

Instructions for Completing the
PROMISe Provider Enrollment Base Application Dated 4/19/2005
For OMR Providers

From the OMAP web site print the Provider Enrollment Base Application to get the application form that corresponds to the instructions provided below. The web site can be found at <http://www.dpw.state.pa.us/omap/promise/enroll/omappromiseenroll.asp>.

Applications must be typed or completed in black ink, or they will not be accepted.

Note: Out-of-State providers must submit proof of participation in your State's Medicaid Program.

1. Enter the complete name of the individual or the facility name. (The facility name cannot include a street address).
2. Check the appropriate box(es) for the action(s) you request. (Check 2a. Initial Enrollment)
 - 2a. This is an initial enrollment, check if it is for an individual or a facility **AND** add your nine digit MPI number and 4 digit service location to the right (even though there is no designated space)
 - 2b. Leave Blank
 - 2c. If this is a name change, indicate the old name and the new name. **To verify your new name, a copy of your Social Security card or FEIN/IRS documentation must accompany your application.**
 - 2d. If this is a change of ownership with no change in the IRS number, complete the "Ownership or Control Interest" sheet.
 - 2e. Leave Blank
3. Enter the requested effective date for all providers enrolling FY05-06 use 2005/07/01 action request.
4. To enter your provider type number and description refer to **Attachment 1. OMR Provider Type/Specialty Document**
5. Enter your specialty name and code number. Refer to Attachment 1.
6. Enter N/A in this field
7. For Individuals Only: Enter your Social Security Number. **A copy of your Social Security card, W-2, or document from the IRS containing your Social Security Number must accompany your application. If completing #7, do not complete #8.**

8. For Facilities: Enter your Tax Identification Number (TIN). **A copy of the TIN label or document from the IRS containing your IRS number must accompany this application. A W-9 form will not be accepted. If completing #8, do not complete #7.**

9. Enter your legal name as it is filed with the IRS and as it appears on the IRS documentation.

10a. Check "no"

10b. Enter N/A

11a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.

11b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/stamped fictitious business name statement/permit.**

12. For Individuals Only: Enter your date of birth.

13. For Individuals Only: Enter your gender.

14. For Individuals Only: Enter the title/degree you currently hold.

15a. Enter your legal entity address. The address must be a physical location. A post office box is not a valid legal entity address.

15b-f. Enter the contact information for the legal entity address.

16. Check the appropriate box for your business type. Check 1 box only. Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.

17. Enter your license number, issuing state, issue date, and expiration date. **A copy of your license must accompany your application.**

18. Enter N/A

19a. Enter a valid service location address. The address must be a physical location, not a post office box. **For additional address(es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 19a, use page 11.**

19b. Select the box that corresponds to the address you want Medical Assistance Bulletins to be sent.

19c. Enter the Medicare number(s) for this address.

19d-g. Enter the contact information for this address

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- 19h. Check whether you or your staff is able to communicate with patients in any language other than English.
- 19i. List the languages that you or your staff is able to communicate with patients other than English.
- 19j. Answer questions 1 through 4 pertaining to the Americans with Disabilities Act (ADA).
- 19k. Enter the appropriate Provider Eligibility Program(s) (PEP). Use Consolidated, P/FDS, MR Base for all Provider Types except 52, Community Residential Rehabilitation. If the location is for Provider Type 52, use Consolidated and MR Base. If you do not provide waiver services, use MR Base only.
- 20a-e. Complete ALL confidential information questions, A through E.
If you answer "Yes" to any of the questions, provide a detailed explanation (on a separate piece of paper) and attach it to your application.
- 20f. Include responses to 20f, 1 to 14, if you answered YES to any of the questions in 20a-e.
21. Sign the application (CEO or CFO) and print your name, title, and date.
22. Use page 11 **only** to add a mail-to, pay-to, and/or home office address to the **previously defined** service location entered in 19a. This sheet **cannot be used to add a service location**. You must fill out a new application to add a service location.
- 22a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location. County should be the county the service location is physically located.
- 22b. Indicate whether you are adding a mail-to, pay-to, and/or home office address. It can be any combination of these.
- 22c. Enter the e-mail address of the contact person for this address.
- 22d-g. Enter the contact information for this address.
When completed, review **the "Did You Remember..." Checklist on page 13**. Then return your application and other documentation to the HCSIS Help Desk via FAX at 1-717-540-0960.

Note: Sign and date the Provider Agreement for Outpatient Providers included in the On-line PROMISE Provider Enrollment Base Application