

Application Submitted Data

Tracking ID

Application name
Submitted at

000-000-015 Enrollment Application 8/6/18, 3:12 PM



Identifying information

General Information

Prefix D. O. First Name Jon Last Name Snow MI sd

Suffix

Gender Male
Date of birth 2012-11-10
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?

ID type NPI/API

Licensure

Provider type and program information

Provider type Individual
Program participation Medicaid/ MHSP



Select the clientele you intend to serve

Licensure, Certification, Accreditation, Endorsement

Licensure, Certification, Accreditation, Endorsement

Taxonomy

Taxonomy

Specialties and subspecialties

Specialty Gastroenterology, Otolaryngology

Specialties and subspecialties

Insurance

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)

National provider identification (NPI)

Drug enforcement agency (DEA)

Drug enforcement agency

Other Medicaid state

Are you or have you been previously enrolled as a Title XIX Medicaid or Title No

XXI CHIP provider in another state?

Other Medicaid/CHIP state

Are you enrolled in Medicare?

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

Phone/Fax

Location contact person(s)

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| Location | contact |
|-----------|---------|
| person(s) | |

| First name | MI | Last name | Phone | Ext | Fax | Email | Position |
|-----------------------------|-------------|-------------------|-------------------|----------|------------|---------|----------|
| UserF | | UserL | (032)155-66 66 | | | | |
| Email | | | | | | | |
| Email | | | | | | | |
| Email type | Email addı | ress | | | | | |
| C-Correspondence | kjhkjh@ma | nil.ca | | | | | |
| 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 serv | ices? | | No | | |
| Number | | | | | 1 | | |
| Is this location TDD/TTY | equipped? | | | | No | | |
| TDD/TTY Phone | | | | | | | |
| Population served availab | ole | | | | Waiver | | |
| Available accessibility | | | | | | | |
| Servicing area | | | | | | | |
| County | | | | | All count | ies | |
| Selected counties | | | | | | | |
| Reservation | | | | | All reserv | rations | |
| Selected reservations | | | | | | | |
| Office hours | | | | | | | |
| Is this location open 24 ho | | | | | No | | |
| Are the office hours the s | ame Monday | - Friday? | | | No | | |
| From: | | | | | | | |
| То: | | | | | | | |
| From: | | | | | | | |
| To: | | | | | | | |
| From: | | | | | | | |
| To: | | | | | | | |
| Does this location provide | e emergency | services after st | andard busines | s hours? | No | | |
| After Hours Contact Phor | ne | | | | | | |
| Special needs | | | | | | | |



Check all that location is equipped to serve

Laboratory services

Do you bill laboratory services?

Mailing Address

Is this mailing address the same as service location?

Physical address(PO box not accepted)

Building, suite

Zip

National Provider Information

National Provider Information

Location contact person

Personal Info

Electronic funds payment

Provider information

Provider name Provider
Provider address Dexter Ave
Building, Suite Building 1
Zip 01643-4586

Provider identifiers information

Provider identifiers

EIN number TIN number

National provider identifier(NPI) 123321231231

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

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Billing address

Is this billing address the same as the service location?

Physical address(PO box not accepted)

Building, suite

Zip

Phone/Fax

Location contact person(s)

Yes

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

Provider federal tax identification number(TIN)

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

Bi-weekly



Begin date End date

Other details. Primary claims submission method

Paper

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?

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

No

No

No

Billing software

Billing software

| Software company name | Software name | Version | Protocol |
|-----------------------|---------------|---------|--------------------------|
| CName | SName | 1.0 | 1 |
| Submit | | : | 837I Institutional claim |
| Receive | | , | 271 Eligibility response |

Billing agent/Clearing house

Billing agent/Clearing

| house | |
|-------|--|
|-------|--|

| Agent/Clearinghouse name | Contact first name | Contact last name | Contact phone number | Street address | Street address 2 | City | State | Zip |
|--------------------------|--------------------|-------------------|----------------------|-------------------|------------------|------|-------|-----|
| aaa | firstN | lastN | (000)000-0 000 | str. 1 | | city | CA | |

Submit 837I Institutional claim Receive 271 Eligibility response

Ownership

Have you ever had ownership in any organization that has billed, or is currently billing Medicare or Title XIX program services?

Ownership information

Have you ever managed or directed any organization that has billed or is currently No billing Medicare, Title XIX or Title XXI program services?

Managing/directing information

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)

Subcontractor information

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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? Relative information

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

Name

2. Do you, under any name or business identity, have any outstanding overpayments with Title XIX or any other federal program? 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 | |
| 8. Civil monetary penalty(s)? | No |
| Date of occurrence | |
| 9. Assessment(s)? | No |
| Date of occurrence | |
| 10. Program debarment(s)? | No |

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?

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

document_pdf_example.pdf Bank account number Current license document_pdf_example.pdf Applicable board certification document_pdf_example.pdf National Provider Identifier (NPI) document_pdf_example.pdf **Trading Partner Agreement** document_pdf_example.pdf IRS-P575 or W-9 document_pdf_example.pdf CLIA certification document_pdf_example.pdf CMS Provider-Based Facility Designation document_pdf_example.pdf Application fee receipt document_pdf_example.pdf Additional documents document_pdf_example.pdf



enrollmentApplication.pdf TITLE

MNG5b68655414d2df...4680028732080.pdf **FILE NAME**

4d07ca5177582e6c9b63d3aeb83784af25c61a7c **DOCUMENT ID**

Completed **STATUS**

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