

Alabama Medicaid Agency

Medicaid



Alabama EIP Provider Enrollment Web Portal Training Document

07/25/2011

2011 Enhancement Implementation Phase (EIP) Project

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Table of Contents

1	DOCUMENT CONTROL.....	1
1.1	DOCUMENT INFORMATION PAGE.....	1
1.2	AMENDMENT HISTORY	1
1.3	RELATED DOCUMENTATION	1
2	INTRODUCTION.....	2
2.1	ALABAMA MEDICAID PROVIDER ENROLLMENT WEB MANUAL OVERVIEW	2
2.2	ALABAMA MEDICAID PROVIDER ENROLLMENT WEB MANUAL OBJECTIVE	2
3	ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL OVERVIEW	3
3.1	INTRODUCTION TO THE ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL.....	3
3.2	AUDIENCE.....	3
3.3	PURPOSE	3
3.4	SUPPORTING DOCUMENTATION	3
4	ALABAMA MEDICAID PROVIDER WEB PORTAL NAVIGATION.....	4
4.1	WEB BROWSER SETUP.....	4
4.2	NAVIGATION BUTTONS.....	4
4.3	PERSONAL COMPUTER RECOMMENDATIONS	4
4.4	SCREEN DISPLAY FEATURES	4
4.5	WEB ADDRESS.....	5
4.6	USER IDS AND PASSWORDS.....	5
4.7	RESETTING PASSWORDS.....	5
5	SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS	6
5.1	PAGE LAYOUT.....	6
5.2	FUNCTIONS	8
6	SUBMITTING A PROVIDER ENROLLMENT ELECTRONIC APPLICATION.....	9
6.1	HOME PAGE	10
6.1.1	Home Page Fields and Actions	10
6.2	THE PROVIDER ENROLLMENT WELCOME PAGE.....	11
6.2.1	Welcome Page Fields and Actions.....	11
6.3	PROVIDER ENROLLMENT: REQUEST INFORMATION PAGE	12
6.3.1	Request Information Page for All Enrollment Types Except 'Individual Within A Group' ...	12
6.3.1.1	Request Information Page Fields and Actions	13
6.3.2	Request Information Page when enrolling as an Individual Within Group.....	14
6.3.2.1	Request Information Page Fields and Actions	14
6.4	PROVIDER ENROLLMENT: SPECIALTIES	15
6.4.1	Specialties Page Fields and Actions	16
6.5	PROVIDER ENROLLMENT: PROVIDER IDENTIFICATION PAGE.....	17
6.5.1	Provider Identification Page.....	17
6.5.1.1	Provider Identification Page Fields and Actions.....	18
6.5.2	Provider Identification Page When the Enrollment Type is Group	19
6.5.2.1	Provider Identification Page Fields and Actions when the Enrollment Type is Group	19
6.5.3	Provider Identification when the Enrollment Type is Facility.....	20
6.5.3.1	Provider Identification Page Fields and Actions when the Enrollment Type is Facility	20
6.5.3.2	Provider Identification Page Fields and Actions when the Provider type is DME.....	21
6.6	PROVIDER ENROLLMENT: ADDRESSES	22
6.6.1	Provider Addresses Page Fields and Actions	23
6.7	PROVIDER ENROLLMENT: BANK ACCOUNT INFORMATION	25
6.7.1	Bank Account Information Page Fields and Actions.....	25

6.8	PROVIDER ENROLLMENT: OTHER INFORMATION PAGE	27
6.8.1	Independent Nurse Practitioner, Physician-Employed Practitioners or Nurse Midwife Page	27
6.8.1.1	Independent Nurse Practitioner, Physician-Employed Practitioners or Nurse Midwife Page Fields and Actions.....	27
6.8.2	Facility Providers and Board Members Page	28
6.8.2.1	Other Information Page Fields and Actions	28
6.9	PROVIDER ENROLLMENT: DISCLOSURES.....	30
6.9.1	Disclosures Page Fields and Actions	32
6.10	PROVIDER ENROLLMENT: AGREEMENT.....	33
6.10.1	Agreement Page Fields and Actions	35
6.11	PROVIDER ENROLLMENT: SUMMARY	36
6.11.1	Summary Page Fields and Actions	39
6.11.2	Print Preview	40
6.11.3	Print Preview Page Fields and Actions	40
6.12	PROVIDER ENROLLMENT TRACKING INFORMATION	41
6.13	PROVIDER ENROLLMENT: ENROLLMENT CREDENTIALS PAGE	43
6.13.1	Credentials Page Fields and Actions	43
6.14	PROVIDER ENROLLMENT: ENROLLMENT STATUS	44
6.14.1	Enrollment Status Page	44
6.14.2	Provider Enrollment Status Fields and Actions	44
6.15	PROVIDER ENROLLMENT: FINISH LATER	45
6.15.1	Credentials Page Fields and Actions	45
6.16	PROVIDER ENROLLMENT: RESUME ENROLLMENT	46
6.16.1	Resume Page Fields and Actions	46
6.17	HELP.....	47

1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	Alabama EIP Provider Enrollment Web Portal Training Document
Version:	1.0
Location:	https://pwb.alxix.slg.edcs.com/alxix/Subsystem/utlis/FolderList.asp?Folder=../ProjectPlan2010/Enhancements/Provider%20Web
Owner:	HPES/Agency
Author:	Linda Hanks, Cyndi Crockett, Mark Bonner
Approved by:	Clay Gaddis
Approval Date:	09/06/2011

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
07/25/2011	0.1	Linda Hanks, Cyndi Crockett, Mark Bonner	Initial draft of document	
09/06/2011	1.0	Linda Hanks, Cyndi Crockett, Mark Bonner	Agency approved	

1.3 RELATED DOCUMENTATION

Document	Description	url

2 INTRODUCTION

2.1 ALABAMA MEDICAID PROVIDER ENROLLMENT WEB MANUAL OVERVIEW

The Alabama Medicaid Provider Enrollment Web allows new providers to enroll with Alabama Medicaid.

This user manual is designed to cover the information necessary to perform the tasks associated with the Alabama Medicaid Provider Enrollment Web Portal.

This manual covers the following:

- Alabama Medicaid Provider Enrollment Web Portal Overview
- Alabama Medicaid Provider Enrollment Web System Navigation
- System Wide Common Terminology and Layouts
- Alabama Medicaid Provider Enrollment Web Pages
- Help

2.2 ALABAMA MEDICAID PROVIDER ENROLLMENT WEB MANUAL OBJECTIVE

The purpose of the Alabama Medicaid Provider Enrollment Web Training Manual is to provide Alabama Medicaid providers with detailed descriptions of the online system, including page field descriptions, page functionality descriptions and graphical representations of pages.

3 ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL OVERVIEW

3.1 INTRODUCTION TO THE ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL

The Alabama Medicaid Provider Enrollment Web Portal allows providers to enroll with Medicaid as a new provider, check status of a submitted application, and make corrections as determined by Provider Enrollment staff on submitted applications.

The Web Portal has been developed by Hewlett-Packard Enterprise Systems (HPES) and is offered at no cost to Alabama Medicaid providers. This site is available 24-hours a day, seven days a week, excluding time for scheduled maintenance. Through the use of the online web portal, the provider can enroll with Medicaid, check status of a submitted application and make corrections as determined by Provider Enrollment staff on submitted applications.

3.2 AUDIENCE

The information described in this document is designed for use by providers already enrolled with Alabama Medicaid or new providers requesting enrollment in the program.

3.3 PURPOSE

This document equips the provider with the necessary steps to access the Web Portal, navigate the Web Portal, to successfully update information or enroll with Alabama Medicaid. The provider will be required to send in paper documentation for applicable information.

3.4 SUPPORTING DOCUMENTATION

Provider should refer to Alabama Medicaid Provider Billing Manual, Chapter 2, Becoming a Medicaid provider for information on becoming a provider with Alabama Medicaid.

4 ALABAMA MEDICAID PROVIDER WEB PORTAL NAVIGATION

4.1 WEB BROWSER SETUP

Workstations must be minimally equipped with Internet Explorer version 7.0.

Please refer to the websites for Internet Explorer (www.microsoft.com) for additional information on downloading the versions available.

The AOL browser does not work well with this Web application.

4.2 NAVIGATION BUTTONS

Do not select the previous/back or following/forward website navigation buttons in the toolbar if the website navigation button offers a selection for “next” or “previous” screen. If you use the navigation or windows buttons instead of those provided by the application, you may risk losing work in progress.

4.3 PERSONAL COMPUTER RECOMMENDATIONS

The website is designed to operate on a personal computer with the following configurations:

Website Requirements

The system requirements below ensure best possible user-experience while visiting the HealthCare Portal.

<h5>Browser & Screen Resolution</h5> <ul style="list-style-type: none">▶ Microsoft Internet Explorer version 7.0 and later▶ Mozilla Firefox version 2.0 and later▶ Screen Resolution - 1024 x 768 pixels	<h5>Document Viewing</h5> <ul style="list-style-type: none">▶ Adobe Reader version 8.0 and later▶ Microsoft Office Suite 2000 and later <p>If you do not have the software needed for document viewing, you can download them using the links provided below.</p> <ul style="list-style-type: none">▶ Adobe Reader▶ MS Office Viewer
<h5>Internet Connection</h5> <ul style="list-style-type: none">▶ Dial-up users need a minimum modem speed of 64Kbps.	<h5>Important Registration Note</h5> <p>When registering as a portal user, you are asked if you are using a personal or a public computer. Please use caution while answering this question, as the security and the privacy required to protect the healthcare data relies on this step of the registration process.</p>

4.4 SCREEN DISPLAY FEATURES

The Alabama Medicaid Provider Enrollment Web Portal is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels and pages into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.5 WEB ADDRESS

The address to access the Interactive Services website is:

<https://www.medicaid.alabamaservices.org/ALPortal>

4.6 USER IDS AND PASSWORDS

A user ID or password is not required to access and submit a Provider Enrollment application, however, when selecting the “finish later” function a tracking number, tax ID and password will be required. To check the status of a submitted enrollment application a tracking number and tax ID will be required. The password must be 8 to 20 characters in length, not the same as the user ID and contain a minimum of 1 numeric digit, 1 uppercase letter and 1 lowercase letter. **Be aware that passwords cannot be reset.**

4.7 RESETTING PASSWORDS

Passwords cannot be reset. When an application is submitted or the “finish later” function is selected, a password is created by the user. If the password is not available when returning to the web portal to complete an application, the password cannot be reset. HP Provider Enrollment does not have access to the password nor the password be reset.

5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS

The following section identifies common system terminology and features, and associated screens capture or design layout where applicable. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the novice user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or, more importantly, documenting aspects of the system.

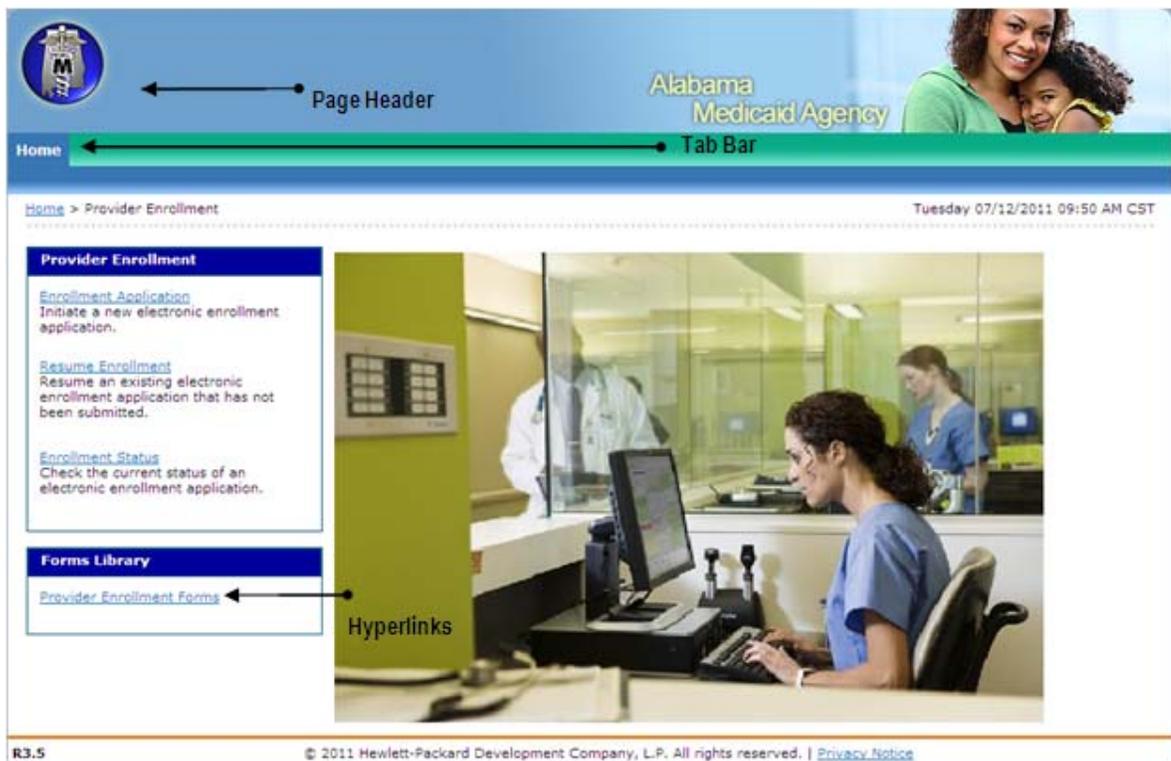
Below is a partial list of common terms described within this document:

- Hyperlink
- Page
- Page Header

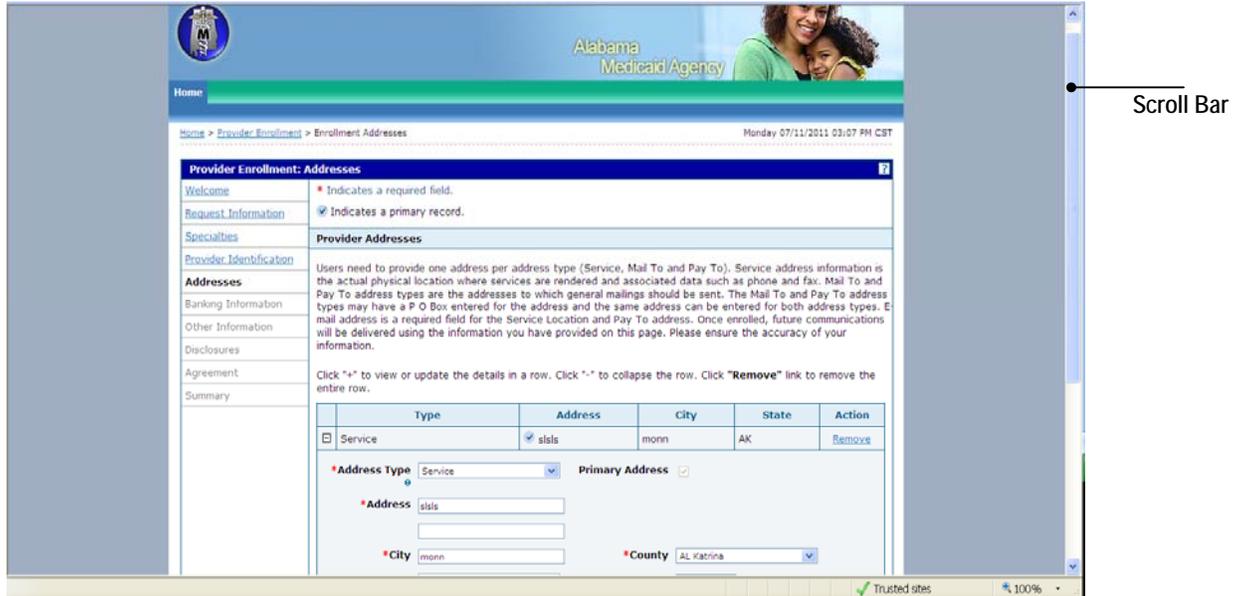
5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, table of contents, and any associated hyperlinks.

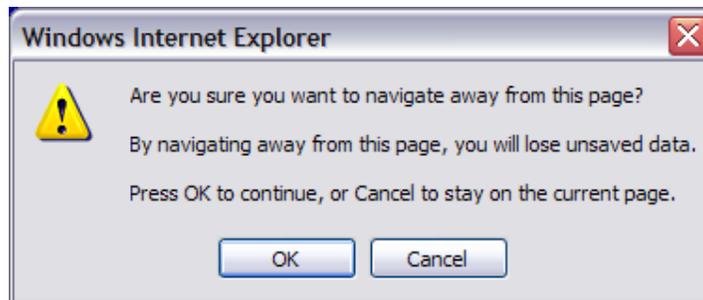
The table of contents contains a vertical list of pages. The pages are accessed after required information is entered on a page and the continue button is selected



In general, when navigating a page, the vertical scroll bar is the only scroll bar needed to view extended pages.

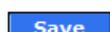


If a user attempts to add, update, or delete information within the page, then tries to navigate away from the page without saving or cancelling the changes, the system prompts the user with a pop-up window message. When the system generates the message and OK button is selected any information entered on the page will be lost. If the cancel button is selected the user will be returned to the page to continue processing the application.



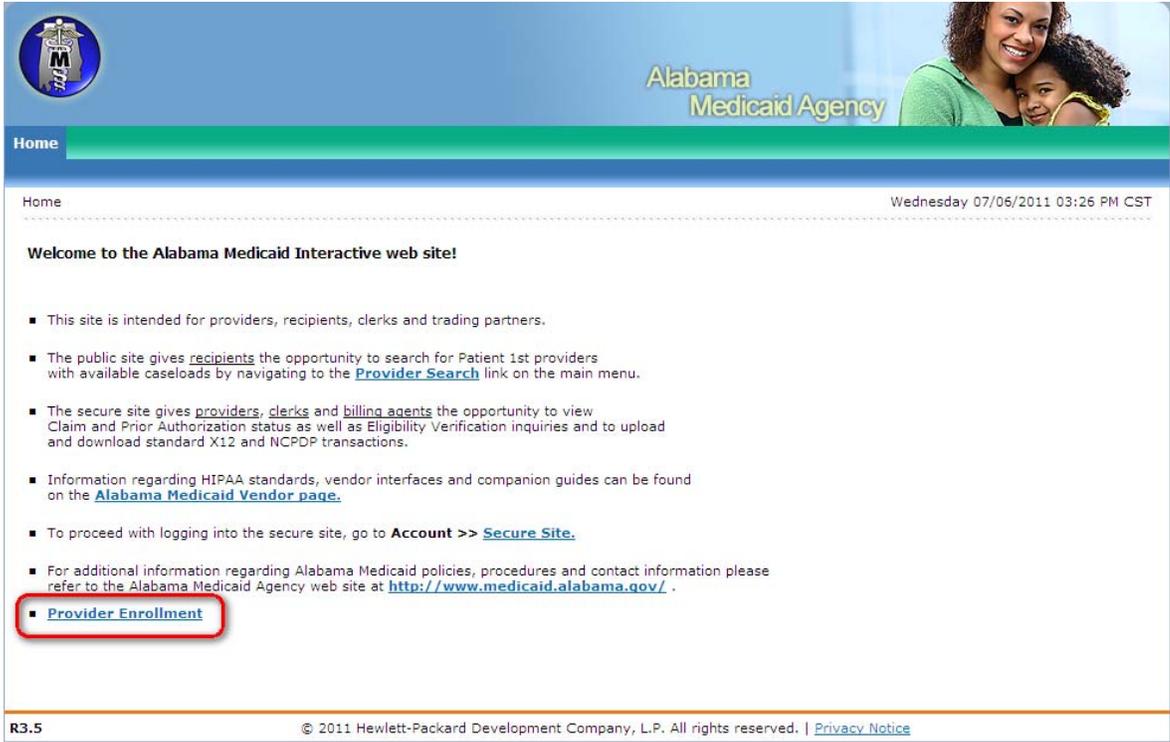
5.2 FUNCTIONS

Listed below are icons that can be found on one or more pages.

Name	Icon	Action
Add Button		Inserts a new data record.
Cancel Button		Cancels all changes applied to all panels on the page.
Check Box		Select as applicable.
Continue Button		Allows user to navigate to the next page.
Print		Prints document.
Radio Button	<input type="radio"/> Yes <input checked="" type="radio"/> No	Select appropriate value.
Reset Button		Resets page to original content.
Save Button		Saves all changes to all panels on the page.
Collapse		Click to collapse a row of data.
View or Update		Click to view or update a row of data.
Help		Select to display the help text for the page.

6 SUBMITTING A PROVIDER ENROLLMENT ELECTRONIC APPLICATION

Users access the provider Enrollment Electronic application by accessing the Alabama Medicaid Agency Interactive Website and selecting on Provider Enrollment link.



Alabama Medicaid Agency

Home

Home Wednesday 07/06/2011 03:26 PM CST

Welcome to the Alabama Medicaid Interactive web site!

- This site is intended for providers, recipients, clerks and trading partners.
- The public site gives recipients the opportunity to search for Patient 1st providers with available caseloads by navigating to the [Provider Search](#) link on the main menu.
- The secure site gives providers, clerks and billing agents the opportunity to view Claim and Prior Authorization status as well as Eligibility Verification inquiries and to upload and download standard X12 and NCPDP transactions.
- Information regarding HIPAA standards, vendor interfaces and companion guides can be found on the [Alabama Medicaid Vendor page](#).
- To proceed with logging into the secure site, go to **Account >> Secure Site**.
- For additional information regarding Alabama Medicaid policies, procedures and contact information please refer to the Alabama Medicaid Agency web site at <http://www.medicaid.alabama.gov/>.
- **Provider Enrollment**

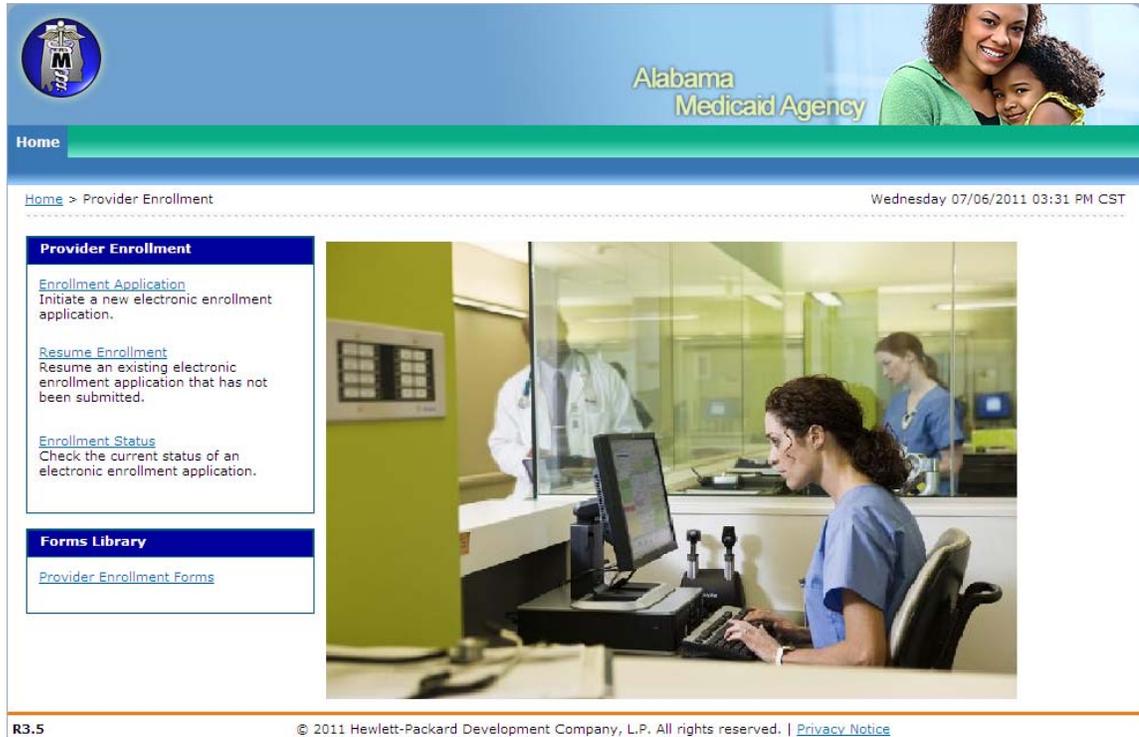
R3.5 © 2011 Hewlett-Packard Development Company, L.P. All rights reserved. | [Privacy Notice](#)

6.1 HOME PAGE

The Home page opens when the Alabama Medicaid Provider Enrollment Web Portal is selected. From the home page, users can access the following Sub Menu options:

- Enrollment Application
- Resume Enrollment
- Enrollment Status
- Provider Enrollment Forms

To begin the enrollment application process, select Enrollment Application.



6.1.1 Home Page Fields and Actions

Field	Action
Enrollment Application	Select Enrollment Application link to initiate a new electronic enrollment application.
Resume Enrollment	Select Resume Enrollment link to resume the processing of an existing electronic enrollment application that has not been submitted. See Section 5.16, page 45.
Enrollment Status	Select Enrollment Status link to check the current status of an electronic enrollment application. See Section 5.14, page 43.
Provider Enrollment Forms	Select Provider Enrollment Forms to access the Alabama Medicaid website's Provider Enrollment Forms page.

6.2 THE PROVIDER ENROLLMENT WELCOME PAGE

The Provider Enrollment Welcome opens when the user selects the Enrollment Application. A user can access a listing of specific qualifications for each provider type by selecting "Alabama Medicaid Participation Requirements". Before selecting "continue", the user must have the information needed to complete the next page listed in the table of contents to the left. If the user chooses to "finish later" be aware that he or she will be required to enter a tax ID and create a password in order to resume the application at another time. A tracking number will also be assigned. If the provider, at any time, chooses to "cancel", no data will be saved.

NOTE: A password is required to return to an application when the "finish later" option is selected or revising an application. The password cannot be reset or retrieved by HP personnel.

An error message will be displayed in red if data is entered in an invalid format or required information is not entered.

Select the Continue Button to begin the enrollment process.

Select the Cancel Button to return to the Provider Enrollment home page.

Provider Enrollment: Welcome	
Welcome	Provider applicants must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Alabama Medicaid Participation Requirements chart. Please review to ensure you meet the minimum enrollment requirements to participate in the Alabama Medicaid program.
Request Information	
Specialties	
Provider Identification	To complete an application you will need to know or be able to obtain about the provider applicant all or some of the following information, depending on the type of enrollment you are completing:
Addresses	
Other Information	<ul style="list-style-type: none"> ▶ National Provider Identifier ▶ Basic Business Office Data (i.e., address, phone, fax, email address, etc.) ▶ Specific Office Data (i.e., CLIA Certification, Name and SSN of employees/personnel, etc.)
Agreement	<ul style="list-style-type: none"> ▶ Specific Provider Data (i.e., CLIA Certification, SSN, Licensure Information, etc.) ▶ IRS Tax Identification Data ▶ Banking Information ▶ Group Identification Data (i.e., Name, NPI, Medicaid ID)
Summary	<p>As pages of the application are completed, additional information may be required and some documentation may need to be submitted to validate entries. The application can be saved and resumed as needed; however, once a page is accessed, the page must be completed before the application can be saved.</p> <p>When all steps of the application have been completed, please "Submit" and "Confirm" the application for further processing by HPES Provider Enrollment Staff.</p> <p>Please click the "Continue" button to start the enrollment application.</p>
<input type="button" value="Continue"/> <input type="button" value="Cancel"/>	

6.2.1 Welcome Page Fields and Actions

Field	Action
Alabama Medicaid Participation Requirements	Select the Alabama Medicaid Participation Requirements link for a chart listing the participation requirements.
Continue	Select the Continue Button to begin the enrollment process.
Cancel	Select the Cancel Button to cancel the process and return to the Provider Enrollment page.

6.3 PROVIDER ENROLLMENT: REQUEST INFORMATION PAGE

The Provider Enrollment: Request Information page provides the initial enrollment and contact information to begin the provider enrollment process. The provider can initiate, resume, or revise an electronic enrollment application. All required fields below must be completed in order to "continue" or "finish later". Select carefully the Enrollment Type as this selection will drive what information will be required to complete the electronic application. Please provide accurate contact information, including the e-mail address, as it will be used for any concerns/questions or notifications regarding this application. Be aware that although the provider is asked to provide a "Requesting Enrollment Effective Date" the provider is NOT guaranteed this effective date. The effective date will be determined by Provider Enrollment based on when the application is received and documentation submitted.

6.3.1 Request Information Page for All Enrollment Types Except 'Individual Within A Group'

Provider Enrollment: Request Information	
Welcome	
Request Information	You are initiating, resuming, or revising an electronic enrollment application. All required fields below must be completed in order to "Continue" or "Finish Later". Before selecting "Continue" be sure to have ready information you may possibly need to complete the next page listed in the table of contents to the left. If you choose to "Finish Later" be aware that you will be required to enter your tax ID and create a password in order to resume the application at another time. A tracking number will also be assigned. If you, at any time, choose to "Cancel" no data will be saved.
Specialties	
Provider Identification	Select carefully the Enrollment Type as this selection will drive what information you will be required to complete going forward. Provide accurate contact information, including the email address, as it will be used for any concerns/questions or notifications regarding this application. Be aware that although you are asked to provide a "Requesting Enrollment Effective Date" you are NOT guaranteed this effective date.
Addresses	
Other Information	
Agreement	* Indicates a required field.
Summary	<div style="border: 1px solid black; padding: 5px;"> <p>Initial Enrollment Information</p> <p>*Enrollment Type <input type="text"/></p> <p>*Provider Type <input type="text"/></p> <p>*Requesting Enrollment Effective Date <input type="text" value="07/07/2011"/></p> <hr/> <p>Contact Information</p> <p>*Contact Name <input type="text"/></p> <p>*Contact Phone <input type="text"/> Ext <input type="text"/></p> <p>*Contact Email <input type="text"/></p> <p>*Confirm Email <input type="text"/></p> <p style="text-align: right;"> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </p> </div>

6.3.1.1 Request Information Page Fields and Actions

Field	Action
Enrollment Type	Select the appropriate Enrollment type using the drop down list
Provider Type	Select the appropriate Provider type using the drop down list.
Requesting Enrollment Effective Date	Enter the requested effective date for the provider enrollment. NOTE: Provider Enrollment will determine the effective date based on the enrollment application and documentation submitted.
Contact Name	Enter the name of the person who should be contacted regarding questions on the enrollment application.
Contact Phone	Enter the telephone number of the contact person.
Ext	Enter the telephone number extension of the contact person.
Contact E-mail	Enter the E-mail address of the contact person. Information or questions regarding the enrollment application will be sent to this e-mail address.
Confirm E-mail	Enter the e-mail address of the contact person to confirm the address is entered correctly.
Continue	Select the continue button to navigate to the next page of the enrollment process.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time. See Section 5.15, page 44.

6.3.2 Request Information Page when enrolling as an Individual Within Group

Provider Enrollment: Request Information ?	
Welcome	You are initiating, resuming, or revising an electronic enrollment application. All required fields below must be completed in order to "Continue" or "Finish Later". Before selecting "Continue" be sure to have ready information you may possibly need to complete the next page listed in the table of contents to the left. If you choose to "Finish Later" be aware that you will be required to enter your tax ID and create a password in order to resume the application at another time. A tracking number will also be assigned. If you, at any time, choose to "Cancel" no data will be saved.
Request Information	
Specialties	
Provider Identification	
Addresses	Select carefully the Enrollment Type as this selection will drive what information you will be required to complete going forward. Provide accurate contact information, including the email address, as it will be used for any concerns/questions or notifications regarding this application. Be aware that although you are asked to provide a "Requesting Enrollment Effective Date" you are NOT guaranteed this effective date.
Other Information	
Agreement	
Summary	* Indicates a required field.
Initial Enrollment Information	
<p>*Enrollment Type <input type="text" value="IndividualWithinGroup"/></p> <p>*Provider Type <input type="text"/></p> <p>*Requesting Enrollment Effective Date <input type="text" value="07/13/2011"/> <input type="button" value=""/></p>	
Group Association	
If enrolling as part of an existing Medicaid group you must provide the information below. If the group is not yet enrolled, you must establish a group enrollment prior to completing an application for an Individual Within A Group.	
<p>*Group NPI <input type="text"/> *Group Medicaid # <input type="text"/></p> <p>*Group Name <input type="text"/></p>	
Contact Information	
<p>*Contact Name <input type="text"/></p> <p>*Contact Phone <input type="text"/> Ext <input type="text"/></p>	

6.3.2.1 Request Information Page Fields and Actions

Field	Action
Group NPI	Enter the group NPI.
Group Medicaid #	Enter group Medicaid number.
Group Name	Enter the group name.

6.4 PROVIDER ENROLLMENT: SPECIALTIES

The Provider Enrollment: Specialties page allows you to add, view, and maintain specialty information for the provider type selected on the Request Information page.

Before Primary Specialty is Selected (Box Unselected)

The screenshot shows the 'Provider Enrollment: Specialties' page. The left sidebar contains navigation links: Welcome, Request Information, Specialties, Provider Identification, Addresses, Banking Information, Other Information, Disclosures, Agreement, and Summary. The main content area is titled 'Specialties' and includes instructions: '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.' and 'When selecting specialties such as EPSDT, additional qualifications must be met and additional documentation will be required. Be aware if you select a specialty for which the provider applicant does not qualify this application may be rejected.' Below this are two legends: '* Indicates a required field.' and 'Indicates a primary record.' (with a checked checkbox). A table with columns 'Specialty', 'Taxonomy Code', and 'Action' is shown, with a 'Click to collapse.' link. The form below the table has 'Type Dentist', '*Specialty' (dropdown), '*Taxonomy Code' (dropdown), and 'Primary' (checkbox, unselected). 'Add' and 'Reset' buttons are at the bottom. Below this is the 'Additional Taxonomy Code' section with instructions and a 'Taxonomy Code' input field. At the bottom right are 'Continue', 'Finish Later', and 'Cancel' buttons.

After Primary Specialty is Selected (Box Selected)

This is a close-up of the specialty form. It shows 'Type Dentist', '*Specialty' dropdown set to 'Periodontist', '*Taxonomy Code' dropdown, and 'Primary' checkbox which is now checked. 'Add' and 'Reset' buttons are visible below the form.

After Primary Specialty is Selected and Added

To view or update the details in a row click "+". To collapse the detailed information click "-".

Click on "Remove" under the action field to remove a row.

When updating a row click on "Save" to retain any changed information.

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

6.4.1 Specialties Page Fields and Actions

Field	Action
Type	Displays the provider type selected on the Request Information page.
Specialty	Select a specialty using the drop down list. The specialties choices are based on the provider type selected on the Request Information page.
Taxonomy Code	Select a taxonomy code using the drop down list Taxonomy codes choices are based on the specialty type selected.
Primary	Select which specialty is the primary by checking the box. One primary specialty must be selected by clicking the Primary check box. Specialty choices are dependent upon the provider type chosen on the Request Information page.
Add	Select the add button to add the specialty and taxonomy codes that have been selected.
Reset	Select the reset button to reset the information on the page to add, view or delete information.
Taxonomy Code (Additional)	Enter any additional taxonomy codes.
Continue	Select the continue button to navigate to the next page of the enrollment process
Finish Later	Select the Finish later button to save the enrollment application and finish it at a later time.
Cancel	Select the cancel button to cancel the process and return to the Provider Enrollment page.

6.5 PROVIDER ENROLLMENT: PROVIDER IDENTIFICATION PAGE

The Provider Enrollment Provider Identification page allows the user to enter information, such as legal name, individual, group practice or facility name and any identification numbers, such as NPI, tax ID, DEA, CLIA, etc. For facility and group enrollment types, provider legal name is equivalent to the name under which the facility or group does business (aka DBA name). For individual and individual within a group enrollment types, provider legal name is equivalent to the legal name of the individual enrolling. The provider legal name may or may not be the same as the tax name required in the next section. When entering DEA or CLIA information you will be required to submit copies of the DEA and CLIA certificates.

6.5.1 Provider Identification Page

Alabama Medicaid Agency

Home > Provider Enrollment > Enrollment Provider Identification Friday 07/08/2011 08:36 AM CST

Provider Enrollment: Provider Identification

Welcome * Indicates a required field.

[Request Information](#)

[Specialties](#)

Provider Identification

Addresses

Banking Information

Other Information

Disclosures

Agreement

Summary

Provider Legal Name

For Facility and Group enrollment types, Provider Legal Name is equivalent to the name under which the facility or group does business (aka DBA name). For Individual and Individual Within A Group enrollment types, Provider Legal Name is equivalent to the legal name of the individual enrolling. The Provider Legal Name may or may not be the same as the Tax Name required in the next section.

* Last Name

* First Name

Middle Title

Gender Birth Date

* Organization type

Provider Identification Numbers

Tax name is equivalent to the legal tax name registered with the IRS.

* Tax Name

* Tax ID * Tax ID Type EIN SSN

* NPI

* License State

* License # * Effective Date * Expiration Date

Medicare # Effective Date Medicare Type

DEA # Effective Date

CLIA # Effective Date

* SSN

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

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6.5.1.1 Provider Identification Page Fields and Actions

Field	Action
Last Name	Enter the provider's last name.
First Name	Enter the provider's first name.
Middle	Enter the provider's middle initial. This is not a required field.
Title	Select the provider's title from the drop down list. This is not a required field.
Gender	Select the provider's gender from the drop down list. This is not a required field.
Birth Date	Enter the provider's date of birth.
Organization Type	Select the provider's organization type from the drop down list.
Tax Name	Enter the provider's legal tax name.
Tax ID	Enter the provider's tax identification number.
Tax ID Type	Select the appropriate button to select the provider's tax identification type
NPI	Enter the provider's NPI.
License State	Select the state of origin of the provider's license number from the drop down list.
License #/Effective and Expiration Date	Enter the provider's license number and the effective date and expiration date of the license number.
Medicare # / Effective Date	Enter the provider's Medicare number and the effective date of the number.
Medicare Type	Select the Medicare type of the provider's Medicare Number from the drop down list.
DEA # / Effective Date	Enter the DEA number and the effective date of the DEA number.
CLIA # / Effective Date	Enter the CLIA number and the effective date of the CLIA number.
SSN	Enter the provider's Social Security Number.
Continue	Select the Continue button to navigate to the next page of the enrollment process.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time.
Cancel	Select the Cancel Button to cancel the process and return to the Provider Enrollment page.

6.5.2 Provider Identification Page When the Enrollment Type is Group

6.5.2.1 Provider Identification Page Fields and Actions when the Enrollment Type is Group

Field	Action
Legal Name	Enter the legal name of the Group or Facility
Organization Type	Select the provider's organization type from the drop down list.
Tax Name	Enter the provider's legal tax name.
Tax ID	Enter the provider's tax identification number.
Tax ID Type	Select the appropriate button to select the provider's tax identification type.
NPI	Enter the group's or facility's NPI information.
CLIA # / Effective Date	Enter the CLIA number and the effective date of the CLIA number.

6.5.3 Provider Identification when the Enrollment Type is Facility

6.5.3.1 Provider Identification Page Fields and Actions when the Enrollment Type is Facility

Field	Action
Legal Name	Enter the legal name of the facility.
Organization Type	Select the provider's organization type from the drop down list.
Tax Name	Enter the provider's legal tax name.
Tax ID	Enter the provider's tax identification number.
Tax ID Type	Select the appropriate button to select the provider's tax identification type.
NPI	Enter the group's or facility's NPI information.
Medicare #/Effective Date	Enter the Medicare Number and the effective date.
Medicare Type	Select the type of Medicare number using the drop down list.
DEA #/Effective Date	Enter the DEA number and effective date. Submit a copy of the DEA certificate by fax with the bar coded cover sheet and mail with a copy of the bar coded cover sheet.
CLIA # / Effective Date	Enter the CLIA number and the effective date of the CLIA number. Submit a copy of the CLIA certificate by fax with the bar coded cover sheet and mail the form with a copy of the bar coded cover sheet.
Medicaid Bond #	Enter the Medicaid bond number.
Medicaid Bond # Effective Date	Enter the Medicaid bond number effective date.

Field	Action
Medicaid Bond# End Date	Enter the Medicaid bond number end date.

6.5.3.2 Provider Identification Page Fields and Actions when the Provider type is DME

Field	Action
Medicaid Bond #	Enter the Medicaid bond number.
Medicaid Bond # Effective Date	Enter the Medicaid bond number effective date.
Medicaid Bond# End Date	Enter the Medicaid bond number end date.
Medicare Bond#	Enter the Medicare bond number.
Medicare Bond # Effective Date	Enter the Medicare bond number effective date.
Medicare Bond # End Date	Enter the Medicare bond number end date.
ACC Effective Date	Enter the Medicare accreditation effective date.
ACC End Date	Enter the Medicare accreditation end date.

6.6 PROVIDER ENROLLMENT: ADDRESSES

The Provider Enrollment Addresses page allows users to enter address information. Users need to provide one address per address type (service, mail to and pay to). Service address information is the actual physical location where services are rendered and associated data such as phone and fax. The service address should be indicated as the primary address. Mail to and pay to address types are the addresses to which general mailings should be sent. The mail to and pay to address types may have a P O Box entered for the address and the same address can be entered for both address types. E-mail address is a required field for the service location and pay to address. Once enrolled, future communications will be delivered using the information the user has provided on this page. Please ensure the accuracy of the information prior to submission.

Addresses Page Prior to Addresses Being Added

Provider Enrollment: Addresses
?

[Welcome](#)

[Request Information](#)

[Specialties](#)

[Provider Identification](#)

Addresses

[Other Information](#)

[Agreement](#)

[Summary](#)

* Indicates a required field.
 ✓ Indicates a primary record.

Provider Addresses

Users need to provide one address per address type (Service, Mail To and Pay To). Service address information is the actual physical location where services are rendered and associated data such as phone and fax. Mail To and Pay To address types are the addresses to which general mailings should be sent. The Mail To and Pay To address types may have a P O Box entered for the address and the same address can be entered for both address types. E-mail address is a required field for the Service Location and Pay To address. Once enrolled, future communications will be delivered using the information you have provided on this page. Please ensure the accuracy of your information.

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

	Type	Address	City	State	Action
-	Click to collapse.				
+	<div style="border: 1px solid #ccc; padding: 5px;"> <div style="display: flex; justify-content: space-between;"> * Address Type <input type="text"/> Primary Address <input type="checkbox"/> </div> <div style="display: flex; margin-top: 5px;"> <div style="flex: 1;"> <p>* Address <input type="text"/></p> <p><input type="text"/></p> </div> <div style="flex: 1; margin-left: 20px;"> <p>* County <input type="text"/></p> </div> </div> <div style="display: flex; margin-top: 5px;"> <div style="flex: 1;"> <p>* City <input type="text"/></p> </div> <div style="flex: 1; margin-left: 20px;"> <p>* Zip Code <input type="text"/></p> </div> </div> <div style="display: flex; margin-top: 5px;"> <div style="flex: 1;"> <p>* State <input type="text"/></p> </div> <div style="flex: 1; margin-left: 20px;"> <p>Confirm Email <input type="text"/></p> </div> </div> <div style="display: flex; margin-top: 5px;"> <div style="flex: 1;"> <p>Phone <input type="text"/> <input type="text"/> Ext <input type="text"/></p> </div> <div style="flex: 1; margin-left: 20px;"> <p>Phone <input type="text"/> <input type="text"/> Ext <input type="text"/></p> </div> </div> <div style="display: flex; margin-top: 5px;"> <div style="flex: 1;"> <p>Phone <input type="text"/> <input type="text"/> Ext <input type="text"/></p> </div> </div> </div>				

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

Addresses Page after addresses have been added.

Provider Enrollment: Addresses																																			
Welcome	* Indicates a required field.																																		
Request Information	☑ Indicates a primary record.																																		
Specialties	Provider Addresses																																		
Provider Identification	Users need to provide one address per address type (Service, Mail To and Pay To). Service address information is the actual physical location where services are rendered and associated data such as phone and fax. Mail To and Pay To address types are the addresses to which general mailings should be sent. The Mail To and Pay To address types may have a P O Box entered for the address and the same address can be entered for both address types. E-mail address is a required field for the Service Location and Pay To address. Once enrolled, future communications will be delivered using the information you have provided on this page. Please ensure the accuracy of your information.																																		
Addresses	Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.																																		
Banking Information	<table border="1"> <thead> <tr> <th></th> <th>Type</th> <th>Address</th> <th>City</th> <th>State</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>Service</td> <td><input checked="" type="checkbox"/> 123 Main</td> <td>Main City</td> <td>ME</td> <td>Remove</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Mail To</td> <td>123 Main</td> <td>Main City</td> <td>ME</td> <td>Remove</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Pay To</td> <td>123 Main</td> <td>Main City</td> <td>ME</td> <td>Remove</td> </tr> <tr> <td><input type="checkbox"/></td> <td colspan="5">Click to add address.</td> </tr> </tbody> </table>						Type	Address	City	State	Action	<input type="checkbox"/>	Service	<input checked="" type="checkbox"/> 123 Main	Main City	ME	Remove	<input type="checkbox"/>	Mail To	123 Main	Main City	ME	Remove	<input type="checkbox"/>	Pay To	123 Main	Main City	ME	Remove	<input type="checkbox"/>	Click to add address.				
	Type	Address	City	State	Action																														
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<input type="checkbox"/>	Click to add address.																																		
Other Information																																			
Disclosures																																			
Agreement																																			
Summary																																			
	<div style="text-align: right;"> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </div>																																		

6.6.1 Provider Addresses Page Fields and Actions

Field	Action
Address Type	Select the provider's address type from the drop down list. Valid values are: Mail to, Pay to, and Service.
Primary Address	Select the check box to indicate which address is the primary address for the provider. The service location is the primary address.
Address	Enter the provider's address.
City	Enter the provider's city.
County	Select the provider's county from the drop down list. Valid values are: alphabetical list of Alabama counties and state name for out of state providers.
State	Select the provider's state from the drop down list.
Zip Code	Enter the provider's zip code.
E-mail	Enter the provider's e-mail address. An e-mail address is required for the service and Pay to addresses.
Confirm E-mail	Enter the provider's e-mail address to confirm the provider's e-mail address.
Phone	Select the provider's phone type from the drop down list. Valid values are: cell, fax, home, office, and toll-free. Service Location: A fax, office and toll free phone number are required Mail to address: An office phone number is required Pay to address: A fax and office phone number is required.
Phone / Ext	Enter the provider's telephone number and extension after the phone type has been selected from drop down list.
Add	Select the add button to add a new information segment.

Field	Action
Reset	Select the reset button to reset the page to add, view or delete information.
Continue	Select the continue button to navigate to the next page of the enrollment process.
Finish Later	Select the Finish later button to save the enrollment application and finish it at a later time.
Cancel	Select the cancel button to cancel the process and return to the Provider Enrollment page.

6.7 PROVIDER ENROLLMENT: BANK ACCOUNT INFORMATION

The Provider Enrollment Bank Account Information page allows the user to enter the provider's bank name, address, and account information. Electronic Funds Transfer (EFT) is a participation requirement. All fields are required. When the application is complete be sure to fax AND mail with the bar-coded cover sheet an official EFT Form and a copy of a voided check for verification purposes. The EFT Form can be found on the Provider Agreement page or under the Forms Library section of the Provider Enrollment page.

6.7.1 Bank Account Information Page Fields and Actions

Field	Action
ABA Routing Number	Enter the bank account's routing number.
Account Number	Enter the account number.
Account Type	Select the account type from the drop down list.
EFT Type	Select the EFT type from the drop down list.
Address	Allows the user to enter the provider's address.
Bank Name	Enter the bank name.
Address	Enter the bank's address.
City	Enter the bank's city.
State	Select the bank's state from the drop down list.
Zip Code	Enter the bank's zip code.

Field	Action
Phone	Enter the bank's phone number.
Cancel	Select the Cancel button to cancel the process and return to the Provider Enrollment page.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time.
Cancel	Select the Cancel to cancel the process and return to the Provider Enrollment page.

6.8 PROVIDER ENROLLMENT: OTHER INFORMATION PAGE

The Provider Enrollment: Other Information page offers a location to enter additional information, such as independent nurse practitioner, physician-employed practitioners or nurse midwife data (if applicable). If the provider is enrolling as a pharmacy due to change in ownership, please provide the pharmacy data. Facility or group need to indicate board members.

6.8.1 Independent Nurse Practitioner, Physician-Employed Practitioners or Nurse Midwife Page

This information is required only when the enrolling provider is an Independent Nurse Practitioner, Physician-Employed Practitioners or Nurse Midwife,

Provider Enrollment: Other Information	
Welcome	Please provide additional information for each enrollment type as applicable.
Request Information	
Specialties	Independent Nurse Practitioner, Physician-Employed Practitioner or Nurse Midwife
Provider Identification	If enrolling an independent nurse practitioner, physician-employed practitioner or nurse midwife, the name and NPI of the collaborating/supervising physician must be indicated below.
Addresses	
Banking Information	
Other Information	Collaborating Physician Last Name <input type="text"/> First Name <input type="text"/> NPI <input type="text"/>
Disclosures	Continue Finish Later Cancel
Agreement	
Summary	

6.8.1.1 Independent Nurse Practitioner, Physician-Employed Practitioners or Nurse Midwife Page Fields and Actions

Field	Action
Collaborating Physician Last Name	Enter the collaborating physician last name.
First Name (Collaborating Physician)	Enter the collaborating physician first name.
NPI (Collaborating Physician)	Enter the collaborating physician NPI.
Continue	Select the Continue button to navigate to the next page of the enrollment process.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time.
Cancel	Select the Cancel button to cancel the process and return to the Provider Enrollment page.

6.8.2 Facility Providers and Board Members Page

The pharmacy information displays when the Pharmacy provider type was selected on the **Request Information** page.

The Board members information displays when the Enrollment type of Group or Facility is selected on the **Request Information** page.

Note: You are required to print, complete and submit a disclosure form for each individual whose name and social security number was entered. The disclosure form is located under **Supporting Documentation** in the web portal application.

Provider Enrollment: Other Information																
Welcome	Please provide additional information for each enrollment type as applicable.															
Request Information																
Specialties	Facility Providers															
Provider Identification	If enrolling a pharmacy due to a change of ownership, the previous name and NPI of the pharmacy must be indicated below.															
Addresses	Decertifying Pharmacy <input type="text"/> NPI <input type="text"/>															
Other Information	Board Members															
Agreement	Providers who operate as a corporation, organization, institution, agency, partnership, professional association, or similar entity must provide the name and social security number (SSN) for each of the following individuals affiliated with this facility/group: Owners; Officers; Agents; Directors; Managing Employees and/or Shareholders with 5% or more controlling interest.															
Summary	In addition, for each person whose name and SSN is entered below, a Disclosure Form MUST be printed, completed and submitted via mail or fax. A link to the Disclosure Form can be found on the Agreement page or under the Forms Library section of the Provider Enrollment page. A copy of the Bar Coded Cover Sheet must accompany these items when submitted. Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.															
	<table border="1"> <thead> <tr> <th>Board Member Name</th> <th>SSN</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="3">[-] Click to collapse.</td> </tr> <tr> <td>*Last Name <input type="text"/></td> <td></td> <td></td> </tr> <tr> <td>*First Name <input type="text"/></td> <td>*SSN <input type="text"/></td> <td></td> </tr> <tr> <td colspan="3"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </td> </tr> </tbody> </table>	Board Member Name	SSN	Action	[-] Click to collapse.			*Last Name <input type="text"/>			*First Name <input type="text"/>	*SSN <input type="text"/>		<input type="button" value="Add"/> <input type="button" value="Reset"/>		
Board Member Name	SSN	Action														
[-] Click to collapse.																
*Last Name <input type="text"/>																
*First Name <input type="text"/>	*SSN <input type="text"/>															
<input type="button" value="Add"/> <input type="button" value="Reset"/>																
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>															

6.8.2.1 Other Information Page Fields and Actions

Field	Action
Decertifying Pharmacy	Enter the name of the pharmacy that is being closed due to a change of ownership. This field displays when the Pharmacy provider type was selected on the Request Information page.
NPI (Decertifying Pharmacy)	Enter the NPI of the pharmacy that is being closed due to a change of ownership. This field displays when the pharmacy provider type was selected on the Request Information page.
Last Name	Enter the last name of the individual affiliated with this group/facility and an Owner; Officer; Agents; Director; Managing Employee and/or Shareholder with 5% or more controlling interest. The Board members information displays when the Enrollment type of Group or Facility if selected on the Request Information page.
First Name	Enter the first name of the affiliated with this group/facility and an Owner; Officer; Agents; Director; Managing Employee and/or Shareholder with 5% or more controlling interest. The Board members information displays when the Enrollment type of Group or Facility if selected on the Request Information page.

Field	Action
SSN	Enter the social security number of the individual affiliated with this group/facility and an Owner; Officer; Agents; Director; Managing Employee and/or Shareholder with 5% or more controlling interest. The Board members information displays when the enrollment type of Group or Facility is selected on the Request Information page.
Add	Select the Add button to add a new information segment.
Reset	Select the reset button to reset the page to add, view or delete information.
Continue	Select the Continue Button to navigate to the next page of the enrollment process.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time.
Cancel	Select the Cancel Button to cancel the process and return to the Provider Enrollment page.

6.9 PROVIDER ENROLLMENT: DISCLOSURES

The Provider Enrollment Disclosures page allows the user to provide answers to all disclosure questions. If the question is not applicable to you, answer `No.` For all `Yes` responses, provide an explanation in the text box that follows the Yes response. If a disclosure explanation requires more detail than what the text box allows, contact Provider Enrollment.

Answer all questions. If you do not believe that a question is applicable, you should select a response of "No". For any "Yes" response, please provide an explanation in the text box provided for each link. For disclosures that require further information than can be submitted using this function, please contact Provider Enrollment at (888) 223-3630 or (334) 215-0111 (out-of-state) for further instructions.

* Indicates a required field.

Disclosure Questions

Disclosure

Licensure

- *Is your license currently suspended or restricted? If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license.**
 Yes No
- *Has any action ever been taken against your license or certification, by any state or certification board?**
 Yes No
- *Have there ever been any changes to your license, registration or certification?**
 Yes No

Affiliations

- *Has any action ever been taken against your medical privileges or any other associations, by any hospital, healthcare institution or governing board?**
 Yes No
- *Have you ever voluntarily withdrawn your privileges based on any action by a hospital, healthcare institution or governing board?**
 Yes No
- *Has an agent, managing employee or person/entity with ownership/controlling interest of 5% or more of this business ever been convicted of a felony or misdemeanor for fraud/abuse in a government program, been found liable for fraud/abuse in a civil proceeding or entered into a settlement in lieu of conviction of fraud/abuse? If yes, give their name(s) and their relationship to you.**
 Yes No
- *Have you ever been terminated or not renewed your enrollment, or subject to any disciplinary action by any healthcare organization or licensing agency?**
 Yes No

Education

- *Have you ever been disciplined in any manner during your medical education?**
 Yes No
- *Have you ever voluntarily withdrawn or terminated your medical education due to an investigation?**
 Yes No
- *Has your board certification ever been suspended or terminated?**
 Yes No
- *Have you ever chosen to terminate your board certification while under investigation?**
 Yes No

Substance Registration

12. *Has any action ever been taken against your federal or state controlled substance certifications or authorizations?
 Yes No

Governmental Programs

13. *Has any action ever been taken against you during your participation in, or have you ever been excluded, suspended, sanctioned, or debarred from, any federal or state governmental healthcare program? If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license. (Attach additional sheets if necessary)
 Yes No

Investigations

14. *Have you ever been the subject of an investigation by any healthcare organization or military agency, related to your performance of medical duties, for any action that qualifies as fraudulent activities?
 Yes No
15. *Are you aware of any information being reported regarding your performance as a medical practitioner, to any public medical malpractice reporting agency?
 Yes No
16. *Have you ever been under investigation by any state or federal regulatory agencies?
 Yes No
17. *Have you ever been convicted, or are you currently under investigation, by any licensing authority, law enforcement agency or any other entity for any legal misconduct?

Convicted Means that:

- 1) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
 - a) There is a post trial motion or appeal, or
 - b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
- 2) A Federal, State or local court has made a finding of guilt against an individual or entity;
- 3) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
- 4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license. (Attach additional sheets if necessary).
 Yes No

Liability

18. *Has any action ever been taken against your professional liability coverage based on your history of medical practice?
 Yes No
19. *Have you ever had an adverse professional liability action?
 Yes No

Legal History

20. *Have you ever been convicted or plead guilty to a felony or misdemeanor (excluding minor traffic citations)?
- Convicted Means that:**
- 1) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
 - a) There is a post trial motion or appeal, or
 - b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
 - 2) A Federal, State or local court has made a finding of guilt against an individual or entity;
 - 3) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
 - 4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.
- If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license. (Attach additional sheets if necessary).
 Yes No
21. *Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state?
 Yes No

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

6.9.1 Disclosures Page Fields and Actions

Field	Action
Text Box	A text box appears when a response to a question is yes. Provide an explanation for the yes response.
Continue	Select the Continue button to navigate to the next page of the enrollment process.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time.
Cancel	Select the Cancel button to cancel the process and return to the Provider Enrollment page.

6.10 PROVIDER ENROLLMENT: AGREEMENT

The Provider Enrollment: Agreement page allows the user to view the terms of enrollment, and displays a link to the Provider Agreement and Signature Form. The provider must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted. The provider must access and read the Provider Agreement, which the user should also print for the provider's records. Please do not submit Provider Agreement pages to HPES. The provider must also access, print, sign, fax and mail with the bar-coded cover sheet the Signature Form. The Signature Form must be faxed and mailed, as an original signature is required. The Signature Form must contain the signature of the individual applicant requesting enrollment OR the signature of an authorized representative of the facility/group requesting enrollment.

It is strongly advised that the provider access the Summary of Enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Upon making changes, the enrollment application can be reviewed again. Once submitted, ability to update data on the application will most likely be limited to specific data and permission to do so is granted only by HPES Provider Enrollment staff and only under specific circumstances.

Once the application is submitted and confirmed, a tracking number will be assigned and a bar-coded cover sheet can be printed for submission with all hard copy materials (fax and/or paper mailings) to the HPES Provider Enrollment office.





**Alabama
Medicaid Agency**

Home

Home > [Provider Enrollment](#) > Enrollment Agreement
Saturday 07/09/2011 10:08 AM CST

Provider Enrollment: Agreement
?

<p>Welcome</p> <p>Request Information</p> <p>Specialties</p> <p>Provider Identification</p> <p>Addresses</p> <p>Banking Information</p> <p>Other Information</p> <p>Disclosures</p> <p>Agreement</p> <p>Summary</p>	<p>Instructions</p> <p>The Terms of Enrollment, a link to the Provider Agreement and Signature Form are provided below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted. You must access and read the Provider Agreement, which you should also print for your records. Please do not submit Provider Agreement pages to HPES. You must also access, print, sign, fax and mail with the bar-coded cover sheet the Signature Form. The Signature Form must be faxed and mailed, as an original signature is required. The Signature Form must contain the signature of the individual applicant requesting enrollment OR the signature of an authorized representative of the facility/group requesting enrollment.</p> <p>It is strongly advised that you access the Summary of Enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Upon making changes, the enrollment application can be reviewed again. Once submitted, ability to update data on the application will most likely be limited to specific data and permission to do so is granted only by HPES Provider Enrollment staff and only under specific circumstances.</p> <p>Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet must be printed for submission with all hard copy materials (fax and/or paper mailings) to the HPES Provider Enrollment office.</p> <p>Supporting Documentation</p> <p>Using the links and fields below, the following actions must be taken to complete the enrollment process. Refer to the Attachments link to determine the supplemental documents you must submit for your application. Read and Print for your files the Provider Agreement. Read, Print, Complete, Sign, Fax and Mail the Electronic Funds Transfer Form along with a copy of a voided check for verification purposes. Read, Print, Sign, Fax and Mail the Signature Form. If you need to submit supplemental documentation you may do so by fax and/or mail. All items faxed or mailed must be accompanied by the bar coded cover sheet.</p> <p style="text-align: center;">Read: Link to page listing required attachments.</p> <p style="text-align: center;">Read & Print: Link to Provider Agreement</p> <p style="text-align: center;">Print, Sign & Submit: Link to Signature Form.</p> <p style="text-align: center;">Print, Complete, Sign & Submit: Link to EFT Form.</p>
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Terms of Agreement

Legal Name Ima Provider	Tax ID Type EIN
Primary Address 123 Main Main City ME, 12345-6789	Tax ID 22222222 NPI
Contact Name Ima Provider	
Contact Email drillmaster@brushyourteeth.com	

I, the above provider, confirm to the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to HPES and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency/HPES of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency/HPES for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

You will be submitting this enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature. However as explained above, you are also required to submit an original signature.

***I accept** I understand that my electronic signature is equivalent to written signature, however, written signature is also required.

***Your Signature**

(Entering your name in the box to the right will constitute your electronic signature.)

Title

Agreement Date 07/09/2011

Submit
Finish Later
Cancel

R3.5

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6.10.1 Agreement Page Fields and Actions

Field	Action
Read	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to page listing required attachments.
Read & Print	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to Provider Agreement.
Print, Complete, Sign & Submit	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to Disclosure Form. Submit the form by fax with the Bar Coded Cover sheet and mail the form with a copy of the Bar Coded Cover sheet.
Print, Sign & Submit	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to Signature Form. Submit the form by fax with the Bar Coded Cover sheet and mail the form with a copy of the Bar Coded Cover sheet.
Print, Complete, Sign & Submit	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to EFT Form. Submit the form by fax with the Bar Coded Cover sheet and mail the form with a copy of the Bar Coded Cover sheet.
I accept	Select the check box next to I accept. This box must have a check indicating the electronic signature is equivalent to the written signature.
Your Signature	Enter the name of the individual signing the agreement.
Title	Enter the title, if applicable, of the individual signing the agreement.
Agreement Date	Displays the terms of agreement date of the provider enrollment contract.
Submit	Select the Submit Button to submit the application.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time.
Cancel	Select the Cancel Button to cancel the process and return to the Provider Enrollment page.

6.11 PROVIDER ENROLLMENT: SUMMARY

Provider Enrollment Summary Page allows the user to review and make any revisions to previous pages as needed. The provider is strongly encouraged to verify if the information on the summary is correct. If the user needs to make changes it can be done by selecting the appropriate page(s) in the table of contents. If all information is correct the provider is strongly encouraged to print a copy of the summary for your records. The user must select 'Confirm' for the application to be submitted for review.

Provider Enrollment: Summary																																																																									
Welcome Request Information Specialties Provider Identification Addresses Banking Information Other Information Disclosures Agreement Summary	<table border="1"> <thead> <tr> <th colspan="2">Request Information</th> </tr> </thead> <tbody> <tr> <td>Enrollment Type</td> <td>Individual</td> </tr> <tr> <td>Provider Type</td> <td>Dentist</td> </tr> <tr> <td>Contact Name</td> <td>Ima Provider</td> </tr> <tr> <td>Contact Phone</td> <td>1-555-555-5555</td> </tr> <tr> <td>Ext</td> <td>_</td> </tr> <tr> <td>Contact Email</td> <td>drillmaster@brushyourteeth.com</td> </tr> <tr> <td>Requesting Enrollment Effective Date</td> <td>07/09/2011</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="2">Specialties</th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/> Specialty</td> <td>Pediatric Dentistry</td> </tr> <tr> <td>Taxonomy</td> <td>1223P0221X</td> </tr> <tr> <td>Taxonomy Code</td> <td>_</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="2">Provider Identification</th> </tr> </thead> <tbody> <tr> <td>Last Name</td> <td>Provider</td> </tr> <tr> <td>First Name</td> <td>Ima</td> </tr> <tr> <td>Middle</td> <td>_</td> </tr> <tr> <td>Gender</td> <td>_</td> </tr> <tr> <td>Title</td> <td>_</td> </tr> <tr> <td>Birth Date</td> <td>_</td> </tr> <tr> <td>Organization type</td> <td>Individual Practitioner</td> </tr> <tr> <td>Tax Name</td> <td>Ima Provider</td> </tr> <tr> <td>Tax ID</td> <td>222222222</td> </tr> <tr> <td>Tax ID Type</td> <td>EIN</td> </tr> <tr> <td>NPI</td> <td>1457535494</td> </tr> <tr> <td>License State</td> <td>ME</td> </tr> <tr> <td>License #</td> <td>1111111111111111</td> </tr> <tr> <td>Effective Date</td> <td>06/15/2011</td> </tr> <tr> <td>Expiration Date</td> <td>06/15/2012</td> </tr> <tr> <td>Medicare #</td> <td>_</td> </tr> <tr> <td>Effective Date</td> <td>_</td> </tr> <tr> <td>Medicare Type</td> <td>_</td> </tr> <tr> <td>DEA #</td> <td>_</td> </tr> <tr> <td>Effective Date</td> <td>_</td> </tr> <tr> <td>CLIA #</td> <td>_</td> </tr> <tr> <td>Effective Date</td> <td>_</td> </tr> <tr> <td>SSN</td> <td>333-33-3333</td> </tr> </tbody> </table>	Request Information		Enrollment Type	Individual	Provider Type	Dentist	Contact Name	Ima Provider	Contact Phone	1-555-555-5555	Ext	_	Contact Email	drillmaster@brushyourteeth.com	Requesting Enrollment Effective Date	07/09/2011	Specialties		<input checked="" type="checkbox"/> Specialty	Pediatric Dentistry	Taxonomy	1223P0221X	Taxonomy Code	_	Provider Identification		Last Name	Provider	First Name	Ima	Middle	_	Gender	_	Title	_	Birth Date	_	Organization type	Individual Practitioner	Tax Name	Ima Provider	Tax ID	222222222	Tax ID Type	EIN	NPI	1457535494	License State	ME	License #	1111111111111111	Effective Date	06/15/2011	Expiration Date	06/15/2012	Medicare #	_	Effective Date	_	Medicare Type	_	DEA #	_	Effective Date	_	CLIA #	_	Effective Date	_	SSN	333-33-3333
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Addresses Expand All Collapse All				
	Type	Address	City	State
<input type="checkbox"/>	Service	<input checked="" type="checkbox"/> 123 Main	Main City	ME
<input type="checkbox"/>	Mail To	123 Main	Main City	ME
<input type="checkbox"/>	Pay To	123 Main	Main City	ME

Languages
No Languages exist for this application

Banking Information
<p>ABA Routing Number *****7777</p> <p>Account Number *****7777</p> <p>Account Type Checking</p> <p>EFT Type Deposit</p> <hr/> <p>Bank Name The Bank</p> <p>Address 1 Bank Dr</p> <p>-</p> <p>City Bank City</p> <p>State ME Zip Code 12345-6789</p> <p>Phone 1-666-666-6666</p>

Other Information
<p>Collaborating Physician Last Name Provider</p> <hr/> <p>First Name Mia NPI 1457535494</p>

Disclosures
<p>Disclosure</p> <p>Licensure</p> <p>1. Is your license currently suspended or restricted? If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license. No</p> <p>2. Has any action ever been taken against your license or certification, by any state or certification board? No</p> <p>3. Have there ever been any changes to your license, registration or certification? No</p> <hr/> <p>Affiliations</p> <p>4. Has any action ever been taken against your medical privileges or any other associations, by any hospital, healthcare institution or governing board? No</p> <p>5. Have you ever voluntarily withdrawn your privileges based on any action by a hospital, healthcare institution or governing board? No</p> <p>6. Has an agent, managing employee or person/entity with ownership/controlling interest of 5% or more of this business ever been convicted of a felony or misdemeanor for fraud/abuse in a government program, been found liable for fraud/abuse in a civil proceeding or entered into a settlement in lieu of conviction of fraud/abuse? If yes, give their name(s) and their relationship to you. No</p> <p>7. Have you ever been terminated or not renewed your enrollment, or subject to any disciplinary action by any healthcare organization or licensing agency? No</p> <hr/> <p>Education</p> <p>8. Have you ever been disciplined in any manner during your medical education? No</p> <p>9. Have you ever voluntarily withdrawn or terminated your medical education due to an investigation? No</p> <p>10. Has your board certification ever been suspended or terminated? No</p> <p>11. Have you ever chosen to terminate your board certification while under investigation? No</p> <hr/> <p>Substance Registration</p>

12. Has any action ever been taken against your federal or state controlled substance certifications or authorizations?

No

Governmental Programs

13. Has any action ever been taken against you during your participation, or have you ever been excluded, suspended, sanctioned, or debarred from, any federal or state governmental healthcare program? If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license. (Attach additional sheets if necessary)

No

Investigations

14. Have you ever been the subject of an investigation by any healthcare organization or military agency, related to your performance of medical duties, for any action that qualifies as fraudulent activities?

No

15. Are you aware of any information being reported regarding your performance as a medical practitioner, to any public medical malpractice reporting agency?

No

16. Have you ever been under investigation by any state or federal regulatory agencies?

No

17. Have you ever been convicted, or are you currently under investigation, by any licensing authority, law enforcement agency or any other entity for any legal misconduct?

Convicted Means that:

- 1) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
 - a) There is a post trial motion or appeal, or
 - b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
- 2) A Federal, State or local court has made a finding of guilt against an individual or entity;
- 3) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
- 4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license. (Attach additional sheets if necessary).

No

Liability

18. Has any action ever been taken against your professional liability coverage based on your history of medical practice?

No

19. Have you ever had an adverse professional liability action?

No

Legal History

20. Have you ever been convicted or plead guilty to a felony or misdemeanor (excluding minor traffic citations)?

Convicted Means that:

- 1) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
 - a) There is a post trial motion or appeal, or
 - b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
- 2) A Federal, State or local court has made a finding of guilt against an individual or entity;
- 3) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
- 4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license. (Attach additional sheets if necessary).

No

21. Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state?

No

Supporting Documentation

Using the links and fields below, the following actions must be taken to complete the enrollment process. Refer to the Attachments link to determine the supplemental documents you must submit for your application. Read and Print for your files the Provider Agreement. Read, Print, Complete, Sign, Fax and Mail the Electronic Funds Transfer Form along with a copy of a voided check for verification purposes. Read, Print, Sign, Fax and Mail the Signature Form. If you need to submit supplemental documentation you may do so by fax and/or mail. All items faxed or mailed must be accompanied by the bar coded cover sheet.

Read: [Link to page listing required attachments.](#)

Read & Print: [Link to Provider Agreement](#)

Print, Sign & Submit: [Link to Signature Form.](#)

Print, Complete, Sign & Submit: [Link to EFT Form.](#)

Terms of Agreement

I, the above provider, confirm to the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to HPES and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency/HPES of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency/HPES for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

You will be submitting this enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature. However as explained above, you are also required to submit an original signature.

I accept I understand that my electronic signature is equivalent to written signature, however, written signature is also required.

Your Signature Ima Provider
(Entering your name in the box to the right will constitute your electronic signature.)
Title _
Agreement Date 07/09/2011

Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if either of the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again, and update all fields that are contingent upon these two fields.
 Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing.
 Please print a copy of this summary for your records.

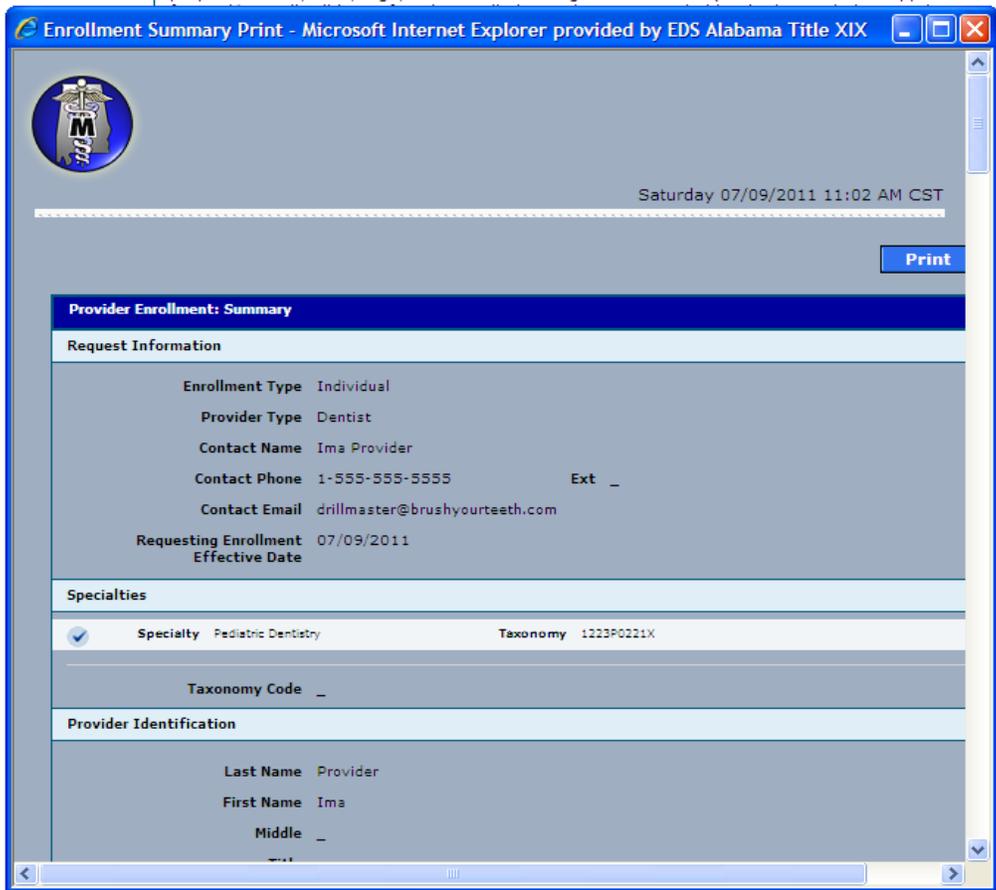
[Print Preview](#) [Confirm](#) [Finish Later](#) [Cancel](#)

6.11.1 Summary Page Fields and Actions

Field	Action
Print Preview	Select Print Preview to view the printed summary.
Confirm	Select the Confirm button to submit the application. The application sent for processing.
Finish Later	Select the Finish Later button to save the enrollment application and finish it at a later time.
Cancel	Select the Cancel Button to cancel the process and return to the Provider Enrollment page.

6.11.2 Print Preview

On the summary page the user can select Print Preview to view a printed summary of the information entered on the application. The user can print a copy of the summary page from the print preview page.



6.11.3 Print Preview Page Fields and Actions

Field	Action
Print	Select Print to print the summary pages.

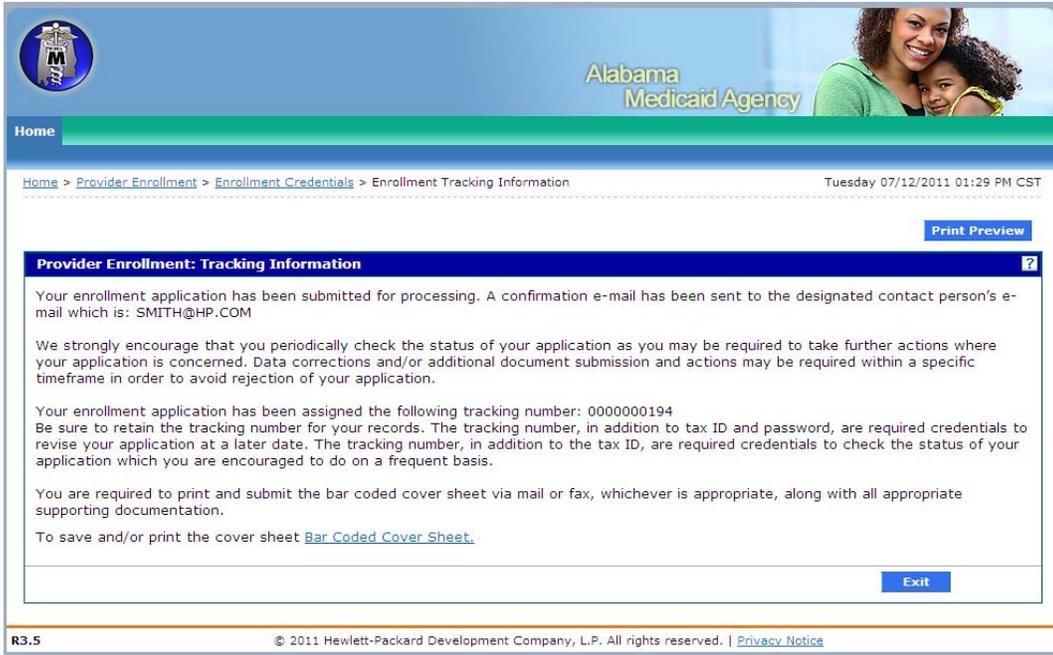
6.12 PROVIDER ENROLLMENT: TRACKING INFORMATION

The enrollment application is submitted for processing when the confirm button is selected.

A confirmation e-mail will be sent to the contact person entered on the application. Users are strongly encouraged to check the status of the application as additional documentation or data corrections may be necessary.

The application has been assigned a tracking number. The tracking number along with the tax id will be required to check the status of the application. The tracking number, tax id and password are required to make corrections identified by Provider Enrollment.

Select the Bar Coded Cover Sheet to print and/or save the cover sheet. Users are required to print and submit the bar coded cover sheet via mail and fax along with all appropriate documentation.



The screenshot shows the Alabama Medicaid Agency website interface. At the top left is the state seal of Alabama. To the right, the text "Alabama Medicaid Agency" is displayed next to a photograph of a woman and a child. Below the header is a navigation bar with "Home" highlighted. A breadcrumb trail reads: "Home > Provider Enrollment > Enrollment Credentials > Enrollment Tracking Information". The date and time "Tuesday 07/12/2011 01:29 PM CST" are shown in the top right. A "Print Preview" button is located in the upper right of the main content area. The main content area has a blue header "Provider Enrollment: Tracking Information" with a help icon. The text in the main area reads: "Your enrollment application has been submitted for processing. A confirmation e-mail has been sent to the designated contact person's e-mail which is: SMITH@HP.COM. We strongly encourage that you periodically check the status of your application as you may be required to take further actions where your application is concerned. Data corrections and/or additional document submission and actions may be required within a specific timeframe in order to avoid rejection of your application. Your enrollment application has been assigned the following tracking number: 000000194. Be sure to retain the tracking number for your records. The tracking number, in addition to tax ID and password, are required credentials to revise your application at a later date. The tracking number, in addition to the tax ID, are required credentials to check the status of your application which you are encouraged to do on a frequent basis. You are required to print and submit the bar coded cover sheet via mail or fax, whichever is appropriate, along with all appropriate supporting documentation. To save and/or print the cover sheet [Bar Coded Cover Sheet](#)." An "Exit" button is located at the bottom right of the main content area. The footer contains "R3.5" on the left and "© 2011 Hewlett-Packard Development Company, L.P. All rights reserved. | [Privacy Notice](#)" on the right.

Bar Coded Cover Sheet

Provider Enrollment: Cover Sheet



Date 7/12/2011
Tracking Number 0000000194

HPES Provider Enrollment P O Box 241685
Montgomery, AL 36124-1685

Cover sheet for the following provider for the following service location:

SALLY
12 SMITH RO
MONTGOMERY, AL 36211-1000

All documents you have printed/will print, which require an original signature, must be faxed and mailed to HPES via the fax number below and address above along with a copy of the bar coded cover sheet. All documents listed for your provider type which you viewed under the Required Attachments link on the Provider Agreement page, should be faxed along with a copy of this cover sheet. If you need to again review the list of Required Attachments you may do so via a link on the Provider Enrollment Page under Forms Library.

For further questions, please feel free to contact the HPES Provider Enrollment Staff at 1-888-223-3630 (in state) or (334) 215-0111 (out of state).

HPES Provider Enrollment Fax number is:

6.13 PROVIDER ENROLLMENT: ENROLLMENT CREDENTIALS PAGE

When the application is submitted the Enrollment Credentials Page will display. The tracking number assigned to the application will be displayed and users will be prompted to create a password. The tracking number and tax id submitted on the application will be required to check status of a submitted application. The tracking number, tax id and password will be required to resume the enrollment when the finish later function has been chosen.

If the user chooses to finish later, the enrollment application will be saved for 60 days. If the user does not resume completing the enrollment application within the specified number of days, the application will be purged and the user will need to start a new enrollment application.

6.13.1 Credentials Page Fields and Actions

Field	Action
Tax ID	Displays the tax ID entered on the application.
Password	Enter a password to submit application. NOTE: The password cannot be reset or retrieved by HP staff.
Confirm Password	Reenter the password to confirm the password and submit application.
Submit	Select the Submit button to submit your application.
Cancel	Select the Cancel button to cancel the process and return to the Provider Enrollment page.

6.14 PROVIDER ENROLLMENT: ENROLLMENT STATUS

6.14.1 Enrollment Status Page

The Provider Enrollment: Enrollment Status Page allows the user to enter an assigned tracking number and tax ID and click "Search" to check the current status of an application. For any further inquiries, please contact the HPES Provider Enrollment Staff at 1-888-223-3630 (in state) or (334) 215-0111 (out of state).

6.14.2 Provider Enrollment Status Fields and Actions

Field	Action
Tracking Number	Enter the tracking number assigned when the application was submitted.
Tax ID	Enter a tax id in order to resume an existing application.
Search	Select the Search button to start the search for the submitted application.
Cancel	Select the cancel button to cancel the process and return to the Provider Enrollment page.

6.15 PROVIDER ENROLLMENT: FINISH LATER

The Finish later function allows the user to save the information entered on an application and exit the application. If the user chooses to finish later, the enrollment application will be saved for 60 days. If the user does not resume completing the enrollment application within the specified number of days, the application will be purged and the user will need to start a new enrollment application.

When the finish later function is selected the Enrollment Credentials page is displayed.

Provider Enrollment: Credentials

Upon creating your password and clicking "Submit" your enrollment application will be submitted for processing, pending approval. Upon checking status, you may be able to revise your application.

The password, your tax ID and tracking number are required to revise your application. The password must be 8 to 20 characters, contain at least one capital letter and at least one numeric value. Once you create your password and click "Submit" the tracking number will be provided.

Please be aware that HPES' Provider Enrollment Department is not privy to and cannot provide to you nor reset the information you need to enter on this page in order to resume an existing application.

* Indicates a required field.

Tax ID 222222222

* Password

* Confirm Password

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6.15.1 Credentials Page Fields and Actions

Field	Action
Tax ID	Displays the tax id entered on the application.
Password	Enter a password to submit application. NOTE: The password cannot be reset or retrieved by HP staff.
Confirm Password	Reenter the password to confirm the password and submit application.
Submit	Select the Submit button to submit your application.
Cancel	Select the Cancel button to cancel the process and return to the Provider Enrollment page.

6.16 PROVIDER ENROLLMENT: RESUME ENROLLMENT

The Provider Enrollment: Resume Enrollment Page allows the user to enter an assigned Tracking Number, Tax ID and Password in order to resume an existing provider enrollment application. For further questions, please feel free to contact HPES' Provider Enrollment Department at 1-888-223-3630 (in state) or (334) 215-0111 (out of state). Please be aware that HPES' Provider Enrollment Department is not privy to and cannot provide nor reset the information needed to enter on this page in order to resume an existing application.

Alabama Medicaid Agency

Home

Home > Provider Enrollment > Resume Enrollment Monday 07/11/2011 07:50 AM CST

Provider Enrollment: Resume Enrollment ?

Enter your assigned Tracking Number, Tax ID and Password in order to resume an existing provider enrollment application. For further questions, please feel free to contact HPES' Provider Enrollment Department at 1-888-223-3630 (in state) or (334) 215-0111 (out of state).

Please be aware that HPES' Provider Enrollment Department is not privy to and cannot provide to you nor reset the information you need to enter on this page in order to resume an existing application.

* Indicates a required field.

*Tracking Number

*Tax ID

*Password

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6.16.1 Resume Page Fields and Actions

Field	Action
Tracking Number	Enter the tracking number that was assigned when the Finish later function was selected.
Tax ID	Enter a tax id that was submitted on the application.
Password	Enter the password that was created when the Finish Later function was selected. NOTE: The password cannot be reset or retrieved by HP staff.
Submit	Select the Submit button to resume an application.
Cancel	Select the Cancel button to cancel the process and return to the Provider Enrollment page.

6.17 HELP

Each page of the enrollment application has a help icon  located in the upper right hand corner of the page. Help text will display when the user clicks on the icon.

Provider Enrollment is available to answer questions concerning the provider enrollment process and Provider enrollment web portal.

NOTE

Passwords cannot be reset or retrieved by HPES staff.

Phone	Mail
1(334) 215-0111 1(888) 223-3630 Fax - TBD	HPES Provider Enrollment 301 Technacenter Drive Montgomery, Al 36117 or P.O. Box 241685 Montgomery, AL 31624