Healthy Connections
VISUAL GUIDE

Online Enrollment Application

Updated July 2015
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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.

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. If the application is not completed and submitted at the time the Reference ID is issued, the provider has thirty (30) calendar days from the issuance date of the Reference ID in which to log back into the online application and complete the submission or the record will be deleted from the system.

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 are 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 the following apply: (1) pay wages to one or more employees, or (2) you file a pension or excess 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, ordering/referring providers 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

— CMS defines atypical providers as “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, waste 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 providing 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 providing 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 (GoNicks, agencies, groups, etc) enrolled with a unique combination of an Employer existing enrollment. The location being added must operate under the same EIN/NPI as the previously application file. When the EIN/NPI combination is not the same as a previously enrolled location, providers will need to complete a new enrollment application to add the new location.

Change Request

— Providers successfully enrolling as a SC Medicaid provider through the web application are able to add a location. Providers will not be able to make changes to submitted enrollment applications until after the application is approved or the location has been received by the provider.

Revalidation Request

— Participating providers (individuals and Organizations) enrolled on or before December 31, 2014, would have their enrollment information revalidated. The enrolled information will be verified and screened to ensure compliance according to the patient protection and affordable care act of the provider enrollment and screening regulations published by the center for Medicare and Medicaid services.
Choose Enrollment Type
Choose *New Enrollment*.

**Individual Information**

Select *Provider Information*.
Enter your Personal Information.

Provider Information

Required fields are marked with an asterisk (*).

- Are you enrolled in Medicare? *: Yes No
- Are you enrolled in Other State’s Medicaid/CHIP? *: Yes No
- Enter your name as entered on your IRS income tax return:
  - Provider First Name *
  - Provider Last Name *
  - Provider Middle Name
- Social Security Number *
- National Provider Identifier (NPI) *
- Suffix — Select One —
- Title (Mr., Mrs.) — Select One —
- Date of Birth (mm/dd/yyyy) *
- Provider Gender — Select One —
- 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

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

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.

Provider Contact Person

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

Provider Contact First Name *
Provider Contact Last Name *
Provider Contact Middle Name
Suffix -- Select One --

Telephone Number *
Telephone Number Extension
Other Telephone Number
Other Telephone Number Extension
Fax Number

Email Address *
Re-enter Email Address *

Does the contact person have a managing relationship to the applicant? If yes, this person will be included in the Managing Relationship section of this application.

Yes ☐ No ☐

Social Security Number *
Date of Birth (mm/dd/yyyy) *

Business Relationship to Enrolling Provider -- Select One --
Familial Relationship to Enrolling Provider -- Select One --
**Hours of Operation**
Enter your hours of operation.

**After-Hours Coverage**
Enter your after-hours information.
Correspondence Address Information
Enter your correspondence information.

Correspondence Address Information

Accounting Correspondence/Pay To Address Information

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

Required fields are marked with an asterisk (*).

☐ 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.

Organization/Business Name
First Name *
Last Name *
Middle Name
Suffix
Office Phone # *
Fax Number
Corresponding email address *
Re-enter corresponding email address *
Street *
Street Line 2
City *
State/Province *
Zip Code/Postal Code *

ZIP CODE Look-Up
Enter your contact person.

**Provider 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 Number**

**Corresponding email address**

**Re-enter corresponding email address**

**Street**

**Street Line 2**

**City**

**State/Province**

**ZIP Code/Postal Code**

Does the contact person have a managing relationship to the applicant? If yes, this person will be included in the Managing Relationship section of this application.

- Yes
- No

**Social Security Number**

**Date of Birth (mm/dd/yyyy)**

**Business Relationship to Enrolling Provider**

**Familial Relationship to Enrolling Provider**
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
- Tagalog

Special Needs
Please check all that this location is equipped to serve.
- Blind/Visually Impaired
- Deaf/Hearing Impaired
- Physically Handicapped
- Sexually Aggressive
- Behaviorally Disruptive
Is this location TDD/TTY Equipped? Yes No

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 Form](image)

Existing Licenses

<table>
<thead>
<tr>
<th>License Type</th>
<th>License Certification</th>
<th>License</th>
<th>State/Province</th>
<th>License#</th>
<th>Effective Date</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional (Board)</td>
<td>Anesthesiologist Assistant</td>
<td>Anesthesiologist Assistant</td>
<td>SC</td>
<td>231321</td>
<td>01/01/2015</td>
<td>01/01/2016</td>
</tr>
</tbody>
</table>
Certification
Add any certifications you have.
Taxonomy & Relationships

Taxonomy Code
List any taxonomy codes that apply to you.
Managing Relationships
Disclose any 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.

List Managing Relationships

<table>
<thead>
<tr>
<th>Managing Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name *</td>
</tr>
<tr>
<td>Last Name *</td>
</tr>
<tr>
<td>Middle Name</td>
</tr>
<tr>
<td>Social Security Number *</td>
</tr>
<tr>
<td>Suffix: -- Select One --</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy) *</td>
</tr>
<tr>
<td>Business Relationship to Enrolling Provider *</td>
</tr>
<tr>
<td>Familial Relationship to Enrolling Provider *</td>
</tr>
</tbody>
</table>

Add Managing Relationship

<table>
<thead>
<tr>
<th>Managing Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>Provider Contact Person</td>
</tr>
</tbody>
</table>
Ownership, Associations & Affiliations

Ownership & Associations
Discuss any ownership and association information.

Ownership & Associations

Required fields are marked with an asterisk (*).

Select the appropriate Ownership 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

Existing Shareholder or Partner for Business

<table>
<thead>
<tr>
<th>Business Legal Name</th>
<th>Provider Tax Identification Number (TIN) or Employer Identification Number (EIN)</th>
<th>% Ownership</th>
<th>Delete</th>
</tr>
</thead>
</table>

Existing Shareholder or Partner for Individual

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Suffix</th>
<th>Date of Birth</th>
<th>SSN</th>
<th>% Ownership</th>
<th>Familial Relationship</th>
<th>Delete</th>
</tr>
</thead>
</table>
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.

<table>
<thead>
<tr>
<th>SC DHHS #</th>
<th>NPI</th>
<th>Provider Name</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>123123123</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add Affiliation

### Existing Affiliation for Business
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: 09/16/2015
W-9 Information
Enter your W-9 information.

W-9 Request for Taxpayer Identification Number and Certification

Provider Tax Classification

Name (should match the name on your income tax return):

Business Name:

Select the applicable federal tax classification *

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

Address Information

Address Line 1
Address Line 2

City
State/Province

Zip Code/Postal Code (Zip * + 4)

List account number(s) here (optional):

Requestor's name and address
SC Health & Human Services, P.O. Box 8009 Columbia, SC 29202-8009
Part I: Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the Name box 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 2.

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 check 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: 06/02/15

Electronic Funds Transfer (EFT) Authorization Agreement

Enter your EFT information.
Financial Institution Information

- Financial Institution Name
- Street
- Street Line 2
- City
- State/Province
- 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)

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 8806, Columbia, SC 29602-8806 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: 2016/10/15

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.

Participation and Payment Agreement

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE:

That this agreement shall not be assigned or transferred.

That upon acceptance of this agreement, the provider's claims will be paid according to the terms of this agreement.

That services shall be provided in accordance with the terms of this agreement.

Participation and Payment Attestation
When your enrollment requires the execution of a contract, SCDHHS will contact you prior to enrollment approval.

I certify that I have read the terms of participation and payment and that I understand and agree to the conditions of the contract. I have not been involved in any material fact that would constitute a false, fraudulent or fraudulent statement or representation and that I will report any change that occurs.

I will obtain authorization from each Medicaid patient to release to South Carolina Department of Health and Human Services for processing Medicaid claims.

Furthermore, by checking this box, I consent to criminal history background checks including fingerprinting when required to determine suitability to screen based on risk of fraud, waste or abuse as determined for that category of provider.

Date: 06/10/2015

Participation and Payment Agreement Electronic Signature

I understand that by checking the electronic signature box of this Participation and Payment Agreement included with the provider enrollment application constitutes a signed contract with South Carolina Department of Health and Human Services.

Electronically Signed By: [signature]
Date: 06/16/2015

South Carolina Trading Partner Agreement For Electronic Claims And Related Transactions

I. General
The Trading Partner identified on the SC Medicaid Trading Partner Agreement Enrollment Form agrees to the terms and conditions of this agreement.

II. Purpose
A. This TPA outlines the requirements for the electronic exchange of patient health information (PHI) between the Trading Partner and the State of South Carolina Department of Health and Human Services.

Trading Partner Agreement Attestation

I have read, understand, and agree with the conditions set forth in the SCDHHS Trading Partner Agreement for Electronic Claims and Related Transactions.

I understand that by checking the electronic signature box of this Trading Partner Agreement, included with this provider enrollment application constitutes a signed contract with South Carolina Department of Health and Human Services.

Electronically Signed By: [signature]
Date: 06/16/2015

Provider Enrollment Application Electronic Signature

I understand that by checking the electronic signature box on the Terms and Conditions page, the provider enrollment application constitutes a signed contract with South Carolina Department of Health and Human Services.

Date: 06/16/2015

Electronically Signed By: [signature]
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

Click *Continue an Existing Enrollment*.

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

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

Click *Begin a New Enrollment*.

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

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

Provider Name *

Provider Tax Identification Number (TIN) or Employer Identification Number (EIN) *

National Provider Identifier (NPI) *

Month of Fiscal Year End* — Select One — *

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 name (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:

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:
Revalidation

Click *Enrollment Revalidation*.

Type in the corresponding information from the revalidation letter you received.

Please complete Enrollment Revalidation Request

Required fields are marked with an asterisk (*).

Enter your Revalidation Number, Medicaid Legacy ID and NPI if applicable

Revalidation Number *:  
Medicaid Legacy Id *:  
National Provider Identifier (NPI):  

Select *Retrieve Current Enrollment Application*.

Then verify your information as you follow the standard enrollment process.