Application Submitted Data

Tracking ID	**000-000-002**
Application name	**Enrollment Application**
Submitted at	6/21/18 10:53 AM

Identifying information

General Information

Prefix	D. O.
First Name	Jon
Last Name	Snow
MI	sd
Suffix	
Gender	Male
Date of birth	2012-10-11
Country of birth	Uruguay
State	AK
May gender information be shared with members?	Yes
Application contact email	asd@mail.ca

Tax information

SSN	000000000
Is this the number you use for tax reporting purposes?	Yes
FEIN	
Legal business name	

Race	Black or African American

Current/Previous NPI\API

Were you previously enrolled in federal or state health care programs?	No
ID type	
NPI/API	

Licensure

Provider type and program information

Provider type	
Program participation	
Select the clientele you intend to serve	

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Licensure, Certification, Accreditation, Endorsement

Taxonomy

Specialties and subspecialties

Specialty	Gastroenterology

Insurance

The State recognizes provider based facilities that have received official designation from CMS. Have you been designated by CMS as a 'provider based facility'?	No

Provider identifier number

National provider identification (NPI)

Drug enforcement agency (DEA)

Other Medicaid state

Are you or have you been previously enrolled as a Title XIX Medicaid or Title XXI CHIP provider in another state?	No
Are you enrolled in Medicare?	No

Pay for performance

Are you a participant in Medicare's pay for performance (P4P) incentive program?	No
Lump sum dollar amount	
Percent (%) of Payment	
Begin date	
End date	

Service location billing

Address Information

Physical address(PO box not accepted)	Some str
Building, suite	
Zip	12312-3123

Location contact person(s)

Email

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Service	
Gender served	Male
Languages supported	Italian
Age range served	All
Interpretive services	
Accepting new patients?	No
Reason	
Reason date	
Are you a pharmacy or do you provide pharmacy services?	No
Number	1
Is this location TDD/TTY equipped?	No
TDD/TTY Phone	
Population served available	Waiver
Available accessibility	
Servicing area	
County	All counties
Selected counties	
Reservation	All reservations
Selected reservations	
Office hours	
Is this location open 24 hours?	No
Are the office hours the same Monday - Friday?	No
From:	
To:	
From:	
To:	
From:	
To:	
Does this location provide emergency services after standard business hours?	No
After Hours Contact Phone	
Special needs	
Check all that location is equipped to serve	
Laboratory services	
Do you bill laboratory services?	No
Mailing Address	
Is this mailing address the same as service location?	Yes
Physical address(PO box not accepted)	
Building, suite	
Zip	
National Provider Information	
Location contact person	

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Electronic funds payment

Provider information	
Provider name	EditedProvider
Provider address	Dexter Ave
Building, Suite	1
Zip	93742-8712
Provider identifiers information	
Provider identifiers	
EIN number	
TIN number	
National provider identifier(NPI)	National provider identifier(NPI)
Provider contact information	
Provider contact name	
Email Address	user@mail.ca
Telephone number	(032)345-6578
Fax number	
Financial institution information	
Financial institution name	Sample Institution
Financial institution routing number	001
Type of account at financial institution	Checking
Providers account number with financial institution	1213
Account number linkage to provider identifier	National provider identifier(NPI)
TIN number	
NPI number	
Reason for submission	New enrollment
Included enrollment submission	
Authorized signature	
Electronic signature of person submitting enrollment	
Printed title of person submitting enrollment	
Submission date	
Requested EFT Start/Change/Cancel date	
Billing address	
Is this billing address the same as the service location?	Yes
Physical address(PO box not accepted)	
Building, suite	
Zip	

Remittance advice

Provider information	
Provider name	

Provider address
Building, Suite
Zip
Provider identifiers information
Provider identifiers
TIN identifier
EIN identifier
National provider identifier(NPI)
Other identifiers
Assigning authority
Trading partner ID
Provider contact information
Provider contact name
Email Address
Telephone number
Fax number
Preference for aggregation of remittance data
TIN number
NPI number
Method of retrieval
Electronic remittance advice clearinghouse information
Clearinghouse name
Telephone number
Email Address
Reason for submission
Authorized signature
Electronic signature of person submitting enrollment
Printed title of person submitting enrollment
Submission date
Requested ERA effective date
Remittance advice frequency
Begin date
End date
Other details. Primary claims submission method

Electronic transaction submission

Does a third party billing agent submit your claims?	No
Does this Billing agent have access to make inquires on your behalf?	No

Indicate which of the following will be used to submit claims electronically:
Billing software

Submit

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Receive

Billing agent/Clearing house

Submit

Receive

Ownership

Have you ever had ownership in any organization that has billed, or is currently billing Medicare or Title XIX program services?	No
Have you ever managed or directed any organization that has billed or is currently billing Medicare, Title XIX or Title XXI program services?	No
Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/provider has contracted or delegated some of its management functions)	No
Do any of the members of your immediate family (spouse, parent, child, sibling) have ownership of 5% or greater in a subcontractor to your business or practice?	No

Exclusion / Sanction

Exclusion / Sanction information

1. Have you or any member of your immediate family or household ever been convicted or excluded from the Title XVIII,Title XIX,or Title XX program or any federal program due to fraud, obstruction of an investigation, controlled substance violation?	No
2. Do you, under any name or business identity, have any outstanding overpayments with Title XIX or any other federal program?	No
3. Have you ever been convicted of a felony under federal or state law?	No
4. Administrative sanction(s)?	No
Date of occurrence	
5. Professional board disciplinary action(s)?	No
Date of occurrence	
6. Program exclusions?	No
Date of occurrence	
7. Suspension of payments?	No
Date of occurrence	

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8. Civil monetary penalty(s)?	No
Date of occurrence	
9. Assessment(s)?	No
Date of occurrence	
10. Program debarment(s)?	No
Date of occurrence	
11. Criminal fine(s)?	No
Date of occurrence	
12. Restitution order(s)?	No
Date of occurrence	
13. Pending civil judgment(s)?	No
Date of occurrence	
14. Pending criminal judgment(s)?	No
Date of occurrence	
15. Judgment(s) pending under the false claims act?	No
Date of occurrence	

PCCM

Do you wish to participate in the PCCM?	No

PASSPORT Information

Please select type	Join existing group
How many clients will you agree to accept?(up to 1,000 per solo provider)	
24-Hour phone number	
Call prior to member assignment	No
Group NPI	

Upload documents

HELLOSIGN

Audit Trail

TITLE	enrollmentApplication.pdf
FILE NAME	MNG5b2b83b3a4ff61...8407411839222.pdf
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