

Individual Pay-To/Facility Provider Enrollment Tutorial

Revised 4/5/18



Individual Pay-to/Facility Enrollment

Documents you will need:

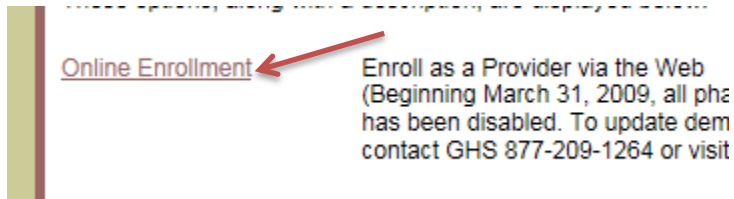
- Copy of Confirmation Letter or email from the National Plan and Provider Enumeration System (NPPES)
- Copy of CLIA if billing for laboratory services
- Copy of license or certification
- If requesting a back-dated enrollment, include a request letter with proof of enrollment in another State's Medicaid 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:

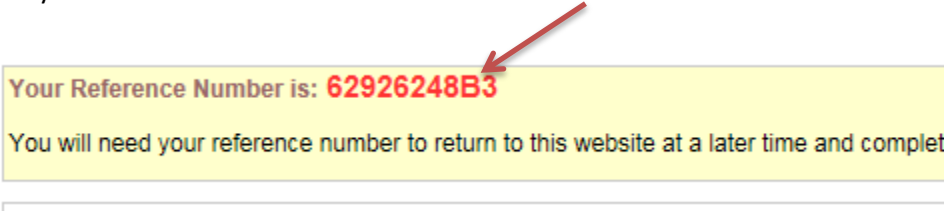
1. Navigate to the enrollment portion of the website:
<https://wymedicaid.portal.conduent.com/wy/general/providerEnrollmentHome.do>

2. Click on Online Enrollment to start a new enrollment

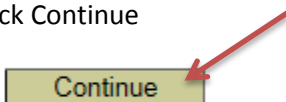


3. Enter your email address under Create a New Application, click Create

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

*Type of Enrollment: Individual Pay-to Practitioner/Facility ▼

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

PROVIDER NAME

Note: Any combination of Professional Title or Degree, Last Name or Organization, First Name, and Middle Initial cannot exceed (45) characters. Full name is required if you are an individual practitioner.

Professional Title or Degree:

*Last Name or Organization: First Name: M.I.:

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

Are you doing business under a different name? Yes No

DOING BUSINESS AS

* Doing Business As:

Note: If you are doing business under a different name, enter it as it appears on your W-9.

10. Enter the physical address

PHYSICAL ADDRESS

* Address: (PO Boxes are not acceptable)

Address Line 2: (PO Boxes are not acceptable)

* City: * State: WY ▼ * Zip: [Find ZIP+4 by Address](#)

County: Laramie ▼ (Only required for in-state provider)

* Primary Phone: Alternate Phone: Fax:

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

Is your Payment Address different from your Physical Address? Yes No

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

Is your Correspondence Address different from your Physical Address? Yes No

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

PROVIDER TAXONOMY

Note: Enter your Primary Taxonomy information.

* Taxonomy Category: Hospitals ▼

* Taxonomy Description: 282N00000X-General Acute Care Hospital ▼

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

Enter your NPI information below.

* NPI:

17. Add any additional taxonomy codes if applicable

Primary Taxonomy Code: 207P00000X - Emergency Medicine

If you have additional taxonomy codes listed on the NPI confirmation letter or email you received from the National Plan and Provider Enumeration S may result in your claims being rejected. You may enter up to 29 additional Provider Taxonomy codes and descriptions.

After selecting the desired Taxonomy information, press the 'ADD' button to enter the Taxonomy code and description to the Additional Taxonomy T.

* Taxonomy Category:

* Taxonomy Description:

18. License Information – Complete with most current license information

MOST CURRENT PROFESSIONAL LICENSE OR CERTIFICATION INFORMATION

* License or Certification Number: State:

* Effective Date: mm dd ccy * Expiration Date: mm dd ccy

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.

Yes 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

* Ownership: * Type:

* Last Name: * First Name: MI:

* Date of Birth: * Social Security #:

Country of Birth:

State of Birth: (Only required if Country of Birth is US) County of Birth: (Only required if Country of Birth is US)

Provider #: (Enter your most recent Wyoming Medicaid number or NPI)

* Address: (PO Boxes are not acceptable)

Address Line 2: (PO Boxes are not acceptable)

* City: *State: *Zip: [Find ZIP+4 by Address](#)

Are you related as spouse, parent, child, or sibling of a person with ownership or control interest? Yes No

Have you ever been convicted of a criminal offense? Yes No

Have you ever had your license sanctioned, suspended or revoked in any State? Yes No

Have you ever been fined or had civil money penalties under any State or Federal Program? Yes No

Have you ever been sanctioned, debarred, suspended, or excluded from any State or Federal Program? Yes No



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

- TYPE OF BUSINESS _____

Select the appropriate type of business.

* Type of Business:

24. Enter the Tax ID number

- TAX IDENTIFIER INFORMATION _____

Enter the applicable Social Security Number (SSN) of the individual or Employer Identification Number (EIN) of the business for which this application is being filed

* Tax Identifier: * Tax Identifier Type:

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.

ENROLLMENT PERIOD _____


Enter the date you first began or will begin rendering services to Wyoming Medicaid clients. The date must be wit

* Earliest Date of Service: mm dd ccy  [Timely Filing Limit](#)


If applicable, enter the date you wish to cease rendering services to Wyoming Medicaid clients.

Enrollment End Date: mm dd ccy 


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.

 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? Yes No

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

 Do you bill laboratory services? Yes No

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.

 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? Yes 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.

 Will you submit claims to Medicaid electronically? Yes No

30. DEA Number – Leave blank


DEA NUMBER _____

* Drug Enforcement Agency (DEA) Number: DEA X Number:

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

 Have you previously billed Wyoming Medicaid? Yes No

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

 Are you a member of a group practice, or do you work for a hospital that bills for you? Yes 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.

 Are you an ordering, rendering, prescribing, or other type of non-billing provider? Yes No

Note: Selecting a non-billing provider type indicates that you are neither a pay-to nor treating provider and do not intend to accept Wyoming Medicaid clients nor bill any claims to Wyoming Medicaid for payment.

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

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

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

ADDITIONAL INFORMATION

If there is any additional information you feel will help Conduent and Medicaid in the assessment of your application

Additional Information:

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

CONTACT INFORMATION FOR ENROLLMENT

Provide contact information in case there are questions regarding this Enrollment Application.

* Contact Name:

* Contact Phone:

38. Read and check the declaration statement.

I hereby declare to the best of my knowledge and belief, that all the information provided is true and correct.

39. Click Submit

40. Click on Application Supplement and print all documents.

Step 1

Print, Review, Complete and Sign Your Application Supplement

Your application will not be processed until this information is received via mail.

Click the following link to print the packet of documents you will need to return.

All documentation listed in the Application Supplement needs to be reviewed, signed and dated as applicable. Copied or stamped signatures are not acceptable.

Medical Instructions are provided at the bottom of this page.

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