

Online Enrollment Application



Visual Guide

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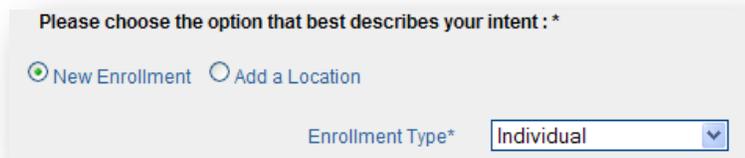
Quick Start Overview

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

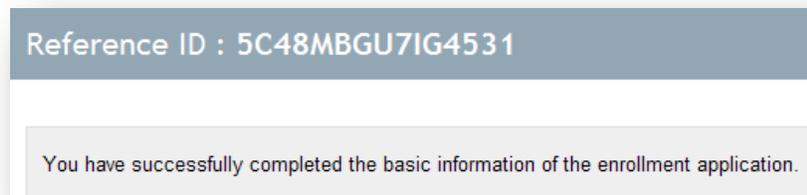
1. Access the online enrollment application at provider.scdhhs.gov



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.

South Carolina Health & Human Services

Provider Enrollment

Individuals, Organizations, Atypical Individuals, Atypical Organizations, Ordering/Referring providers as well as currently enrolled providers adding a new location can enroll into the system. A unique Reference ID is assigned to each application. Emails containing the Reference ID will be sent to both the authorized individual completing the application and the provider. The Reference ID is required to retrieve a saved application and to correct or update enrollment information after the application is approved.

Who Can Enroll

Individual Provider

-- An individual provider is a person enrolled directly who provides health services to health care members. An individual may bill independently for services or may have an affiliation with an organization. Individuals enrolling in SCDHHS' Medicaid program are required to submit their Social Security Number (SSN) and National Provider Identifier (NPI).

Individual- Sole Proprietor

-- An individual sole proprietor is a person enrolled directly who provides health services to health care members. An individual may bill independently for services or may have an affiliation with an organization. An individual sole proprietor enrolling in SCDHHS' Medicaid program is required to submit their Social Security Number (SSN) and National Provider Identifier (NPI).

For SCDHHS' individual Medicaid enrollment, type of ownership defaults to Individual, Sole Proprietor when an EIN is submitted on the application. As a sole proprietor, you would need to obtain an identification number if either of the following apply: (1) pay wages to one or more employees, or (2) you file pension or excise tax returns. If these conditions do not apply, your SSN is your taxpayer identification number.

Ordering/Referring Providers

-- All providers of health care services may be ordering/referring providers but not all ordering/referring providers are billing providers. In an effort to capture all providers who order services and/or refer Medicaid beneficiaries for services and who do not submit claims to SCDHHS for payment, are required to enroll. All ordering/referring providers are required to have an NPI and that NPI must be submitted on the claims as the ordering/referring provider. All claims will be subject to denial if the ordering/referring NPI is not on the claim and/or the ordering/referring provider is not enrolled in SCDHHS' Medicaid program. Examples of ordering/referring providers are Physicians, a Licensed Nurse Practitioners, and Certified Midwives.

Organization

-- Any entity, agency, facility or institution that provides health services to health care members. An organization may bill independently for services performed or may be an affiliation of individual providers. Organizations enrolling in SCDHHS' Medicaid program are required to submit their Employer Identification Number (EIN) and NPI.

Atypical Providers

-- As defined by CMS: Atypical providers are providers that do not provide health care, as defined under HIPAA in Federal regulations at 45 CFR section 160.103. Providers who perform home and vehicle modifications, respite services, and attendants working in Community Long Term Care (CLTC) facilities are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI.

Atypical Individual

-- An Atypical Individual provider is a person enrolled directly who provides non-health related services to health care members. An atypical individual may bill independently for services or may have an affiliation with an organization. Individuals enrolling in SCDHHS' Medicaid program are required to submit their Social Security Number (SSN). The provider may or may not be eligible for an NPI and NPI is not required.

Atypical Organization

-- An Atypical Organization provider is a facility, agency, entity, institution, clinic or group of providers enrolled directly who provide non-health related services to health care members. An atypical organization may bill independently for services or may have an affiliation with an individual. Organizations enrolling in SCDHHS' Medicaid program are required to submit their Employer Identification Number (EIN). The provider may or may not be eligible for an NPI and NPI is not required.

Add a Location

-- Organizations (facilities, agencies, groups, etc.) enrolled with a unique combination of an Employer Identification Number (EIN) and a National Provider Identifier (NPI) may add a new location to a previously existing enrollment. The location being added must operate under the same EIN/NPI as the previously enrolled location. The location must complete an enrollment application fee. When the EIN/NPI combination is not the same as a previously enrolled location, providers must complete an enrollment application fee.

Change Request

-- Providers successfully enrolling as a SC Medicaid provider through the web application are able to submit changes to their enrollment information through the provider portal. Providers will not be able to make changes to submitted enrollment applications until after the application is approved and notification of such has been received by the provider.

Continue a Previous Enrollment **Begin a New Enrollment**

Choose Enrollment Type

Choose *New Enrollment*.

Provider Services Menu

Required fields are marked with an asterisk (*).

Please choose the option that best describes your intent : *

New Enrollment Add a Location

Enrollment Type* Individual

Medicaid Service Area (MSA) Determination:

Please choose the State of your Primary Practice Location *:

SC

The Medicaid Service Area determination is In-State.

Individual Information

Select *Individual Information*.



Enter your Personal Information.

Individual Information

Required fields are indicated with an asterisk (*).

Enter your name as entered on your IRS income tax return.

First Name *

Last Name *

Middle Name

Suffix -- Select One --

Title (Mr.,etc) -- Select One --

Date of Birth (mm/dd/yyyy) *

Social Security Number *

Provider Gender * -- Select One --

NPI # *

Contact Email Address *

Re-enter Contact Email Address *

Providers Email Address *

Re-enter Providers Email Address *

Do you report your income using an Employer Identification Number (EIN)? *: Yes No

Do you operate under a trade or company name, e.g. John K. Provider doing business as (DBA) Provider Family Practice? *: Yes No

Reference ID

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

Reference ID : 5C48MBGU7IG4531

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 and the Provider email addresses" listed on the provider's Individual or Organizational Information page.

Reference ID #: 5C48MBGU7IG4531

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.

Provider Type and Specialty/Sub Specialty

Required fields are marked with an asterisk (*).

After selecting the appropriate Provider Type in the first menu, the associated specialty information will then appear in the next menu.

Please select a Provider Type, Specialty and Sub specialty from the following drop-down lists that best describe the services you will be rendering.

Provider Type *:	Physician, Osteopath Individual	
Primary Specialty *:	Oncology	Primary Subspecialty: No Subspecialty
Secondary Specialty:	Pathology	Secondary Subspecialty: No Subspecialty

Location Information

Primary Practice Location

Provide your primary practice location.

Primary Practice Location

Required fields are marked with an asterisk (*).

This is the physical location where service will be rendered, or in the case of mobile services, where service is provided. (This information is **not Acceptable**.)

Address Line 1 *

Address Line 2

City *

State SC

County * -- Select One --

ZIP Code (Zip * + 4)

Contact Person

Provide a contact person.

Contact Person (Authorized Individual)

Individual authorized to receive information or make business decisions on behalf of the applying provider.

First Name *

Last Name *

Middle Name

Suffix -- Select One --

Office Phone # * Ext

Other Phone # Ext

Fax #

Authorized Individual e-mail Address *

Re-enter Authorized Individual e-mail Address *

Does the contact person have a managing relationship to the applicant? If yes, this person must be identified as such.

Yes No

Hours of Operation

Enter your hours of operation.

Hours Of Operation							
Day	Hour					Copy Hours	
Monday	-- Select One --	to	-- Select One --	--and--	-- Select One --	to -- Select One -- <input type="checkbox"/> Closed	<input type="checkbox"/> Copy Hours
Tuesday	-- Select One --	to	-- Select One --	--and--	-- Select One --	to -- Select One -- <input type="checkbox"/> Closed	<input type="checkbox"/> Copy Hours
Wednesday	-- Select One --	to	-- Select One --	--and--	-- Select One --	to -- Select One -- <input type="checkbox"/> Closed	<input type="checkbox"/> Copy Hours
Thursday	-- Select One --	to	-- Select One --	--and--	-- Select One --	to -- Select One -- <input type="checkbox"/> Closed	<input type="checkbox"/> Copy Hours
Friday	-- Select One --	to	-- Select One --	--and--	-- Select One --	to -- Select One -- <input type="checkbox"/> Closed	<input type="checkbox"/> Copy Hours
Saturday	-- Select One --	to	-- Select One --	--and--	-- Select One --	to -- Select One -- <input type="checkbox"/> Closed	<input type="checkbox"/> Copy Hours
Sunday	-- Select One --	to	-- Select One --	--and--	-- Select One --	to -- Select One -- <input type="checkbox"/> Closed	<input type="checkbox"/> Copy Hours

After-Hours Coverage

Enter your after-hours information.

After-Hours Coverage

Type of after-hours or 24/7 responder coverage*

- Answering Service
- Answering Machine that gives the number of the provider to call
- Hospital operator who pages on-call provider
- Call forward or stay-on-line transferring
- Nurse Triage Service
- 24 hour Hospital Switchboard
- ER Triage
- Physician on call
- Other

Correspondence Address Information

Enter your correspondence information.

Send correspondence to

This is the address where all paper and accounting correspondence is to be mailed and the email address.

Required fields are marked with *.

Check this box if the correspondence person is the same as the Authorized Individual entered earlier.

Check this box if the correspondence address is the same as the physical address entered earlier.

First Name *

Last Name *

Middle Name

Suffix

Office Phone # * Ext

Fax #

Corresponding email address *

Re-enter corresponding email address *

Address Line 1 *

Address Line 2

City *

State *

County *

ZIP Code (Zip * + 4)

Enter your contact person.

Contact Person

Check this box if the correspondence contact is the same as the Authorized Individual entered earlier.

Check this box if the correspondence contact address is the same as the physical address entered earlier.

First Name *

Last Name *

Middle Name

Suffix

Office Phone # * Ext

Fax #

Corresponding email address *

Re-enter corresponding email address *

Address Line 1 *

Address Line 2

City *

State *

County *

ZIP Code (Zip * + 4)

Does the contact person have a managing relationship to the applicant? If yes, this person must be identified

Yes No

Services

Explain which services apply to you.

Interpretation Services

Are Oral Interpretation services available? Yes No

Is Braille supported? Yes No

Is sign Language supported? Yes No

Languages Supported

Languages Supported

English

Spanish

French

German

Italian

Chinese

Tagalong

New Patients Accepted

Are you accepting new patients? Yes No

Do you accept siblings of established patients? Yes No

Age and Gender Served

Male

0-3

3-12

12-18

18-60

60 and Above

Female

0-3

3-12

12-18

18-60

60 and Above

Licenses, Certifications & Accreditation

License Details

Add any licenses you have.

License Details

Required fields are marked with an asterisk (*).

Add a license by filling out the fields below. You may add as many licenses as needed.

License Type * :

State * :

DHEC License Type * :

License #* :

Effective Date * :

Expiration Date * :

Existing Licenses

License Type	State	DHEC	License#	Effective	Expiration	
Optometry	SC	Hospitals	1231231231	02/02/2008	02/02/2012	-

Certification

Add any certifications you have.

Certification

Required fields are marked with an asterisk (*).

Please select Certificate Type.

Certification Type * :

Certifying Entity * :

State * :

Certification #* :

Effective Date * :

Expiration Date * :

Existing Certificates

Certification Type	Entity	State	Certificate#	Effective	Expiration	
Marriage and Family Therapy Licensure Board	Board of Optometry	SC	1234564445	02/02/2006	02/02/2010	-

Accreditation Details

Add any accreditations you have.

Accreditation Details

Required fields are marked with an asterisk (*).

Please select an Accreditation type.

Accreditation Type *

Accreditation Number *

Effective Date *

Expiration Date *

Existing Accreditations

Accreditation Type	Number	Effective	Expiration	
Board of Optometry	1234567887	02/02/2006	02/02/2011	<input type="button" value="-"/>

Taxonomy & Relationships

Taxonomy Code

List any taxonomy codes that apply to you.

Taxonomy Code

Taxonomy

[Taxonomy Codes](#). Clicking on the link will display a new page for the Taxonomy Codes set. User may copy and past the appropriate Taxonomy classification into fields as appropriate

Please enter all Taxonomy Codes. (You may enter upto 15 codes).

Taxonomy 1*	<input type="text"/>	Taxonomy 9	<input type="text"/>
Taxonomy 2	<input type="text"/>	Taxonomy 10	<input type="text"/>
Taxonomy 3	<input type="text"/>	Taxonomy 11	<input type="text"/>
Taxonomy 4	<input type="text"/>	Taxonomy 12	<input type="text"/>
Taxonomy 5	<input type="text"/>	Taxonomy 13	<input type="text"/>
Taxonomy 6	<input type="text"/>	Taxonomy 14	<input type="text"/>
Taxonomy 7	<input type="text"/>	Taxonomy 15	<input type="text"/>
Taxonomy 8	<input type="text"/>		

Managing Relationships

Disclose any managing relationships

Managing Relationships

Managing Relationships

As required by 42 CFR 1002.3, the provider must disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator).

Failure to provide the required information may result in a denial for participation.

In addition to yourself, do you have any managing relationships?*

Yes No

Relationship

First Name *

Last Name *

Middle Name

Suffix:

Social Security Number *

Date of Birth (mm/dd/yyyy) *

Business Relationship to Enrolling Provider *

Familial Relationship to Enrolling Provider *

(A managing relationships list will appear tabulated below as they are added) .

Relationships

First Name	Last Name	Middle Name	Suffix	ssn(4 digits)	Dob	Relationship	Familial relationship	
John	Doe	Randolph		100-00-0000	02/02/1970	Officer	Spouse	

Ownership, Associations & Affiliations

Ownership & Associations

Disclose any ownership and association information.

Ownership & Associations

Required fields are marked with an asterisk (*).

the appropriate Business Type Individual

Do you have one or more Shareholders/Partners with 5% or more ownership?

Yes No

Shareholders and Partners

Please provide information on all shareholders / partners who have 5% or more shares / ownership.

This Shareholder / Partner is Individual Business

Business Legal Name*:

Employer Identification Number (EIN)*:

% Ownership*:

Existing Shareholder or Partner for Business

Business Legal Name*	Employer Identification Number	% Ownership	
ABC Medical	12-4545665	25.	-

Existing Shareholder or Partner for Individual

Last Name	First Name	Middle Name	Suffix	Data of Birth	SSN	% Ownership	
John	Doe	Randolph		02/02/1970	123-45-6789	50.	-

Affiliation Information

Disclose any affiliation information.

Affiliation Information

Required fields are marked with an asterisk (*).

Note : This section will affiliate an individual provider with an organization/group. This affiliation will not reassign benefits. Only the provider may reassign benefits to the organization/group.

Do you wish to link or affiliate with an organization or group?

Yes No

Affiliated Provider Information

Provide the NPI, SCDHHS # (Medicaid Provider Number), and the Name of the Organization or Group for each affiliation. In order to affiliate to an organization or a group, the organization must be enrolled.

Note: When the organization or group you are affiliating is enrolled with SCDHHS using one NPI across multiple locations, you must enter the assigned SCDHHS # (Medicaid Provider Number) of the specific location you wish to affiliate. If you do not know the SCDHHS # of the specific location, contact the Provider Services Center at (888) 289-0709, option 4.

SC DHHS # *:

NPI #:

Organization Name:

Existing Affiliation for Business

DHHS number	NPI Number	Organization Name	
123214455566664	1072254455	ABC Medical	<input type="button" value="−"/>

Sanctions, Trading Partners, W-9 & EFT

Sanctions

Disclose any exclusions or sanctions you may be subject to.

Sanctions

Required fields are marked with an asterisk (*).

A. Have you ever been convicted of a criminal offense in re

Yes No

B. Has the applicant, owners, or agents ever been convict agreement for a felony? *

Yes No

C. Has the applicant, owners, or agents ever had disciplin license to practice ever been restricted, reduced, or revoke

Trading Partner Agreement

Enter your trading partnership information.

Trading Partner Agreement

Note: For assistance completing this form, Contact the EDI Support Center at (888) 289-0709, select option 1

Required fields are marked with *

Acceptance Date	08/23/2012				
First Name	John	Middle Name	Smith	Last Name	Doe
Trading Partner ID (if applicable):	<input type="text"/>				
NPI #	1078954512				

Type of Business *: Medicaid Provider Billing Service Clearinghouse Software Vender Other

South Carolina Medicaid Web-Based Claims Submission Tool

Select One *: Requesting Access No Access Needed Link To Existing IDs

Only use this section when you are filing X12 claims directly to SC Medicaid. DO NOT USE if you submit X12 claims through a vendor or clearinghouse.

Protocol * (Multiple Selections allowed): Secure FTP WS_FTP Pro CD Diskette

Technical Contact Information

First Name *:

Middle Name:

Last Name *:

Suffix:

Email *:

Verify Email *:

Business Phone #: Business Phone Ext.:

Alternate Contact Phone #: Alternate Contact Ext.:

Fax #:

For Software Vendors or Billing Agents (please complete)

Is the SC Web Tool Used to Submit Claims? *: Yes No

Only use this section when you are filing X12 claims directly to SC Medicaid. DO NOT USE if you submit X12 claims through a vendor or clearinghouse.

Transaction Requested *

270 - Eligibility IN:	<input type="radio"/> Yes <input type="radio"/> No	835 - Electronic Remittance Advice:	<input type="radio"/> Yes <input type="radio"/> No	820 - Premium Payments:	<input type="radio"/> Yes <input type="radio"/> No
271 - Eligibility OUT:	<input type="radio"/> Yes <input type="radio"/> No	837 - Institutional Claims:	<input type="radio"/> Yes <input type="radio"/> No	278 - Authorization:	<input type="radio"/> Yes <input type="radio"/> No
276 - Claims Status IN:	<input type="radio"/> Yes <input type="radio"/> No	837P - Professional Claims:	<input type="radio"/> Yes <input type="radio"/> No	834 - Benefit Enrollment:	<input type="radio"/> Yes <input type="radio"/> No
277 - Claims Status OUT:	<input type="radio"/> Yes <input type="radio"/> No	837D - Dental Claims:	<input type="radio"/> Yes <input type="radio"/> No		

Providers

If you submit X12 claim files directly to SC Medicaid, please complete this section to indicate providers to link to your Submitter ID. DO NOT USE this page if you are submitting claims through a vendor or clearinghouse.

Important: All individual providers who submit X12 claim files directly to SC Medicaid must have a separate Trading Partner Agreement.

Provider Last Name:

Provider First Name:

Provider Middle Name:

Medicaid ID *:

NPI *:

State *:

W-9 Information

Enter your W-9 information.

W-9 Information

Required fields are marked with an asterisk (*).

Provider Tax Classification

Provider Name: **John Smith Doe**

Select the appropriate box for federal tax classification * :

Individual/Sole Proprietor
 C Corporation
 S Corporation
 Partnership
 Trust/Estate
 Limited Liability Company
 Other

Address Information

Address Line 1	101 Main St.	Address Line 2	
City	Columbia	State	SC
		ZIP Code (Zip + 4)	29203
Requestor's name and address	SC Health & Human Services, P.O. Box 8206, Columbia, SC 29202-8206		

Part1: 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	101-22-2222
EIN	

Part2: Certification

Under penalties of perjury, I certify that:

- 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
- 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
- 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.

I accept the terms of this agreement *

Full Legal Name *

Acceptance Date *

Terms & Conditions/Review & Submit

Terms and Conditions

Agree to the terms and conditions.

Terms And Conditions

Required fields are marked with an asterisk (*).

PARTICIPATION AND PAYMENT AGREEMENT

* The following terms and conditions are applicable to all r
 - Community Long Term Care (CLT) AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE *

* That this agreement shall not be

* That upon acceptance of this agr

Review and Submit

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

REVIEW AND SUBMIT

To review or print your application in Adobe PDF format, click the Review Application or the Print button. To make changes to information entered, click on the applicable link(s) available at the top of the screen. If you have successfully completed all required information for your provider enrollment application and are satisfied the information is complete and accurate, submit your application by clicking the Submit button. After submission, you will have the option to print a copy of the completed application for your records.

Once you have submitted your application, you will not be able to retrieve the application via the Reference ID or reprint the submitted application.

If you have not already done so, please record you reference number.
 Please select Submit to complete your enrollment.

Reference ID #:

Back
Print Application
Submit the Application
Cancel

Submission Complete

Click Exit once your enrollment has been successfully submitted.

Submission Complete

Your enrollment has been successfully submitted.

Exit

Other Enrollment Types

This addendum builds on the enrollment procedures shown above.

Continue a Previous Enrollment

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

Provider Enrollment

Continue Previous Enrollment

Please enter your Reference Number

Reference ID #:

Back Retrieve Application

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

Provider Enrollment

Continue Previous Enrollment

 • The enrollment has already been submitted. Further viewing or modifications are not allowed.

Please enter your Reference Number

Reference ID #:

Add a Location

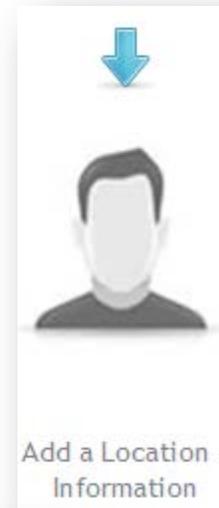
Select *Add a Location*, complete the required information, and receive your Reference ID #.

Provider Services Menu

Required fields are marked with an asterisk (*).

Please choose the option that best describes your intent : *

New Enrollment Add a Location



Medicare and Other State Medicaid/CHIP Information

As an individual, are you currently enrolled with Medicare?: Yes No

As an individual, are you currently enrolled in another state's Medicaid or Children's Health Insurance Program (CHIP)? : Yes No

As an individual, do you intend to enroll in another State's Medicaid/CHIP?: Yes No

Organization Details

Please enter Organization Name - as shown on income tax return..

Organization Name *

Employer Identification Number (EIN) *

NPI *

Month of Fiscal Year End*

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? Do you operate under a trade or company name, e.g. John K. Provider doing business as (DBA) Provider Family Practice? *: Yes No

Reference ID : AAOJL8136G89380

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 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 and the Provider email addresses" listed on the provider's Individual or C

Reference ID #: AAOJL8136G89380