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Welcome to the Online Provider Enrollment Process

Please complete each step in the enrollment process. When you have completed all steps of the application, "Submit" and "Confirm" the application for further processing.

As a condition for entering into or renewing a provider agreement all applicants must complete an application. A true, accurate and complete disclosure of all requested information is required by the Federal and State regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State regulations to update the information submitted on the application.

You will need the following information to complete your enrollment request:

- ▶ National Provider Identifier
- ▶ Address Information including Zip Code + 4
- ▶ Taxonomy Codes
- ▶ Tax ID - either Employee Identification Number or Social Security Number
- ▶ License Number

Also, please look for required attachments for your application below and click the "Continue" button to start the enrollment application.

Enrollment Type **Provider Type** **Specialty**

Document(s) required to be attached

Make sure you have all document(s) ready to attach before submitting application.

[Continue](#)[Cancel](#)**Make the following selections-****Enrollment Type: Atypical****Provider Type: 95-REGISTERED, NONCREDENTIALLED PROVIDER****Specialty: NU-RESIDENT**

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You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".

The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application.

You are enrolling as a new provider and you will get a new number.

The * indicates a required field.

Initial Enrollment Information

*Enrollment Type

*Provider Type

Provider Information

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

NPI NPI Zip + 4 Primary Taxonomy

*Tax ID (Employee Identification Number or Social Security Number) *Tax ID Type EIN SSN

*Are you a personal care aide? Yes No

Effective Date *Fiscal End Date

Contact Information

*Last Name

*First Name

Title

*Phone Ext

Fax Number

*Contact Email

*Confirm Email

Preferred Method of Communication

-Enter your personal phone number and email address in this section.

Provider Enrollment: Credentials

Please provide the following information, which will be required to resume your application at a later date. Your password must be between 8 to 20 alphanumeric characters. Your tax id (Employee Identification Number or Social Security Number) is provided, if already contained within your provider enrollment application.

Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number along with the following information, will be used as your credentials to resume your suspended enrollment application.

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The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty. Taxonomies are available to be added for the selected provider.

The * (in red) indicates required fields.

 Indicate**Provider Enrollment: Tracking Information**

Your enrollment application has been assigned the following tracking number: 254896. Please retain the tracking number for your records.

The tracking number will be used, in addition to your Tax ID (Employee Identification Number or Social Security Number) and password, as credentials to resume/revise your application at a later date.

Note: This application must be submitted within 90 days. If not, it may no longer be available and a new application must be started.

Make a note of your tracking number.

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The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty.
Taxonomies are available to be added for the selected provider.

The * (in red) indicates required fields.

Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Specialty	Action
<input checked="" type="checkbox"/> RESIDENT	

Click to add specialty.

Additional Taxonomies

Click the "Remove" link to remove the entire row.

Taxonomy Code	Action
<input type="checkbox"/> Click to add Taxonomy	

[Continue](#) [Finish Later](#) [Cancel](#)

Click the collapse button under Additional Taxonomies and remove the section to continue.

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The * (in red) indicates required fields.

 Indicates a primary record.**Provider Addresses**

The provider addresses identify each location where a provider renders services, as well as location where a provider can be reached. A single address can be added for each Address Type.

Click the "Remove" link to remove the entire row.

Type	Address	City
Click to collapse.		
*Address Type	<input type="text"/>	Primary Address <input type="checkbox"/>
Contact Name	<input type="text"/>	
*Address	<input type="text"/>	
*City	<input type="text"/>	
*State	<input type="text"/>	*Zip Code
*Primary Email	<input type="text"/>	Confirm Email
*Phone	<input type="text"/> <input type="text"/> Ext <input type="text"/>	Phone

Here you will be required to list an address for each of the following sections: Home Office, Mail To, Service Location, Pay To.

For Home office and Mail To list your PERSONAL ADDRESS and phone number.

For Service Location and Pay To list the GME Office Address: 920 Madison Avenue, Suite 447, Memphis, TN 38163

and the GME phone number 901-448-5364

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The * (in red) indicates required fields.

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Provider Legal Name

The provider legal name and information is provided once for each enrollment.

*Last Name
 *First Name
 Middle Title
 *Tax Name

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*Gender *Birth Date

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On this page you will enter your personal information at the top. Tax Name will be your given name. On the following sections you will only enter your license # and DEA # if you have your own. Everyone else will click to collapse each box and then remove it to continue.

License

Click the "Remove" link to remove the entire row.

License #	Effective Date	End Date	Issuing Board	Issuing State	Action
<input type="checkbox"/> Click to collapse.					
*License # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	*Issuing State <input type="text"/>	*Issuing Board <input type="text"/>	Classification <input type="text"/>
<input type="button" value="Add"/> <input type="button" value="Reset"/>					

Medicare Participation

Medicare # Effective Date Medicare Type

CLIA Certification

Click the "Remove" link to remove the entire row.

CLIA #	Effective Date	End Date	Action
<input type="checkbox"/> Click to collapse.			
*CLIA # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>			

DEA #

Click the "Remove" link to remove the entire row.

DEA #	Effective Date	End Date	Action
<input type="checkbox"/> Click to collapse.			
*DEA # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>			

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The following actions need to be taken to complete the individual enrollment process. If you need to submit electronic attachments, please follow the instructions in the Attachments panel below.

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Verify that all required documentation, including copies of applicable professional and operating licenses, is included as an attachment.

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If you are submitting **Fingerprint Background information**, include a copy of the proof of fingerprint collection as an attachment.

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Note if you choose to "Upload" attachments by "File Transfer", a maximum of 700 MBs of information can be uploaded.*

[Agreement](#)

The * (in red) indicates required fields.

[Summary](#)**Attachments**

To add an attachment, complete the required fields and click the **Add** button. Use the 'Other' selection to upload attachments not in the list.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action
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Click to collapse.

Transmission Method

Attachment Type

Description

Application Fee

No Application Fee Required

[Continue](#)[Finish Later](#)[Cancel](#)

In this section you will again click collapse and then remove the section to continue.



[Print Preview](#)

Provider Enrollment: Tracking Information



Your enrollment application has been assigned the following tracking number:254896. Please retain the tracking number for your records.

The tracking number will be used, in addition to your Tax ID (Employee Identification Number or Social Security Number) as per your enrollment application and password, as credentials to resume/revise your application at a later date.

A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:HESTES@UTHSC.EDU.

To save or print the coversheet for your records [click here](#).

[Exit](#)

Don't forget to make note of your tracking number!