



Enrollment Type: Individual within a Group

Revalidation/Enrollment Checklist

Provider Enrollment: Request Information	
<ul style="list-style-type: none"> Welcome Request Information Specialties Addresses Provider Identification Network Participation Languages EFT Enrollment ERA Enrollment Other Information Addendums 	<p>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 the next page. All mandatory data is required to "Finish Later". The contact person listed on this page may be contacted to answer any questions regarding the information provided in this enrollment application.</p> <p>* Indicates a required field.</p>
Initial Enrollment Information	
	<p>*Enrollment Type <input type="text"/> choose Individual within a Group here</p> <p>*Provider Type <input type="text"/></p> <p>*Requesting Enrollment Effective Date <input type="text" value="11/17/2015"/></p>
Provider Information	
	<p>The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.</p> <p>*NPI <input type="text"/> *NPI Zip + 4 <input type="text"/> *Taxonomy <input type="text"/></p> <p>*Tax ID Number <input type="text"/> *Tax ID Type <input checked="" type="radio"/> EIN <input type="radio"/> SSN</p>

Figure 1 - Online Provider Enrollment Tool - Request Information page

Want to make sure your application is processed as quickly as possible?
Pay **extra** attention to tips next to this symbol.

Request Information Page - You will need to know:

Your Provider Type

- See a complete list of *provider types* on our [Information by Provider Type web page](#).ⁱ

Requesting Enrollment Effective Date

- If your effective date will be a future date, you can select that future date in the application.
- **TIP:** If your effective date will be a past date, you will need to complete and submit the Backdating form after submitting your application. You can find this form on our [Provider Next Steps web page](#).ⁱⁱ

Group Association Information

- *Group* name, service location address (for the *Group*), *Group's* Medicaid ID, and *Group's* NPI
- ▲ **TIP:** If you belong to more than one *group*, continue to "Add" associations in this same application. You do not need to complete a separate *Individual within a Group* application for each group to which you belong.



National Provider Identifier (NPI)

- You will need to know your individual (Type-1) NPI & zip code.
- Don't have an individual NPI? Please visit the [National Plan & Provider Enumeration System web site to obtain one.](#)ⁱⁱⁱ

▲ TIP: Your application will be returned for correction if you use an organizational (Type-2) NPI on your *Individual within a Group* application.

 Primary Taxonomy Code

- You will need to know your **Individual** primary taxonomy code.
- You can find a complete Health Care Provider Taxonomy Code Set on the [Washington Publishing Company's web site.](#)^{iv}

▲ TIP: At least one of the taxonomy codes you include in your application must match at least one of the taxonomy codes associated to your NPI in NPPES.

- **TIP:** Colorado Medicaid does not offer advice about which taxonomy code(s) you should use, but you can use the [NPPES NPI Registry lookup](#)^v to see the taxonomy codes that are currently associated with your NPI.

 Social Security Number (SSN)

- Effective date for your SSN is optional (individual's birth date).

▲ TIP: An *Individual within a Group* application **must** include your SSN.

 Current CO Medicaid ID

- If you have already have one for this same *provider type*.

 Previous CO Medicaid ID

- If you previously had a provider ID for this same *provider type*, but **are not currently an active provider**.

 Contact Information

- This "Contact" email address will receive notifications about the status of your application.

Specialties Page - You will need to know: **Your Specialty**

- From our [Information by Provider Type web page.](#)ⁱ
- **TIP:** There are many instances where the only *specialty* option is the *provider type* you choose. If this is the case for you, select the only option available and then use the "Taxonomy" drop down to indicate your area of specialty.

 Additional Taxonomy Codes (optional)

Addresses Page - You will need to know:

Service Location Address Information (including zip code + 4)

- You will also need a primary email address and office phone number for this address.
- TIP:** This should be your primary service location. If you belong to more than one group, “Add” additional locations or associations on the *Request Information* page of this same application. You do **not** need to complete a separate Individual within a Group application for each service location.
- TIP:** Service location must be a physical address and cannot be a PO Box.
- TIP:** Including your 9-digit (zip code + 4) service location zip code is crucial for claims payment. Don’t know your 9-digit zip code? [You can look it up on the USPS website.](#)^{vi}

Billing Address Information (including zip code + 4)

- You will also need a primary email address and office phone number for this address. This address may be the same as your service location address.
- TIP:** The “Pay to Name” and the billing address should match the information on your **Group’s** W-9.
- TIP:** Including your 9-digit (zip code + 4) billing address zip code is crucial for claims payment. Don’t know your 9-digit zip code? [You can look it up on the USPS website.](#)^{vi}

Mailing Address Information

- You will also need a primary email address and office phone number for this address. This address may be the same as your service location address.
- TIP:** This address also asks for a “Mail to Name”; e.g. Attn: Front Desk.

Provider Identification Page - You will need to know:

Your Legal Name

Gender and Birth Date

Degree Information (if applicable)

- Degree, school, year of graduation
- TIP:** Do not forget to attach a copy of your degree on the *Attachment and Fees* page of the application.
- TIP:** Transcripts are not sufficient and they will not be accepted as proof of education.

License Information

- License #, effective date, end date, and license state.
- TIP:** Do not forget to attach a copy of your license on the *Attachment and Fees* page of the application.

Medicare Number (if applicable)

- You will also need the Effective Date for your Medicare number and the Medicare Type.
- TIP:** You can find this information on the [PECOS web site.](#)^{vii}
- TIP:** The Medicare information you include in your application should match what is in PECOS.

Drug Enforcement Administration (DEA) information (if applicable)

- DEA # and effective date.



Network Participation Page - You will need to know:

MCO/BHO Network

- Do you participate in any of Colorado Medicaid’s Managed Care Organizations (MCO) or Behavioral Health Organizations (BHO)?
- If so, you will need to know which ones, and your effective date with that network (date the contract was signed).
- ▲ **TIP:** For each MCO or BHO you contract with, we require a copy of the following to be attached on the *Attachment and Fees* page of the application:
 - The entire contract with the MCO or BHO; or
 - The page(s) that identifies the contracting parties and the program name (e.g. Denver Health Medicaid Choice, Access Behavioral Health, VOANS (PACE), etc.) and the page(s) with signatures of both parties, including the date; or
 - [The Provider Network Participation Attestation Form](#).^{viii}

Languages Page - You will need to know:

All languages that you have the ability to translate (if applicable)

Other Information Page - You will need to know:

Insurance Information

- Carrier name, policy ID, effective date, and expiration date.
- ▲ **TIP:** Do not forget to attach a copy of your “Malpractice” insurance face sheet on the *Attachment and Fees* page of the application.

Board Certification Information (if applicable)

- Specialty, certification, effective date, end date, and certification #.
- **TIP:** If your certification does not have an end date, use 12/31/2299. If there is no certification number, write “N/A”.
- **TIP:** Do not forget to attach a copy of your “Malpractice” insurance face sheet on the *Attachment and Fees* page of the application.

On Premise Supervision for non-physician practitioners (Registered Nurses Only)

- Supervising APN/MD last name, first name, and NPI #.
- ▲ **Note:** MUST also complete this [On Premise Supervision form for non-physician practitioners form](#).^{ix}
Add to the *Attachment and Fees* page of the application.

Supplemental Question Answers

- Are you currently enrolled in Medicaid or CHIP in any other state?
- Are you currently applying for enrollment in Medicaid or CHIP in any other state?
- Have you ever been denied enrollment for Medicaid or CHIP in any other state?
- Has your enrollment in Medicaid or CHIP in any other state ever been terminated?



Web site address (optional)

Disclosures Page - You will need to know:

Disclosure Information

- Colorado Medicaid cannot advise providers on how to determine owner data and controlling interest requirements, but we can provide the following resources:
 - [Disclosure Completion Definitions and Instructions for Enrollment using a Social Security Number \(SSN\).](#)^x
 - Please note that you are the “disclosing entity” for the purposes of these questions.

Attachment and Fees Page:

You will need to scan and attach:

Insurance face sheet

Board certifications and/or licenses (if applicable)

- ▲ Please see our [Information by Provider Type web page](#)ⁱ for a list of requirements for your *provider type*.

Proof of education (if applicable)

- ▲ **TIP:** Transcripts are not sufficient and they will not be accepted as proof of education.

[On Premise Supervision form](#)^{ix} for Registered Nurses (RN) only

For each MCO or BHO you contract with, we require a copy of the following:

- The entire contract with the MCO or BHO; or
- The page(s) that identifies the contracting parties and the program name (e.g. Denver Health Medicaid Choice, Access Behavioral Health, VOANS (PACE), etc.) and the page(s) with signatures of both parties, including the date; or
- [The Provider Network Participation Attestation Form](#).^{viii}

ⁱ www.co.gov/hcpf/information-provider-type

ⁱⁱ www.co.gov/hcpf/provider-next-steps

ⁱⁱⁱ <https://nppes.cms.hhs.gov/>

^{iv} www.wpc-edi.com/reference

^v <https://npiregistry.cms.hhs.gov>

^{vi} <https://tools.usps.com/go/ZipLookupAction!input.action>

^{vii} <https://pecos.cms.hhs.gov/>

^{viii} <https://www.colorado.gov/pacific/sites/default/files/Colorado%20Medicaid%20and%20CHP%2B%20Network%20Participation%20Verification.pdf>

^{ix} <https://www.colorado.gov/pacific/sites/default/files/RN%20Supervision%20Form.pdf>

^x <https://www.colorado.gov/pacific/sites/default/files/Disclosure%20Instructions%20SSN.pdf>

