Treating Provider Enrollment Tutorial

Revised 4/4/18

Treating Provider Enrollment

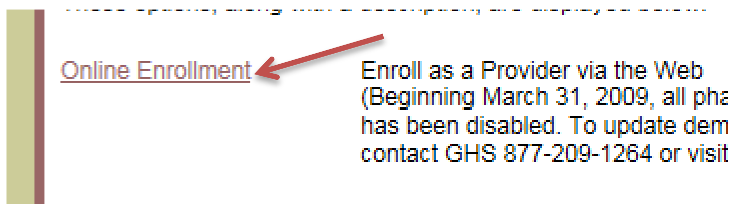
Documents you will need:

- Copy of license or certification
- Copy of Confirmation Letter or email from the National Plan and Provider Enumeration System (NPPES)
- 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)

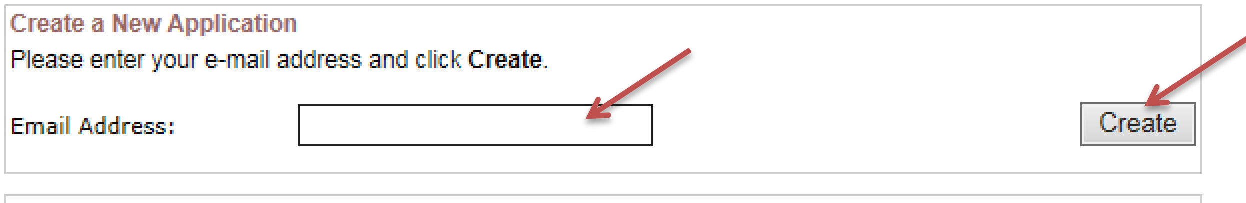
Follow the steps below when completing an enrollment for a treating provider. This tutorial may also be used to complete an enrollment for an Ordering, Rendering and Prescribing (ORP) provider.

STEPS:

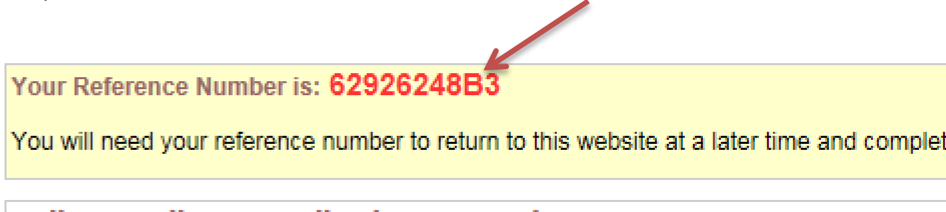
1. Navigate to the enrollment portion of the website: https://wymedicaid.portal.conduent.com/wy/general/providerEnrollmentHome.do
2. Click on Online Enrollment to start a new enrollment



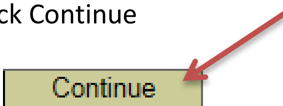
3. Enter your email address under Create a New Application, click Create



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.

Is this enrollment a re-enrollment? ○ Yes ○ No

7. Choose the Type of Enrollment: Individual Treating Provider

*Type of Enrollment: Individual Treating Practitioner

8. Enter the name of the provider

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: MD

Last Name or Organization: Smith First Name: John M.I.:

9. Are you doing business under a different name? For a treating/ORP enrollment, this should be 'no'.

Are you doing business under a different name? ○ Yes ◉ No

10. Enter the provider's physical address

PHYSICAL ADDRESS

* Address: 123 Main Street (PO Boxes are not acceptable)

Address Line 2: (PO Boxes are not acceptable)

* City: Cheyenne * State: WY * Zip: 820011111 Find ZIP+4 by Address

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

* Primary Phone: 3071234555 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 provider

PROVIDER TAXONOMY

Note: Enter your Primary Taxonomy information.

* Taxonomy Category: Allopathic & Osteopathic Physicians

* Taxonomy Description: 207P00000X-Emergency Medicine

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

Add Contact E-mail Address | Update Contact E-mail Address

15. Click Save & Continue

Save & Continue | Save & Exit | Back | Cancel | Clear Fields

16. Enter the providers NPI number

Enter your NPI information below.

* NPI: 1234567890

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:

Add Taxonomy Code

18. Enter the provider's most current license information

MOST CURRENT PROFESSIONAL LICENSE OR CERTIFICATION INFORMATION

* License or Certification Number: 123123 State: WY

* Effective Date: mm 01 dd 01 ccyy 2018 * Expiration Date: mm 01 dd 01 ccyy 2019

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. Remember that all questions on this enrollment are in reference to the individual enrolling.

Do you have ownership or control interest of 5% or more in another organization that bills for publicly funded health care programs? Yes No

20. Skip the Ownership/Control Information section

21. Type of Business: Use drop down box to choose Individual Treating Provider and complete date of birth

TYPE OF BUSINESS

Select the appropriate type of business.

* Type of Business: Individual Treating Provider

* Date of Birth: mm 01 dd 01 ccyy 1960

22. Enter the provider's SSN and choose Tax Identifier Type: SSN

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 f

* Tax Identifier: 121212121 * Tax Identifier Type: SSN

23. 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 ccyy Timely Filing Limit

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

Enrollment End Date: mm dd ccyy

24. 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

25. The next three questions are already marked 'No' and do not apply to treating/ORP enrollments, skip questions.
26. DEA Number – Enter the provider's DEA number and DEA X Number if applicable

DEA NUMBER

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

27. 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

28. Are you a member of a group practice, or do you work for a hospital that bills for you? Treating Provider – Answer 'Yes' and enter the NPI for the group practice. ORP – Answer 'No'

Are you a member of a group practice, or do you work for a hospital that bills for you? (•) Yes ( ) No

GROUP PRACTICE OR HOSPITAL ID

Up to ten (10) Wyoming Medicaid IDs, NPIs, or Employer Identification Numbers (EINs) can be added for Group Practices or Hospitals. Group practice is defined as

* Group Practice or Hospital ID:

Add ID | Update ID

29. Is your organization a subsidiary company or joint venture? This does not apply to treating/ORP enrollments, leave marked 'No'.
30. Are you an ordering, rendering, prescribing, or other type of non-billing provider? Mark 'Yes' only if you are enrolling as an ORP provider and will not be linked to a group.

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.

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

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

32. 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 applicat

Additional Information:

33. 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.

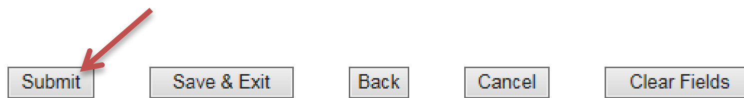
* Contact Name: John Smith

* Contact Phone: 3077777777

34. Read and check the declaration statement.

☐ I hereby declare to the best of my knowledge and belief, that all the infor

35. Click Submit



36. 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.

Application Supplement

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

To Complete Supplemental Documents

Provider Certification:

- Printed Name of Practitioner or Organization: Enter the name of the individual 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 the enrollment was completed for
- Street City State Zip: Enter the address for the individual enrolling
- 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: Not required for individual treating/ORP enrollments