



gainwell

Florida Medicaid Provider Enrollment Application Guide

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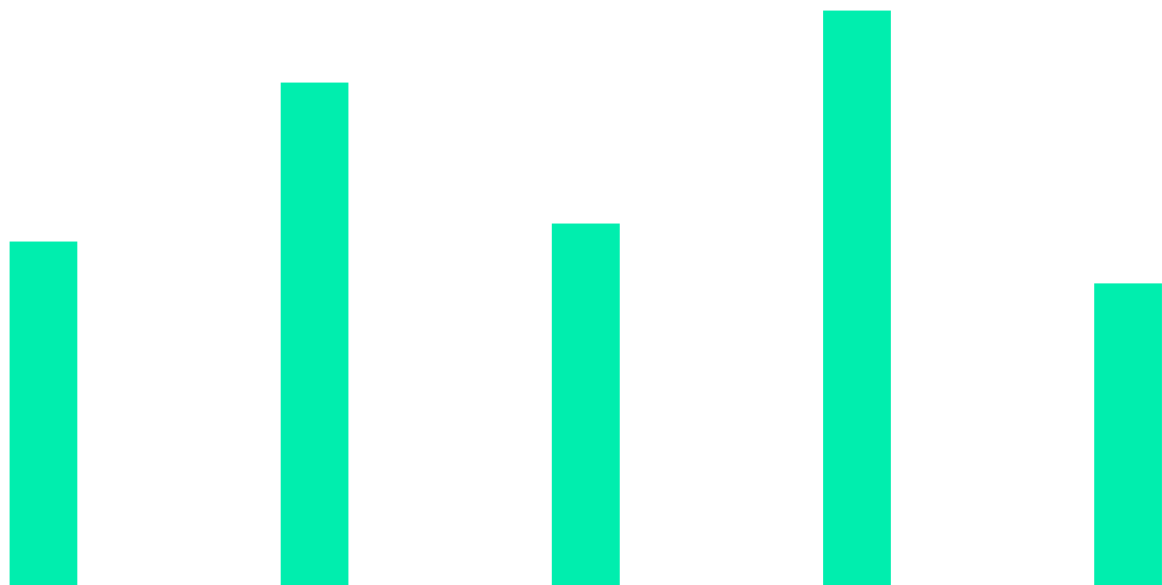


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1 Purpose

The Agency for Health Care Administration (Agency) and its fiscal agent, Gainwell Technologies (Gainwell), have created this comprehensive reference guide to assist applicants with completing the enrollment process using the Florida Medicaid online enrollment wizard. This guide references and ties together provider enrollment-related information that is publicly available on the Florida Medicaid Web Portal, and provides guidance for completing the process for submission, uploading documentation, and verifying the status of a submitted application. All public Web Portal resources can be accessed via <http://www.mymedicaid-florida.com>. Agency resources can be found on the Agency page at <http://ahca.myflorida.com>.

2 Contents

General Information	Mailing Address
Enrollment Qualifications	Pay To Address
Accuracy of Information	Home / Corp Office Address
Notice Regarding Use of Social Security Number	Xref NPI
Supporting Documentation Requirements	ATN Information (ATN is generated at this time)
Enrollment Process	Member of the Following Groups
Before You Enroll	Billing Agent Agreement
Submitting a Provider Enrollment Application	Owners and Operators
Welcome Statement	EFT Agreement
Enrollment Type	Applicant History
Enrollment Type Confirmation	Supporting Documents
Application Tips	Certification
Request Type	Application Confirmation
Before You Continue	Verifying the Status of an Enrollment Application
Identifying Information	Application Status Descriptions
Certification and Attestation Panel	Submitting Corrections to a Pending Application
License & More Identifying Information	Maintaining Provider Information
Collaboration Agreement	Helpful Resources
Contact Information	
Service Location	

2.1 General Information

In order to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered. Every entity that provides Medicaid services to recipients and all third-party software vendors offering services of any kind to providers must enroll as a Medicaid provider.

2.2 Enrollment Qualifications

Providers must meet all provider requirements and qualifications. Practices must be fully operational before they can be enrolled as Medicaid providers. General enrollment requirements are covered in the Medicaid Provider General Handbook. Program specific qualifications for each provider type are listed in the Coverage and Limitations Handbooks. All handbooks are available at <https://ahca.myflorida.com/>.

2.3 Accuracy of Information

All enrollment statements or documents submitted to the Agency for Health Care Administration (Agency) or the Medicaid fiscal agent must be true and accurate. Filing of false information is sufficient cause for denial of an enrollment application or termination from Medicaid participation.

2.4 Notice Regarding Use of Social Security Number

As a part of your application for enrollment as a Florida Medicaid provider, all individuals listed as Owner(s) and Operator(s) are required to provide their social security number (SSN) to the Agency pursuant to 26 U.S.C. 6109. Disclosure of your social security number is mandatory. Failure to provide your social security number will be a basis to refuse to enroll you as a Medicaid provider.

Your social security number will be used to secure the proper identification of persons for whom the Agency is responsible for making a return, statement, or other document in accordance with the Internal Revenue Code, and to assist in the administration of the Florida Medicaid program.

2.5 Supporting Documentation Requirements

The application process cannot be completed until all required documents as stipulated in the applicable Handbook sections, including an accurately completed Florida Medicaid provider agreement and background screening, are received.

Applicants must include the Application Tracking Number (ATN) provided by the Online Enrollment Wizard when uploading supporting documents.

Please visit the Enrollment Forms page via <http://www.mymedicaid-florida.com> to obtain the forms needed for initial enrollment. Applicants are encouraged to use the [Interactive Enrollment Checklist](#) tool to verify supporting documentation requirements prior to completing their online application.

2.6 Enrollment Process

Most provider enrollment applications will go through the following process:

1. Applicant submits an Enrollment Application via the Florida Medicaid Web Portal Online Enrollment Wizard.
2. The Enrollment Application is evaluated based on the enrollment rules. The Agency completes the credential verification process and site visit, when applicable.
3. The Enrollment Application is finalized. Provider receives a letter containing the final status, whether approved or denied.
4. Once the Enrollment status is Active, the provider receives a Welcome Letter, and Florida Medicaid ID. Full and limited enrolled providers will also receive a PIN Letter, that will be used to create a secure web portal account.

3 Before You Enroll

Before initiating the enrollment process, please follow the instructions listed below:

1. Review the [Provider General Handbook](#), Chapter 2, for general enrollment requirements. The handbook is located on the Agency's website at <http://ahca.myflorida.com>.
2. Determine which **Enrollment Type** will be used.
3. Determine which Provider Type and Specialty will be used. View the Provider Type and Specialty to learn which qualifies for fully enrolled, limited enrolled, or order or referring enrollment.
4. Refer to the [Interactive Enrollment Checklist](#) to identify enrollment application requirements based on enrollment type, application type, provider type, and specialty, prior to starting the application process. To access the Interactive Enrollment Checklist, visit mymedicaid-florida.com. From the homepage, hover over the Provider Services tab, and click Enrollment. Once at the Provider Enrollment page, look under the New Medicaid Providers section, and click Interactive Enrollment Checklist.
5. Before the application can be submitted, all supporting documentation must be uploaded.

4 Submitting a Provider Enrollment Application

The Florida Medicaid Provider Enrollment Application gathers information related to the applicant's eligibility to enroll in Florida Medicaid. Providers use this page to complete an enrollment application to become a participating provider in the Florida Medicaid program.

The following provides guidance for accurately reporting the elements of the application. By logging into the secure Web Portal at <http://www.mymedicaid-florida.com>, providers can complete their enrollment application by navigating to Provider Services tab and clicking on the Enrollment.

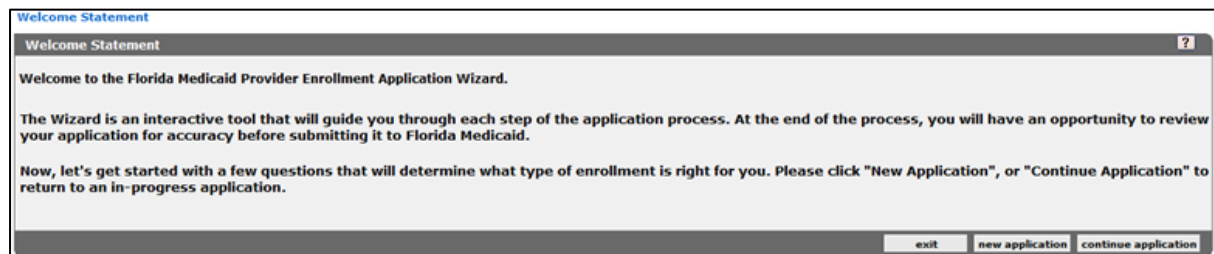
The online enrollment application cannot be used if applying for Out of State Enrollment or Additional Location Codes.

4.1 Navigation

Button	Description
New application	Click to create a new application.
Continue application	Click to continue an application that was previously saved and assigned an ATN (Application Tracking Number).
Save and continue	Click to save changes made to the current panel and proceed to the next. Note: Enrollment information is only temporarily stored in the Enrollment Wizard until you have reached the stage where an ATN has been created.
Previous	Click to return to the previous panel.
Exit	Click to exit from the Online Enrollment Wizard.
?	Click to access contextual page help.
Delete	Click to delete the selected row.
Refresh session	Click to extend the Online Enrollment Wizard session expiration time. Note: By default, the session will expire after 60 minutes. All unsaved information will be lost.

4.2 Welcome Statement

Upon launching the Florida Medicaid Enrollment Application Wizard, applicants will be greeted with a Welcome Statement panel, and will have the option to create a new application or access on that was previously started.



4.3 Enrollment Type

The Enrollment Type Determination panel will ask the applicant to choose the option that most accurately describes the reason they are applying to be a Medicaid provider. The selection made on this panel will determine all of the steps that will follow in the application.

Provider must enroll as one of the following:

Fully Enrolled allows providers to:

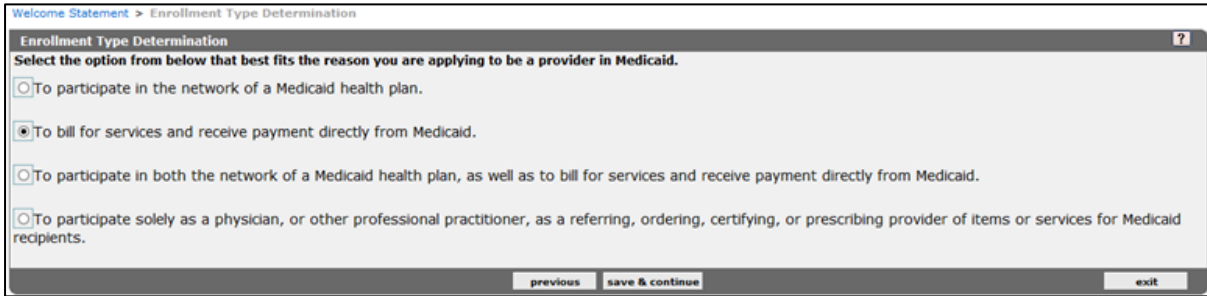
- Bill for services and receive payment directly from Medicaid.
- Participate in both the network of a Medicaid health plan as well as to bill for services and receive payment directly from Medicaid.

Limited Enrolled allows providers to:

- Participate in the network of a Medicaid health plan.

Ordering or Referring will allow providers to:

- Participate solely as a physician, or other professional practitioner, as a referring, ordering, certifying, or prescribing provider of items or services for Medicaid recipients.



4.4 Enrollment Type Confirmation

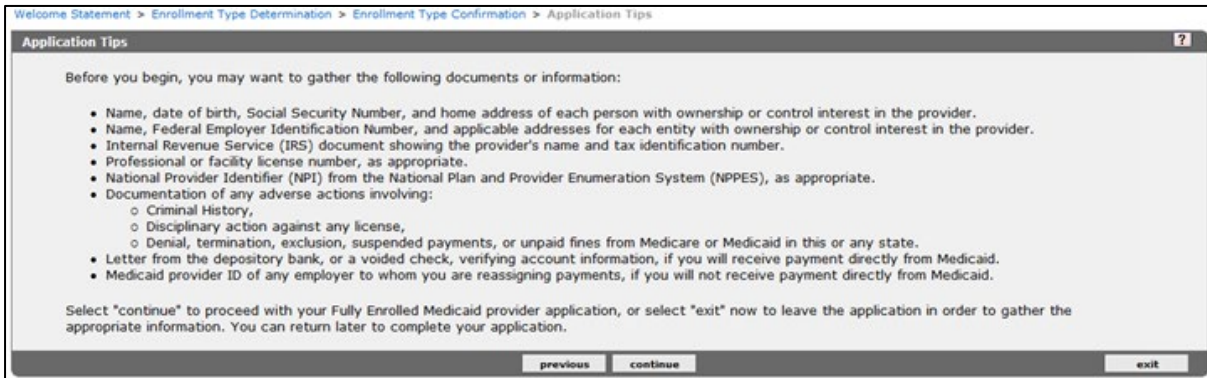
After selecting the desired enrollment type determination response, providers will reach the Enrollment Type Confirmation panel that will confirm the selection made on the previous screen.

If a choice was made incorrectly, providers can click **previous** or if correct, click **continue**.



4.5 Application Tips

Providers are encouraged to obtain all necessary documents or information, before proceeding with the application. The Application Tips panel lists details that may be necessary to complete application processing.



4.6 Request Type

The information presented in the Request Type panel results may vary. The information displayed is contingent on the enrollment type selected in the previous panel. Applicants will only be presented with provider type and specialty selections that are available for the enrollment type selected, as well as taxonomies that align to the specialties chosen. Applicants may view the Provider Type and Specialty crosswalk to learn which qualifies for fully enrolled, limited enrolled, or ordering or referring enrollment.

Applicants must also select an Application Type within the panel.

A Sole Proprietor is an individual who plans to bill Medicaid directly. This option should be selected if you are individual that plans to submit claims to Medicaid and receive payments directly.

A Sole Proprietor Enrolling as a Member of a Group is an individual who plans to bill solely through a group membership and will not submit claims or receive payment directly from Medicaid.

Group should be selected if there is more than one member.

A Facility or Other Business Entity should be selected if the applicant is an entity that is formed and administered in accordance with commercial laws in order to engage in business activities

The screenshot shows a web-based form titled "Request Type". At the top, there is a breadcrumb trail: "Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type". The form contains several sections:

- *Indicates required item**: A heading for the first two questions.
- Is the provider enrolled with Medicare?***: A radio button selection with "No" selected and "Yes" unselected.
- Is this a Crossover only application?***: A radio button selection with "No" selected and "Yes" unselected.
- Application Type***: A radio button selection with four options: "SOLE PROPRIETOR", "SOLE PROPRIETOR ENROLLING AS A MEMBER OF A GROUP" (selected), "GROUP", and "FACILITY OR OTHER BUSINESS ENTITY".
- Provider Type***: A dropdown menu with "39-BEHAVIOR ANALYSIS" selected.
- Primary Specialty***: A dropdown menu with "390-REGISTERED PROVIDER TECHNICIAN" selected.
- Primary Taxonomy***: A dropdown menu with "106500000X-BEHAVIOR TECHNICIAN" selected.
- Secondary Specialty**: An empty dropdown menu.
- Secondary Taxonomy**: An empty dropdown menu.
- Third Specialty**: An empty dropdown menu.
- Third Taxonomy**: An empty dropdown menu.
- Fourth Specialty**: An empty dropdown menu.
- Fourth Taxonomy**: An empty dropdown menu.

At the bottom of the form, there are three buttons: "previous", "save & continue", and "exit".

4.6.1 Change of Ownership Application

If the applicant is seeking to submit a CHOW application, they can visit the [CHOW](#) page on the public Web Portal for more information.

If the application is based on a change of ownership (CHOW) providers applying for full enrollment should select Yes to the CHOW question and enter the previous owner's information such as the Name, Provider Number, Federal Tax ID, and Date of CHOW into the required fields. They must also upload the supporting documentation for the CHOW.

Note: Once an application is submitted, the CHOW response cannot be changed and a new application will be required if updates are needed.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type

Request Type

*Indicates required item

Is the provider enrolled with Medicare?* No Yes

Is this a Crossover only application?* No Yes

Is this application based on a change of ownership (CHOW)?* No Yes

CHOW Information:
Submit a copy of stock transfer document or bill of sale and complete the following information about the previous owner.

Name* Provider Number*
Federal Tax ID* Date of CHOW*

4.7 Before You Continue

Providers should obtain the information below before proceeding with the remainder of the application.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue

Before You Continue

Enrollment Application

Before you continue:

It may be helpful to have the information listed below *before* you begin answering the questions.

- National Provider Identifier (NPI)
- Facility or Professional License Number
- Clinical Laboratory Improvement Certificate (CLIA) Number
- Drug Enforcement Agency (DEA) Number
- Tax ID used for Income Reporting
 - Individual applicants use their Social Security Number
 - Incorporated individual or entity applicants use their FEIN
- Name, Home Address, Date of Birth, and SSN of all Managing Employees and Individuals with 5% or more Controlling Interest in the Provider
- Name, Business Address, and FEIN for all Entities with 5% or more Controlling Interest in the Provider
- Bank Account and Routing Number to Establish Electronic Payments
- Name, Telephone Number, and Email Address for Contact Person and the Medical and Financial Records Custodians

previous save & continue exit

4.8 Identifying Information

4.8.1 Provider Name

This is the legal name by which you are known to the Internal Revenue Service. Enter the name of the entity or the last name, first name, and middle initial of an individual. The name must also match the name listed on the provider's license.

4.8.2 Doing Business As (D/B/A)

This is for individual or entity applicants doing business under a trade or company name. Individual providers doing business under his/her own name should leave this section blank.

4.8.3 Tax Identification Number (TIN)

- Social Security Number (SSN) - Individual providers who are not personally incorporated will enter their SSN and supply a copy of their Social Security card.

Note: Individual providers may not use their employer's Tax ID on their individual provider file.

- Federal Employer Identification Number (FEIN) - Enter your FEIN if you are an entity or are individually incorporated. Attach a legible copy of proof of Tax ID such as an IRS Form SS-4, 1072, 147c, or W-9 to verify ownership of the Tax ID.

Note: Please ensure that the TIN information on the application is accurate before submission as this information cannot be updated once the application is submitted. If updates are needed, a new application will be required.

4.9 Certification and Attestation Panel

This panel is conditional and only presented to applicants who are applying for the Behavior Analysis program (PT 39). The attest options presented in this panel is contingent upon the behavior analysis specialty that is chosen. Applicants should select an attest option and enter a certification number, the effective date, and list their name in the “Signed By” field.

4.10 License & More Identifying Information

This panel is where applicants who are licensed by the State of Florida provides license information. All other applicants choose Other/Not Required. The Online Enrollment Wizard will generate an error and not allow the applicant to proceed with the application if the:

- License type is incorrect
- License information is not entered;
- License information is inactive; or
- Name entered on the application does not match the name on the applicant’s license.

If a license is entered, it must also be active.

4.11 Collaboration Agreement

This panel is conditional and only presented to applicants who are applying for Physician Assistant (PT 29) and Advanced Practice Registered Nurse (PT 30). The name on the license must match the name of the collaborator (supervising physician).

Note: The Name of Collaborator field should only include the first and last name of the supervising physician.

The Online Enrollment Wizard will generate an error and not allow the applicant to proceed with the application if the:

- License type is incorrect
- License information is not entered;
- License information is inactive; or
- Name entered on the application does not match the name on the applicant’s license.

4.12 Contact Information

The Contact Information panel is where applicants should enter information for the individual who is completing the application. This is the person with which Gainwell will correspond to at the provider applicant's place of business.

4.13 Service Location

The Service Location address is the complete address including county of the location where services are rendered. P.O. Boxes and mail drop locations are not accepted.

4.14 Mailing Address

The mailing address entered should be the location which general correspondence is sent.

The screenshot shows the 'Mailing Address' form. At the top, a breadcrumb trail reads: 'Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Type > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address'. The form title is 'Mailing Address' and the instruction is 'Enter the address, phone and fax numbers, and email of your Mailing Address'. A note states: 'Legal documents will be sent to the email-address entered below. If there is no email-address on file, the street address will be used.' There are two radio button options: 'Same as Service Location Address' and 'None of the above'. The form fields include: 'Address 1*' (text box), 'Address 2' (text box), 'City*' (text box), 'State*' (dropdown menu), 'Zip Code*' (two text boxes), 'County*' (dropdown menu), 'Mailing Address E-mail' (text box with placeholder '[yourname@domain.com]'), 'Phone*' (text box), and 'Fax' (text box). At the bottom, there are three buttons: 'previous', 'save & continue', and 'exit'.

4.15 Pay To Address

The Pay To Address is where special payments and tax documents (IRS Form, 1099-Misc, etc.) are sent.

Note: If submitting a W-9 or 147c, the Pay To address must match the address on the document provided.

The screenshot shows the 'Pay To Address' form. At the top, a breadcrumb trail reads: 'Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Type > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address'. The form title is 'Pay To Address' and the instruction is 'Enter the address, phone and fax numbers, and email of your 'Pay To' Address'. There are three radio button options: 'Same as Service Location Address', 'Same as Mailing Address', and 'None of the above'. The form fields include: 'Address 1*' (text box), 'Address 2' (text box), 'City*' (text box), 'State*' (dropdown menu), 'Zip Code*' (two text boxes), 'County*' (dropdown menu), 'Pay To Address E-mail' (text box with placeholder '[yourname@domain.com]'), 'Phone*' (text box), and 'Fax' (text box). At the bottom, there are three buttons: 'previous', 'save & continue', and 'exit'.

4.16 Home/Corp Office Address

In the Home / Corporate Office Address panel, providers are given the option to enter new address details or make a selection to use the same address entered for the Service Location, Mailing, or Pay To Address.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address

Home/Corp Office Address ?

Enter the address, phone and fax numbers, and email of your 'Home/Corp Office' Address

Same as Service Location Address
 Same as Mailing Address
 Same as Pay To Address
 None of the above

Address 1*
 Address 2
 City*
 State*
 Zip Code*
 County*
 Home/Corp Office Address E-mail
 [yourname@domain.com]
 Phone*
 Fax

previous save & continue exit

4.17 Xref NPI

The Xref NPI panel is conditional, and only contingent upon provider type.

Providers can obtain or verify your NPI on the National Plan and Provider Enumeration System (NPPES) before completing this panel.

Note: Only providers who require an NPI will be presented with this panel.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > Xref NPI

Xref NPI ?

NPI Number	Taxonomy	Zip Code	Zip Ext
A	253Z00000X		

Type data below for new record.

You can obtain or verify your NPI on the [National Plan and Provider Enumeration System \[NPPES\]](#) before completing this panel.

You can research your NPI on the [NPI to Medicaid ID Search Engine](#) to verify if it is already in use on a Medicaid ID before completing this panel.

NPI Number*
 Taxonomy* 253Z00000X-IN HOME SUPPORTIVE CARE
 Zip* +4 (Optional)

NOTE: Providers with one NPI who are already using that NPI on another Medicaid ID must enter a Taxonomy and/or ZIP+4 here that is different from the Taxonomy and/or ZIP+4 in use on the other Medicaid ID.

Once approved for enrollment, you must submit all electronic submissions to Medicaid, or to a Medicaid health plan, using the NPI, Taxonomy, and ZIP+4 as entered on this panel in order to be associated with your new Medicaid ID.

delete add

previous save & continue exit

4.18 ATN Information

Once the ATN Information panel displays, this confirms that appropriate provider information has been captured to save the application. The application is then given an Application Tracking Number (ATN) to be entered when completing an existing application or to check the status of a recently submitted application.

Note: Providers must ensure that the Application Type, Enrollment Type, Provider Type, CHOW indicator (yes/no), Tax ID, and Tax ID Type selected are accurate, as these items cannot be altered after an Application Tracking Number (ATN) has been assigned.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > Xref NPI > ATN Information

Please make note of your ATN: 743982 and Name: GROUP TESTER

ATN Information ?

We have collected enough information to save your application. Your application will be automatically saved as you progress through each page remaining in the application.

Your application has been assigned Application Tracking Number (ATN) **743982** and the name entered for this Application is **GROUP TESTER**. Please write down both the ATN and name and keep them in a safe place.

You can exit this application and return at a later time to continue. Once the application has been submitted you can check the status from the Enrollment Status link. You will need to enter both the ATN and name to continue the application or to check the status.

previous save & continue exit

4.19 Member of the Following Groups

The Member of the Following Groups panel is only presented to providers applying for full enrollment with the application type of *Sole Proprietor Enrolling as a Member of a Group*. This panel will require the applicant to enter the group's 9-digit Medicaid ID and effective date. Individuals should contact the group which they are enrolling as a member of to obtain the group's Medicaid ID. Applicants may refer to the Pending Provider Listing (PPL) to obtain the Medicaid ID number, if the group is in the process of enrolling.

Note: The effective date cannot be prior to the current date.

4.20 Billing Agent Agreement

The Billing Agent Agreement panel is only applicable if the provider plans to use a billing agent or trading partner. Obtain information such as the Billing Agent Provider Number, Billing Agent Name, Trading Partner ID, and Trading Partner Name from the agent they are adding.

4.21 Owners and Operators

4.21.1 If you are:

An Individual Who Plans To Bill Medicaid Directly: If you plan to submit claims to Medicaid and receive payments directly, you must disclose yourself, the medical and financial records custodian(s), and all individuals who hold signing privileges on the depository account.

An Individual Who Plans To Bill Medicaid Through A Group: If you plan to bill solely through a group membership and will not submit claims or receive payment directly from Medicaid, you must disclose yourself.

Group, Facility or Other Business Entity: You must disclose all entities and individual persons with five (5) percent or greater controlling interest and all managing employees including all individuals who hold signing privileges on the depository account.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > ATN Information > Member of the Following Groups > Owners and Operators

Please make note of your ATN: 743957 and Name: TESTER

Business Name	Last Name	First Name	Title	Affiliation	Tax ID Type	Tax ID	Lic. Source	License #	% Owner	Date of Birth
Type data below for new record.										
To complete this panel, list yourself along with all required information. Sole Proprietors must disclose their name, home address, date of birth, and SSN.										
Business Name	<input type="text"/>									
Last Name	TESTER									
First Name, MI	DXC <input type="text"/>									
Affiliation*	<input type="text"/>									
Title	<input type="text"/>									
Lic. Source*	<input type="radio"/> DOH <input type="radio"/> HQA <input checked="" type="radio"/> OTHER									
License	<input type="text"/>									
Tax ID Type*	<input checked="" type="radio"/> FEIN <input type="radio"/> SSN									
Tax ID*	123456789									
Date of Birth*	<input type="text"/>									
% Owner	0									
Home Address (This should be home address of the individual listed above):										
Phone*	<input type="text"/>									
Address 1*	<input type="text"/>									
Address 2	<input type="text"/>									
City*	<input type="text"/>									
State*	<input type="text"/>									
Zip*	<input type="text"/>									
<input type="checkbox"/> Add this owner as Financial Record Custodian <input type="checkbox"/> Add this owner as Medical Record Custodian										
										delete owner
										add additional owner
<input type="button" value="previous"/> <input type="button" value="save & continue"/> <input type="button" value="exit"/>										

4.22 EFT Agreement

The EFT Agreement panel is only presented to providers applying for full enrollment with an application type of Group, Sole proprietor, or Facility or other business entity. Providers are required to complete all fields and upload a voided check or a letter on a bank letterhead to certify the routing and account numbers are correct when submitting the application. Applicants should ensure that the EFT information is accurate prior to submitting the application as this information cannot be modified until after the application is finalized.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > Xref NPI > ATN Information > Billing Agent Agreement > Owners and Operators > EFT Agreement

Please make note of your ATN: 743982 and Name: GROUP TESTER

EFT Agreement ?

Electronic Funds Transfer (EFT) Agreement:

The undersigned authorize the fiscal agent for the Florida Medicaid Program to make deposits to the checking or savings account at the depository bank indicated.

Provider Name*

Provider Identifier: TIN 123456789

Provider Identifier: NPI 1043637226

Financial Institution Routing Number*

Financial Institution Name

Financial Institution Address:

Street

City

State

Zip

Telephone Number

Type of Account at Financial Institution*

Provider's Account Number with Financial Institution*

Account Number Linkage to Provider Identifier*

Reason for Submission NEW ENROLLMENT

Authorized Signature (The individual(s) listed below are authorized by the provider or its agent to initiate, modify or terminate an EFT enrollment.)

Using the drop down feature, select the name of each person who is authorized to sign on the depository account. If any name on the account is not available in the drop down, return to the Owners and Operators page to add them before proceeding with this page.

Printed Name of Person Submitting Enrollment 1*

Printed Name of Person Submitting Enrollment 2

Printed Name of Person Submitting Enrollment 3

Printed Name of Person Submitting Enrollment 4

Review the [Electronic EFT Enrollment Guide](#) for more information

4.23 Applicant History

Providers are required to report if there is any adverse history associated with any applicant. If providers answer Yes to any of the questions submitted within this panel, additional documentation is required.

For felony conviction, pleaded nolo contendere, or entered into a pre-trial arrangement, upload court documents showing the disposition of the charges.

If previously denied, terminated, or excluded from Medicare or Medicaid, upload documentation related to the denial, termination, or exclusion including the resolution, if any.

If you previously had suspended payments from Medicare or Medicaid or were employed by an entity that had suspended payments, upload documentation related to the suspension, including the resolution, if any.

If you owe money to Medicare or Medicaid, upload documentation related to the money owed, including the resolution, if any.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > Xref NPI > ATN Information > Billing Agent Agreement > Owners and Operators > EFT Agreement > Applicant History

Please make note of your ATN: 743982 and Name: GROUP TESTER

Applicant History ?

Has any entity or individual owner/operator ever::

1. Been convicted of a felony, had adjudication withheld on a felony, pled nolo contendere to a felony, or entered into a pre-trial agreement for a felony?
 No Yes. If yes, please submit supporting documentation.
 Name

2. Had any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state?
 No Yes. If yes, please submit supporting documentation.
 Against Whom?
 What Date?

3. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?
 No Yes. If yes, please submit supporting documentation.
 Name
 Provider Number

4. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that ever had suspended payments from Medicare or Medicaid in any state?
 No Yes. If yes, please submit supporting documentation.
 Name
 Provider Number

5. Owes money to Medicaid or Medicare that has not been paid?
 No Yes. If yes, please submit supporting documentation.
 Name
 Provider Number

6. Have ownership in any other Medicaid enrolled business?
 No Yes. If yes, please submit supporting documentation.
 Name of Other Business
 Provider Number
 Name of Owner

previous save & continue exit

4.24 Supporting Documents

The applicant must upload all required supporting documentation before the application can be submitted. Only one document per required document type can be attached except for Other Supporting Documents which will allow a maximum of two (2) documents.

Note: Supporting documentation can only be uploaded in PDF and TIF files formats.

The applicant cannot continue with the application until each of the required documents have been attached. The applicant will use the Browse button to select the desired document(s) to upload. Once all required documents are attached, the applicant will need to select the “save & continue” button.

Applicants are able to upload their background screening to the Supporting Documents panel; however, this action is not required for the application to process. If the applicant does not have a background screening or is a provider who is exempt from the background screening requirement, the application will still process as long as other required document(s) have been uploaded.

Note: If a file fails to upload, the applicant must make corrections before continuing with the application.

Welcome Statement > Search > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > Xref NPI > Billing Agent Agreement > Owners and Operators > EFT Agreement > Applicant History > Supporting Documents

Please make note of your ATN: _____ and Name: _____

Supporting Documents ?

IMPORTANT: This application cannot be submitted until all required documents are attached. Please attach supporting documents to the corresponding document types. For example, an Internal Revenue Services (IRS) document should be attached to the Proof of Tax ID document type. Other Supporting Documents should only be used when there is not a specific document type available for the document being submitted.

For each required document, use "Browse..." button to locate the supporting document.

Need enrollment forms? Forms are available on the *Enrollment Forms* page of the public Web Portal.

Item	Status		
MEDICAID PROVIDER AGREEMENT - NON INSTITUTIONAL	REQUIRED	C:\Users\TZWSVT\OneDrive - DIXC Production\Regression and Data Fix Notes	Browse...
PROOF OF TAX ID	REQUIRED	C:\Users\TZWSVT\OneDrive - DIXC Production\Regression and Data Fix Notes	Browse...
PROOF OF EFT (VOIDED CHECK OR BANK LETTER)	REQUIRED	C:\Users\TZWSVT\OneDrive - DIXC Production\Regression and Data Fix Notes	Browse...
COPY OF PROFESSIONAL LICENSE OR CERTIFICATION	REQUIRED	C:\Users\TZWSVT\OneDrive - DIXC Production\Regression and Data Fix Notes	Browse...
LIVESCAN BACKGROUND SCREENING OR PROOF OF EXEMPTION	REQUIRED ACTIVITY		
OTHER SUPPORTING DOCUMENTS 1	OPTIONAL		Browse...
OTHER SUPPORTING DOCUMENTS 2	OPTIONAL		Browse...

previous save & continue exit

4.25 Certification

Providers must acknowledge and accept the terms of the Enrollment Agreement by selecting the check box in the Certification panel and click *Submit* once complete.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > Xref NPI > ATN Information > Billing Agent Agreement > Owners and Operators > EFT Agreement > Applicant History > Certification

Please make note of your ATN: 743982 and Name: GROUP TESTER

Certification ?

MEDICAID PROGRAM PROVIDER ENROLLMENT AGREEMENT

This is to certify that

Name of Provider or Registered Agent*

Title

Date* 03/07/2019

"For the purpose of establishing eligibility to receive direct or indirect payment for services rendered to recipients of the Florida Medicaid Program, I understand that, under Section 409.920, Florida Statutes, knowingly submitting false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider is a felony and is sufficient cause for termination from the Florida Medicaid Program. I further understand that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. I understand that I am responsible for the information presented on this application and that the information is true, accurate, and complete. Furthermore, I agree to abide by the provisions of this provider agreement from the date it is effective per Section 409.907(11), Florida Statutes.

Furthermore, I understand that it is my responsibility to notify Medicaid's

I accept the terms of the Enrollment Agreement

previous submit exit

4.26 Application Confirmation

A confirmation panel will display upon successful submission of the application.

Once submitted, the application and supporting documents will be reviewed for accuracy and compliance with all provider eligibility requirements.

Welcome Statement > Enrollment Type Determination > Enrollment Type Confirmation > Application Tips > Request Type > Before You Continue > Identifying Information > License & More Identifying Information > Contact Information > Service Location > Mailing Address > Pay To Address > Home/Corp Office Address > Xref NPI > ATN Information > Billing Agent Agreement > Owners and Operators > EFT Agreement > Applicant History > Supporting Documents > Certification >

Please make note of your ATN: _____ and Name: _____

The provider enrollment application for _____ has been sent to Medicaid for review.

The Application Tracking Number (ATN) is: _____ Provider Screening Category: LIMITED

Status:

Your application has been successfully submitted.

GENERAL INSTRUCTIONS

- Print a copy of the application for your records. [Print Application](#)
- You can check the status of this application and status of receipt of documents from the [Enrollment Status](#) page.

If you have questions regarding your enrollment or on any message(s) received on this enrollment, please call Provider Enrollment at 1-800-289-7799, option 4.

[exit](#)

4.27 Verifying the Status of an Enrollment Application

Providers are urged to utilize the Enrollment Tracking Search tool (https://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/Provider_Enrollment_Enrollment_Status/tabId/57/Default.aspx) to view and confirm the current status of their application(s).

To search for your application’s status, enter your ATN, followed by either the business name or last name. The name must be submitted **exactly** as it appears on the application, including special characters. Once the correct information is entered, click search.

Enrollment Tracking Search

ATN*

Business OR Last Name*

A Search Results panel will appear under the Enrollment Tracking Search panel. The Status column shows the application status in the first row, followed by each application component’s status in the following rows. Providers may also print a copy of the application, or upload documents from this panel.

Providers are encouraged to use the Web Chat feature for any questions or concerns regarding their application. To initiate a web chat, click the green button found on the bottom-right of the Search Results panel.



4.28 Application Status Descriptions

Application Status Code descriptions with average timeframes.

Application Status Codes	Definition	Timeframe
Not Submitted	The application has not been submitted to Medicaid for processing. The applicant must log into the online application, complete all sections of the application, and submit before processing can begin.	Awaiting Provider
Awaiting Supporting Documentation	The application was submitted. The applicant needs to upload the required supporting documentation as shown in the search results above before the application will be processed.	Awaiting Provider
In process	Application is being reviewed for accuracy and compliance with all provider eligibility requirements.	Approximately 14 Business Days
Background Screening	Application processing has been completed. Results of background screening have not been received from the Background Screening Clearinghouse.	Approximately 5 Business Days
QC	The application has been processed and is being reviewed to ensure accurate handling by the processor.	Approximately 5 Business Days
Application Deficient	<p>The application or supporting documentation was deemed deficient. A letter detailing the items to be corrected and resubmitted was sent to the applicant.</p> <p>Deficiencies increase the enrollment application processing timeframe.</p> <p>Most common application deficiencies include:</p> <ul style="list-style-type: none"> • Background screening results have not been received or shows an ineligible status. • Missing required supporting documentation; applicants submitting individual documents in intervals opposed to sending all documents at one time. • Supporting documentation signed by an unauthorized signer (person who signed the document is not listed in the owner section of the application). • Proof of Tax ID is missing or does not match the information on the application. 	Awaiting Provider
Clearinghouse	The application has no deficiencies and is awaiting results of the background screening.	< 15 calendar days. If screening results are not received within 14 calendar days, a deficiency letter will be sent to the applicant.
State Review	Applications pending verification by the Agency will show a status of “State Review.” State Review consists of validating the information provided on an enrollment application, such as certification and expiration dates, search for any prior history with the applicant and Medicaid or any other state agencies, and a review of the applicant’s financial history. The application requires review by the Agency for Health Care Administration for one or more of the following:	

Application Status Codes	Definition	Timeframe
	Change of Ownership for Facility Providers	Facility Providers, length of review depends on if a survey or rate setting is required before rates are released
	Change of Ownership for Non-Facility Providers	Non-facility Providers, < 15 Days
	Facility Rate Setting	Varies by Facility Type
	Onsite visit	< 60 Days
	Pre-Certification Survey for Behavioral or Home Health Services	< 365 Days
	Previous Denial/Termination or Background Screening	Approximately 3 Business Days
Enrolled	<p>Enrollment approved. A Welcome Letter will be mailed 2 business days after the activation of the new provider.</p> <p>Applicants will also receive a Florida Medicaid Secure Web Portal PIN Letter via mail. PIN Letter instructions must be followed exactly for providers to gain access to their secure Web Portal account</p>	Approved applications are activated approximately 5 Business Days after all requirements for enrollment have been satisfied, including receipt of eligible screening results from the Background Screening Clearinghouse.
Denied	<p>The application or supporting documentation was deemed deficient.</p> <p>Applicants receive a letter from the Agency informing them their application was denied.</p> <p>If the applicant still wishes to pursue enrollment, a new application must be submitted.</p>	N/A
Closed	The application is incomplete and has been closed due to inactivity. If the applicant still wishes to pursue enrollment, a new application must be submitted.	N/A

4.29 Submitting Corrections to a Pending Application

If the application or supporting documentation is missing pertinent information or is deficient, applicants will be required to utilize the Correct Application or Upload Documentation options on the Enrollment Tracking Search panel. Applicants may also cancel their pending application if they no longer wish to pursue enrollment using the Cancel Application option.

The screenshot displays the 'Enrollment Tracking Search' interface. At the top, there are input fields for 'ATN*' and 'Business OR Last Name*', along with 'search' and 'clear' buttons. Below this is a 'Search Results' section containing a table with columns: ATN, Name, Document, Status, Status Date, Provider ID, Effective Date, and Provider Screening Category. The table lists various document types and their corresponding statuses and dates. Below the table, an alert message states: 'ALERT! This application is deficient and requires one of the following actions to continue:'. Three buttons are provided: 'CORRECT Application' (with subtext 'To review and correct your application.'), 'UPLOAD Documentation' (with subtext 'If documentation is missing or in a deficient status.'), and 'CANCEL Application' (with subtext 'If you no longer want to continue with the application, you can cancel now.'). At the bottom, there is a link to 'Enrollment Forms' and a chatbot icon with the text 'Hello! Let me know if I can help with any questions.'

ATN	Name	Document	Status	Status Date	Provider ID	Effective Date	Provider Screening Category
	LIMITED ENROLLMENT PROCESS		APPLICATION DEFICIENT	02/08/2021		02/02/2021	LIMITED
	FULL ENROLLMENT PROCESS		APPLICATION DEFICIENT	02/08/2021		02/02/2021	LIMITED
	LIVESCAN BACKGROUND SCREENING OR PROOF OF EXEMPTION		NOT RECEIVED	02/02/2021		02/02/2021	LIMITED
	OTHER SUPPORTING DOCUMENTS		OPTIONAL	02/02/2021		02/02/2021	LIMITED
	COPY OF PROFESSIONAL LICENSE OR CERTIFICATION		RECEIVED	02/02/2021		02/02/2021	LIMITED
	MEDICAID PROVIDER AGREEMENT - NON INSTITUTIONAL		RECEIVED	02/02/2021		02/02/2021	LIMITED
	PROOF OF EFT (VOIDED CHECK OR BANK LETTER)		RECEIVED	02/02/2021		02/02/2021	LIMITED
	PROOF OF TAX ID		RECEIVED	02/02/2021		02/02/2021	LIMITED

4.29.1 Correct Application

Applicants can update and correct their pending applications that are in the Application Deficient status in real-time through the Online Enrollment Wizard. This functionality cannot be used for out-of-state providers or additional location codes.

If the Correct Application option is selected, the applicant will navigate through the **entire application**. Applicants cannot change the following:

- Enrollment Type;
- Provider Type;
- Application Type;
- CHOW Indicator (Yes/No);
- Tax ID Type and Tax ID (Identifying Information panel); and
- Electronic Funds Transfer (EFT).

4.29.2 Upload Documentation

If documentation is missing or is in a deficient status, applicants can use the Upload Documentation option to upload the correct documents.

Note: Gainwell does not process printed application corrections uploaded via the Upload Documentation option for applications submitted via the Online Enrollment Wizard. Providers must use the Correct Application option if they wish to update their pending application.

4.29.3 Cancel Application

If the applicant chooses to cancel their pending application, they may cancel the application by selecting the Cancel Application option on the Enrollment Application Status panel. This action is **final** and will require the applicant to create a new application if they wish to enroll in the future.

4.30 Maintaining Provider Information

Providers must continue to meet all the provider qualifications to remain enrolled in Florida Medicaid. Florida Medicaid will terminate any provider's enrollment who no longer meets a provider qualification.

To meet all the provider qualifications, providers must:

- Ensure that information on their enrollment file is accurate and up to date.
- Maintain their files and group linkage information via their secure Web Portal accounts.

Medicaid provider file change requests must be submitted via the Florida Medicaid Secure Web Portal. Providers can enter changes to their address, group membership, Electronic Funds Transfer (EFT) account, and Electronic Data Interchange (EDI) Agreement in their secure Web Portal account. All other change request types must be submitted using the Trade Files Upload panel in the secure Web Portal.

Provider may access the File Upload panel by visiting <http://home.flmmis.com> and use the appropriate account credentials. From the secure Web Portal landing page, select **Trade Files**, then **upload**.

For detailed instructions on how to successfully update addresses, group membership linking/delinking, EFT account, EDI Agreement, or to upload documents via the File Upload panel, refer to the [Self-Service Quick Reference Guides](#) found on the public Web Portal.

4.31 Helpful Resources

For application tracking status, visit the [Enrollment Status](#) page. There is also a Web Chat feature available to assist with resolving your enrollment application concerns.

If the applicant is seeking to submit a CHOW application, they can visit the [CHOW](#) page on the public Web Portal for more information.

Provider Enrollment is available to assist with resolving your enrollment application concerns. Call 1-800-289-7799, Option 4.

Provider Services Field Representatives are available for your training needs, contact 1-800-289-7799, Option 7.

Access the Florida Medicaid Public Web Portal [Quick Reference Guides](#) page for detailed information on how to successfully upload documents, or how to update group memberships, via the secure Web Portal.