

How to submit a PT 95 NT application?

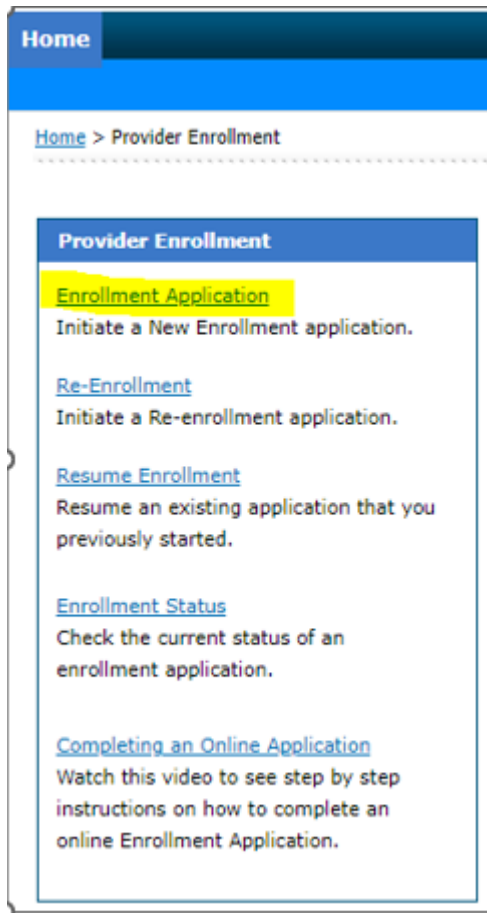


Starting the application

- Click the link to - [Start your application](#)
- Select “Enrollment Application”

Select the options below

- **Enrollment Type:** Atypical
- **Provider Type:** 95
- **Specialty:** NT
- **TAX ID:** List the SSN of the enrolling personal care aide.



The screenshot shows a web application interface. At the top is a blue header with the word "Home". Below it is a breadcrumb trail: "Home > Provider Enrollment". A sidebar on the left contains a "Provider Enrollment" section with several links: "Enrollment Application" (highlighted in yellow), "Re-Enrollment", "Resume Enrollment", "Enrollment Status", and "Completing an Online Application". Each link is followed by a brief description of its function.

Home

Home > Provider Enrollment

Provider Enrollment

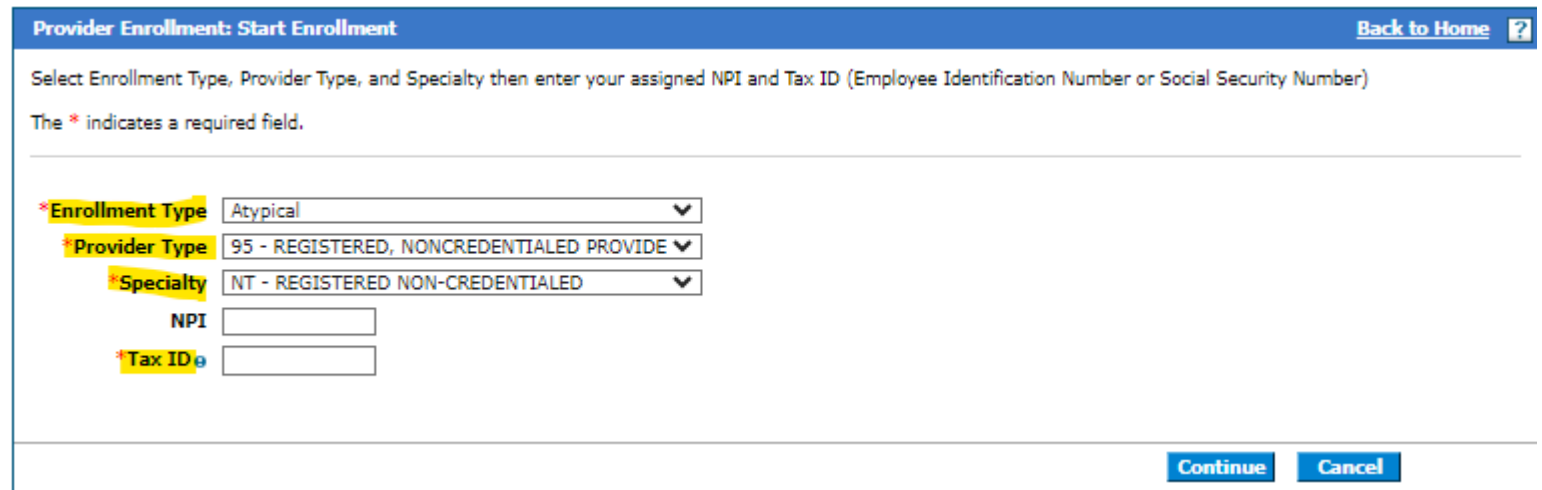
Enrollment Application
Initiate a New Enrollment application.

[Re-Enrollment](#)
Initiate a Re-enrollment application.

[Resume Enrollment](#)
Resume an existing application that you previously started.

[Enrollment Status](#)
Check the current status of an enrollment application.

[Completing an Online Application](#)
Watch this video to see step by step instructions on how to complete an online Enrollment Application.



The screenshot shows the "Provider Enrollment: Start Enrollment" form. It has a blue header with the title and a "Back to Home" link. The main content area contains instructions: "Select Enrollment Type, Provider Type, and Specialty then enter your assigned NPI and Tax ID (Employee Identification Number or Social Security Number)". Below this is a note: "The * indicates a required field." The form fields are: "*Enrollment Type" (dropdown menu with "Atypical" selected), "*Provider Type" (dropdown menu with "95 - REGISTERED, NONCREDENTIALLED PROVIDE" selected), "*Specialty" (dropdown menu with "NT - REGISTERED NON-CREDENTIALLED" selected), "NPI" (text input field), and "*Tax ID" (text input field). At the bottom right are "Continue" and "Cancel" buttons.

Provider Enrollment: Start Enrollment [Back to Home](#) ?

Select Enrollment Type, Provider Type, and Specialty then enter your assigned NPI and Tax ID (Employee Identification Number or Social Security Number)

The * indicates a required field.

*Enrollment Type

*Provider Type

*Specialty

NPI

*Tax ID

[Continue](#) [Cancel](#)

Entering the application data: Welcome tab

- The welcome tab details key information that will be asked during the application process. At the bottom, the online application shows if any documentation needs to be attached towards the end of the application. For PCA enrollments, no additional documentation is needed to submit the application electronically.
- If submitting through the portal it is recommended not to add any additional paper documents unless additional information is requested or
- Hit continue to proceed with the application.

The screenshot shows the ARMedicaid website's Provider Enrollment Welcome tab. The header includes the ARMedicaid logo, a 'Home' button, and links for 'Contact Us' and 'Login'. A breadcrumb trail reads 'Home > Provider Enrollment > Start Enrollment > Enrollment Application', and the date 'Thursday 05/23/2024 12:05 PM CST' is displayed. The main content area is titled 'Provider Enrollment: Welcome' and features a sidebar with a list of steps: Welcome (active), Request Information, Specialties, Addresses, Provider Identification, Beds, Languages, EFT Enrollment, Other Information, Addendums, Ownership, Disclosures, Attachments and Fees, Agreement, and Summary. The main panel, titled 'Welcome to the Online Provider Enrollment Process', provides instructions and lists required information: National Provider Identifier, Address Information (including Zip Code + 4), Taxonomy Codes, Tax ID (Employee Identification Number or Social Security Number), and License Number. It also prompts the user to look for required attachments and click the 'Continue' button. Below this, there are dropdown menus for 'Enrollment Type' (Atypical), 'Provider Type' (95 - REGISTERED, NONCREDENTIALIA PROVIDE), and 'Specialty' (NT - REGISTERED NON-CREDENTIALIA). A section labeled 'Document(s) required to be attached' contains a large empty text area. At the bottom, a message states 'Make sure you have all document(s) ready to attach before submitting application.' and two buttons, 'Continue' and 'Cancel', are visible. A 'Privacy Notice' link is located at the very bottom of the page.

ARMedicaid

Home

Home > Provider Enrollment > Start Enrollment > Enrollment Application Thursday 05/23/2024 12:05 PM CST

Provider Enrollment: Welcome

Welcome

Welcome to the Online Provider Enrollment Process

Please complete each step in the enrollment process. When you have completed all steps of the application, "Submit" and "Confirm" the application for further processing.

As a condition for entering into or renewing a provider agreement all applicants must complete an application. A true, accurate and complete disclosure of all requested information is required by the Federal and State regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State regulations to update the information submitted on the application.

You will need the following information to complete your enrollment request:

- ▶ National Provider Identifier
- ▶ Address Information including Zip Code + 4
- ▶ Taxonomy Codes
- ▶ Tax ID - either Employee Identification Number or Social Security Number
- ▶ License Number

Also, please look for required attachments for your application below and click the "Continue" button to start the enrollment application.

Enrollment Type: Atypical

Provider Type: 95 - REGISTERED, NONCREDENTIALIA PROVIDE

Specialty: NT - REGISTERED NON-CREDENTIALIA

Document(s) required to be attached

Make sure you have all document(s) ready to attach before submitting application.

Continue Cancel

Privacy Notice

Entering the application data: Requested Information

- **NPI & Taxonomy:** Not required.
- **TAX ID:** List the **SSN** of the enrolling personal care aide.
- **Effective date** – List a requested effective date or place today's date.
- **Fiscal Year End:** Enter December unless the fiscal year ends on another date.
- **Complete Contact Information:** This section will receive email notifications if the ATN is RTP'd. RTP = Returned to Provider for review/corrections. The contact information listed here is only for the application record.
- **Provider Enrollment Credentials:** Note the password and security questions you completed for your application. If you need to check the status online or re-access the application after RTP to resubmit for processing, this information will be asked and can't be reset.

Once all sections have been completed, hit continue and a message will pop up with your application tracking ID. An email notification will also be sent.

Provider Enrollment: Tracking Information

Your enrollment application has been assigned the following tracking number: 241785. Please retain the tracking number for your records.

The tracking number will be used, in addition to your Tax ID (Employee Identification Number or Social Security Number) and password, as credentials to resume/revise your application at a later date.

Note: This application must be submitted within 90 days. If not, it may no longer be available and a new application must be started.

OK

Provider Enrollment: Request Information

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EFT Enrollment

Other Information

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Summary

You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later". The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application. **You are enrolling as a new provider and you will get a new number.** The * indicates a required field.

Initial Enrollment Information

*Enrollment Type: Atypical

*Provider Type: 95 - REGISTERED, NONCREDENTIALLED PRG

Provider Information

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

NPI: NPI Zip + 4: Primary Taxonomy:

*Tax ID (Employee Identification Number or Social Security Number): 123565486 *Tax ID Type: EIN SSN

*Are you a personal care aide? Yes No

Effective Date: Fiscal End Date:

Contact Information

*Last Name: *First Name: Title: *Phone: Ext: Fax Number: *Contact Email: Contact Email is a required field. *Confirm Email: Preferred Method of Communication: Email

Provider Enrollment: Credentials

Please provide the following information, which will be required to resume your application at a later date. Your password must be between 8 to 20 alphanumeric characters. Your tax id (Employee Identification Number or Social Security Number) is provided, if already contained within your provider enrollment application.

Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number along with the following information, will be used as your credentials to resume your suspended enrollment application.

*Password: Password is a required field. *Confirm Password: Confirm Password is a required field.

*What was the name of your elementary / primary school? *What was the last name of your third grade teacher? *What is the name of the last high school you attended?

Continue Finish Later Cancel

Entering the application data: Specialties tab

- Hit continue to proceed with the application.

[Home](#)

[Home](#) > [Provider Enrollment](#) > [Start Enrollment](#) > [Enrollment Application](#) > [Enrollment Request Information](#) > [Enrollment Specialties](#) Thursday 05/23/2024 12:16 PM CST

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Specialties

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. Taxonomies are available to be added for the selected provider.

The * (in red) indicates required fields. (Note: When the Add/Save button is present, all fields with * are only required when selecting Add/Save for that section.)

☒ Indicates a primary record.

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

	Specialty	Action
<input checked="" type="checkbox"/>	REGISTERED NON-CREDENTIALLED	
<input checked="" type="checkbox"/>	Click to add specialty.	

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

[Privacy Notice](#)

Entering the application data: Addresses

- **Service location is required.** Once entered, you must hit “Verify Address” before the application will allow you to save the information.
- Complete address info for the Home Office, Mail to, and Pay to. If these sections are not completed, the information listed on the service location will be copied to all addresses upon enrollment.

Home > Provider Enrollment > Enrollment Addresses Tuesday 09/05/2023 10:58 PM CST

Provider Enrollment: Addresses

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The * (in red) indicates required fields.
Indicates a primary record.

Provider Addresses

The Service Location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The Service Location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The Service Location name must match the business name on the W-9.
- The Service Location address must be a physical location. A post office box is not a valid Service Location address.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their Service Location address.

Click the "Remove" link to remove the entire row.

Type	Address	City	State	Action
Click to collapse.				
*Address Type	Service Location		Primary Address <input checked="" type="checkbox"/>	
Contact Name			Location Code	
*Address				
*City			County	
*State			*Zip Code	
Verify Address				
County Code			Longitude	
Latitude			Confirm Email	
*Primary Email			Phone	
*Phone			Ext	
Add Reset				
Continue Finish Later Cancel				

Entering the application data: Addresses

Type	Address	City	State	Action
<input type="checkbox"/> Click to collapse.				
*Address Type	<div>Service Location</div>			
Contact Name	<div>Home Office</div> <div>Mail To</div> <div>Service Location</div> <div>Pay To</div>			
*Address				
*City				
*State				
<input type="button" value="Verify Address"/>				
County Code				
Latitude				
*Primary Email				
*Phone				
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

☒ Primary Address

Location Code

County

*Zip Code

County Code

Latitude

Longitude

Confirm Email

Phone

Ext

Address Verification: Results?

Original Address

**Original address may be undeliverable.

Line 1 526 South Fairway Ave

Line 2

City Sherwood

State ARKANSAS

Zip Code 72120

County

Latitude

Longitude

Exact Address Match Found

Click on **SELECT** to choose the address.

Address	City, State	County	ZipCode	Action
526 S FAIRWAY AVE	SHERWOOD, ARKANSAS	PULASKI	72120-5807	<input type="button" value="Select"/>

Entering the application data: Requested Information

Click to collapse.

*Address Type

Service Location

Primary Address

☒

Contact Name

John Brickey

Location Code

In State

*Address

526 S FAIRWAY AVE

*City

SHERWOOD

*State

ARKANSAS

County

*Zip Code

721205807

Verify Address

County Code

Latitude

Longitude

*Primary Email

John.brickey@gainwelltechnologie

Confirm Email

John.brickey@gainwelltechnologie

*Phone

Office

5015906005

Ext

Phone

Ext

Add

Reset

Continue

Finish Later

Cancel

Entering the application data: Requested Information

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The * (in red) indicates required fields.
☒ Indicates a primary record.

Provider Addresses

The Service Location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The Service Location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The Service Location name must match the business name on the W-9.
- The Service Location address must be a physical location. A post office box is not a valid Service Location address.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their Service Location address.

Click the "Remove" link to remove the entire row.

	Type	Address	City	State	Action
<input checked="" type="checkbox"/>	Service Location	<input checked="" type="checkbox"/> 526 S FAIRWAY AVE	SHERWOOD	ARKANSAS	Copy Remove
<input checked="" type="checkbox"/>	Click to add address.				

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

Entering the application data: Requested Information

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The * (in red) indicates required fields.
☒ Indicates a primary record.

Provider Addresses

The Service Location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The Service Location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The Service Location name must match the business name on the W-9.
- The Service Location address must be a physical location. A post office box is not a valid Service Location address.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their Service Location address.

Click the **"Remove"** link to remove the entire row.

	Type	Address	City	State	Action
<input checked="" type="checkbox"/>	Service Location	<input checked="" type="checkbox"/> 526 S FAIRWAY AVE	SHERWOOD	ARKANSAS	Copy Remove
<input checked="" type="checkbox"/>	Click to add address.				

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

Entering the application data: Provider Identification

- **Provider Legal Name:** List the Individual personal care aides' legal name.
- **Tax Name:** This section should match the same individual name.
- **Gender/DOB:** Enter the gender & DOB of the Personal Care provider.
- **License, Medicare, CLIA, and DEA** – These sections do not apply to enrolling PCA providers. Should be left blank, and the application will allow you to continue through submission.

Provider Enrollment: Provider Identification

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The * (in red) indicates required fields. (Note: When the Add/Save button is present, all fields with * are only required when selecting Add/Save for that section.)

Provider Legal Name

The provider legal name and information is provided once for each enrollment.

*Last Name John

*First Name Brickley

Middle Title

*Tax Name John Brickley

Individual Providers

*Gender Male *Birth Date 06/23/1987

License

Click the "Remove" link to remove the entire row.

License #	Effective Date	End Date	Issuing Board	Issuing State	Action
Click to collapse.					
*License #	*Effective Date	*End Date	*Issuing State ARKANSAS	*Issuing Board	
Classification					
Add	Reset				

Medicare Participation

Medicare # Effective Date Medicare Type

CLIA Certification

Click the "Remove" link to remove the entire row.

CLIA #	Effective Date	End Date	Action
Click to collapse.			
*CLIA #	*Effective Date	*End Date	
Add	Reset		

DEA #

Click the "Remove" link to remove the entire row.

DEA #	Effective Date	End Date	Action
Click to collapse.			
*DEA #	*Effective Date	*End Date	
Add	Reset		

Continue Finish Later Cancel

Entering the application data: Languages

- Language is optional – You can list any language or continue to proceed with the application.

The screenshot shows a web application interface for 'Provider Enrollment: Languages'. At the top, there is a navigation bar with 'Home' and a breadcrumb trail: 'Home > Provider Enrollment > Enrollment Languages'. The date and time 'Thursday 05/23/2024 12:27 PM CST' are displayed in the top right. A left sidebar contains a list of menu items: 'Welcome', 'Request Information', 'Specialties', 'Addresses', 'Provider Identification', 'Languages' (highlighted with a yellow background and a right-pointing arrow), 'Attachments and Fees', 'Agreement', and 'Summary'. The main content area has a title bar 'Provider Enrollment: Languages' with a help icon. Below the title bar, there is instructional text: 'Providers that have the ability to translate should select the appropriate language below. This field is not required.' followed by a note about red asterisks indicating required fields. Below this, it says 'Click the "Remove" link to remove the entire row.' The main form area contains a table with two columns: 'Language' and 'Action'. The 'Language' column has a text input field with a placeholder 'Click to add language.' and a small icon to its left. The 'Action' column is currently empty. At the bottom right of the form, there are three buttons: 'Continue' (highlighted in yellow), 'Finish Later', and 'Cancel'.

Home > Provider Enrollment > Enrollment Languages Thursday 05/23/2024 12:27 PM CST

Provider Enrollment: Languages

Providers that have the ability to translate should select the appropriate language below. This field is not required.

The * (in red) indicates required fields. (Note: When the Add/Save button is present, all fields with * are only required when selecting Add/Save for that section.)

Click the "Remove" link to remove the entire row.

Language	Action
<input type="text" value="Click to add language."/>	

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

Entering the application data: Attachments and Fees

- The application doesn't require attachments to be with the initial submission.
- It is recommended not to attach any additional documents to the initial submission unless additional information is being requested.
- Paper pin forms should not be uploaded when submitting applications electronically through the portal website.
- All optional listings are only needed if applicable or requested.

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Home > Provider Enrollment > Attachments and Fees Thursday 05/23/2024 12:28 PM CST

Provider Enrollment: Attachments And Fees

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Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit electronic attachments, please follow the instructions in the Attachments panel below.

Verify that all required documentation, including copies of applicable professional and operating licenses, is included as an attachment.

If you are submitting **Fingerprint Background information**, include a copy of the proof of fingerprint collection as an attachment.

Note if you choose to "Upload" attachments by "File Transfer", a maximum of 700 MBs of information can be uploaded.*

The * (in red) indicates required fields. (Note: When the Add/Save button is present, all fields with * are only required when selecting Add/Save for that section.)

Attachments

To add an attachment, complete the required fields and click the **Add** button.
Use the 'Other' selection to upload attachments not in the list.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action
Click to collapse.				
	Transmission Method		Attachment Type	
	Attachment Type			
	Description			

Application Fee

No Application Fee Required

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

Entering the application data:

Agreement

- Click “I Accept” to terms of agreement
- Enter the providers legal name and title to finalize the signature page for the application.

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Summary

Instructions

The terms of enrollment are stated 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.

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. Once changes are made, the enrollment application can be reviewed again.

The enrollment application terms must be accepted in order to submit the application for approval.

Once the application is submitted, a tracking number will be displayed and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.

Terms of Agreement

Provider Name

Brickey John

Address

710 S FAIRWAY AVE
SHERWOOD
ARKANSAS, 72120-5811

Tax ID (Employee Identification Number or Social Security Number)

123565486

NPI

..

Contact Name

Tyler Brickey

Contact Email

tyler.brickey@gainwelltechnologies.com

The above atypical provider agrees to participate in the Medicaid and/or SeniorCare Program, hereinafter referred to as the Title XIX Program.

I agree that my fees or charges for services or items delivered to Title XIX beneficiaries will not exceed my fees or charges for similar services or items delivered to non-Title XIX individuals. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to Title XIX beneficiaries are not greater than charges for service to non-Title XIX individuals, the Department of Health and Family Services, hereinafter referred to as the Department or its authorized representatives will be used to make such determinations.

I. Provider, in consideration of the covenants therein, agrees:

A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services.

B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By entering your name in the space provided below and submitting this application electronically, you state that, you are the person whom you represent yourself to be herein. If you are an authorized representative for a group you may sign as well.

I accept

I understand that my electronic signature is equivalent to my written signature.

Your Signature

Tyler Brickey

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

Title

Submission Date

05/23/2024

Continue

Finish Later

Cancel

Entering the application data: Summary

- This is a preview of your application before you complete your submission.
- Hit “Print Preview”
- Save a copy of the application summary for your records.
- Must go to the bottom of the page to complete the submission of the application.

Provider Enrollment: Summary

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Request Information
Requesting Enrollment Effective Date 05/23/2024
Enrollment Type Atypical
Provider Type REGISTERED, NONCREDENTIALLED PROVIDERS
Provider Federal Tax Identification Number (TIN) 123565486
Effective Date 02/06/2024
End Date ...
Fiscal End Date December
NPI ...
NPI Zip + 4 72120
Taxonomy ...
Are you a personal care aide? No
Contact Name John Brickey
Contact Phone 1-501-590-6325
Ext ...
Contact Email tyler.brickey@gainwelltechnologies.com
Preferred Method of Communication Email
Email For Provider Publications ...
Addresses [Expand All](#) | [Collapse All](#)

	Address Type	Address	City	State
<input checked="" type="checkbox"/>	Service Location	710 S FAIRWAY AVE	SHERWOOD	ARKANSAS

Specialties
☒ **Specialty** REGISTERED NON-CREDENTIALLED
Provider Identification
Last Name john
First Name Brickey
Middle ...
Gender Male
Title ...
Birth Date 06/23/1987
Tax Name John Brickey
Medicare # ...
Effective Date ...
Medicare Type ...
Languages

Entering the application data: Finalizing Submission

- Must go to the bottom of the page to complete the submission of the application.
- Hit “Submit” to complete the application. Save the tracking ID for your records.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party without cause and/or convenience of either party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:

1. Returned mail
2. Death of provider
3. Change of ownership
4. Or other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual.

The above atypical provider agrees to participate in the Medicaid and/or SeniorCare Program, hereinafter referred to as the Title XIX Program.

I agree that my fees or charges for services or items delivered to Title XIX beneficiaries will not exceed my fees or charges for similar services or items delivered to non-Title XIX individuals. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to Title XIX beneficiaries are not greater than charges for service to non-Title XIX individuals, the Department of Health and Family Services, hereinafter referred to as the Department or its authorized representatives will be used to make such determinations.

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By entering your name in the space provided below and submitting this application electronically, you state that, you are the person whom you represent yourself to be herein. If you are an authorized representative for a group you may sign as well.

I accept ☐ I understand that my electronic signature is equivalent to my written signature.

Your Signature John Brickey

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

Title

Agreement Date

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 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 'Submit' to complete the enrollment application for processing. Please print a copy of this summary for your records.

[Print Preview](#)

[Submit](#)

[Finish Later](#)

[Cancel](#)

[Privacy Notice](#)



Applications submitted on portal

You can **check the status** of any application submitted and see any notes for corrections or documents needed to complete your application.

If corrections are needed, you can click the “Resume Enrollment” to access the previously submitted application and upload any document or make changes need for your application and resubmit.

Provider Enrollment

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Initiate a Re-enrollment application.

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Resume an existing application that you previously started.

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Check the current status of an enrollment application.

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Watch this video to see step by step instructions on how to complete an online Enrollment Application.

Customer Links

[Print an Application for Mailing](#)

[Pay Application Fee \(new window\)](#)

[Provider User Manual](#)

