SOUTH CAROLINA
Healthy Connections
MEDICAID

Online Enrollment Application

Visual Guide

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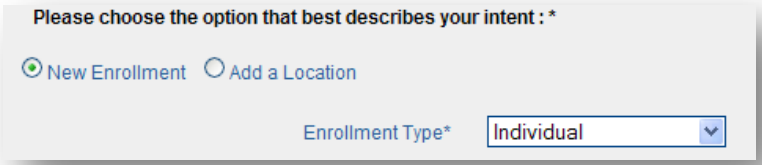
Quick Start Overview

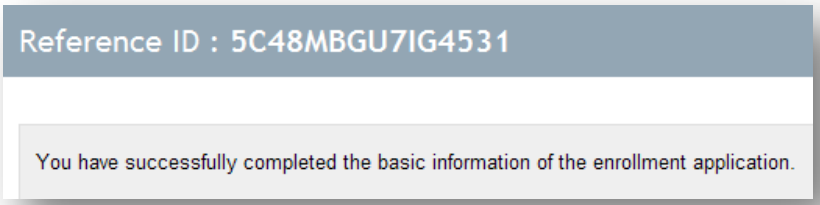
Follow these steps to enroll in South Carolina Medicaid via the online enrollment process.

1. Access the online enrollment application at provider.scdhhs.gov

2. Enter some preliminary basic information.

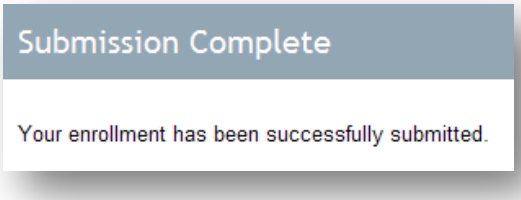


3. Obtain a Reference ID #.



4. Complete more information about your business.

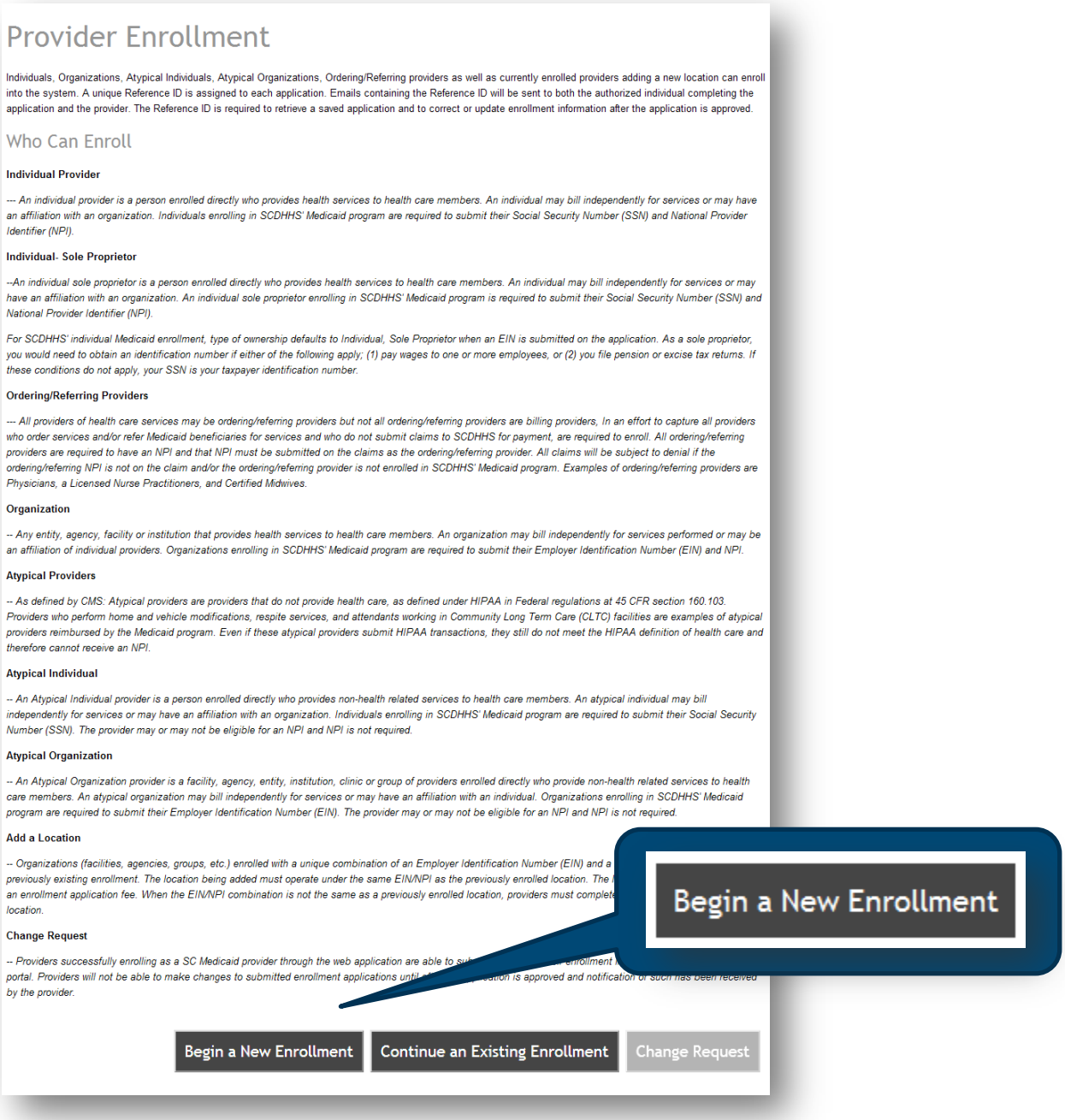
5. Review and submit your application.



Start an Application

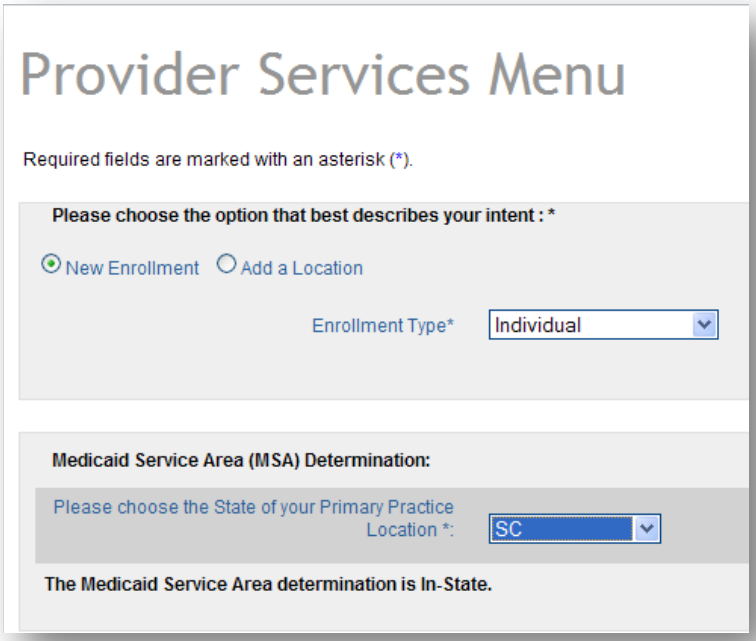
Go to provider.scdhhs.gov and select Online Enrollment Application.

Click *Begin a New Enrollment* to get started.



Choose Enrollment Type

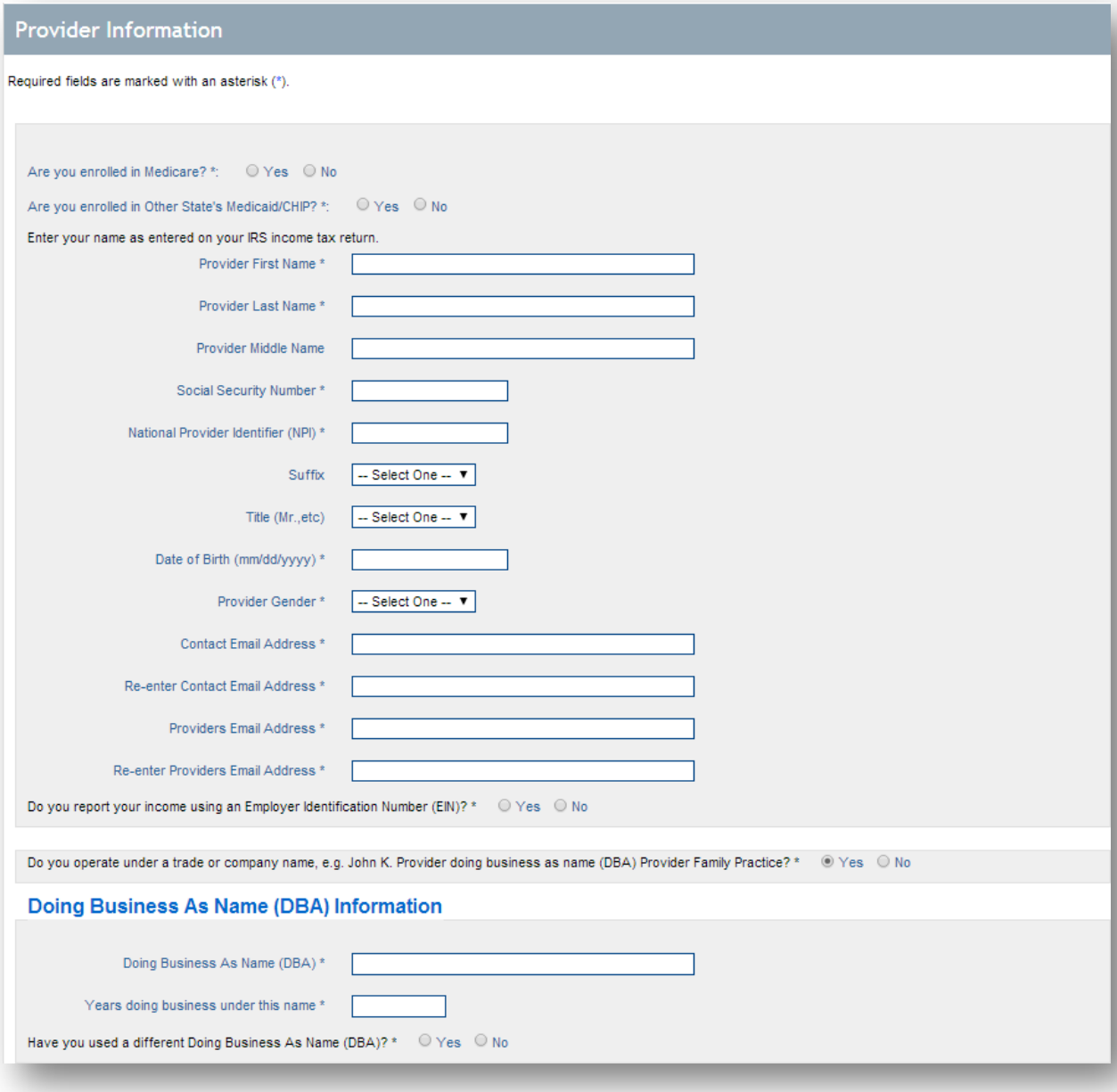
Choose *New Enrollment*.



Individual Information

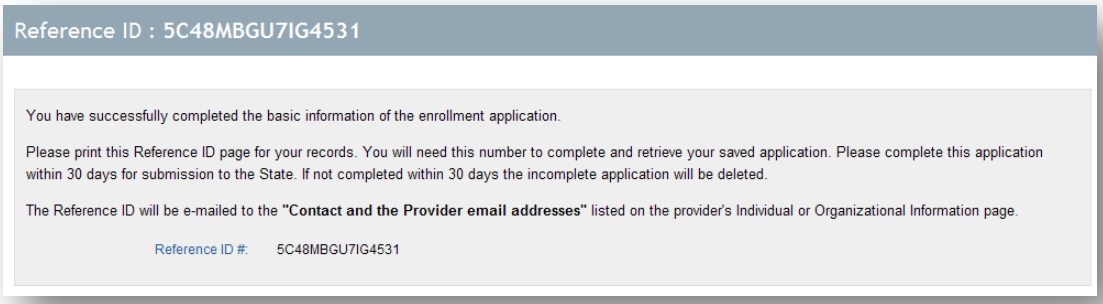
Select *Provider Information*.

Enter your Personal Information.



Reference ID

Receive a Reference ID, useful to retrieve your saved application for the next 30 days.



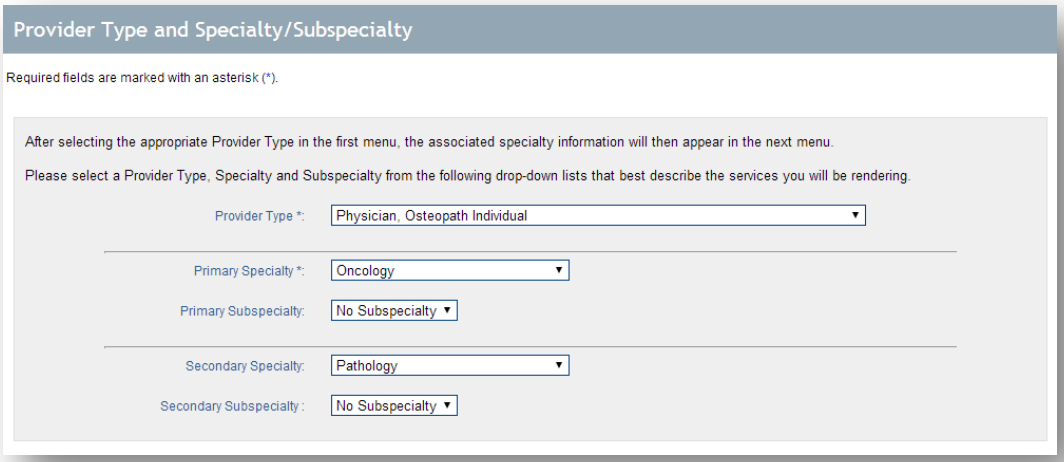
More information about your business

Complete each section of the application.

Provider Type & Specialty

Provider Type and Specialty/Sub Specialty

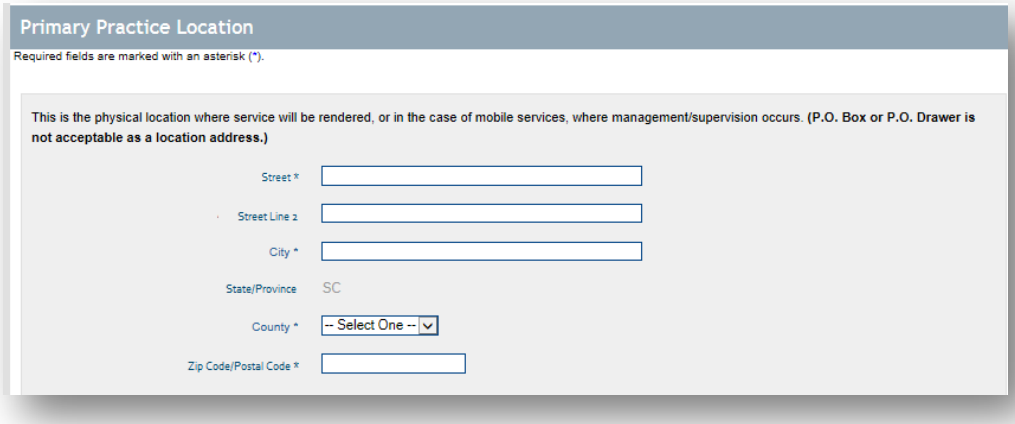
Select your provider type and specialty.



Location Information

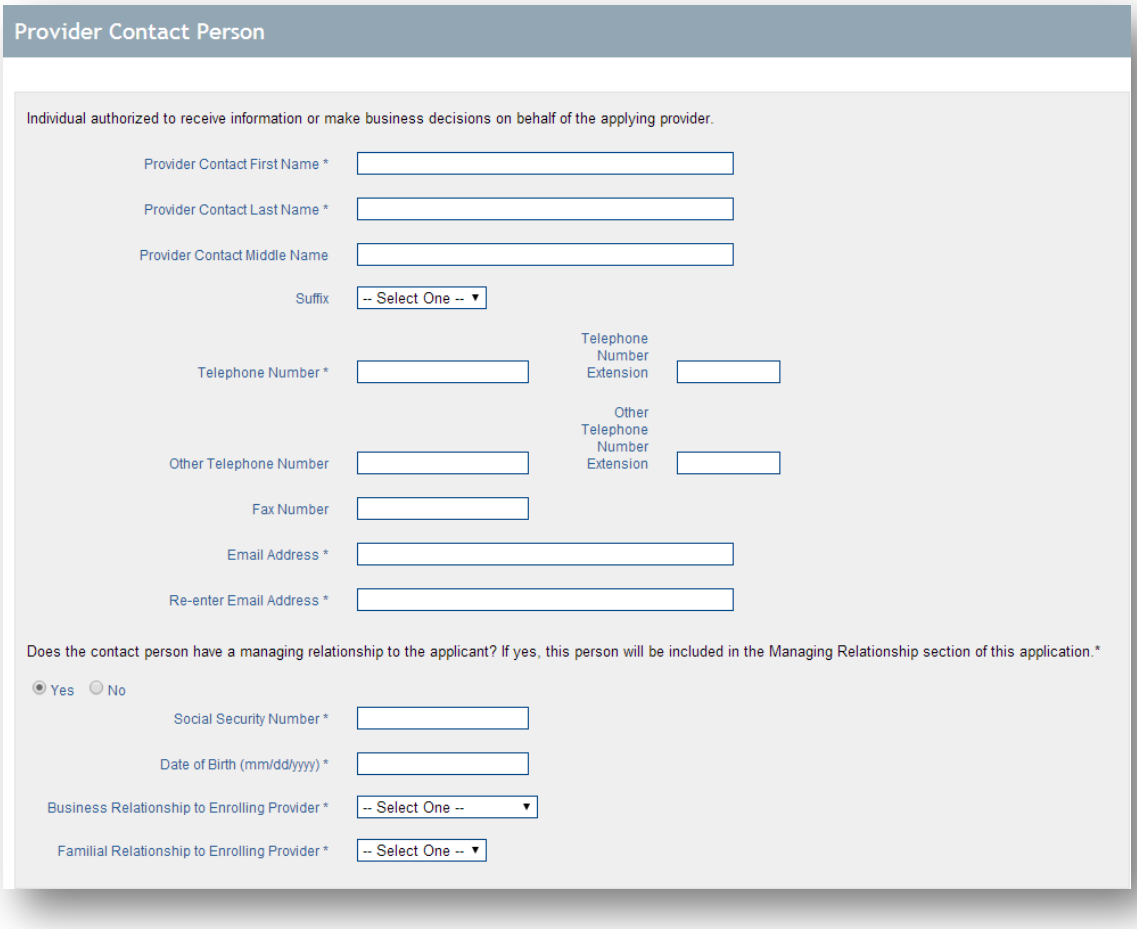
Primary Practice Location

Provide your primary practice location.



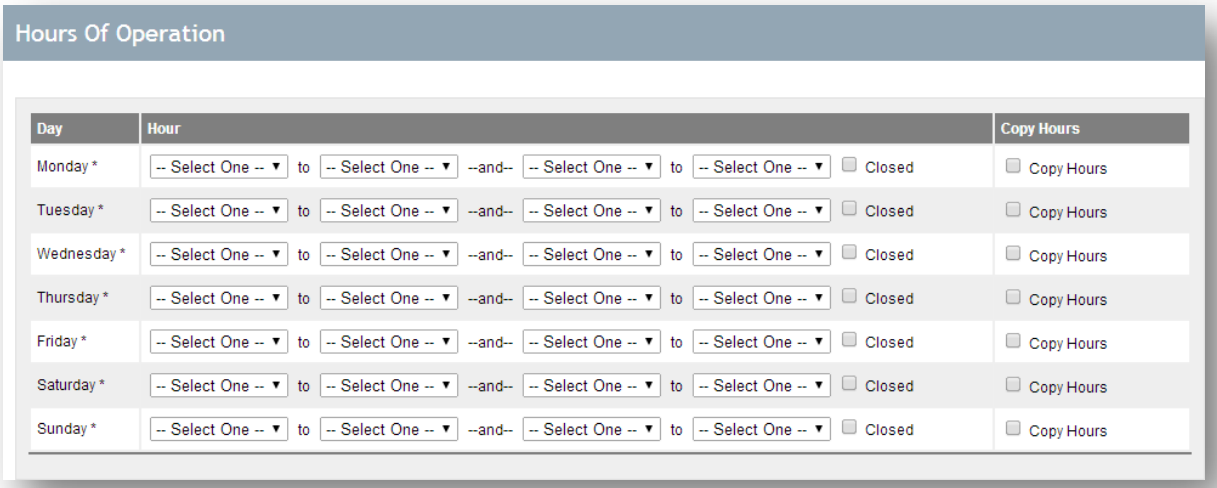
Contact Person

Provide a contact person.



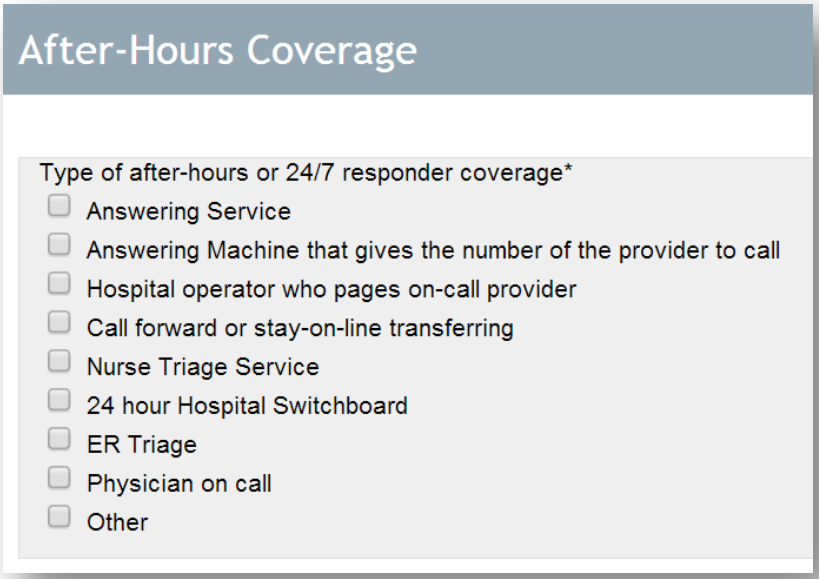
Hours of Operation

Enter your hours of operation.



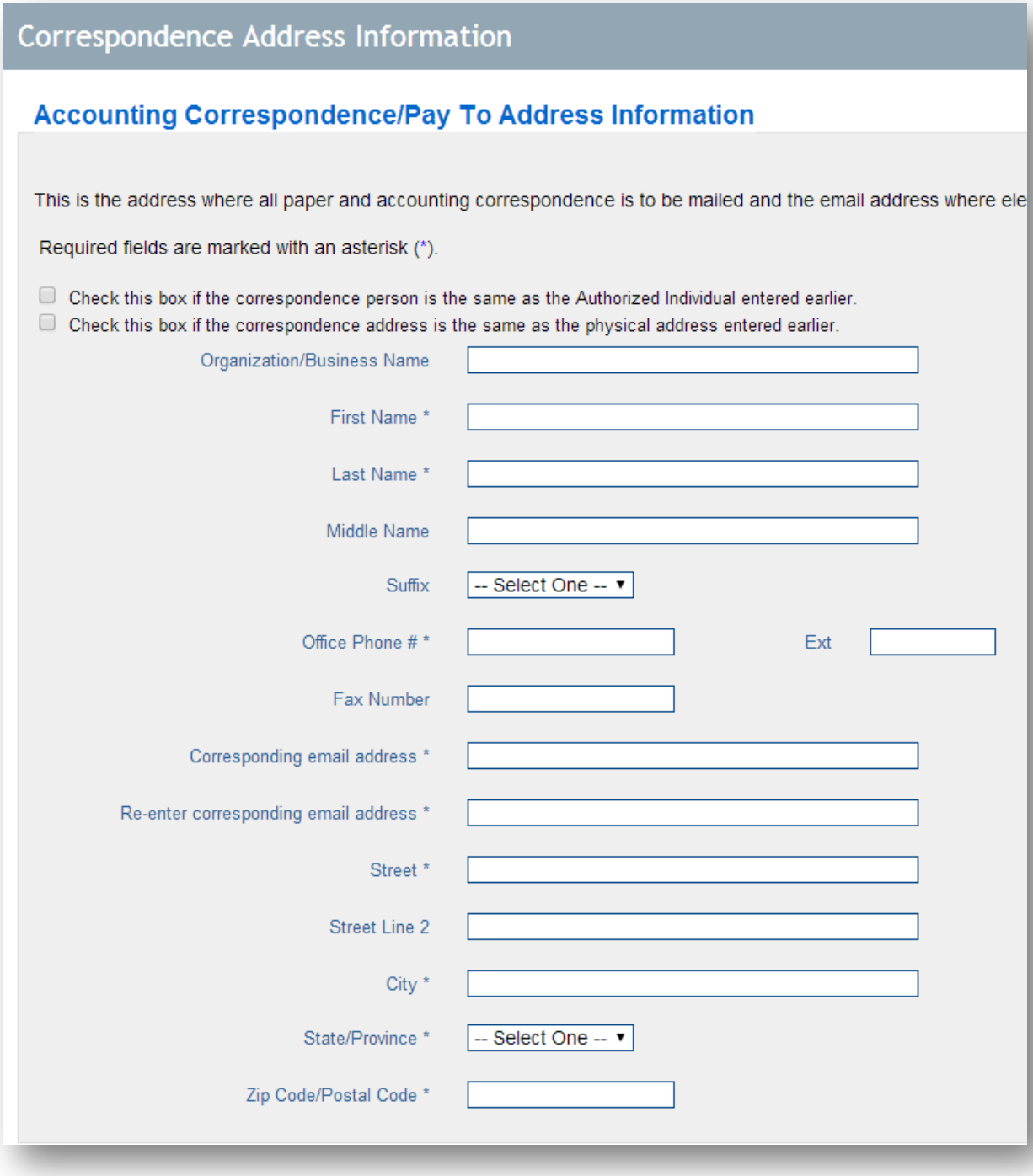
After-Hours Coverage

Enter your after-hours information.

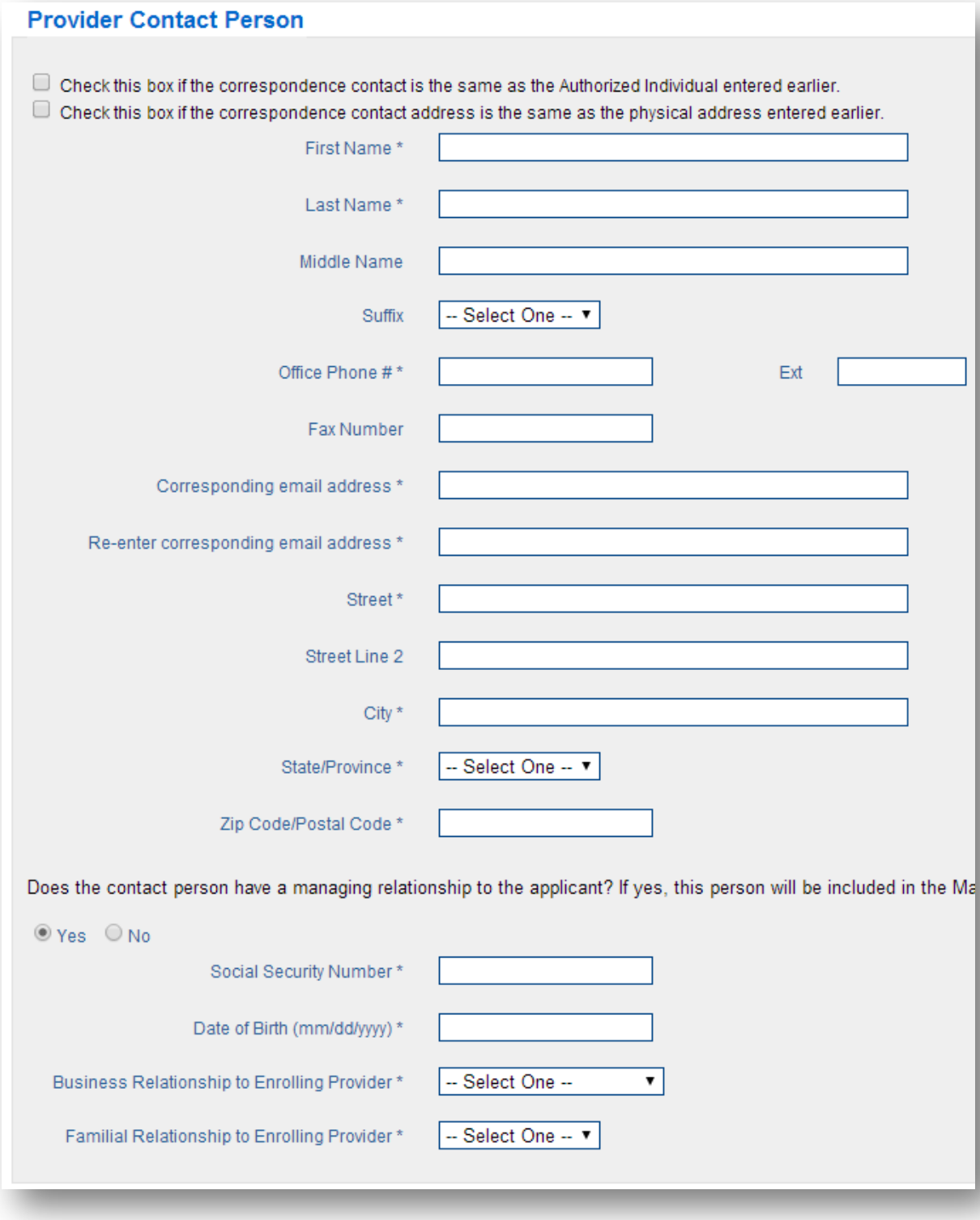


Correspondence Address Information

Enter your correspondence information.

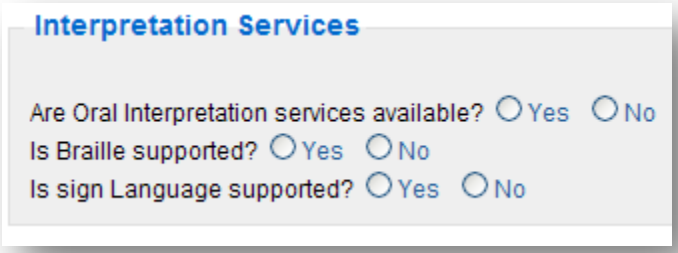


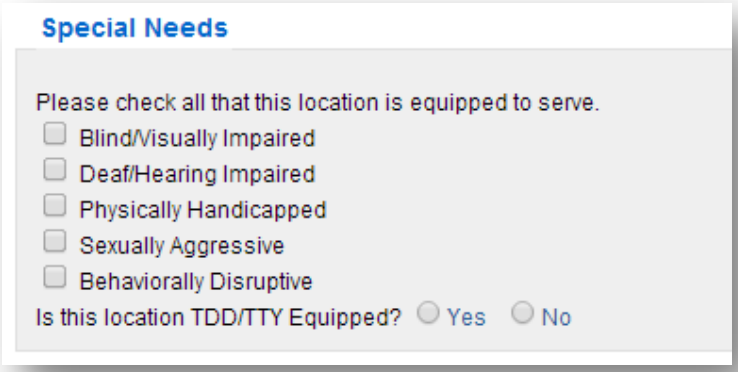
Enter your contact person.

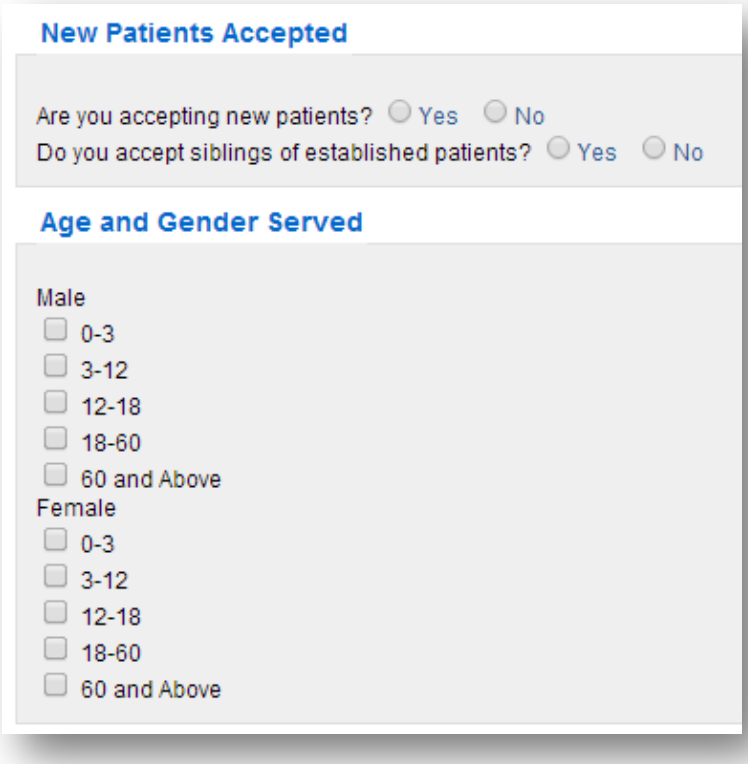


Services

Explain which services apply to you.



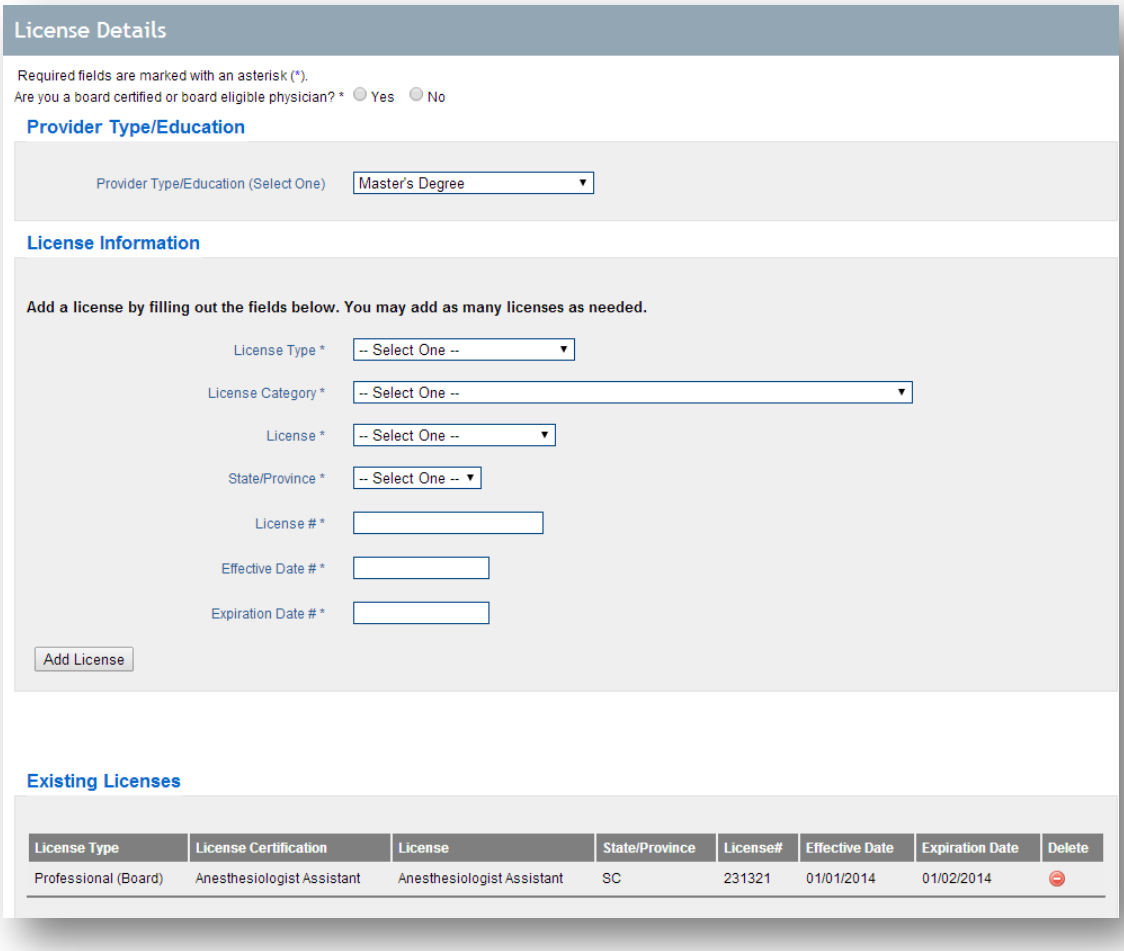




Licenses, Certifications & Accreditation

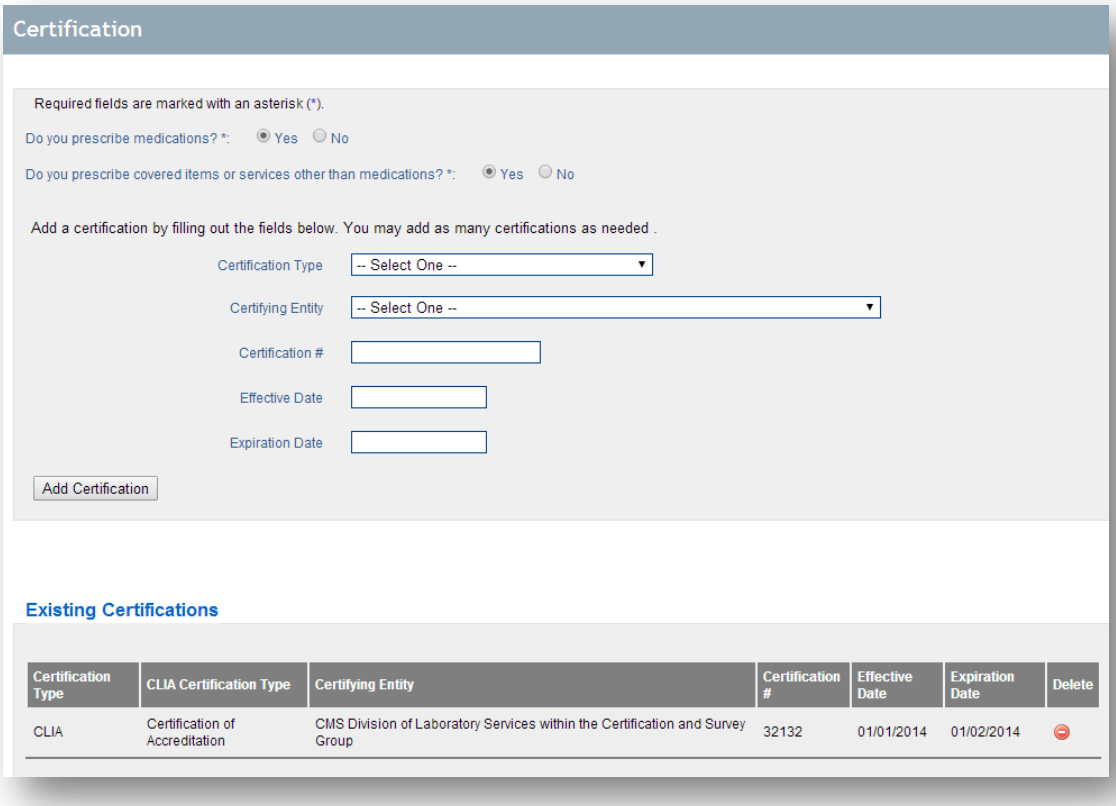
License Details

Add any licenses you have.



Certification

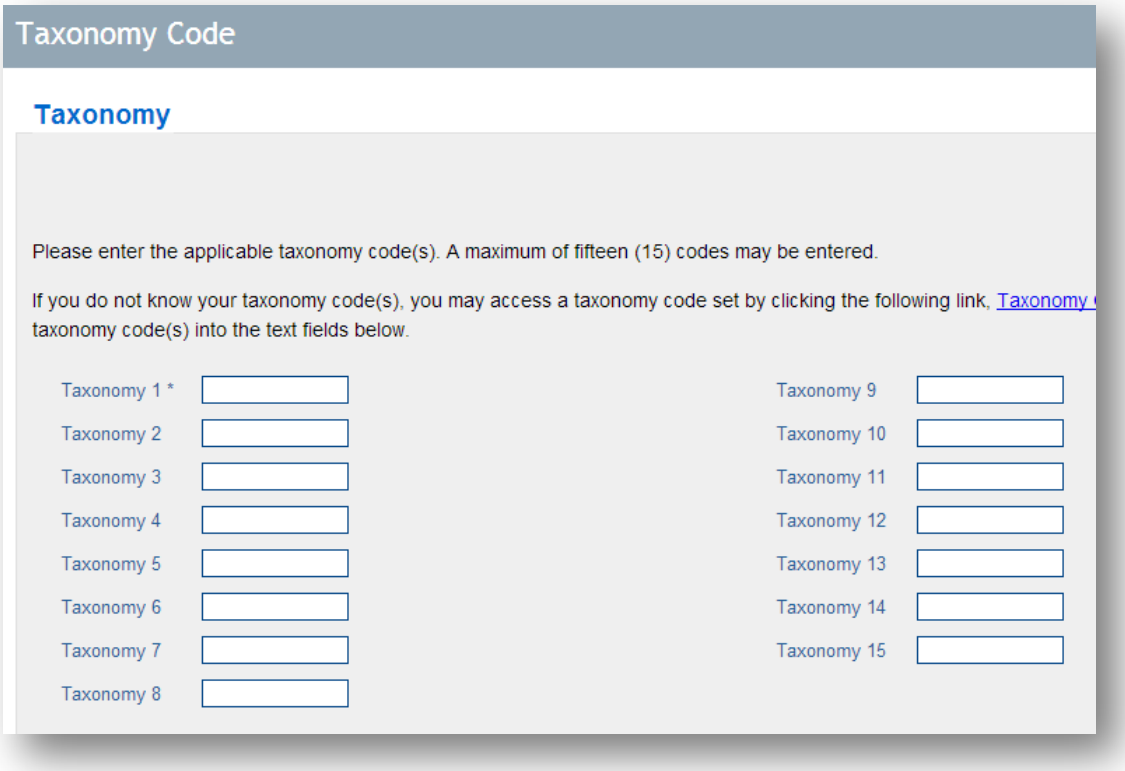
Add any certifications you have.



Taxonomy & Relationships

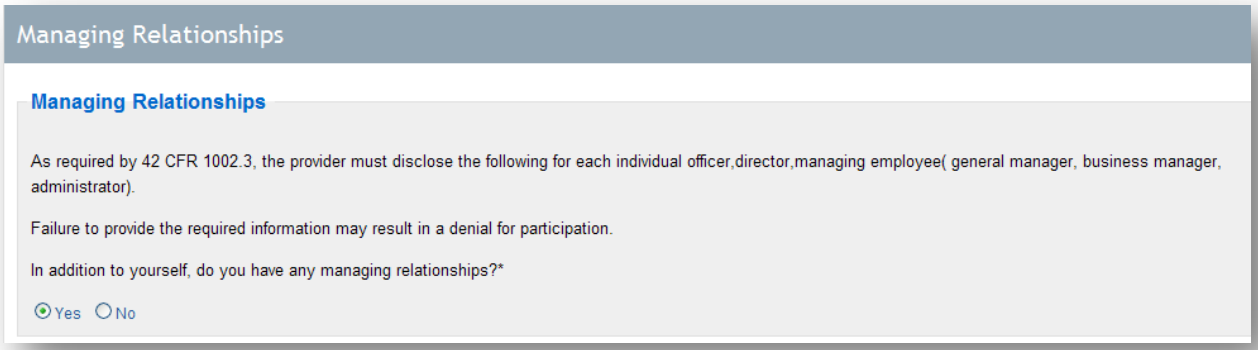
Taxonomy Code

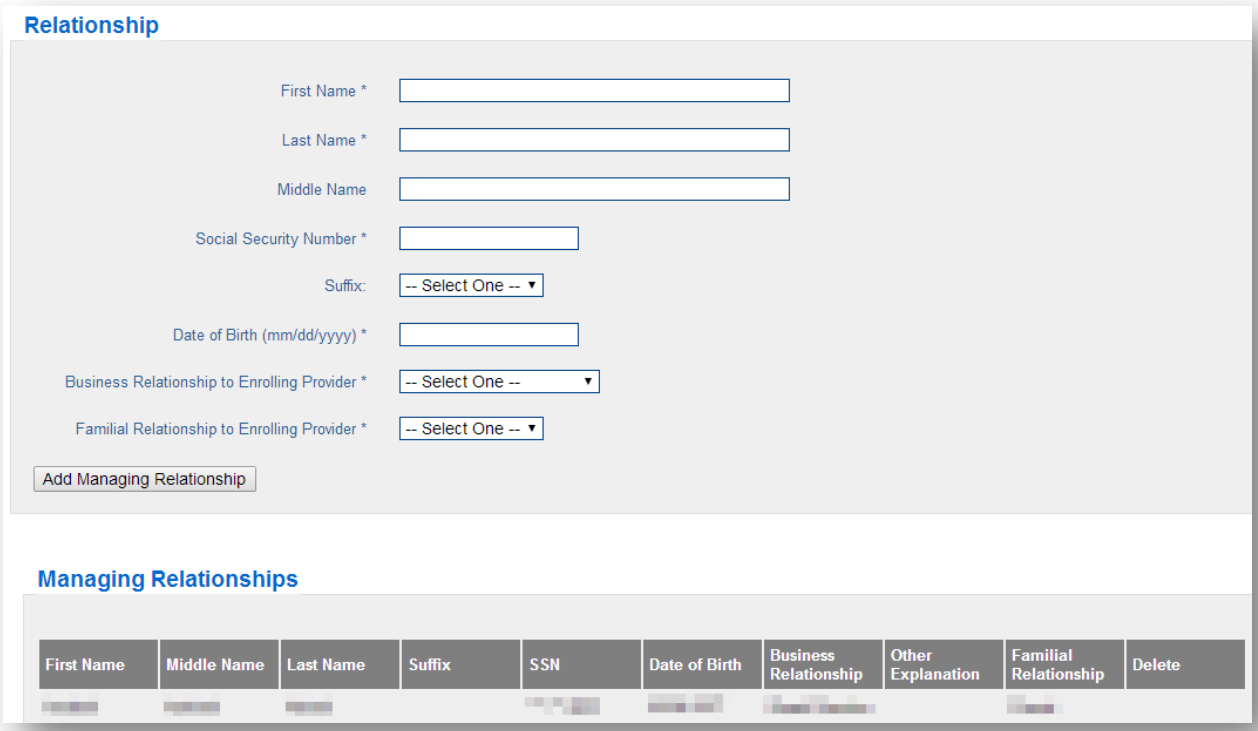
List any taxonomy codes that apply to you.



Managing Relationships

Disclose any managing relationships

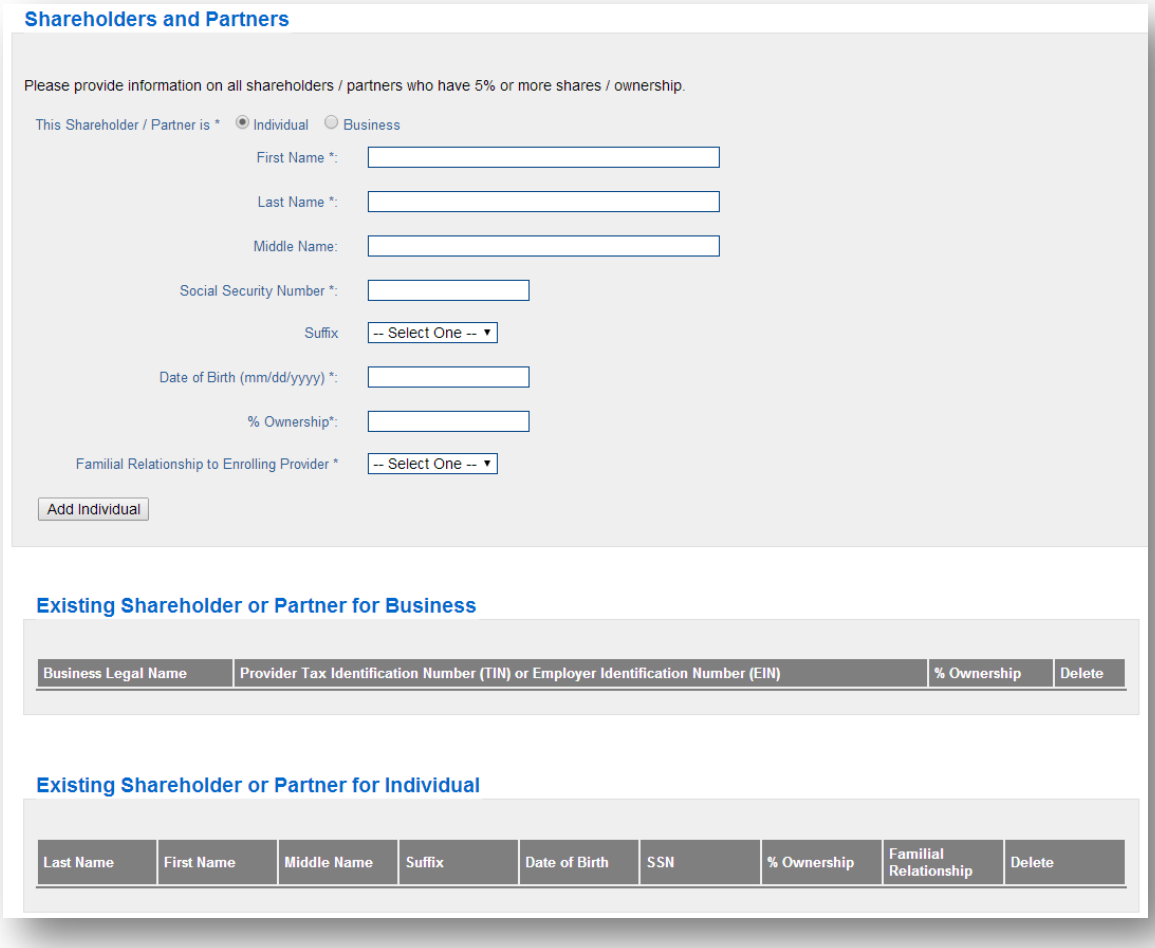




Ownership, Associations & Affiliations

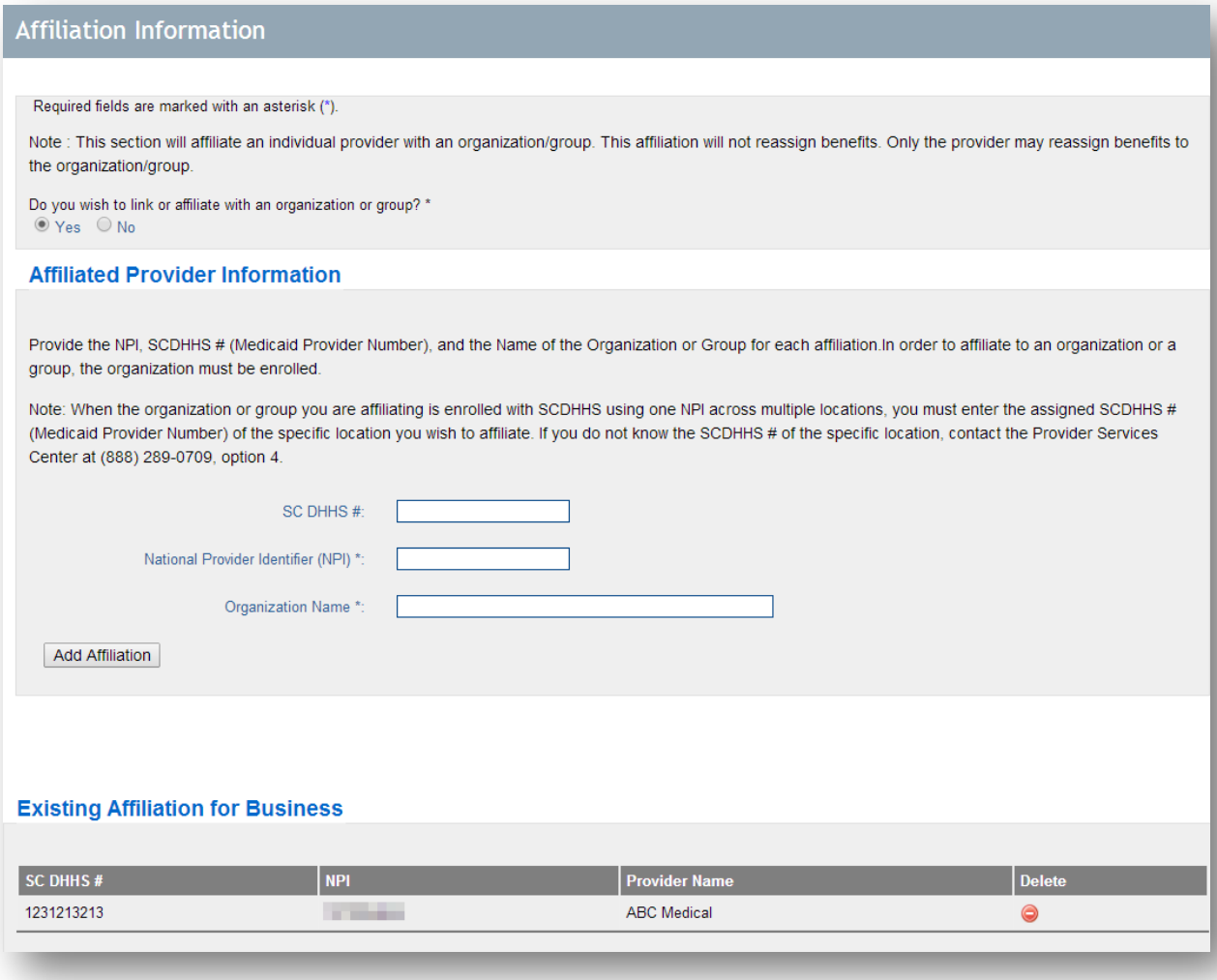
Ownership & Associations

Disclose any ownership and association information.



Affiliation Information

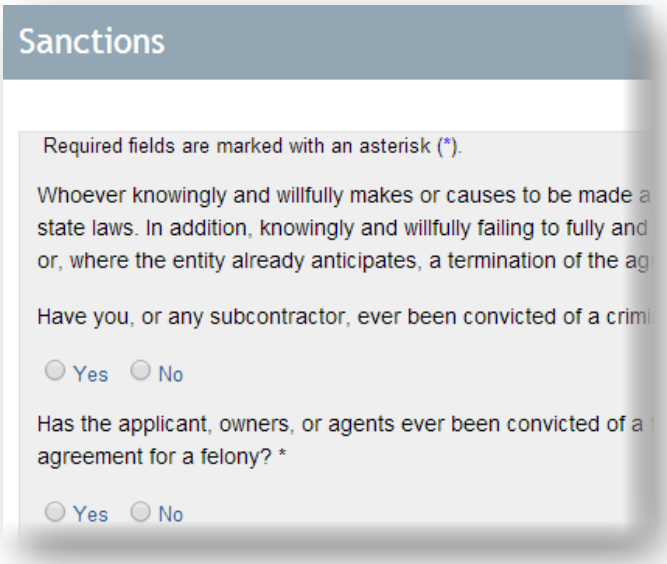
Disclose any affiliation information.



Sanctions, Trading Partners, W-9 & EFT

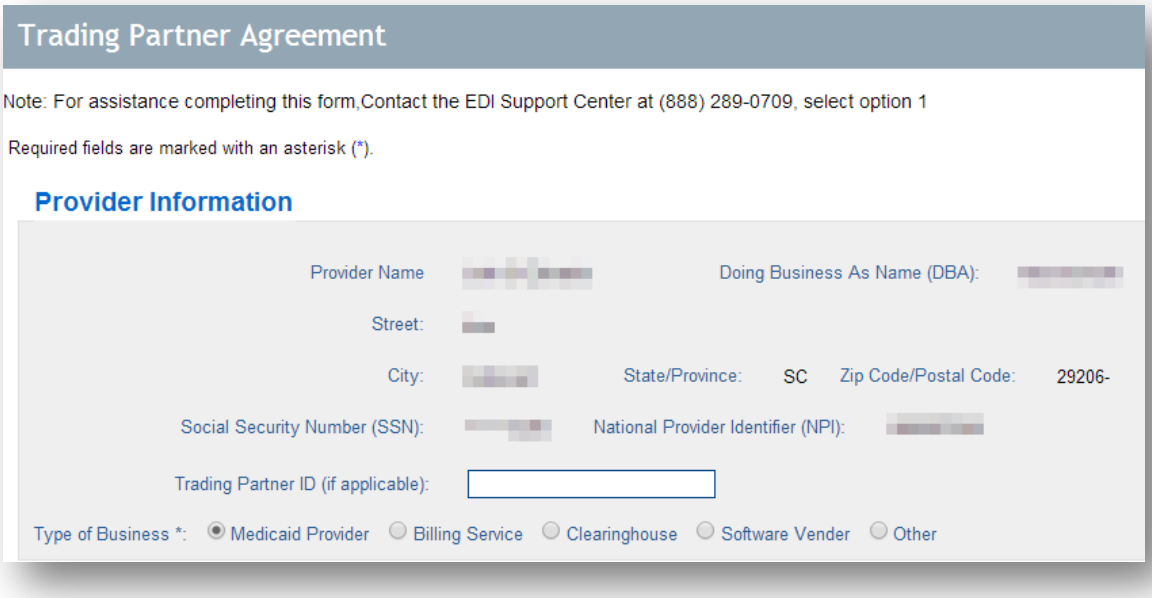
Sanctions

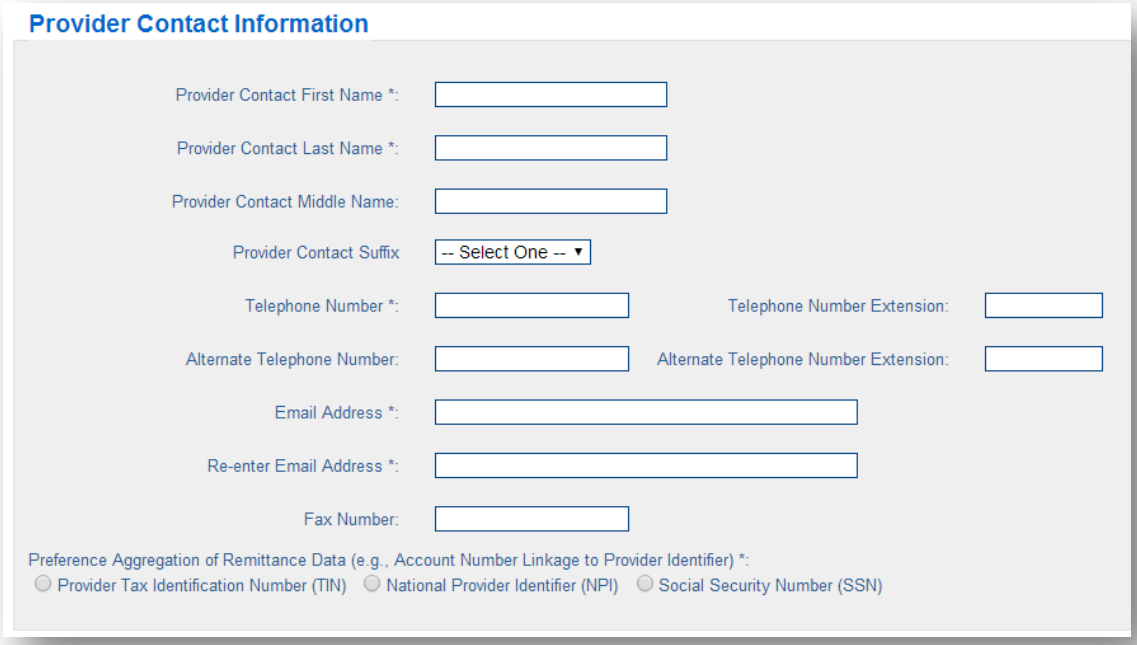
Disclose any exclusions or sanctions you may be subject to.

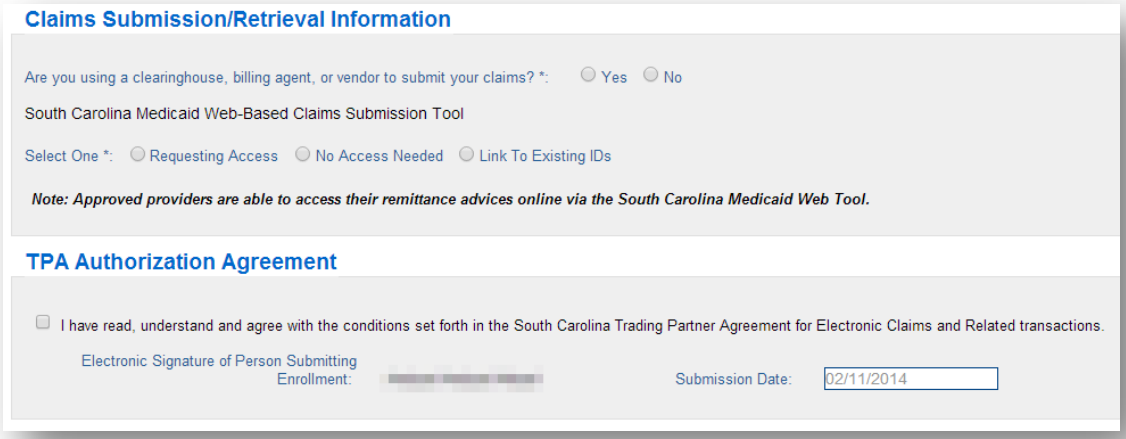


Trading Partner Agreement

Enter your trading partnership information.

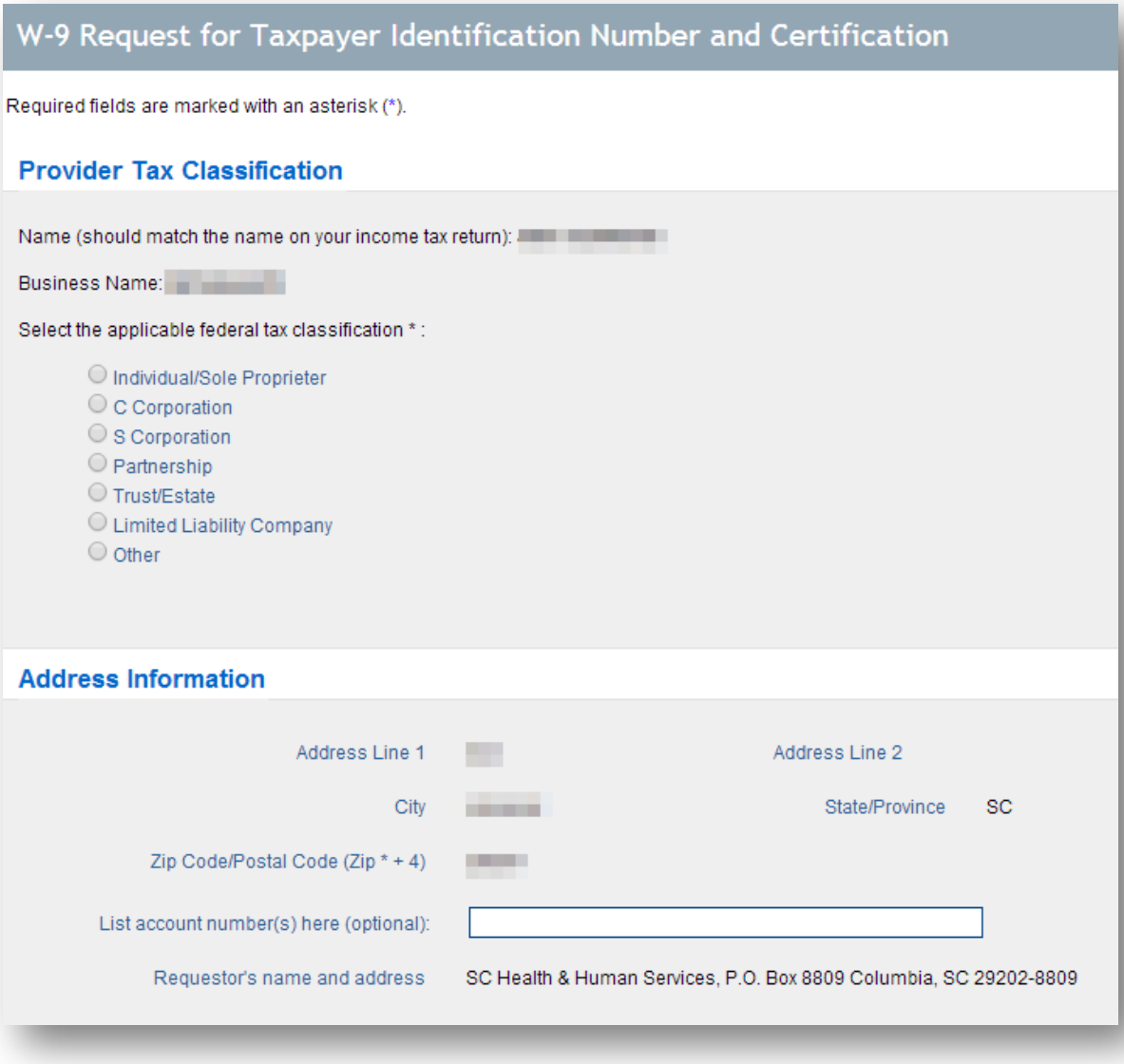


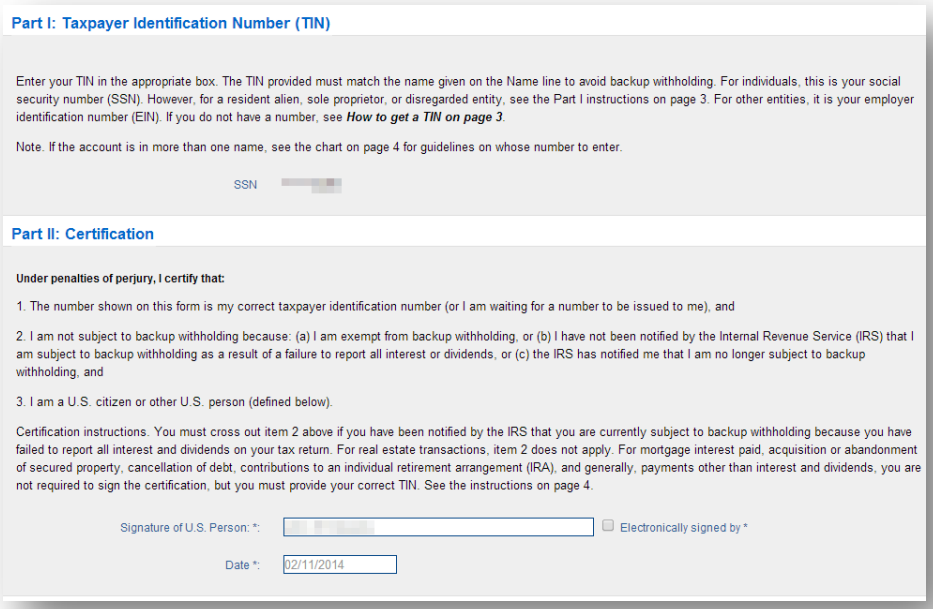

Provider Contact Information
Provider Contact First Name *:
Provider Contact Last Name *:
Provider Contact Middle Name:
Provider Contact Suffix
-- Select One --
Telephone Number *:
Telephone Number Extension:
Alternate Telephone Number:
Alternate Telephone Number Extension:
Email Address *:
Re-enter Email Address *:
Fax Number:
Preference Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) *:
Provider Tax Identification Number (TIN)
National Provider Identifier (NPI)
Social Security Number (SSN)


Claims Submission/Retrieval Information
Are you using a clearinghouse, billing agent, or vendor to submit your claims? *:
Yes
No
South Carolina Medicaid Web-Based Claims Submission Tool
Select One *:
Requesting Access
No Access Needed
Link To Existing IDs
Note: Approved providers are able to access their remittance advices online via the South Carolina Medicaid Web Tool.
TPA Authorization Agreement
I have read, understand and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.
Electronic Signature of Person Submitting Enrollment:
Submission Date:
02/11/2014

W-9 Information

Enter your W-9 information.





Part I: Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the Name line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see ***How to get a TIN on page 3***.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

SSN

Part II: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (defined below).

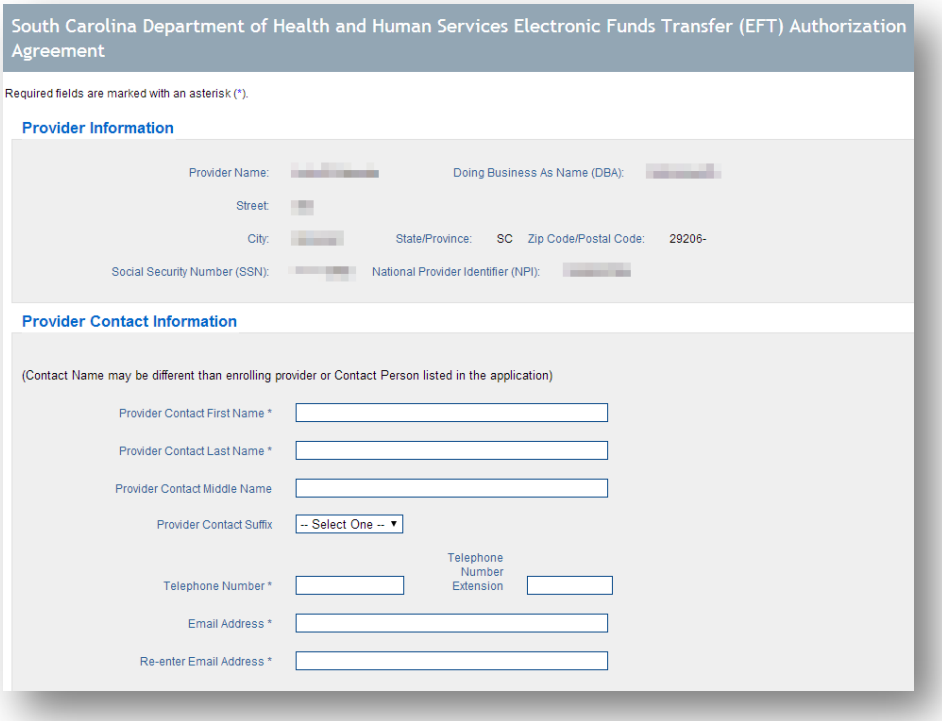
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Signature of U.S. Person: *: Electronically signed by *

Date *: 02/11/2014

Electronic Funds Transfer (EFT) Authorization Agreement

Enter your EFT information.



South Carolina Department of Health and Human Services Electronic Funds Transfer (EFT) Authorization Agreement

Required fields are marked with an asterisk (*).

Provider Information

Provider Name: Doing Business As Name (DBA):

Street:

City: State/Province: SC Zip Code/Postal Code: 29206-

Social Security Number (SSN): National Provider Identifier (NPI):

Provider Contact Information

(Contact Name may be different than enrolling provider or Contact Person listed in the application)

Provider Contact First Name *

Provider Contact Last Name *

Provider Contact Middle Name

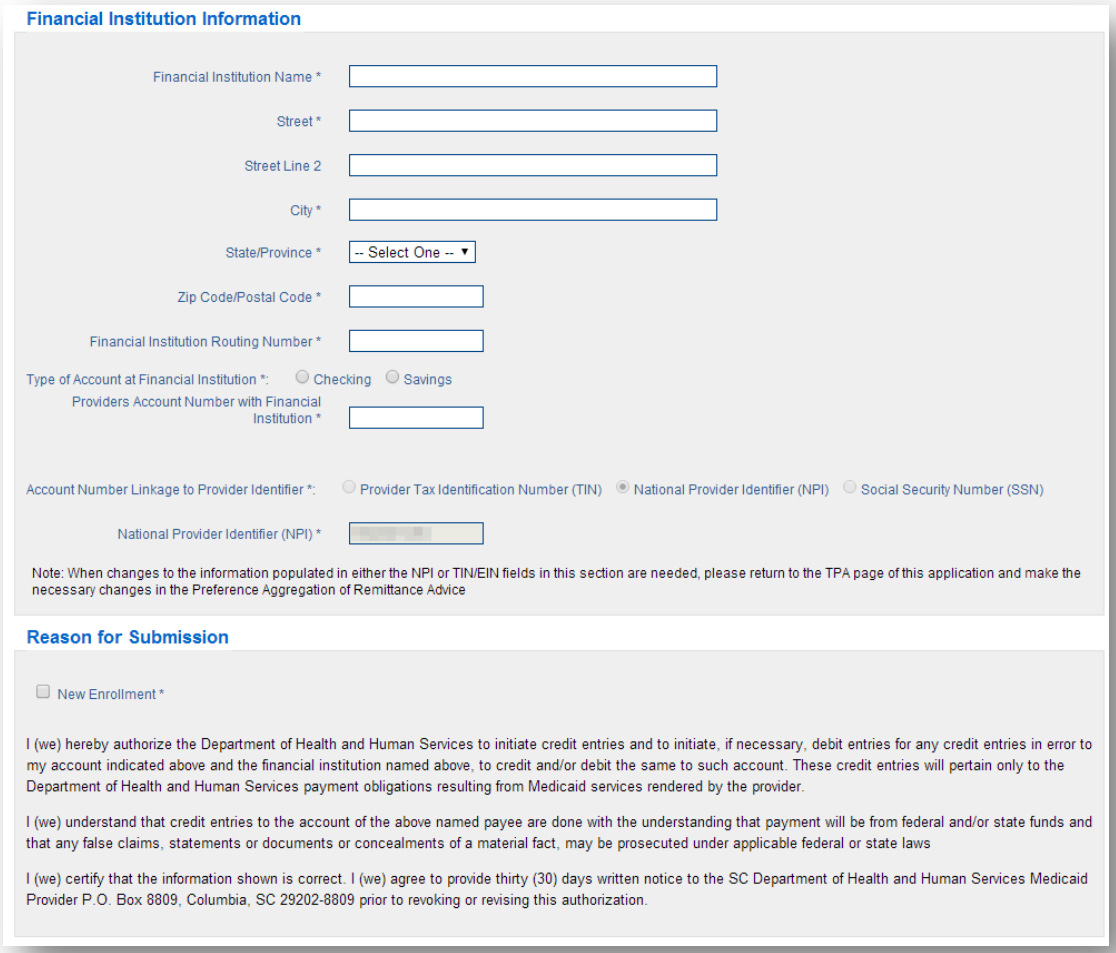
Provider Contact Suffix -- Select One --

Telephone Number *

Telephone Number Extension

Email Address *

Re-enter Email Address *



Financial Institution Information

Financial Institution Name *

Street *

Street Line 2

City *

State/Province * -- Select One --

Zip Code/Postal Code *

Financial Institution Routing Number *

Type of Account at Financial Institution *: Checking Savings

Providers Account Number with Financial Institution *

Account Number Linkage to Provider Identifier *: Provider Tax Identification Number (TIN) National Provider Identifier (NPI) Social Security Number (SSN)

National Provider Identifier (NPI) *

Note: When changes to the information populated in either the NPI or TIN/EIN fields in this section are needed, please return to the TPA page of this application and make the necessary changes in the Preference Aggregation of Remittance Advice

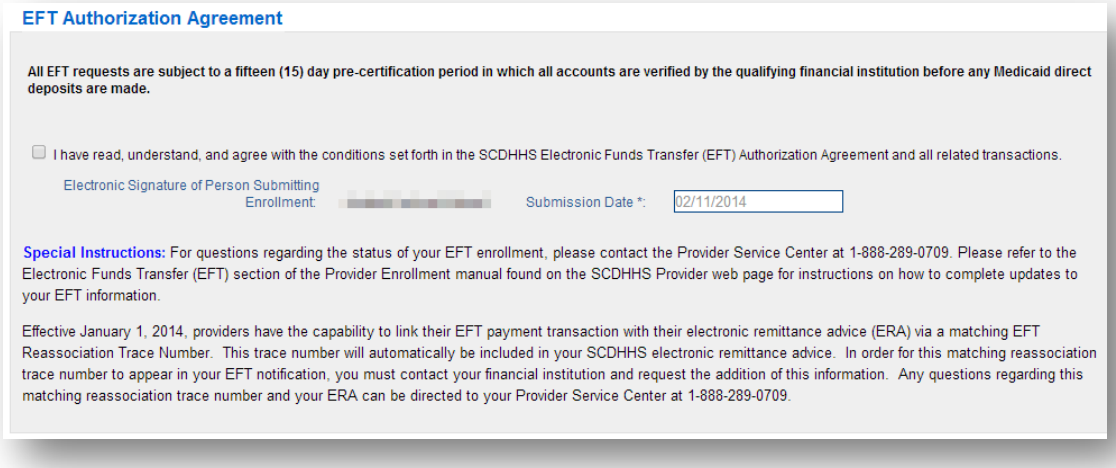
Reason for Submission

New Enrollment *

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated above and the financial institution named above, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the SC Department of Health and Human Services Medicaid Provider P.O. Box 8809, Columbia, SC 29202-8809 prior to revoking or revising this authorization.



EFT Authorization Agreement

All EFT requests are subject to a fifteen (15) day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

I have read, understand, and agree with the conditions set forth in the SCDHHS Electronic Funds Transfer (EFT) Authorization Agreement and all related transactions.

Electronic Signature of Person Submitting Enrollment: Submission Date *: 02/11/2014

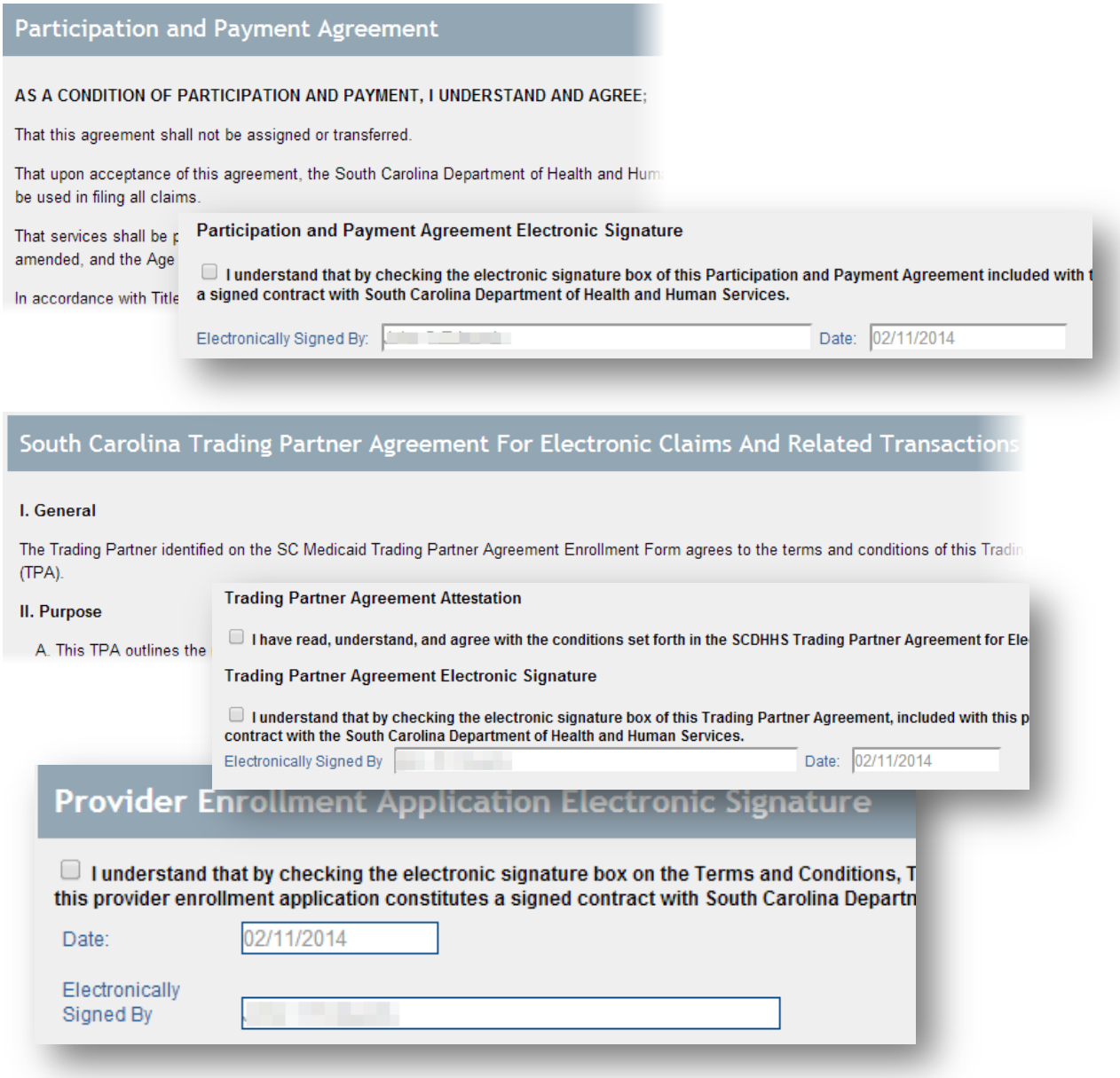
Special Instructions: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 1, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching reassociation trace number and your ERA can be directed to your Provider Service Center at 1-888-289-0709.

Terms & Conditions/Review & Submit

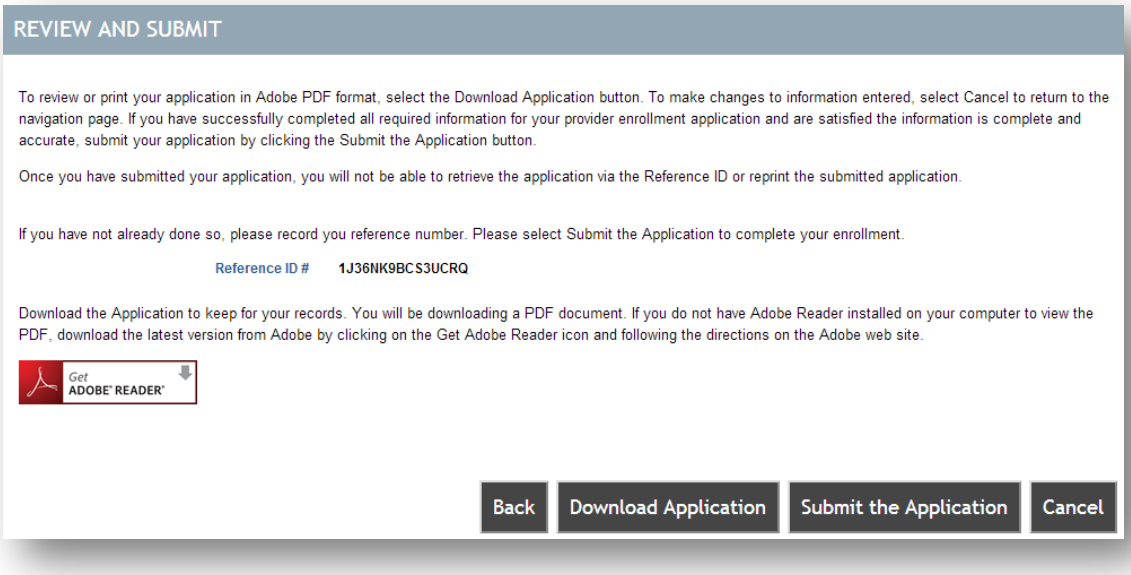
Terms and Conditions

Agree to the terms and conditions.



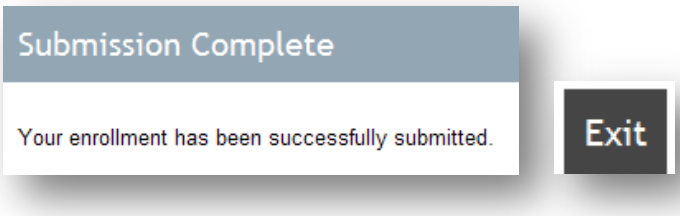
Review and Submit

Review your application, and then click *Submit the Application*.



Submission Complete

Click Exit once your enrollment has been successfully submitted.

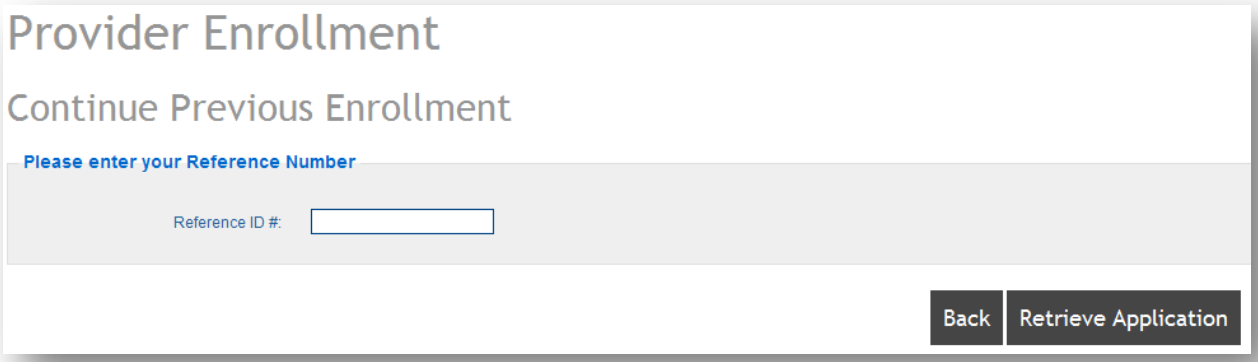


Other Enrollment Types

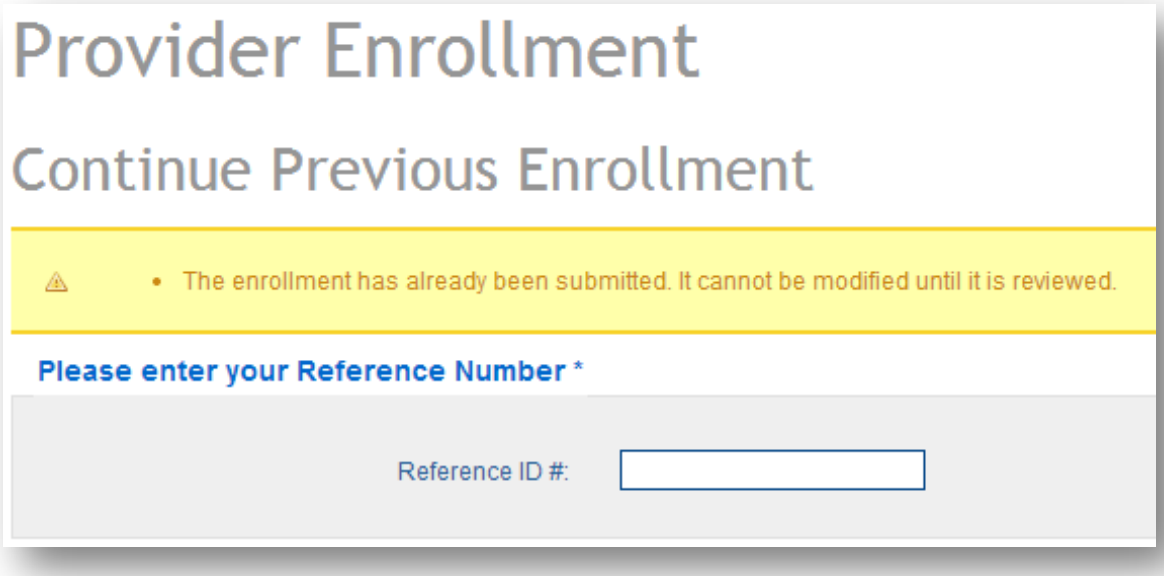
This addendum builds on the enrollment procedures shown above.

Continue a Previous Enrollment

Enter you Reference ID # and select *Retrieve Application*.

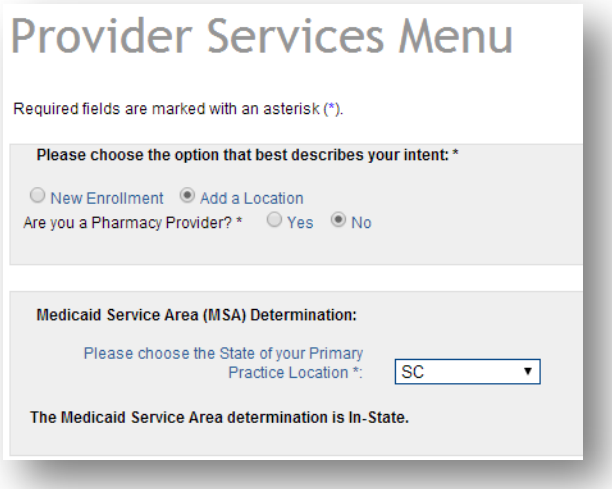


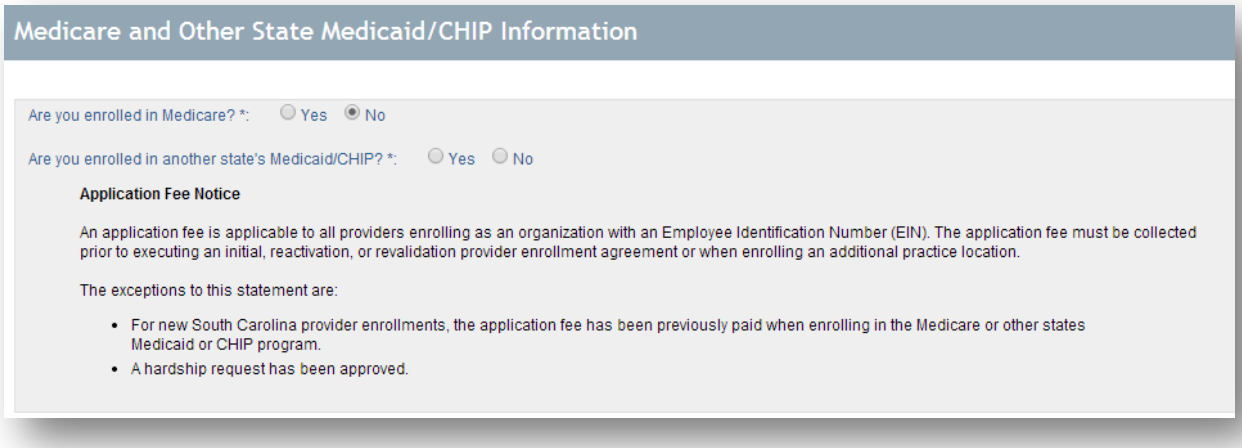
Note: You will not be able to retrieve an application that has already been submitted.

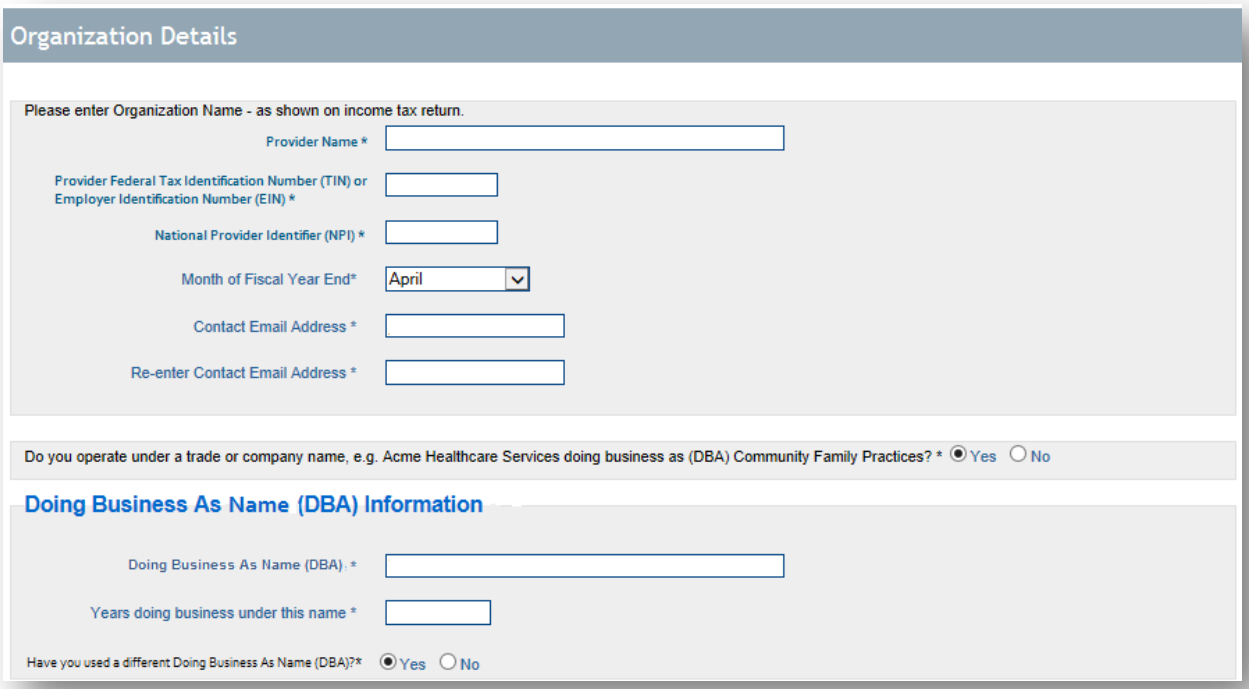


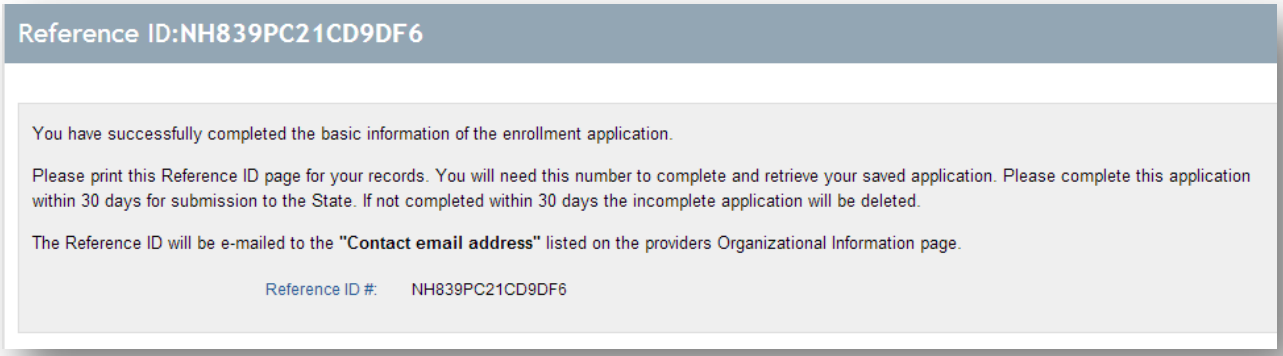
Add a Location

Select *Add a Location*, complete the required information, and receive your Reference ID #.






Organization Details
Please enter Organization Name - as shown on income tax return.
Provider Name *
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *
National Provider Identifier (NPI) *
Month of Fiscal Year End*
April
Contact Email Address *
Re-enter Contact Email Address *
Do you operate under a trade or company name, e.g. Acme Healthcare Services doing business as (DBA) Community Family Practices? * Yes No
Doing Business As Name (DBA) Information
Doing Business As Name (DBA) *
Years doing business under this name *
Have you used a different Doing Business As Name (DBA)?* Yes No


Reference ID:NH839PC21CD9DF6
You have successfully completed the basic information of the enrollment application.
Please print this Reference ID page for your records. You will need this number to complete and retrieve your saved application. Please complete this application within 30 days for submission to the State. If not completed within 30 days the incomplete application will be deleted.
The Reference ID will be e-mailed to the "Contact email address" listed on the providers Organizational Information page.
Reference ID #: NH839PC21CD9DF6