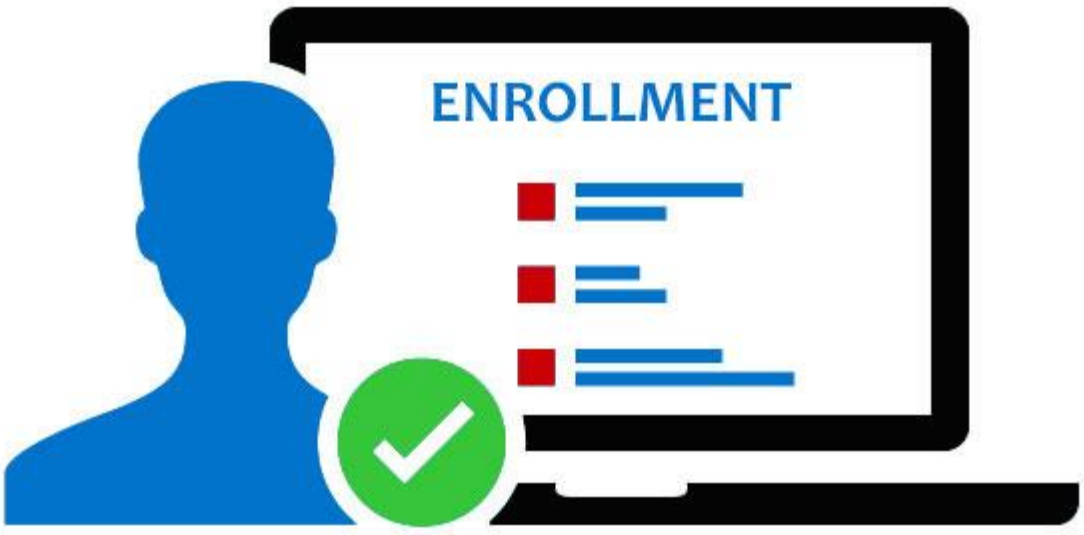
Individual Pay-To/Facility Provider Enrollment Tutorial

Revised 4/5/18



Individual Pay-to/Facility Enrollment

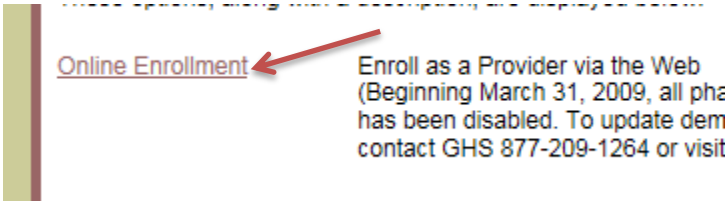
Documents you will need:

- Copy of Confirmation Letter or email from the National Plan and Provider Enumeration System (NPPES)
- Copy of CLIA if billing for laboratory services
- Copy of license or certification
- If requesting a back-dated enrollment, include a request letter with proof of enrollment in another State's Medicaid or Medicare for the backdate being requested
- Provider Enrollment Certification (This will be printed at completion of the web enrollment)
- Provider Agreement (This will be printed at completion of the web enrollment)

Follow the steps below when completing an enrollment for a Individual Pay-to or facility provider.

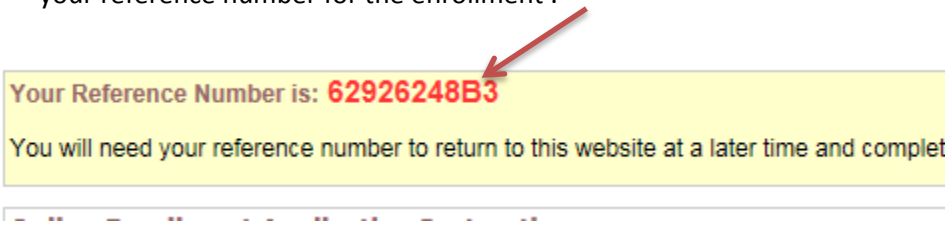
STEPS:

1. Navigate to the enrollment portion of the website: https://wymedicaid.portal.conduent.com/wy/general/providerEnrollmentHome.do
2. Click on Online Enrollment to start a new enrollment

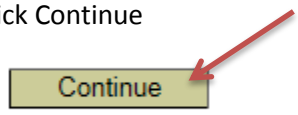


3. Enter your email address under Create a New Application, click Create

4. Online Provider Enrollment Application – Instructions. Ensure to read through the instructions and write down your reference number for the enrollment .



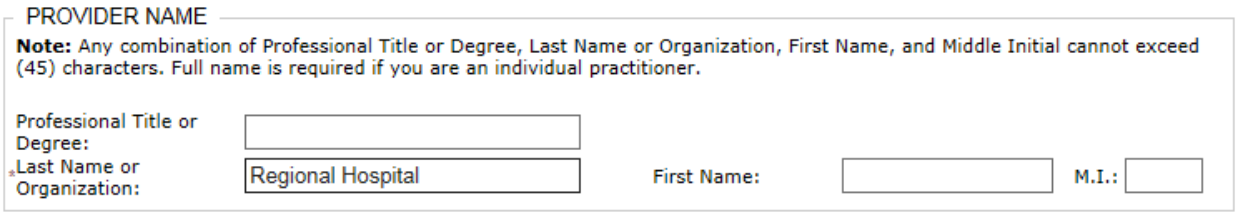
5. Click Continue



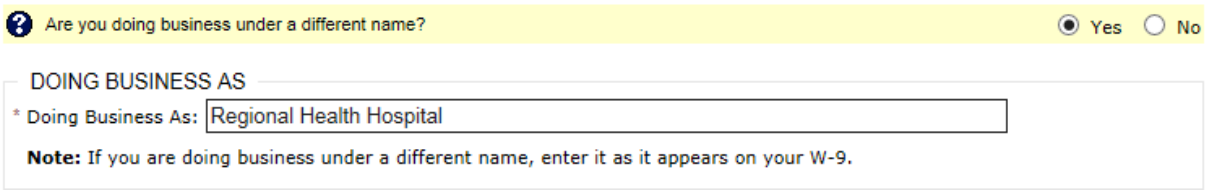
6. Is the enrollment a re-enrollment? Has this provider ever been enrolled with Wyoming Medicaid? Mark Yes or No. If the provider has, provide the provider number or NPI number. If you are unsure, mark no.

7. Choose the Type of Enrollment: Individual Pay-to Practitioner/Facility

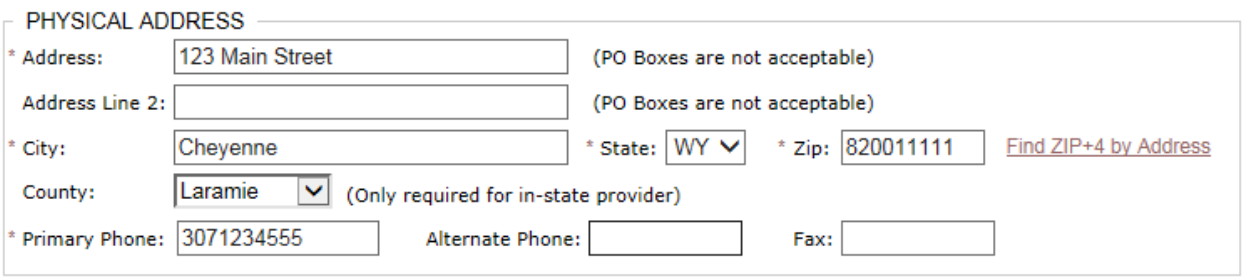
8. Enter the name of the Individual Pay to or Facility



9. Are you doing business under a different name? Mark Yes or No. If Yes, complete DBA.

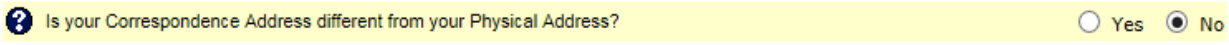


10. Enter the physical address

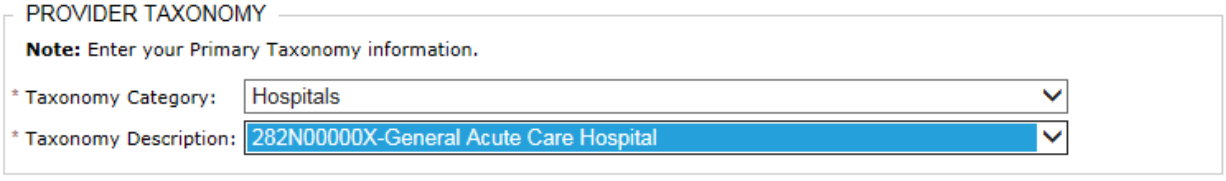


11. Is your Payment Address different from you Physical Address? Change this to yes, if applicable and enter the Payment Address.

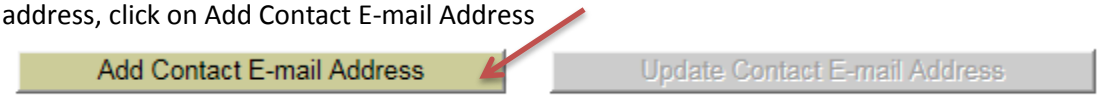
12. Is your Correspondence Address different from your Physical Address? Change this to yes, if applicable and enter the Correspondence Address.



13. Provider Taxonomy - Use the drop down boxes to choose the appropriate Taxonomy Code for the Group

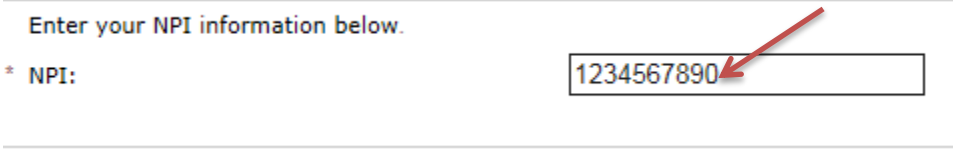


14. Contact Email Addresses – Add all contact email address and Email Notification Type. Once you enter an email address, click on Add Contact E-mail Address

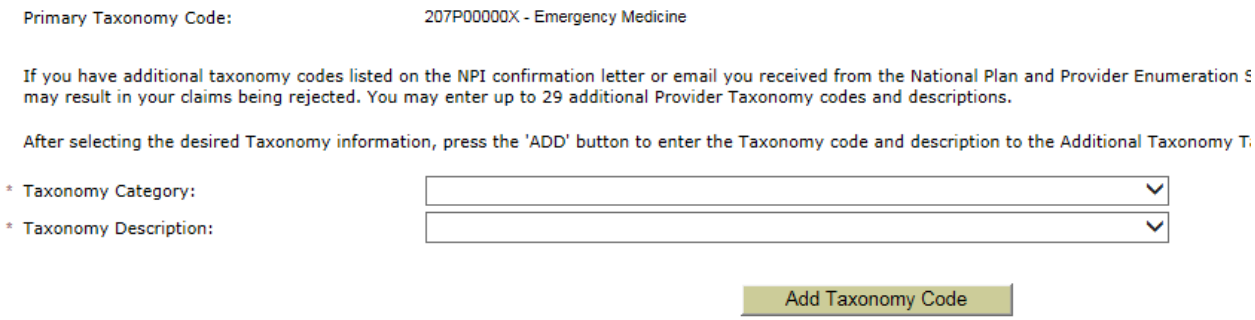


15. Click Save & Continue

16. Enter the NPI number

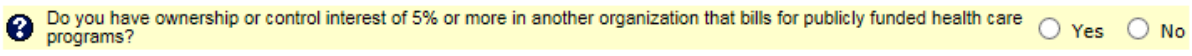


17. Add any additional taxonomy codes if applicable

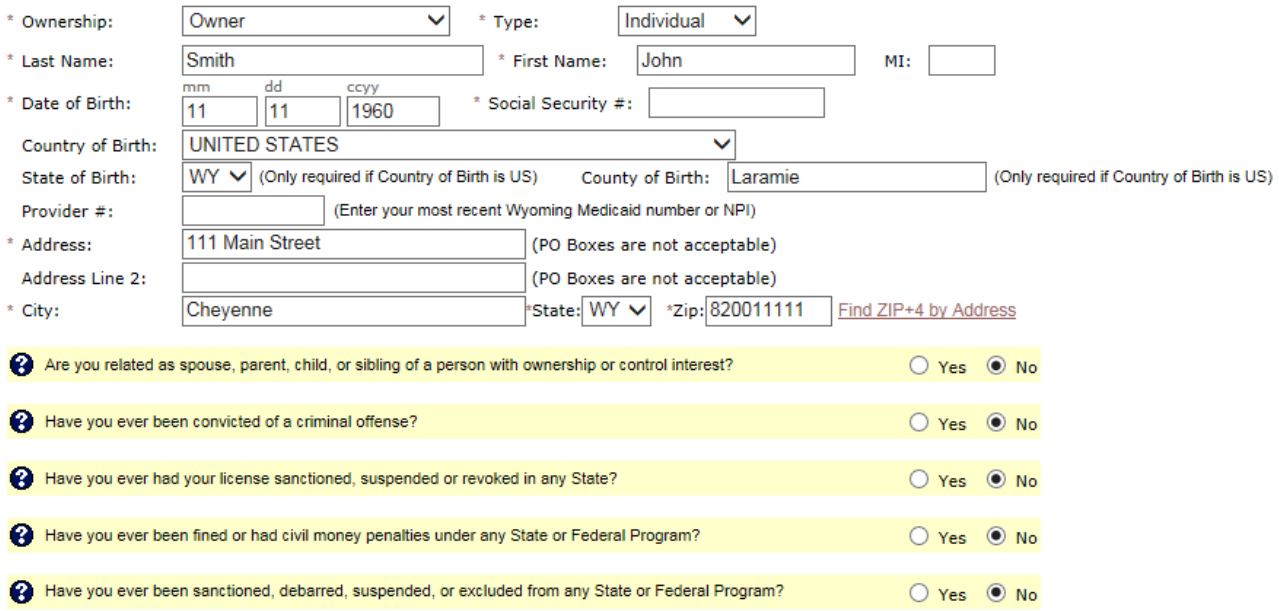


18. License Information – Complete with most current license information

19. Do you have ownership or control interest of 5% or more in another organization that bills for publicly funded health care programs? Mark yes or no.



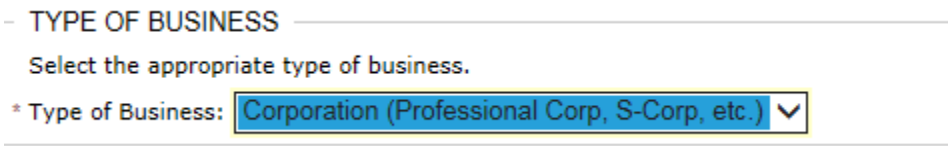
20. Ownership/Control Information section – Complete with Ownership Information
    a. If the business is a for-profit entity, you MUST enter an actual owner or controlling interest for the business
    b. DO NOT enter the facility as the owner of itself, this will not be excepted as valid ownership



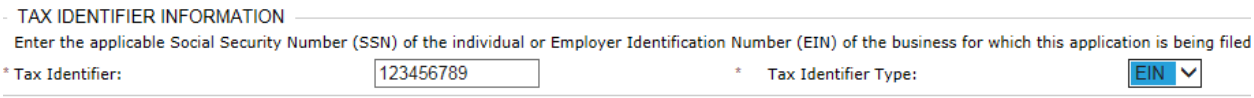
21. Click ADD OWNERSHIP

22. Add any additional owners if applicable using the same steps above

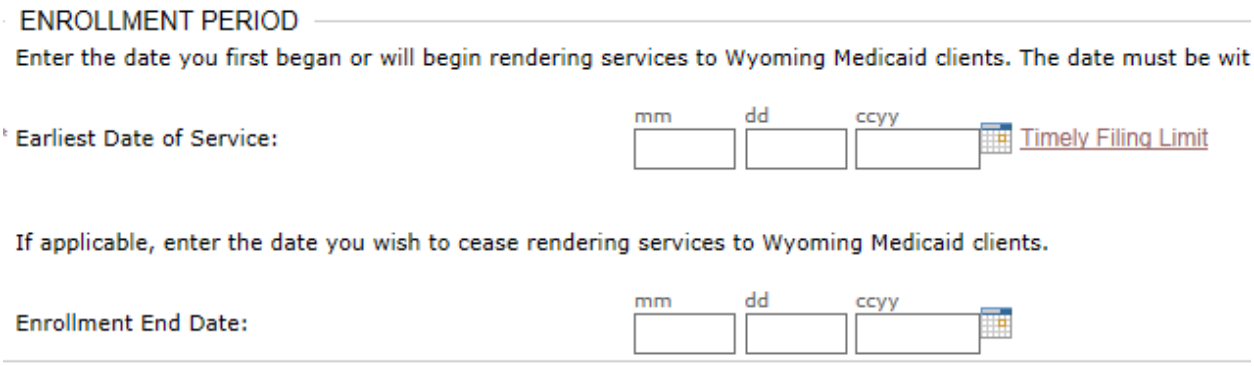
23. Type of Business: Use drop down box to choose the appropriate type of business



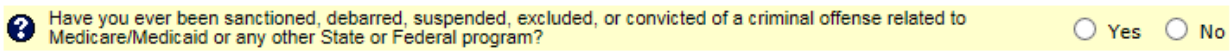
24. Enter the Tax ID number



25. Enrollment Period – Enter the Earliest Date of Service. Enter an enrollment end date only if applicable.
NOTE: To backdate an enrollment, you must send in a backdate request letter with proof of enrollment in another State's Medicaid or Medicare.

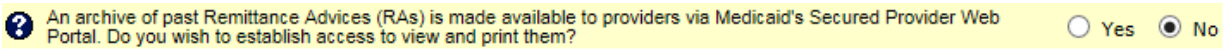


26. Have you ever been sanctioned, debarred, suspended, excluded, or convicted of a criminal offense related to Medicare/Medicaid or any other State or Federal program? Answer Yes or No. If Yes, add explanation.



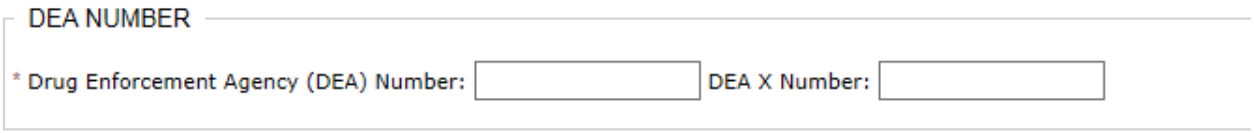
27. Do you bill laboratory services? Mark Yes or No. If Yes, indicate the CLIA number.

28. An archive of past Remittance Advices (RAs) is made available to providers via Medicaid's Secured Provider Web Portal. Do you wish to establish access to view and print them? Mark Yes or No.



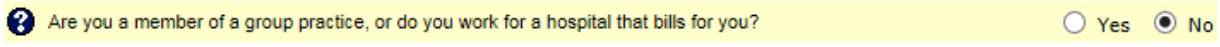
29. Will you submit claims to Medicaid electronically? Mark Yes or No. If yes, indicate how claims will be submitted electronically.
NOTE: If you bill Medicaid more than 25 claims, you are required to bill electronically.

30. DEA Number – Leave blank

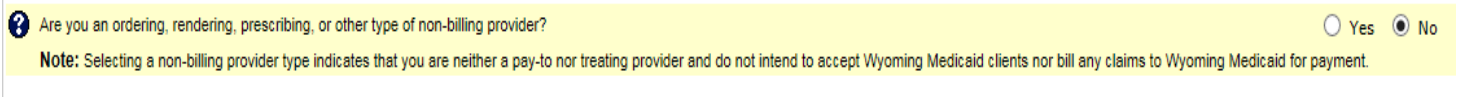


31. Have you previously billed Wyoming Medicaid? Change to yes, if applicable and enter the NPI or Provider number.

32. Are you a member of a group practice, or do you work for a hospital that bills for you? Leave marked No.

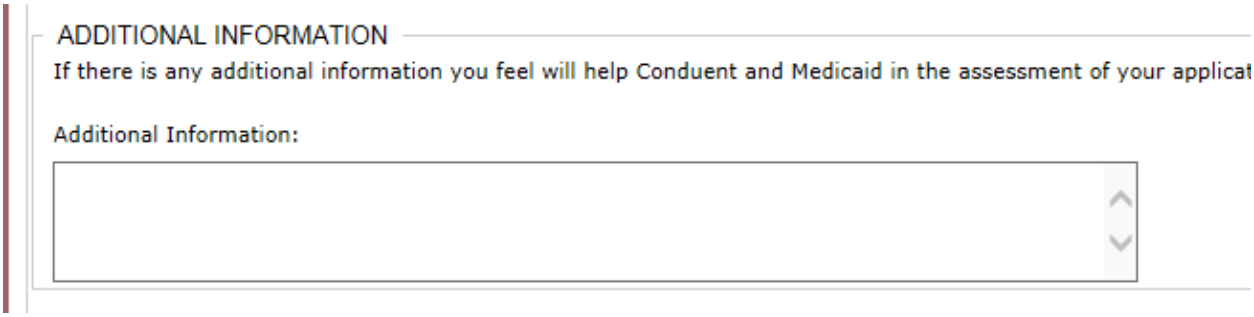


33. Is your organization a subsidiary company or joint venture? Mark Yes or No.
34. Are you an ordering, rendering, prescribing, or other type of non-billing provider? Mark no.

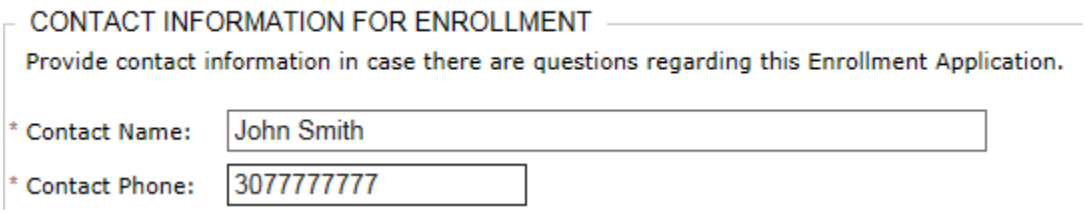


35. Are you a federal employee working at one of the following facilities: Indian Health Services or a 638 Tribal facility? Mark No

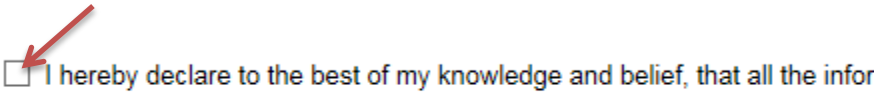
36. Additional Information – Add any additional information that may help in the processing of this enrollment.



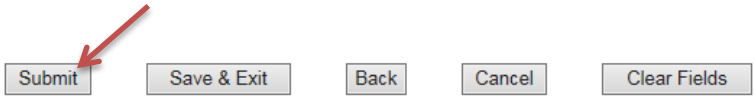
37. Contact Information for Enrollment – Add contact name and phone number for enrollment



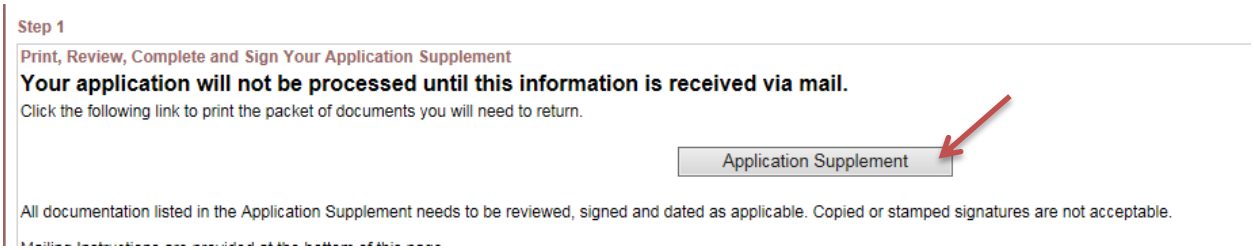
38. Read and check the declaration statement.



39. Click Submit



40. Click on Application Supplement and print all documents.



To Complete Supplemental Documents

Provider Certification:

- Printed Name of Practitioner or Organization: Enter the name of the Individual Pay-to or Facility that the enrollment was completed for
- Signature of Practitioner or Legally Authorized Representative: Sign in **BLUE** ink. This can be signed by any authorized representative and does NOT need to be signed by the provider himself/herself.
- Title/Position: Title/Position of person signing
- Date: Date of Signature
- Printed Name of Person Completing Form: Enter the name of the person completing the enrollment forms
- Telephone Number: Enter the phone number for the person completing the enrollment

Printed Name of Practitioner or Organization:		
Signature of Practitioner or Legally Authorized Representative:	Title/Position:	Date:
Printed Name of Person Completing Form (if different than above):		Telephone Number:

Provider Agreement:

- Printed Name of Individual Practitioner or Organization: Enter the name of the Individual Pay-to or Facility that the enrollment was completed for
- Street City State Zip: Enter the address for the provider
- Signature of Individual or Legally Authorized Representative: Sign in **BLUE** ink. This can be signed by any authorized representative and does NOT need to be signed by the provider himself/herself.
- Title and Date: Enter title and Date of individual signing the Provider Agreement

Please use blue ink when signing form. Original signature is required to process agreement.

Printed Name of Individual Practitioner or Organization			
Street	**City**	**State**	**Zip Code**
Signature of Individual Practitioner or Legally Authorized Representative		**Title**	**Date**

Trading Partner Agreement:

- Sign and Date if billing electronically