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Department of Health
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DEL_PRMMIS_Final_User_Documentation_PEP_Enrollment_Atypical_Ref_Guide

Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider Phase Two Final User Documentation Training Material – Reference Guide

Version 3.1

Change History

Version #	Date	Modified By	Description
3.1	10/22/2021	Gainwell Technologies	Logo updated per CR 21-672
3.0	03/15/2021	Gainwell Technologies	R17/R18 Updates
2.0	10/28/2020	Gainwell Technologies	Gainwell Rebranding
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1 Acronyms

The following table contains the list of abbreviations used within the text of this document. Acronyms found in images are not necessarily addressed unless the acronym is needed to complete the task.

Note: This acronym list will not include all potential HIPAA-related transaction information.

Table 1 – Acronyms

Acronyms	Definition
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ATN	Application Tracking Number
DDE	Direct Data Entry
DEA	Drug Enforcement Administration
EDI	Electronic Data Interchange
EIN	Employer Identification Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
ID	Identifier
LMS	Learning Management System
NPI	National Provider Identifier
PDF	Portable Document Format
PEP	Provider Enrollment Portal
PHI	Protected Health Information
PII	Personally Identifiable Information
PRMMIS	Puerto Rico Medicaid Management Information System
PRMP	Puerto Rico Medicaid Program
RTP	Return to Provider
SSN	Social Security Number
URL	Uniform Resource Locator

2 Overview

The **Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider Reference Guide** includes enrollment application instructions and notifications applicable to providers wishing to enroll in the Puerto Rico Medicaid Program (PRMP) using the Provider Enrollment Portal (PEP). In order to complete an application for enrollment as an Atypical provider in the PRMP, you must complete all required enrollment steps and submit your application for review.

This document may be used in conjunction with training sessions or as a stand-alone reference resource.

Training participants are assumed to have general familiarity with navigating the internet, using computers, and understanding terminology such as icon, desktop, folders, tabs, browsers, search, toolbars, menus, mouse, hyperlinks, printing options, and save options. It is recommended for participants to bring note-taking materials such as writing utensils, a notepad, highlighters or sticky notes.

This document, along with other PEP training documents, is available in the Puerto Rico Medicaid Program (PRMP) Learning Management System (LMS). You can find it by going to the following link: <https://lms.prrmmis.pr.gov>.

After reading the **Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider Reference Guide**, Providers should be able to complete these learning objectives in PEP:

- Complete all required enrollment application steps
- Submit an enrollment application
- Understand the different notifications received from the Provider Enrollment Portal and the required actions to take

Note: This training guide contains fictitious information and does not contain protected health information (PHI) or personally identifiable information (PII) data.

3 New Enrollment Application

A new enrollment application displays after having completed the Enrollment Registration page.

To see the detailed steps for completing the Enrollment Registration page, refer to **Section 2.1** of the **Provider Enrollment Portal (PEP) Navigation Reference Guide**.

The Atypical Provider enrollment type applies to providers who may submit Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions, but do not meet the HIPAA definition of a health care provider and should not receive an NPI number. Examples include taxi services, home and vehicle modifications, and respite services.

The Enrollment Process for an Atypical Provider consists of multiple steps that must be completed in order to accept and submit an enrollment application.

Each step is discussed in the following sections, including the panels and fields that must be completed.

3.1 General Information

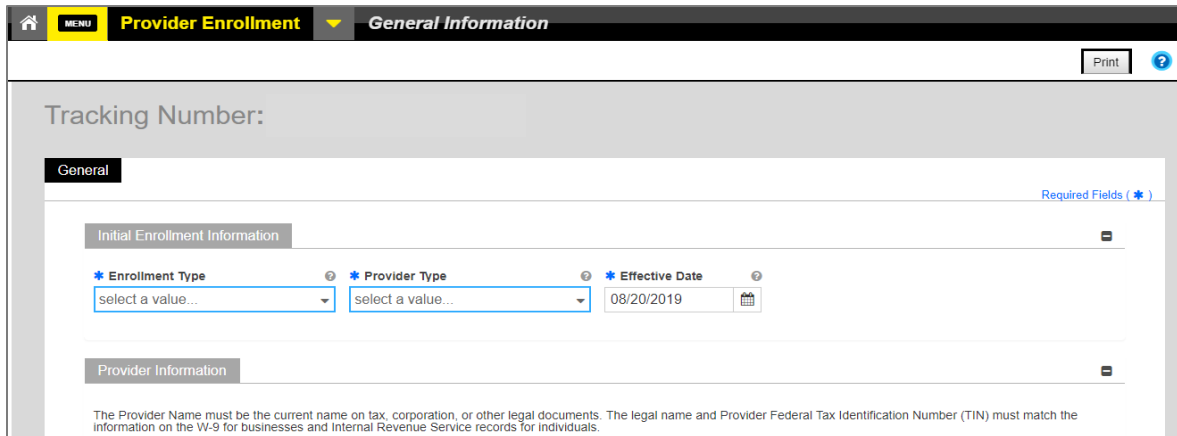
Quick Reference – General Information

Table 2 – General Information

Step	Task	Action	Result
Start from the General Information page, the first step on a new enrollment application page.			
1	Select Enrollment Type.	Click the drop-down list under Enrollment Type and click Atypical Providers.	<ul style="list-style-type: none"> a. Pop-up window displays, indicating that once the application is saved, the Enrollment Type cannot be changed. b. The required enrollment steps and a progress bar display at the top of the page.
2	Select Provider Type.	Click the drop-down list under Provider Type and click the relevant Provider Type.	Pop-up window displays, indicating that once the application is saved, the Provider Type cannot be changed.
3	Add Effective Date.	Enter the date you wish the enrollment in PRMP to be effective.	Effective date is added
4	Add General Information.	Complete the rest of the General Information page, including: <ul style="list-style-type: none"> a. Provider Information and related questions b. Contact Information Click Save and Continue.	General Information is saved. Progress bar advances to the next available page.

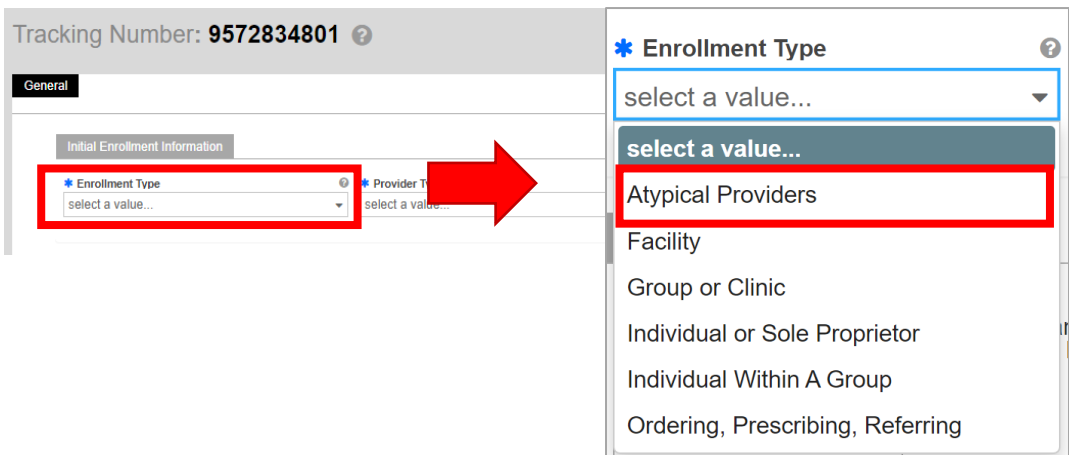
Detailed Steps

1. Once registration has been completed, the new enrollment application begins with the General Information page.



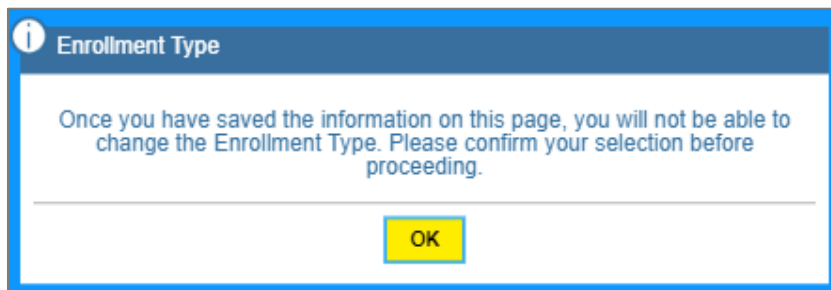
The screenshot shows the 'General Information' page in the Provider Enrollment Portal. The 'Initial Enrollment Information' section contains three required fields: 'Enrollment Type', 'Provider Type', and 'Effective Date'. The 'Enrollment Type' dropdown menu is open, and the 'Atypical Providers' option is selected. The 'Effective Date' is set to 08/20/2019. A red box highlights the 'Enrollment Type' dropdown menu, and a red arrow points to the 'Atypical Providers' option in the dropdown list.

In the Initial **Enrollment Information** section, click the drop-down list under **Enrollment Type** and select the “**Atypical Providers**” option.



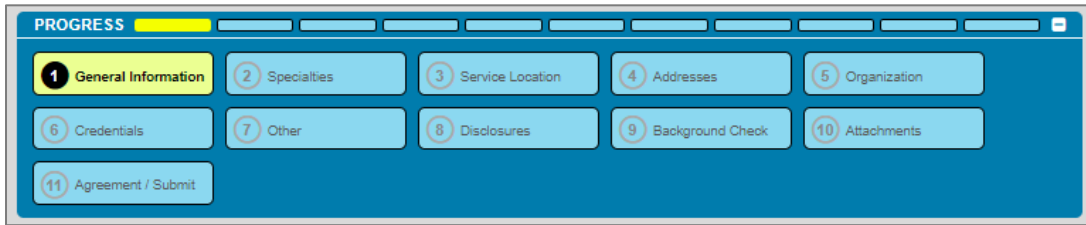
The screenshot shows the 'Initial Enrollment Information' section with the 'Enrollment Type' dropdown menu open. The 'Atypical Providers' option is selected and highlighted with a red box. A red arrow points from the 'Enrollment Type' dropdown menu to the 'Atypical Providers' option.

- a. Once an Enrollment Type is selected, a pop-up window displays, indicating that once the data on this page is saved, the Enrollment Type cannot be changed.



The screenshot shows a pop-up window titled 'Enrollment Type'. The message reads: 'Once you have saved the information on this page, you will not be able to change the Enrollment Type. Please confirm your selection before proceeding.' There is an 'OK' button at the bottom.

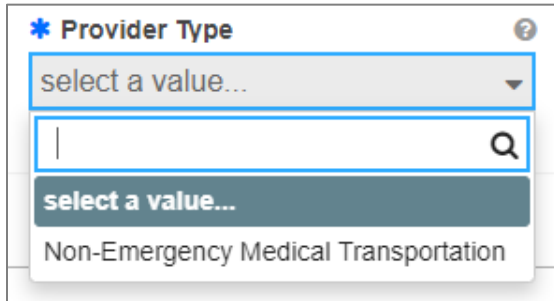
- b. The steps required to complete the enrollment for an Atypical Provider display at the top of the page, along with a progress bar to show your current progress.



DIFFERENT ENROLLMENT STEPS DISPLAYED: The steps displayed at the top of the screen may continue to change during the enrollment process as more information is entered in the application that dictate the remaining steps that are required.

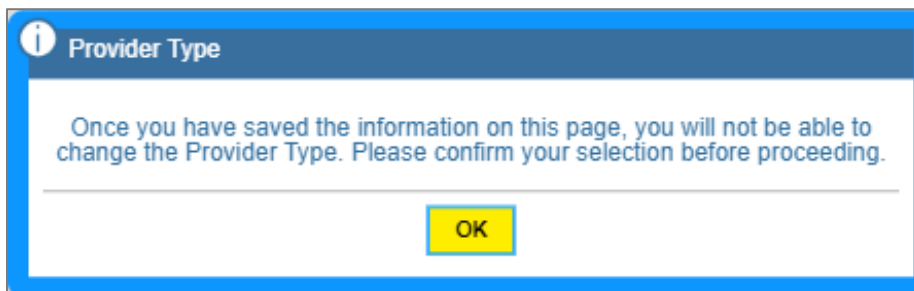
Steps are determined to be required, optional, or non-applicable based on the Provider Type, Specialties, and other related information.

- 2. Click the drop-down list under Provider Type and select the appropriate Provider Type for the Atypical Provider that is enrolling. The Provider Types shown in the drop-down list are for the Atypical Provider Enrollment Type.



PROVIDER TYPE: The Provider Type drop-down list is dynamic based on the Enrollment Type selected. If you do not see your Provider Type in this list, verify that you have selected the correct Enrollment Type.

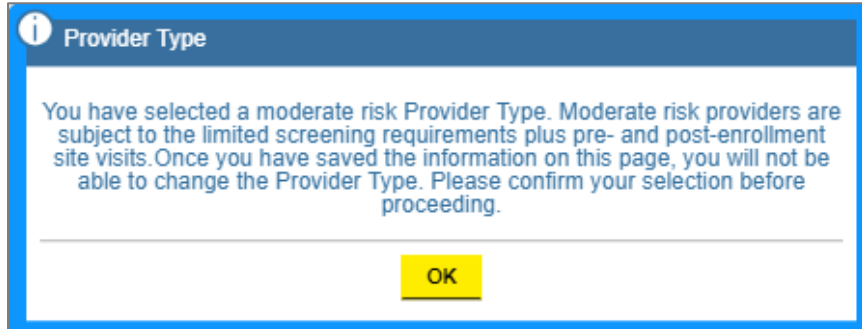
Once the Provider Type is selected, a pop-up window displays, indicating that once the data on this page is saved, the Provider Type cannot be changed.





PROVIDER RISK: Depending on the Provider Type chosen, the provider’s risk level (limited, moderate, or high) and the additional steps that the provider must take in addition to the enrollment will be displayed in the generated pop-up window.

Example of Provider Type pop-up window with provider risk level disclosed:



3. In the **Effective Date** field, select the date (or leave the default) you wish the enrollment in PRMP to be effective once approved.



NOTE: Retroactive enrollment dates will only be considered for approval up to 90 days in the past.

4. Complete the sections of the General information page.
 - a. **Provider Information and related questions** – Identifies information about the provider applying for PRMP enrollment.

For an Atypical Provider, this section displays the option to select **Individual or SP with SSN** or **SP or Business with EIN**.

Individual or SP with SSN is selected if all payments made will be reported to the IRS against an individual Social Security Number (SSN). Selecting **Individual or SP with SSN** displays the following fields:

Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider

Provider Information

Are you an Individual or Sole Proprietor (SP) or Business?

Individual or SP with SSN
 SP or Business with EIN

The Provider Name must be the current name on tax, corporation, or other legal documents. The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9 for businesses and Internal Revenue Service records for individuals.

Title * Legal Last Name * First Last Name Second Last Name * First Name Middle Name

Suffix Gender What is your ethnicity? * Birth Date * SSN

* Preferred Communication Lan...

SP or Business with EIN is selected if all payments made will be reported to the IRS against a business Employer Identification Number (EIN). Selecting **Business** displays the following fields:

Provider Information

Are you an Individual or Sole Proprietor (SP) or Business?

Individual or SP with SSN
 SP or Business with EIN

The Provider Name must be the current name on tax, corporation, or other legal documents. The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9 for businesses and Internal Revenue Service records for individuals.

* Legal Name Tax Name Doing Business As Name * EIN

* Preferred Communication Lan...



NOTE: Characters with accents are not accepted within PEP fields. If you are using your browser’s auto-fill settings, verify that the information in the application’s fields is correct before saving.

Answer the questions that display at the bottom of the **Provider Information** section. Answer the **“Are you currently enrolled as a Provider?”** and **“Were you previously enrolled as a provider?”** based on the appropriate scenario.

i. New Enrollment:

- If you have never been approved for enrollment in PRMP through PEP.

Answer **No** to the currently enrolled and previously enrolled questions.

Are you currently enrolled as a Provider?

Yes No

Were you previously enrolled as a Provider?

Yes No

ii. Additional Enrollment:

- If you have been approved for enrollment in PRMP through PEP,
AND
- If you are currently active in the PRMP,

These steps are most common if you are:

- Adding a new Primary Service Location that was not previously included in your PEP enrollment application. This is most common if you open a new location after your initial enrollment.

OR

- Applying with a different Enrollment Type.

Please note that if you are applying with more than one Enrollment Type, you must **wait for your first enrollment application to be approved** before submitting your second application. You will need the provider identification number generated when your first enrollment application is approved in order to complete these steps.

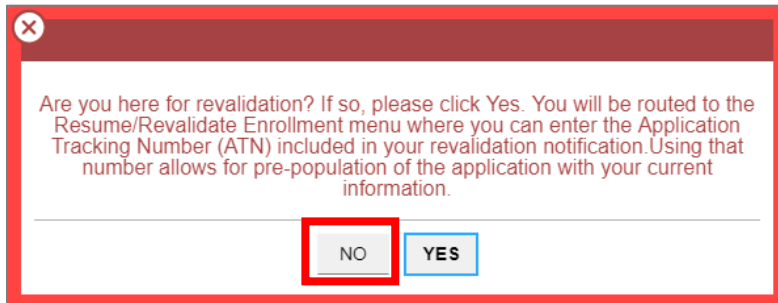
Select **Yes** for the currently enrolled question.



Are you currently enrolled as a Provider? ?

Yes No

Click **No** in the displayed revalidation pop-up window.



Are you here for revalidation? If so, please click Yes. You will be routed to the Resume/Revalidate Enrollment menu where you can enter the Application Tracking Number (ATN) included in your revalidation notification. Using that number allows for pre-population of the application with your current information.

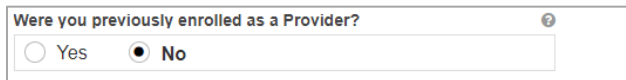
You will be prompted to enter your Current Provider Identifier. This is the Medicaid Identifier (MCD) that was listed in your Welcome Letter and is associated with your previously approved PEP enrollment application. If you have multiple service locations, enter the MCD for any active service location. The one ending in “00” is the primary service location and is preferred.



Are you currently enrolled as a Provider? ? * Current Provider Identifier ?

Yes No

Select **No** for the previously enrolled question.



Were you previously enrolled as a Provider? ?

Yes No

iii. Revalidation (Currently Active):

- If you were previously approved for enrollment in PRMP through PEP,
AND
- If you are currently active in the PRMP,
AND
- You received a letter requesting you to revalidate your enrollment.

The letter will include your ATN from your previously approved enrollment application; the ATN will be used to auto-populate data in your revalidation enrollment application.

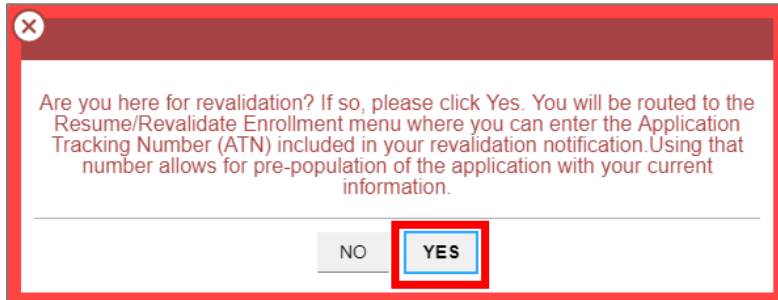
Select **Yes** for the currently enrolled question.



Are you currently enrolled as a Provider?

Yes No

Click **Yes** in the displayed revalidation pop-up window.



Are you here for revalidation? If so, please click Yes. You will be routed to the Resume/Revalidate Enrollment menu where you can enter the Application Tracking Number (ATN) included in your revalidation notification. Using that number allows for pre-population of the application with your current information.

NO YES



NOTE: If Yes is clicked in the revalidation pop-up window, you will be taken to the Resume/Revalidate Enrollment menu option. This option is discussed in **Section 2.4** of the **Provider Enrollment Portal (PEP) Navigation Reference Guide**.

iv. **Reenrollment (Currently Inactive):**

- If you were previously approved for enrollment in PRMP through PEP,
AND
- If you were terminated and are now inactive in the PRMP.

You must apply for reenrollment. Select **No** for the currently enrolled question and **Yes** for the previously enrolled question.



Are you currently enrolled as a Provider?

Yes No

Were you previously enrolled as a Provider?

Yes No

Previous Provider Identifier

When you select **Yes**, you will be prompted to enter your Previous Provider Identifier. This is the Medicaid Identifier (MCD) that was listed in your Welcome Letter and is associated with your previously approved PEP enrollment application. If you have multiple service locations, enter the MCD for any active service location. The one ending in “00” is the primary service location and is preferred.

Answer the remaining question that asks if you are Medicare enrolled.

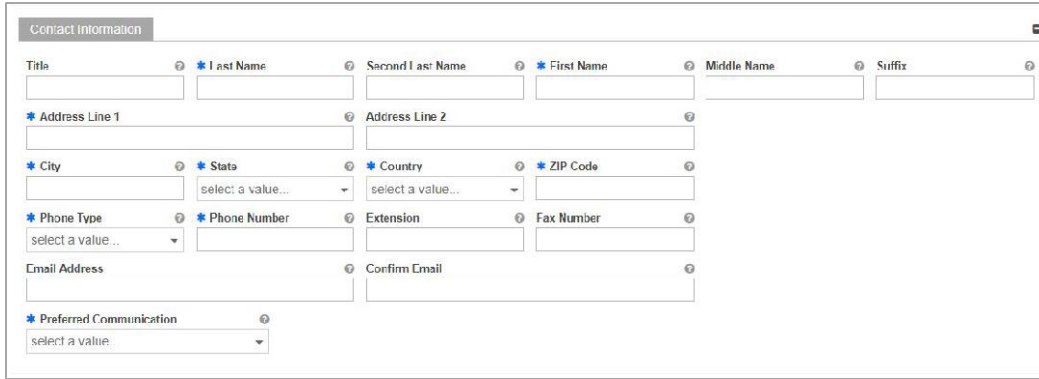


Are you Medicare enrolled?

Yes No

- b. **Contact Information** – Enter contact information for the person responsible for addressing any application-related questions.

Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider



The image shows a 'Contact Information' form with the following fields:

- Title
- Last Name
- Second Last Name
- First Name
- Middle Name
- Suffix
- Address Line 1
- Address Line 2
- City
- State
- Country
- ZIP Code
- Phone Type
- Phone Number
- Extension
- Fax Number
- Email Address
- Confirm Email
- Preferred Communication

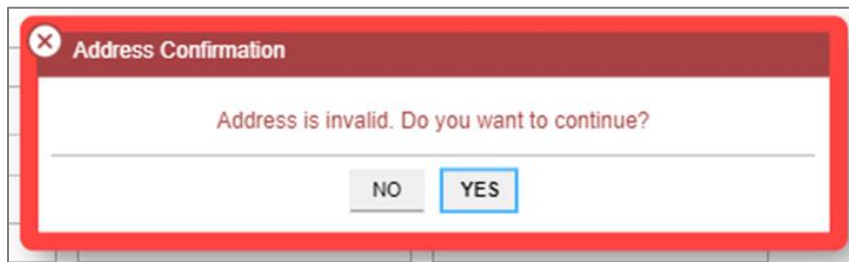


VALID ADDRESS: The PEP system will validate the address entered. If there is an updated variation, select that address from the pop-up window that displays.



Street	City	County	State	Country	ZIP Code
PO BOX 1675	AGUADILLA	AGUADILLA	PR	UNITED STATES	00605-1675

If address is found to be invalid, the following pop-up screen displays:



Address Confirmation

Address is invalid. Do you want to continue?

NO YES

Please note that addresses will only be validated by USPS if they are entered in the following order: In the first line add the building or house number followed by the street name and/or number, and in the second line add the housing, neighborhood or county name.

Example of a valid address: 735 Ave Ponce de León Suite 710

Torre Hospital Auxilio Mutuo

San Juan PR 00917-5030

Example of an invalid address: Torre Hospital Auxilio Mutuo

735 Ave Ponce de León Suite 710

San Juan PR 00917-5030

Click **Save and Continue** at the bottom-right to save the General Information page.

The screenshot shows a 'Contact Information' form with the following fields: Title, * Last Name, Second Last Name, * First Name, Middle Name, Suffix, * Address Line 1, Address Line 2, * City, * State (dropdown), * Country (dropdown), * ZIP Code, * Phone Type (dropdown), * Phone Number, Extension, Fax Number, Email Address, Confirm Email, and * Preferred Communication (dropdown). At the bottom left is a 'CANCEL' button. At the bottom right, there are two 'SAVE AND CONTINUE' buttons; a red arrow points from the first one to the second one, which is highlighted with a red border.



NOTE: If you exit your enrollment application before submitting it, the information you had previously saved will be retained and you may resume your enrollment where you left off.

If you wish to exit your enrollment application without saving the information you have added to the page, click the Cancel button on the bottom left corner of the page.

This close-up shows the 'Preferred Communication' dropdown menu with the text 'select a value...' and a red box highlighting the 'CANCEL' button located below it.

3.2 Specialties

Quick Reference – Specialties

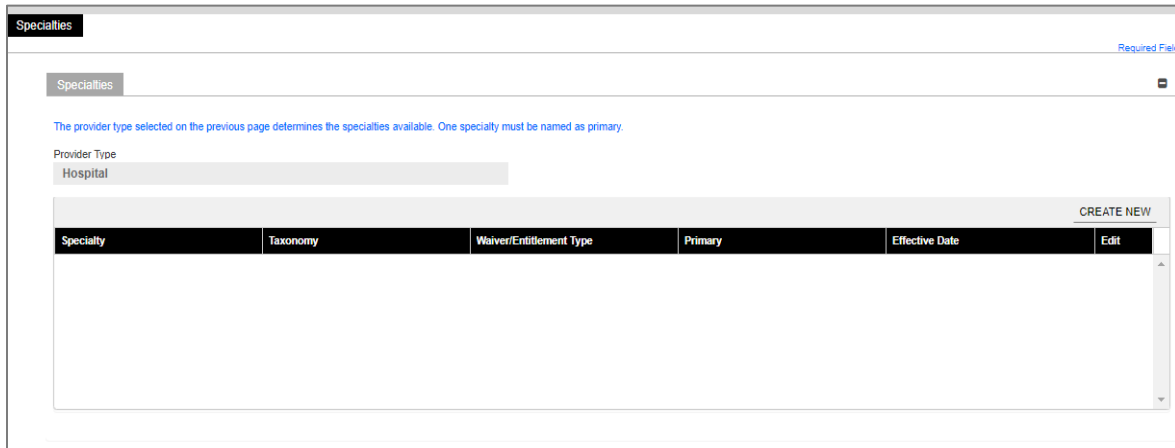
Table 3 – Specialties

Step	Task	Action	Result
Start from Specialties page. This page displays after clicking Save and Continue from the previous page.			
1	Add one or more Specialties.	a. To add a new specialty, click Create New. Once saved, the specialty information will be displayed.	Specialties are added.

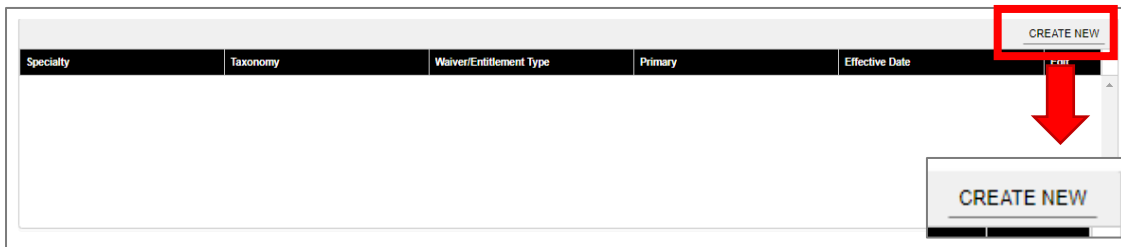
Step	Task	Action	Result
		b. To edit a specialty, click the Edit button next to the desired specialty and save the changes.	
2	Add Additional Taxonomies (if applicable).	a. To add a taxonomy, click Create New at the top-right of the panel. Once filled out and saved, the taxonomy displays in the panel. b. To edit an added taxonomy, click the Edit button next to the desired taxonomy and save the changes. Click Save and Continue.	Additional Taxonomies are added. Progress bar advances to the next available page.

Detailed Steps

1. The Specialties page is displayed. The Provider Type selected on the General Information page is displayed at the top of the **Specialties** section.



- a. To add a specialty, click **Create New** at the top right of the **Specialties** section and complete the required fields in the pop-up window displayed.



Once saved, the specialty displays in the window.

Specialty	Taxonomy	Waiver/Entitlement Type	Primary	Effective Date	Edit
901-General Hospital	282N00000X-General Acute Care Hospital		x	11/15/2018	



PRIMARY SPECIALTY REQUIRED: You must have one Primary Specialty in order to Save and Continue to the next step. To make a Specialty “Primary,” check the Make Primary checkbox in that specific specialty.

 Make Primary

- b. To edit an added specialty, click the Edit button next to the desired specialty and save the changes.

Hospital

CREATE NEW

Specialty	Taxonomy	Waiver/Entitlement Type	Primary	Effective Date	Edit
901-General Hospital	282N00000X-General Acute Care Hospital		x	11/15/2018	

- 2. Related taxonomies can be added and edited in the **Additional Taxonomies** section of the Specialties page.

Additional Taxonomies

Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty.

CREATE NEW

Taxonomy	Edit
----------	------

- a. To add a new taxonomy, click Create New at the top-right of the Additional Taxonomies panel.

Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider

Additional Taxonomies

Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty.

Taxonomy

CREATE NEW

CREATE NEW

New Taxonomy

Required Fields (*)

* Taxonomy

select a value...

CANCEL SAVE

Once a taxonomy is selected from the **Taxonomy** drop-down list and saved, the taxonomy displays in the panel.

Additional Taxonomies

Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty.


Taxonomy	Edit
2865C1500X-Community Health	

CREATE NEW

- b. To edit an added taxonomy, click the Edit button next to the desired taxonomy and save the changes.

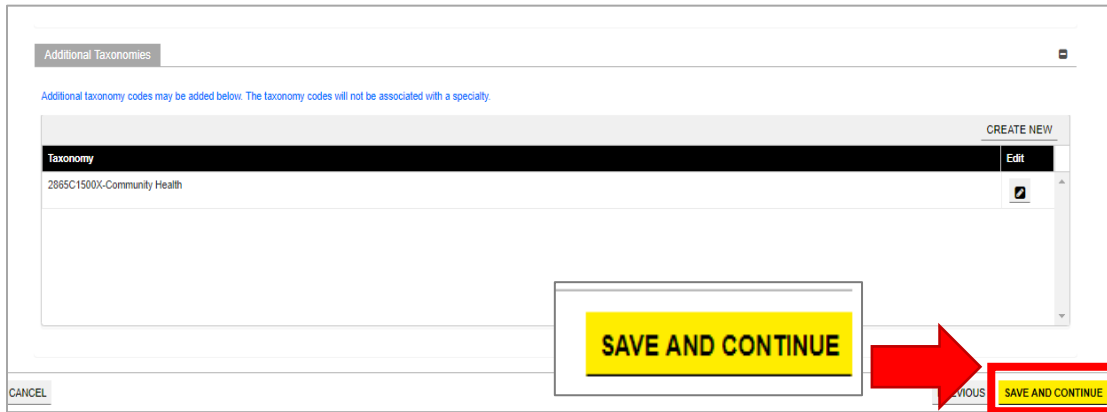
Additional Taxonomies

Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty.

Taxonomy	Edit
2865C1500X-Community Health	

CREATE NEW

Click **Save and Continue** at the bottom-right to save the Specialties page.



3.3 Service Location

Quick Reference – Service Location

Table 4 – Service Location

Step	Task	Action	Result
Start from the Service Location page. This page displays after clicking Save and Continue from the previous page.			
1	Add Service Location.	a. To add a new Service Location, click Create New and complete the required address fields in the displayed pop-up window. b. Click Save to add this information. c. To edit an added Service Location, click the Edit button next to the desired taxonomy and save the changes. Click Save and Continue.	Service Location page is saved. Progress bar advances to the next available page.

Detailed Steps

1. Service Location page is displayed.

The screenshot shows the 'Service Location' page. At the top right, there is a 'Required Fields' indicator with a blue asterisk. Below the page title, there is a 'Service Location' tab and a 'CREATE NEW' button. The main content area contains a table with the following columns: Location Name, Address Line 1, Address Line 2, City, State, Primary, and Edit. The table is currently empty. At the bottom of the page, there are three buttons: 'CANCEL', 'PREVIOUS', and 'SAVE AND CONTINUE'.

Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider

- a. To add a Service Location, click **Create New** and complete the required address fields in the displayed pop-up screen:

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
---------------	----------------	----------------	------	-------	---------	------

Make Primary

Please complete all the required fields under the Service Location address. This will allow you to copy the address to the other address types. Note that copied addresses cannot be edited.

* Location Name

Contact Information

* Last Name Second Last Name * First Name Middle Name Suffix

* Address Line 1 Address Line 2 * Country * State

* City County * ZIP Code Location Code

Email Confirm Email

Phone Number

Service Location Name and Contact Information – Complete the required fields.

New Service Location

Make Primary

Please complete all the required fields under the Service Location address. This will allow you to copy the address to the other address types. Note that copied addresses cannot be edited.

* Location Name

Contact Information

* Last Name Second Last Name * First Name Middle Name Suffix

* Address Line 1 Address Line 2 * Country * State

* City County * ZIP Code Location Code

Email Confirm Email

Phone Number



PRIMARY SERVICE LOCATION: A primary service location is required in order to Save and Continue to the next enrollment step.

Check the “Make Primary” box when adding a new Service Location to mark it as your primary location

Make Primary

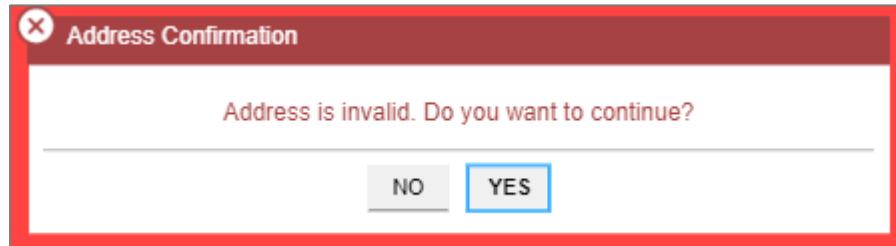
Please complete all the required fields under the Service Location address. This will allow you to copy the address to the other address types. Note that copied addresses cannot be edited.



VALID ADDRESS: The PEP system will validate the address entered. If there is an updated variation, select that address from the pop-up window that displays.

Street	City	County	State	Country	ZIP Code
PO BOX 1675	AGUADILLA	AGUADILLA	PR	UNITED STATES	00605-1675

If address is found to be invalid, the following pop-up screen displays:



Please note that addresses will only be validated by USPS if they are entered in the following order: In the first line add the building or house number followed by the street name and/or number, and in the second line add the housing, neighborhood or county name.

Example of a valid address: 735 Ave Ponce de León Suite 710

Torre Hospital Auxilio Mutuo

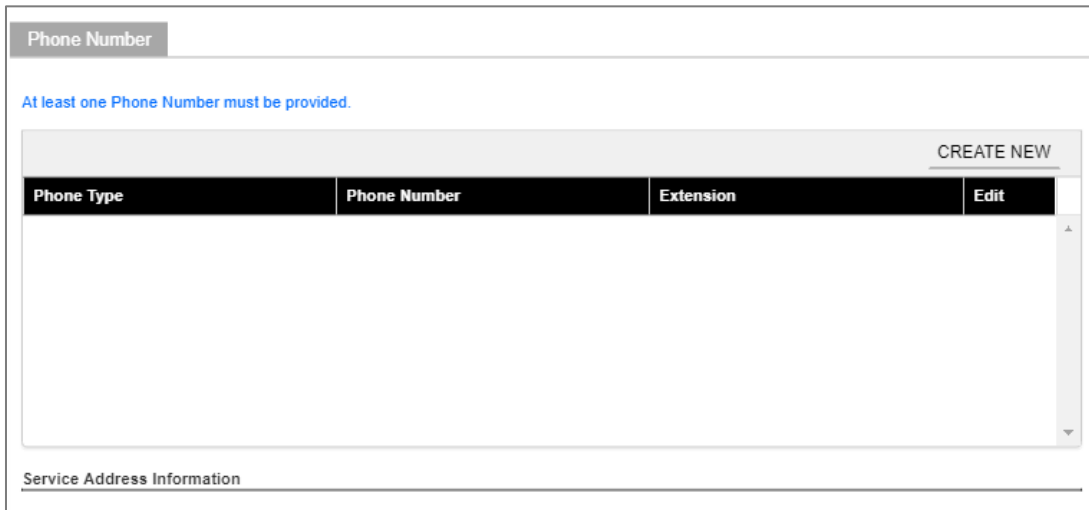
San Juan PR 00917-5030

Example of an invalid address: Torre Hospital Auxilio Mutuo

735 Ave Ponce de León Suite 710

San Juan PR 00917-5030

Phone Number – Add a phone number related to your service location.

A screenshot of a web form titled "Phone Number". At the top left is a tab labeled "Phone Number". Below the tab is a blue error message: "At least one Phone Number must be provided." Below the error message is a table with a "CREATE NEW" link in the top right corner. The table has four columns: "Phone Type", "Phone Number", "Extension", and "Edit". The table is currently empty. At the bottom of the form is a section labeled "Service Address Information".

To add a service location phone number, click **Create New** and complete the required fields in the displayed pop-up screen.

Phone Number

At least one Phone Number must be provided.

Phone Type	Phone Number	Extension	Edit
------------	--------------	-----------	------

CREATE NEW

CREATE NEW

Service Address Information

New Phone Number

Required Fields (*)

* Phone Type ? * Phone Number ? Extension ?

select a value... | |

CANCEL SAVE

Once the information is saved, the phone number displays in the relevant panel.

Phone Type	Phone Number	Extension	Edit
Home	787-882-5581		

CREATE NEW

To edit an added service location phone number, click the **Edit** button next to the phone number and save the changes.

CREATE NEW			
Phone Type	Phone Number	Extension	Edit
Home	787-882-5581		

Service Location Hours – Disclose the Service Location’s hours of operation.

Check the box next to **Hours of Operation**.

Please enter your service location hours of operation

Hours of Operation ?

★ Is the service location ADA compliant? ?

Yes No

★ Is the service location accessible by public transportatio... ?

Yes No

★ What are your after-hour arrangements? ?

Phone Type ? Emergency Phone Number ? Extension ?

select a


In the new Hours of Operation panel that displays, add hours of operation by clicking **Create New** and completing the required fields in the displayed pop-up window.

Please enter your service location hours of operation

Hours of Operation ?

Hours of Operation -

Day	From Hour	To Hour	E
CREATE NEW			



CREATE NEW

New Hours Of Operation

Required Fields (*)

* Day * From Hour * To Hour

select a value... select a value... select a value...

CANCEL SAVE

Once the information is saved, the hours of operation display in the relevant panel.

Hours of Operation

CREATE NEW

Day	From Hour	To Hour	Edit
Weekdays	24 Hours		

To edit the hours of operation, click the **Edit** button next to the desired hours and save the changes.

Hours of Operation

CREATE NEW

Day	From Hour	To Hour	Edit
Weekdays	24 Hours		

Answer the questions regarding your service location hours by selecting or typing in the relevant answer.

* Is the service location ADA compliant? ?
 Yes No

* Is the service location accessible by public transportatio... ?
 Yes No

* What are your after-hour arrangements? ?

Phone Type ? Emergency Phone Number ? Extension ?
select a

Service Address Information – Complete the fields underneath the Service Address Information.

Service Address Information

Accepting New Patients with Special Needs ?

Opt Out of Provider Directory ?

Age Restrictions ?

* Accepting New Patients ?
select a value...

b. Once all sections of the pop-up window are completed, click **Save** at the bottom of the window.

Service Address Information

Accepting New Patients with Special Needs ?

Opt Out of Provider Directory ?

Age Restrictions ?

* Accepting New Patients ?
select a value...

Once the information is saved, the service location displays in the relevant panel.

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
ABC Hospital	Marlin St. 18 Carr. 110	Urb. Villa Aurelia Km. 31.2	Aguadilla	Puerto Rico	x	



MULTIPLE SERVICE LOCATIONS: Based on the application Provider Type, you may be able to add more than one service location on this application.

If the Create New button is disabled after entering one Service Location, this means only one is allowed.

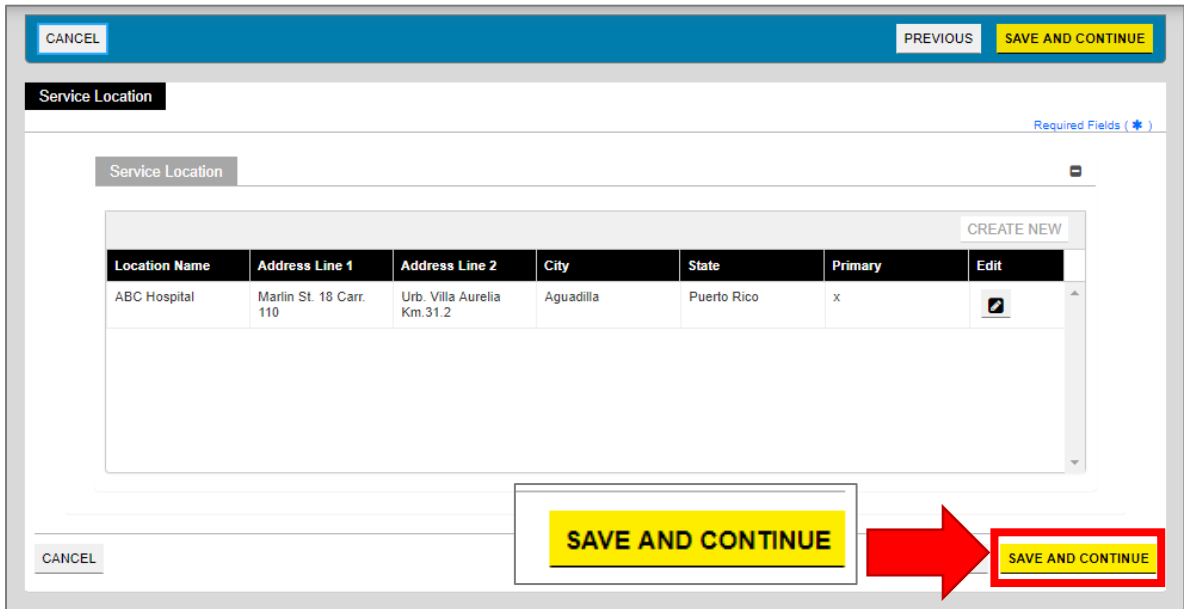
Follow the previous steps to add multiple service locations to your application if applicable.

The multiple service locations that are added must have the same Name, Provider Type, Tax ID, NPI, and Primary Specialty, and the same information in fields related to these sections. The Addresses of these locations must be different.

- c. To edit an added Service Location, click the **Edit** button next to the desired location and save the changes.

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
ABC Hospital	Marlin St. 18 Carr. 110	Urb. Villa Aurelia Km. 31.2	Aguadilla	Puerto Rico	x	

- d. Click the **Save and Continue** button at the bottom right to save the Service Location page.



3.4 Addresses

Quick Reference – Addresses

Table 5 – Addresses

Step	Task	Action	Result
Start from the Addresses page. This page displays after clicking Save and Continue from the previous page.			
1	Add Addresses to enrollment application.	Complete the required fields in all address types presented.	Addresses are added to the enrollment application.
2	Add a Phone Number to each Address type.	<ol style="list-style-type: none"> Click Create New to add at least one phone number. To edit an existing phone number, click the Edit button next to the desired number and save the changes. Click Save and Continue. 	<p>A phone number is added to each Address type. Address information is saved.</p> <p>Progress bar advances to the next available page.</p>

Detailed Steps

1. The Addresses page is displayed. Complete the fields that display below the Service Address Information:

Example: Pay To Address

Pay To

You may enter the Pay To address information only after completing all the required fields for the Service Location address.

Same as Service Location

*** Location Name**

Contact Information

* Last Name	Second Last Name	* First Name	Middle Name	Suffix	Billing Agent Name
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

* Address Line 1	Address Line 2
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

* City	* State	* Country	* ZIP Code
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text" value="select a value..."/>	<input style="width: 95%;" type="text" value="select a value..."/>	<input style="width: 95%;" type="text"/>

Same as Service Location

Email	Confirm Email
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Example: Mail To Address

Mail To

You may enter the Mail To address only after completing all the required fields for the Service Location address.

Same as

Location Name

Contact Information

Last Name	Second Last Name	First Name	Middle Name	Suffix
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Address Line 1	Address Line 2
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

City	* State	* Country	ZIP Code
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text" value="select a value..."/>	<input style="width: 95%;" type="text" value="select a value..."/>	<input style="width: 95%;" type="text"/>

Same as

*** Preferred Communication**

Email

Email	Confirm Email
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>



ADDRESS SAME AS SERVICE LOCATION: If the addresses to be entered in this section are the same address as the Primary Service Location, click the “Same as Service Location” checkbox at the top of each Address type section. This will automatically fill the Address with the same information entered as the primary Service Location on the Service Location page.

Pay To

You may enter the Pay To address information only after completing all the required fields for the Service Location address.

Same as Service Location

For some Address types, you could see a drop-down list at the beginning named “Same As”. The drop-down list will include all address types you have entered up to this point (example: Service Location, Pay To, etc.). This will automatically complete the Address fields with the same information previously entered for the chosen address type.

Same as

select a value...

select a value...

Service Location

Pay To

2. Add phone numbers to the Address step of your enrollment.

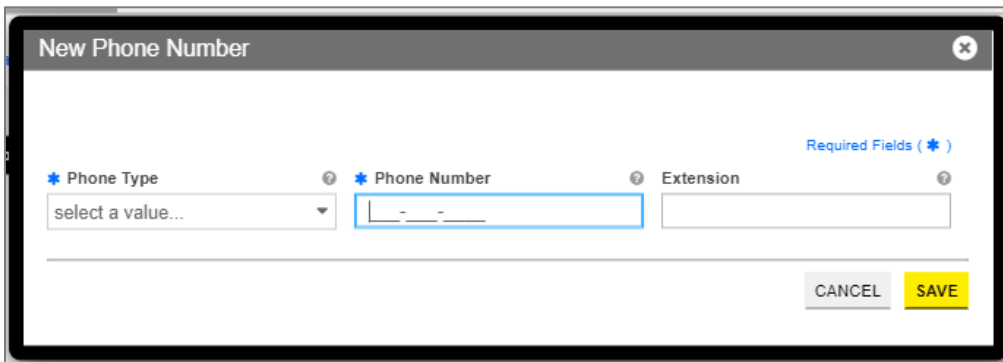
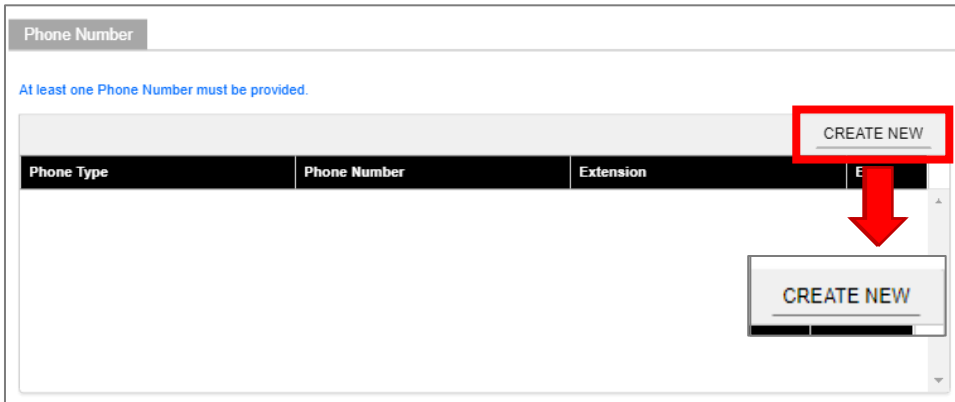
Phone Number

At least one Phone Number must be provided.

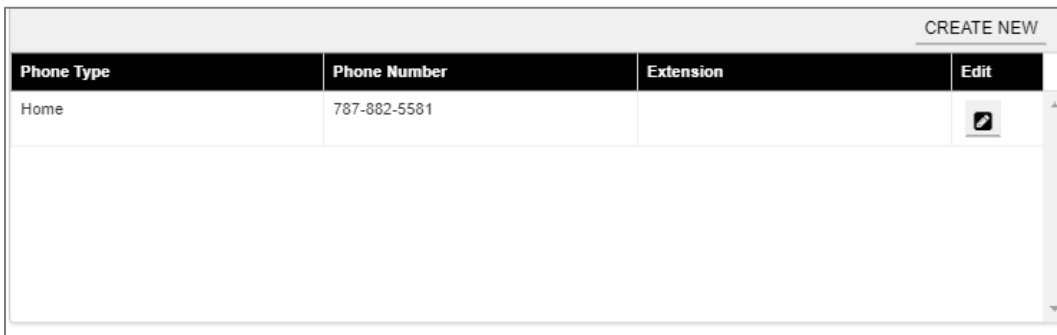
[CREATE NEW](#)

Phone Type	Phone Number	Extension	Edit

- a. To add a phone number, click **Create New** at the top-right of the **Phone Number** section and complete the required fields in the displayed pop-up window.



Once the information is saved, the phone number displays in the relevant panel.



- b. To edit an added address phone number, click the **Edit** button next to the phone number and save the changes.

Phone Type	Phone Number	Extension	Edit
Home	787-882-5581		



Like the Addresses, phone numbers added to a Service Location can be carried over by clicking the Same as Service Location checkbox near the Phone Number panel.

 Same as Service Location

- c. Click **Save and Continue** at the bottom-right to save the Addresses page.

Phone Number

At least one Phone Number must be provided.

Phone Type	Phone Number	Extension	Edit
------------	--------------	-----------	------

SAVE AND CONTINUE

SAVE AND CONTINUE

3.5 Capacities

The Capacity page is presented if the Provider Type and Specialty disclosed in previous steps requires capacity information to be entered. If this page is not available on your application, you can continue to [Section 3.6 Organization](#) to see the instructions for your next required step.

Quick Reference – Capacities

Table 6 – Capacities

Step	Task	Action	Result
Start from the Capacity page. This page displays after clicking Save and Continue from the previous page.			
1	Add Capacity information.	<ul style="list-style-type: none"> a. To add capacity information, click Create New and complete the required fields in the displayed pop-up window. Once the information is saved, the capacity information is displayed. b. To edit added capacity information, click the Edit button next to the desired capacity entry and save the changes. c. Click Save and Continue. 	Capacity information is added and saved. Progress bar advances to the next available page.

Detailed Steps

1. The Capacity page displays. A capacity is the maximum Medicaid Member count for each of a provider’s Specialties within the County and State.

The screenshot shows the 'Capacity' page interface. At the top, there's a search bar labeled 'Capacity By Speciality' with the text '962 - Optometrist' entered. Below this is a table with the following columns: 'State', 'County', 'Waiver/Entitlement Type', 'Maximum Medicaid Member Count', and 'Edit'. The table contains one entry: 'Puerto Rico' for State and 'Isabela Municipio' for County. To the right of the table is a 'CREATE NEW' button. At the bottom of the page, there are three buttons: 'CANCEL', 'PREVIOUS', and 'SAVE AND CONTINUE'.

- a. To add a new capacity, click **Create New** and complete the required fields in the displayed pop-up window.

The screenshot shows the 'Capacity' panel with a table containing one entry: Puerto Rico, Isabela Municipio. A red box highlights the 'CREATE NEW' button in the top right corner of the table, and a red arrow points down to a larger 'CREATE NEW' button below the table.

The screenshot shows the 'New Capacity' pop-up window. It contains three required fields: State (dropdown), County (dropdown), and Maximum Medicaid Member Count (text input). The 'State' and 'County' dropdowns show 'select a value...'. There are 'CANCEL' and 'SAVE' buttons at the bottom right.

Once the information is saved, the capacity displays in the relevant panel.



CAPACITY ALREADY DISPLAYED: Some enrollments show a partially completed capacity entry already added in the Capacity panel, based on the service location address and specialty. You will still need to edit the existing capacity entry to supply the Maximum Medicaid Member Count.

See the next step for instructions on editing a capacity.

- b. To edit an added capacity, click the **Edit** button next to the desired capacity entry and save the changes.

The screenshot shows the 'Capacity' panel with the same table as before. A red box highlights the 'Edit' button (with a pencil icon) next to the first entry in the table.

c. Click **Save and Continue** at the bottom-right to save the Capacity page.

3.6 Organization

Quick Reference – Organization

Table 7 – Organization

Step	Task	Action	Result
Start from the Organization page. This page displays after clicking Save and Continue from the previous page.			
1	Add Organizational Details.	a. Complete the required and relevant fields in the Organizational Details section. b. Click Save and Continue.	Organizational Details are saved. Progress bar advances to the next available page.

Detailed Steps

1. The Organization page is displayed.
 - a. Complete the required and relevant fields in the **Organizational Details** section.

Organization
Required Fields (★)

Organizational Details

If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.
If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.

★ Organization Type ⓘ

select a value...

★ Tax Classification ⓘ

select a value...

Entities doing business in the State, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. For more information on the registration process, please go to the Secretary of State website at <https://www.estado.pr.gov/>

Registered with Secretary Of State ⓘ

Business Start Date ⓘ

Incorporated ⓘ

Incorporation Date ⓘ

Chain Affiliated ⓘ

Operated by Management Company ⓘ

Domestic Owned Corporation ⓘ

Foreign Owned Corporation ⓘ

CANCEL
PREVIOUS
SAVE AND CONTINUE



ORGANIZATIONAL DETAILS: The organizational details added in this page must match the information you disclose when filing your taxes.

If you have any questions regarding what information you enter in this step, consult your tax specialist.

- b. Click **Save and Continue** at the bottom-right of the page to save the information entered on the Organization page.

3.7 Credentials

NOTE: The information collected on this page may differ depending on the Provider Type and Specialty chosen in previous enrollment steps.

Quick Reference – Credentials

Table 8 – Credentials

Step	Task	Action	Result
Start from the Credentials page. This page displays after clicking Save and Continue from the previous page.			
1	Add Credentials information.	Complete the required information for any of the following sections that are presented: a. License b. Medicare Participation c. Medicaid Program d. DEA e. Puerto Rico Controlled Substance Certificate Click Save and Continue.	Credentials are successfully added and saved. Progress bar advances to the next available page.

Detailed Steps

1. The Credentials page displays. The credential information that may be collected for Atypical Provider enrollments are shown below:

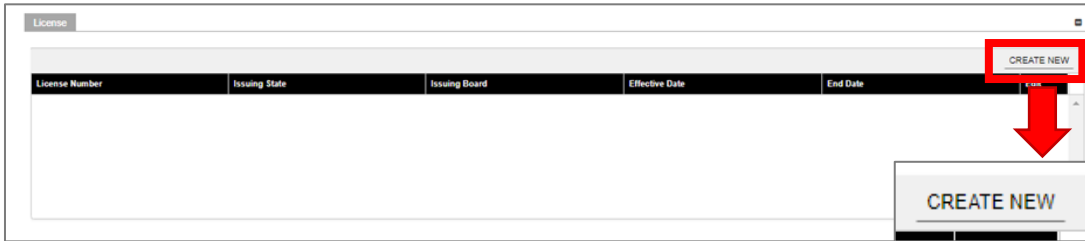
- a. **License** – Add a license, in good standing, in the same state as the service location.

License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit
----------------	---------------	---------------	----------------	----------	------



LICENSE: Only add license information in this panel pertaining to medical licenses belonging to the provider being enrolled.

To add a new license, click **Create New** at the top-right of the **License** section and complete the required fields in the displayed pop-up window.



New License

Required Fields (*)

* License Number

* Issuing State

* Issuing Board

* Effective Date

* End Date

CANCEL SAVE



ISSUING BOARD: The Issuing Board information will come directly from the license that was issued by the appropriate Board, State, or Entity.

Once saved, the license will display in the relevant panel.

To edit an added license, click the **Edit** button next to the desired license and save the changes.

License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit
8685747645	Puerto Rico	Test Org	8/30/2019	8/30/2025	



ADDING MULTIPLE LICENSES: You can add more than one license to the License panel if needed.

Repeat the previous steps to add more licenses.

- b. **Medicare Participation** – If this panel displays, your enrollment requires the collection of Medicare Participation information.

To add new Medicare information, click **Create New** and complete the required fields in the displayed pop-up window.


Once saved, the Medicare Participation information will be displayed.



NOTE: If you answered 'No' to the "Are you Medicare enrolled" question on the General Information page, you will receive this pop-up warning:

Click **Yes** to save the credential information you entered. This will update the answer to the question on the General page to 'Yes'.

To edit an added Medicare Participation entry, click the **Edit** button next to the desired Medicare Participation entry and save the changes.

Medicare Participation					
Medicare Number	Medicare Type	Effective Date	End Date	Consider for Medicare Cro...	Edit
9074389732	Medicare Part A	8/30/2019	8/30/2025		



ADDING MULTIPLE RECORDS: You can add more than one record to the Medicare Participation panel if needed.

Repeat the previous steps to add more records.

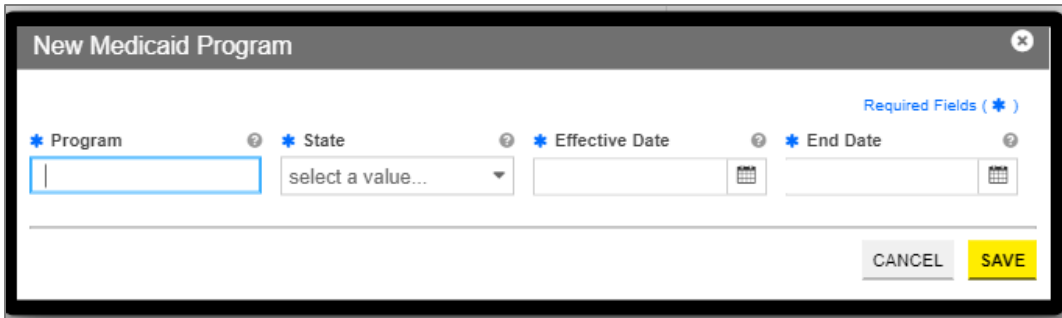
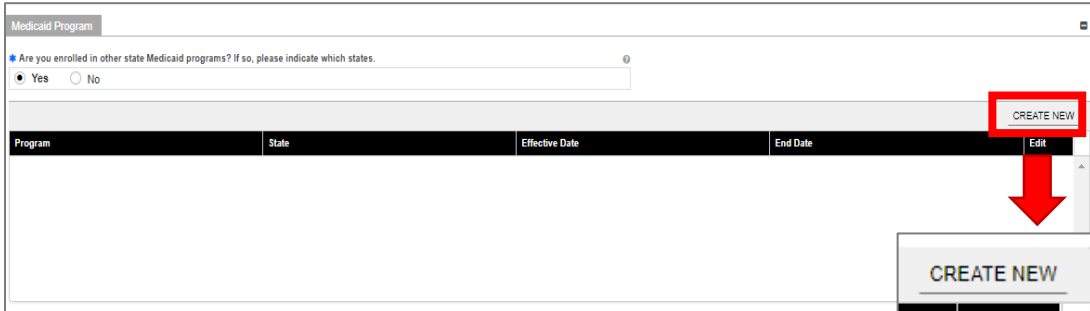
- c. **Medicaid Program** – Answer if you are enrolled in other Medicaid Programs by selecting **Yes** or **No**.

Medicaid Program
<p>* Are you enrolled in other state Medicaid programs? If so, please indicate which states.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>

If **Yes** is selected, a new panel opens for you to indicate which state(s) Medicaid Program you are currently enrolled in.

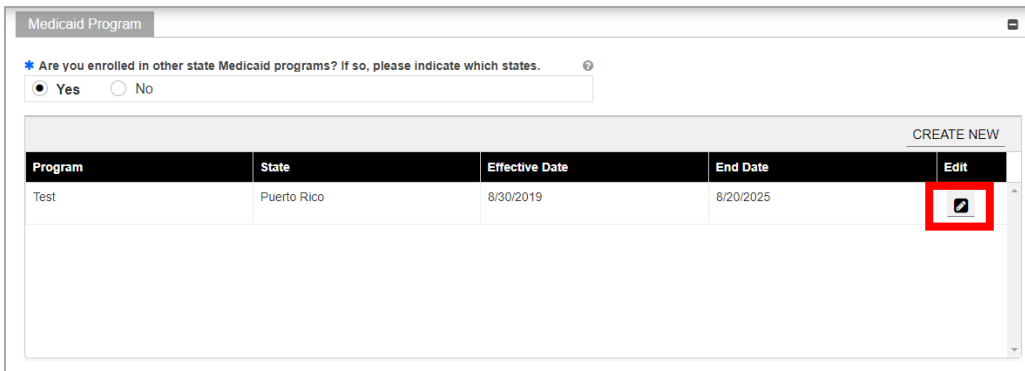
Medicaid Program					
Program	State	Effective Date	End Date	Edit	
<p>* Are you enrolled in other state Medicaid programs? If so, please indicate which states.</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p>					

Click **Create New** at the top-right of the **Medicaid Program** section and complete the required fields in the displayed pop-up window.



Once the information is saved, the credentials display in the relevant window.

To edit an added Medicaid Program entry, click the **Edit** button next to the desired entry and save the changes.



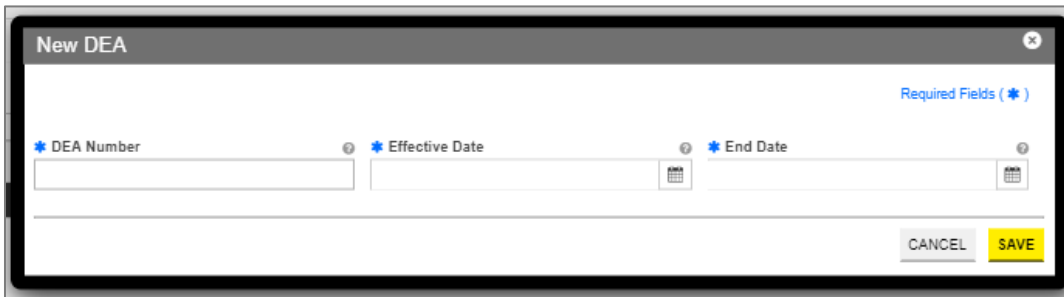
ADDING MULTIPLE RECORDS: You can add more than one record to the Medicaid Program panel if needed.

Repeat the previous steps to add more records.

- d. **DEA** – Add Drug Enforcement Administration (DEA) number information.

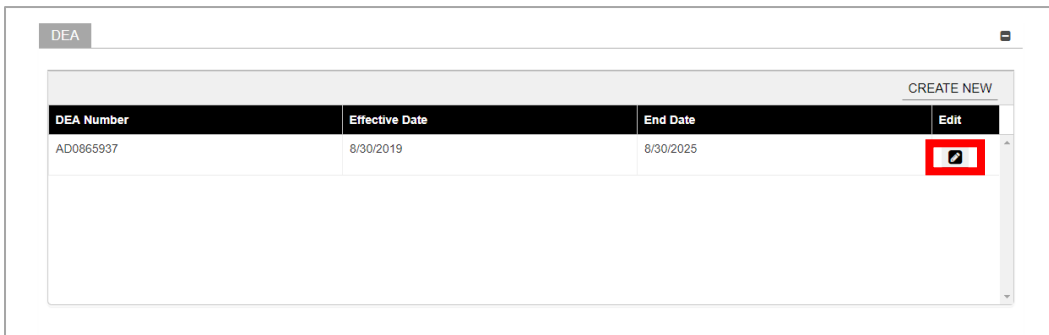


To add a new DEA number, click **Create New** at the top-right of the **DEA** section and complete the required fields in the displayed pop-up window.



Once saved, the DEA license will display in the relevant panel.

To edit an added DEA license, number entry, click the **Edit** button next to the desired DEA number and save the changes.



- e. **Puerto Rico Controlled Substance Certificate** – Indicate if you prescribe and/or dispense controlled substances in Puerto Rico by selecting **Yes** or **No**.

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico? ?

Yes No

Do you dispense controlled substances in Puerto Rico? ?

Yes No

If **Yes** is selected for either question, a new section opens for you to add your Registration Number.

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?
 Yes No

CREATE NEW

Registration Number	Effective Date	End Date	Edit

Do you dispense controlled substances in Puerto Rico?
 Yes No

CREATE NEW

Registration Number	Effective Date	End Date	Edit

Click **Create New** at the top-right of the new section and complete the required fields in the displayed pop-up window.

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?
 Yes No

CREATE NEW

Registration Number	Effective Date	End Date	Edit

CREATE NEW

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Required Fields (*)

* Registration Number ? * Effective Date ? * End Date ?

CANCEL SAVE


Once the information is saved, the Registration Number information is displayed.

To edit an added Registration Number entry, click the **Edit** button next to the desired entry and save the changes.

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?
 Yes No

CREATE NEW

Registration Number	Effective Date	End Date	Edit
AB123467	01/01/2000	01/02/2222	



ADDING MULTIPLE RECORDS: You can add more than one record to the Medicaid Program panel if needed.


Repeat the previous steps to add more records.

Once all credentials have been added, click **Save and Continue** at the bottom-right to save the Credentials page.

Puerto Rico Controlled Substance Certificate (previously ASSMCA)


Do you prescribe controlled substances in Puerto Rico?
 Yes No


CREATE NEW

Registration Number	Effective Date	End Date	Edit
AB123467	01/01/2000	01/02/2222	

Do you dispense controlled substances in Puerto Rico?
 Yes No

CREATE NEW

Registration Number	Effective Date	End Date	Edit
BB962151	01/01/2000	01/01/2222	

CANCEL **SAVE AND CONTINUE**  **SAVE AND CONTINUE**

3.8 Other

NOTE: The information collected on this page may differ depending on the Provider Type and Specialty chosen in previous enrollment steps.

Quick Reference – Other

Table 9 – Other

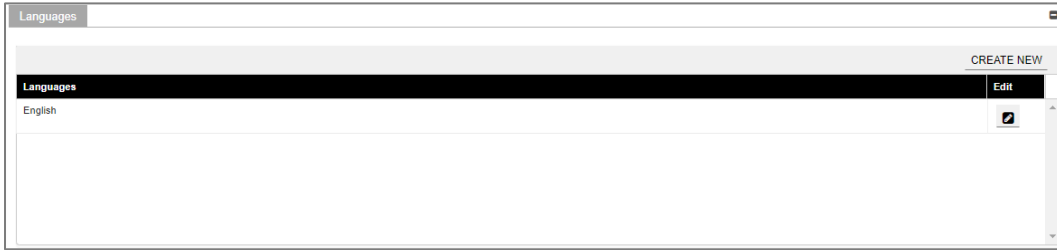
Step	Task	Action	Result
Start from the Other page. This page displays after clicking Save and Continue from the previous page.			
1	Add Other information.	Complete the required information for any of the following sections that are presented: a. Languages b. Certifications c. Additional Information d. Malpractice Carrier Information e. Malpractice Suit Information Click Save and Continue.	Other information is added and saved. Progress bar advances to the next available page.

Detailed Steps

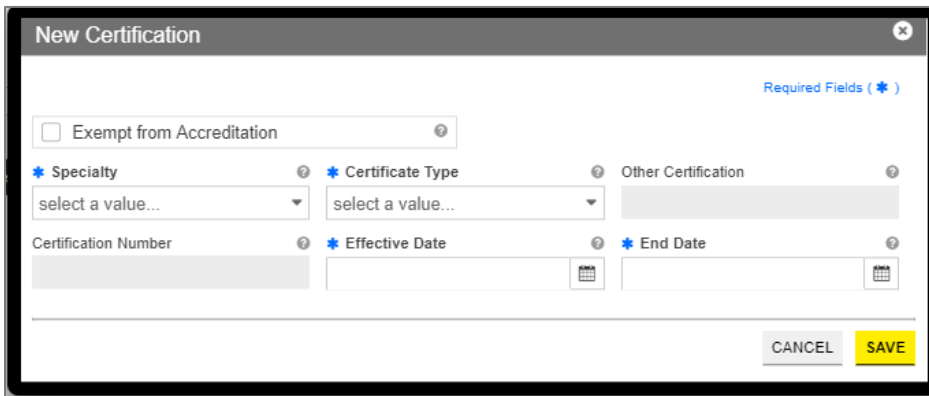
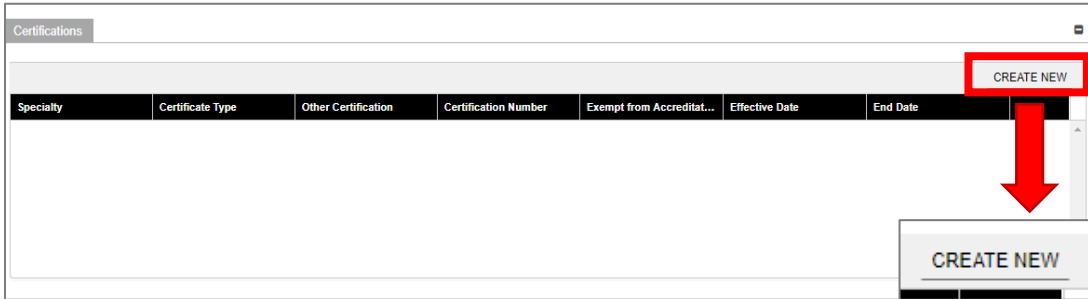
1. The Other page is displayed. The other information that may be collected for Atypical Provider enrollments are shown below.
 - a. **Languages** – To add a new language, click **Create New** at the top-right of the **Languages** section and select the applicable language from the **Languages** drop-down list in the pop-up window.



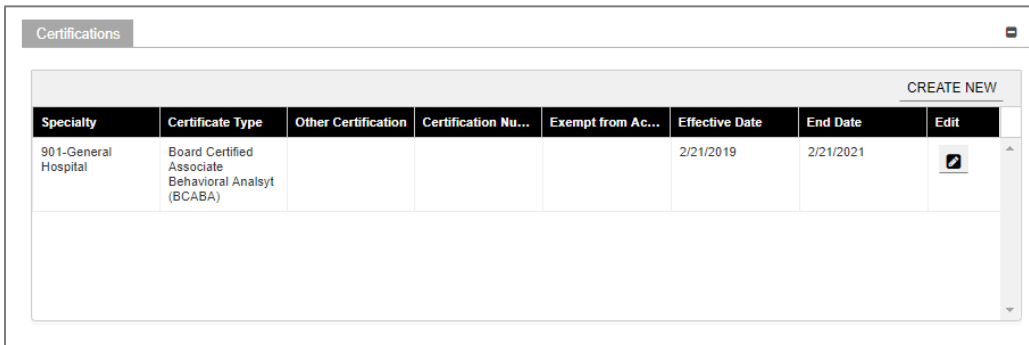
Once the information is saved, the language information is displayed.



- b. **Certifications** – To add a new certification, click **Create New** at the top-right of the **Certification** section and complete the required fields in the displayed pop-up window.



Once the information is saved, the certification information is displayed.



- c. **Additional Information** – Enter the **URL** for your Provider website. This step is optional.

Additional Information

Please enter the provider website address below. It must begin with "http:" or "https:" followed by a valid address.

Provider Website URL ?

- d. **Malpractice Carrier Information** – To add a new malpractice carrier information, click **Create New** at the top-right of the **Malpractice Information** section and complete the required fields in the displayed pop-up window.

Malpractice Information

Please complete the malpractice information below

CREATE NEW

Type of Carrier	Name of Carrier	Coverage Amount Aggr...	Coverage Amount Per O...	Policy Number	Effective Date	End Date	Edit

CREATE NEW

New Malpractice Carrier Information

Required Fields (*)

* Type of Carrier ? * Name of Carrier ? * Policy Number ?

select a value...

* Coverage Amount Aggregate ? * Coverage Amount Per Occurrence ? * Effective Date ? * End Date ?

CANCEL SAVE

Once the information is saved, the carrier information displays in the relevant window.

Malpractice Information

Please complete the malpractice information below

CREATE NEW

Type of Carrier	Name of Carrier	Coverage Amount Aggr...	Coverage Amount Per O...	Policy Number	Effective Date	End Date	Edit
Comprehensive General Liability	Triple S	10000000	25000	387648326	2/12/2019	2/23/2021	✎

- e. **Malpractice Suit Information** – Select **Yes** or **No** to answer the question regarding current and previous Malpractice suits.

If you select **No**, no additional information is needed.

Are you currently or have you within the last 5 years been involved in a malpractice suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit?

Yes No

If you select **Yes**, a panel is presented to collect information regarding current and previous malpractice suits. To add the suit information, click **Create New** at the top-right of the **Malpractice Suit** section and complete the required fields in the displayed pop-up window.

Are you currently or have you within the last 5 years been involved in a malpractice suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit?

Yes No

Patient Name	Policy Number	Your status in the ...	Claimant / Plaintiff...	Status Claim
CREATE NEW				
CREATE NEW				

New Malpractice Information

Required Fields (*)

* Patient/Plaintiff Name
 Patient Name Plaintiff Name

* Patient Name

* Your Involvement in the Case * Date of occurrence * Your status in the Case * Claim Date

* Liability carrier involved * Carrier's phone number * Policy Number * Additional defendants

* Describe the allegations against you * Describe the alleged injury to the patient

* Claimant / Plaintiff filed suit in court
 Yes No

Please enter either State or Federal Court Case Number but not both.

State Court Case Number State County

Federal Court Case Number District

* Status Claim

CANCEL SAVE

Once the information is saved, the malpractice suit information is displayed.

Once all sections of the page have been completed, click **Save and Continue** at the bottom-right of the page to save the Other page.

3.9 Disclosures

Quick Reference – Disclosures

Table 10 – Disclosures

Step	Task	Action	Result
Start from the Disclosures page. This page displays after clicking Save and Continue from the previous page.			
1	Complete Disclosure forms.	<ol style="list-style-type: none"> Complete the disclosure forms displayed by clicking Create New next to each form. To edit or delete a form, click the desired form’s name and then the Edit button in the displayed pop-up window. Click Save and Continue once all forms are completed. 	Disclosures are completed. Progress bar advances to the next available page.

Detailed Steps

1. The Disclosure page lists the required forms that need to be completed.

Disclosure Details

PRIVACY NOTICE STATEMENT

This statement explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs) and dates of birth (DOB), may be requested and used.

Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the Puerto Rico Medicaid Program (PRMP). This information will also be used to ensure that no payments will be made to providers who are excluded from participation. Any information may also be provided to the U.S. DHHS Centers for Medicare and Medicaid Services, the Internal Revenue Service, Puerto Rico Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state or logical agencies as appropriate.

Providing this information is mandatory to be eligible to enroll as a provider with the PRMP, pursuant to 42 CFR § 455 and CFR § 438. Failure to submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain Medicaid funds.

OWNERSHIP/CONTROLLING INTEREST

Federal law requires individuals and entities with ownership, control, management or a business relationship to submit a separate disclosure form for each entity or person affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 106, 42 CFR § 455.436, 42 CFR § 1002.3, and CFR § 438.602 (b)

Note that your list of disclosures may differ from the following examples as the disclosure requirements are based on your responses throughout the enrollment application. Disclosures that do not apply to your application will not display.

DISCLOSURE FORMS

All entities and persons enrolling or revalidating with PRMP are required to report their disclosing entities. (Please note this does not include those providers enrolling as ordering, referring, or prescribing (OPR) providers.) Possible disclosing entities can be: A person with direct or indirect ownership equal to 5% or more, an entity that owns an interest of 5% or more in a mortgage, deed/trust, note or other obligation or a managing employee, and/or a subcontractor.

Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please provide the additional information that may be requested.

Disclosure Form	Status	Create New
Provider Self Disclosure	New	CREATE NEW
Sub-Contractor Disclosure	New	CREATE NEW
Ownership and Control Interest	New	CREATE NEW
Managing Employees	New	CREATE NEW
Business Transaction	New	CREATE NEW

CANCEL
PREVIOUS
SAVE AND CONTINUE

- a. To start completing a disclosure form, click **Create New** next to the desired form name.

Some disclosures allow more than one form to be completed. The **Create New** button will be enabled if the form can be completed again.

For example, if there is more than one owner with controlling interest, a separate disclosure will need to be completed for each owner. Click **Create New** to complete an additional disclosure for each owner with controlling interest.

Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider

DISCLOSURE FORMS

All entities and persons enrolling or revalidating with PRMP are required to report their disclosing entities. (Please note this does not include those providers enrolling as ordering, referring, or prescribing (OPR) providers.) Possible disclosing entities can be: A person with direct or indirect ownership equal to 5% or more, an entity that owns an interest of 5% or more in a mortgage, deed/trust, note or other obligation or a managing employee, and/or a subcontractor.

Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please provide the additional information that may be requested.

Disclosure Form	Status	Create New
Provider Self Disclosure	New	CREATE NEW
Sub-Contractor Disclosure	New	CREATE NEW
Ownership and Control Interest	New	CREATE NEW
Managing Employees	New	CREATE NEW
Business Transaction	New	CREATE NEW

CANCEL
PREVIOUS
SAVE AND CONTINUE

The disclosure details display in a pop-up window. Complete all fields within the form.

Example: Provider Self Disclosure

New Provider Self Disclosure ✕

Required Fields (*)

Providers are required to answer all questions on this form. For questions that may not be applicable, select a response of "No".

Title	Legal Last Na...	First Last Name	Second Last ...	First Name	Middle Name
<input type="text"/>	Last	Last	<input type="text"/>	First	<input type="text"/>
Suffix	SSN	Birth Date			
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Licensure

* Has any action ever been taken against your license or certification, by any state or certification board in the past 10 years? ?

Yes No

* Have there been any changes to your license, registration or certification in the past 10 years? ?

Yes No



ADDITIONAL FIELDS IN FORM: If "Yes" is clicked for any question on the form, an additional field or panel will display to add more information.

Once the form is completed, click **Save**.

s program since the inception of those programs?

* Jurisdiction ?

CANCEL SAVE

When the form is saved, the form’s status will change to “Completed.”

- b. To edit or delete an added disclosure form, click on the name of the desired form.

DISCLOSURE FORMS

All entities and persons enrolling or revalidating with PRMP are required to report their disclosing entities. (Please note this does not include those providers enrolling as ordering, referring, or prescribing (OPR) providers.) Possible disclosing entities can be: A person with direct or indirect ownership equal to 5% or more, an entity that owns an interest of 5% or more in a mortgage, deed/trust, note or other obligation or a managing employee, and/or a subcontractor.

Answer all questions. If you do not believe that a question is applicable, select a response of “No”. If you respond “Yes” to any question, please provide the additional information that may be requested.

Disclosure Form	Status	Create New
Provider Self Disclosure	Completed	CREATE NEW
Sub-Contractor Disclosure	Completed	CREATE NEW
Ownership and Control Interest	Completed	CREATE NEW
Managing Employees	Completed	CREATE NEW
Business Transaction	Completed	CREATE NEW

CANCEL PREVIOUS **SAVE AND CONTINUE**

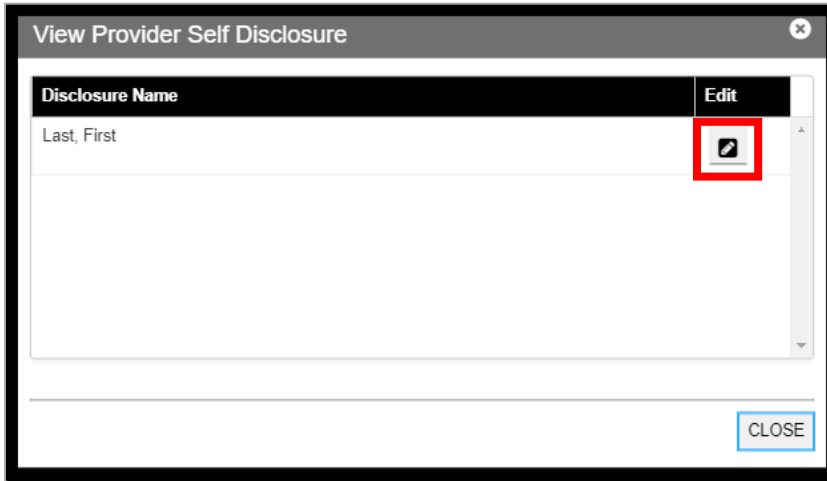
A pop-up window displays the forms you have submitted for that disclosure type. If you completed more than one form for that disclosure type, you will see multiple forms.

View Provider Self Disclosure

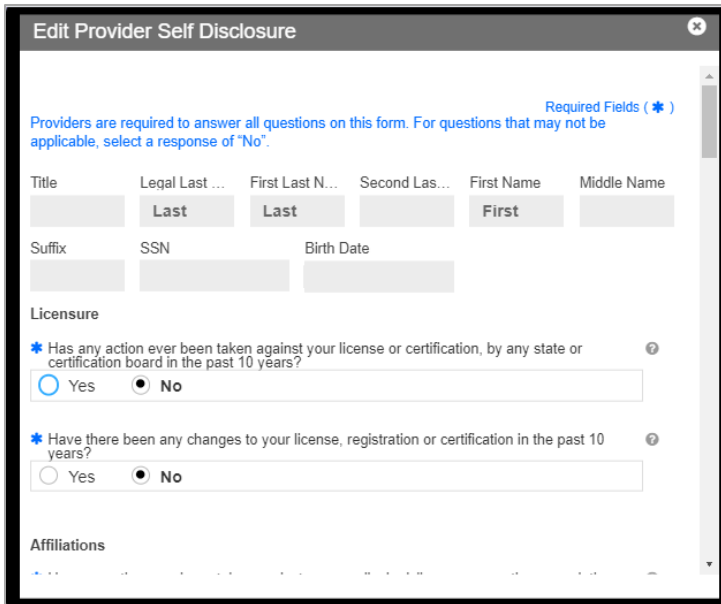
Disclosure Name	Edit
Last, First	

CLOSE

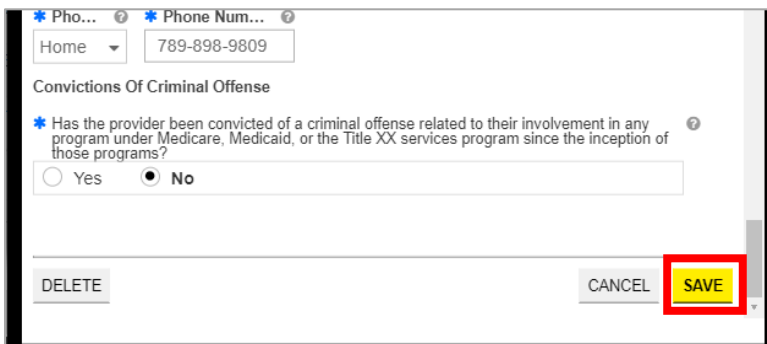
Click the **Edit** button next to the desired form from the list.



The completed form is displayed in a new pop-up window. There you can edit any field you had previously completed.



To save any information you have edited, scroll to the bottom of the form and click **Save** in the bottom-right corner.



If you want to delete the form, scroll to the bottom of the form and click **Delete** in the bottom-left corner.

The screenshot shows a form with a 'Home' dropdown menu and a phone number field containing '789-898-9809'. Below this is a section titled 'Convictions Of Criminal Offense' with a question: 'Has the provider been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs?'. There are radio buttons for 'Yes' and 'No', with 'No' selected. At the bottom of the form, there are three buttons: 'DELETE' (highlighted with a red box), 'CANCEL', and 'SAVE'.

A pop-up window displays for you to confirm if you would like to delete the form. Click **Yes**.

The screenshot shows a 'Delete Confirmation' dialog box with a red border. The text inside asks, 'Are you sure you want to delete this record?'. At the bottom, there are two buttons: 'NO' and 'YES' (highlighted with a red box).

The form is now deleted from your application.

Please note that if you deleted the only form for that disclosure type, the status will change from “Completed” to “New.”

- c. Once all forms are completed, click **Save and Continue** at the bottom-right to save the Disclosures page.

The screenshot shows the 'DISCLOSURE FORMS' page. It includes a table with the following data:

Disclosure Form	Status	Create New
Provider Self Disclosure	Completed	CREATE NEW
Sub-Contractor Disclosure	Completed	CREATE NEW
Ownership and Control Interest	Completed	CREATE NEW
Managing Employees	Completed	CREATE NEW
Business Transaction	Completed	CREATE NEW

At the bottom of the page, there are three buttons: 'CANCEL', 'SAVE AND CONTINUE', and another 'SAVE AND CONTINUE' button (highlighted with a red box) with a red arrow pointing to it from the first 'SAVE AND CONTINUE' button.



SAVING AND CONTINUING: All required forms must display a “Completed” status to save the Disclosures step and continue to the next enrollment step.

If required forms remain incomplete, you will not be allowed to continue to the next step.

3.10 Background Check

NOTE: The Background Check page displays for high-risk providers with an individual owner.

If the Background Check page does not display in your enrollment, it is not required for your Atypical Provider Type. If this is the case, go to [Section 3.11 Attachments](#) to view the instructions for your next required step.

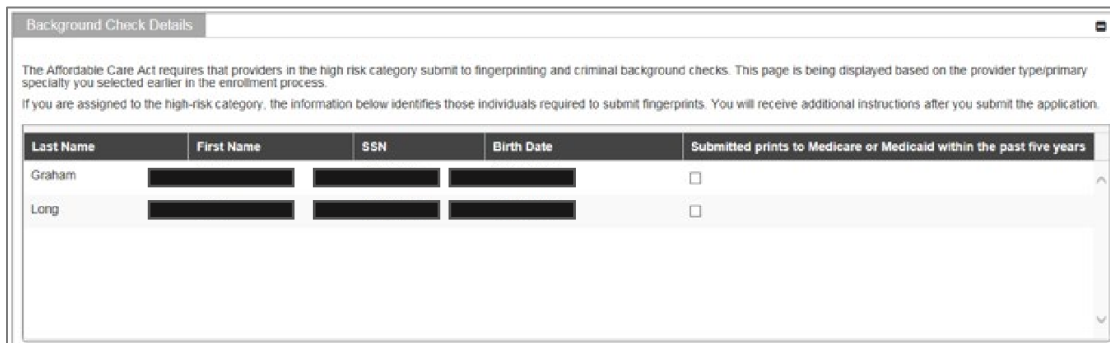
Quick Reference – Background Check

Table 11 – Background Check

Step	Task	Action	Result
Start from the Background Check page. This page displays after clicking Save and Continue from the previous page.			
1	Review Background Check information.	a. Verify that all names displayed in the Background Check Details panel are correct. b. Check the box in the final column of the panel if the person has submitted fingerprints to Medicaid within the past five years. c. Click Save and Continue.	Background check is reviewed. Progress bar advances to the next available page.

Detailed Steps

1. The Background Check page is displayed. Individuals with 5% or greater ownership who may be required to submit fingerprints are displayed in the Background Check Details panel. This information was populated from the Disclosures step.



- a. Verify that all names displayed in the Background Check Details panel are correct.

Last Name	First Name	SSN	Birth Date	Submitted prints to Medicare or Medicaid within the past five years
Graham	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>
Long	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>



MISSING OWNERS OR INCORRECT INFORMATION: If information displayed is incorrect or any owners are missing, go back to the Disclosures step in your enrollment (discussed in [Section 3.9](#)), update and save the information.

- b. Check the **Submitted prints to Medicare or Medicaid within the past five years** box in the final right column of the panel if the person has submitted fingerprints to Medicaid within the past five years.

Last Name	First Name	SSN	Birth Date	Submitted prints to Medicare or Medicaid within the past five years
Graham	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>
Long	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>

NOTE: If no fingerprints have been submitted in the past 5 years, you do not have to click the check box, and no additional steps are required.

- c. Click **Save and Continue** at the bottom-right to save the Background Check page.

Background Check Details

The Affordable Care Act requires that providers in the high risk category submit to fingerprinting and criminal background checks. This page is being displayed based on the provider type/primary specialty you selected earlier in the enrollment process.

If you are assigned to the high-risk category, the information below identifies those individuals required to submit fingerprints. You will receive additional instructions after you submit the application.

Last Name	First Name	SSN	Birth Date	Submitted prints to Medicare or Medicaid within the past five years
Graham	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>
Long	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>

CANCEL

SAVE AND CONTINUE

➔

SAVE AND CONTINUE

3.11 Attachments

Quick Reference – Attachments

Table 12 – Attachments

Step	Task	Action	Result
Start from the Attachments page. This page displays after clicking Save and Continue from the previous page.			
1	Add Attachments.	a. Add the attachments requested at the top of the section by clicking Create New and filling out the required fields in the displayed pop-up screen. Once the documents are uploaded, the attachment information is displayed and the requirement is marked as met. b. Click Save and Continue.	Attachments are added and saved. Progress bar advances to the next available page.

Detailed Steps

1. The Attachments page is displayed.

Attachment Type	Requirement Met
Federal W-9 Form	NO
License	NO
Penal Record Certificate	NO

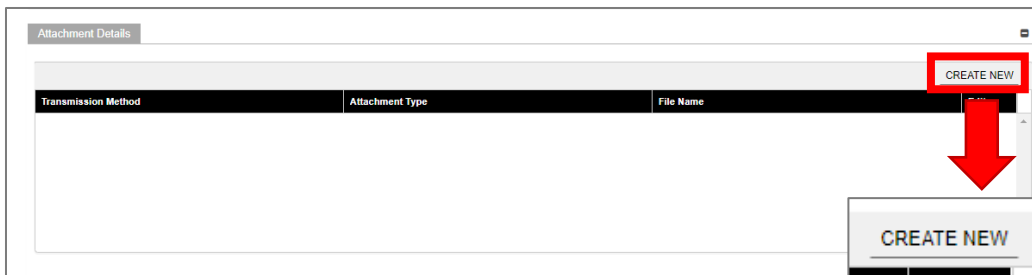
Additional Information indicates any required additional documentation based on your Provider Type and information provided during previous enrollment steps.

Example: Copy of Malpractice or Liability Insurance

Required attachments for your Provider type and specialty are displayed in the **Required Attachments** section. The Requirement Met column displays “No” if attachment has not been added.

Required Attachments	
Below are the list of required attachments. Please submit all of the required documentation to continue with the enrollment.	
Attachment Type	Requirement Met
Federal W-9 Form	NO
License	NO
Penal Record Certificate	NO

- a. Click **Create New** on the Attachment Details panel to add a new attachment.



Complete all the required fields in the pop-up window and upload the document.

New Attachment ✕

* Transmission Method ? * Attachment Type ?

select a value... select a value...

Upload File ?

SELECT FILES...

CANCEL
SAVE



ACCEPTED FILE TYPES: File types currently accepted as attachments include .xlsx, .xls, .docx, .doc, .png, .txt, .jpg, .pdf, .gif, and .zip.

Once saved, the attachment displays in the panel.

Attachment Details			
			CREATE NEW
Transmission Method	Attachment Type	File Name	Edit
Electronic Only	License	1234.docx	<input checked="" type="checkbox"/>
Electronic Only	Federal W-9 Form	1234.docx	<input checked="" type="checkbox"/>
Electronic Only	Penal Record Certificate	1234.docx	<input checked="" type="checkbox"/>

In the Required Attachments panel, the Requirement Met column of an attachment changes from “No” to “Yes” once the attachment has been added.

Attachment Type	Requirement Met
Federal W-9 Form	Yes
License	Yes
Penal Record Certificate	Yes

- b. Click **Save and Continue** at the bottom-right to save the Attachments page.

Attachment Details			
			CREATE NEW
Transmission Method	Attachment Type	File Name	Edit
Electronic Only	Federal W-9 Form	ITIL Certificate (3).pdf	<input checked="" type="checkbox"/>
Electronic Only	License	ITIL Certificate (3).pdf	<input checked="" type="checkbox"/>

CANCEL **SAVE AND CONTINUE** ➔ **SAVE AND CONTINUE**



SAVING AND CONTINUING: All required attachments must be added before saving the Attachments page and continuing to the next enrollment step.

3.12 Fees

If you are required to pay a fee to apply for PRMP enrollment, the Fees page will be available in the application process.

If the Fees page does not display, it is not required for your Provider Type. If this is the case, go to [Section 3.13 Agreement/Submit](#) to view the instructions for your next required step.

Quick Reference – Fees

Table 13 – Fees

Step	Task	Action	Result
Start from Fees page. This page displays after clicking Save and Continue from the previous page.			
1	Disclose and pay Additional Fees.	a. Complete the fields displayed in the Fees section. b. Final Amount Due displays. c. Click Save and Continue.	Answers to the Fee questions and final amount are saved. Progress bar advances to the next available page.

Detailed Steps

1. The Fees page is displayed.

Application Fee

The Affordable Care Act requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidations, and change of ownership, as required, and is assessed in full for each application submitted to the Puerto Rico Medicaid Program (PRMP).

Pursuant to 42 CFR § 455.420 and 455.460, state Medicaid programs must collect an application fee for new provider applications, re-validations, and re-enrollments/reactivations due to being terminated for any reason. The application fee is intended to cover the cost of the Medicaid Program's provider screening. The following providers are exempt from the application fee.

- Individual providers or non-physician practitioners
- Providers who are enrolled with Medicare
- Providers who paid the application fee to either Medicare or another state Medicaid plan

The application fee for 2020 is \$595. A bank manager's check (cashier's check) or money order is required to pay the fee. You must include the following information with the payment:

- Provider's name as indicated on the application
- Provider's National Provider Identifier (NPI)*
- Provider's Application Tracking Number (ATN)

Mail the bank manager's check (cashier's check) or money order to:

Puerto Rico Medicaid Program
 Provider Enrollment Unit
 PO Box 70184
 San Juan, PR 00936-8184

*Non-Emergency Medical Transportation (NEMT) providers who do not have an NPI must include their Tax ID.

Note: In order to waive the application fee, proof of enrollment or revalidation in Medicare or another state Medicaid plan is required. Proof of payment is a receipt or formal notification from Medicare or the other state Medicaid plan specifically indicating payment of the application fee. Proof of payment can be uploaded as an attachment to your application.

If an application is received and deemed to require an application fee and one is not paid, the entire application will be returned to the provider requesting proper payment.

Providers may request a hardship waiver with proper justification. Requests for a hardship waiver should be submitted with your enrollment application and include the following:

- Justification of the hardship
- Provider Name
- Provider Address
- National Provider Identifier (NPI)

If PRMP agrees that the hardship is justified, the request will be forwarded to CMS for review and approval pursuant to Section 1866(j)(2)(C)(ii) of the Social Security Act.

Provider Enrollment Portal (PEP) Enrollment Steps – Atypical Provider

- a. Read the information disclosed in the **Application Fee** section and answer the Application Fee questions underneath.

Please Answer all questions. If you answer 'NO' to all the questions below, then you must pay an application fee.

Application Fee Questions

Service Location - If the service location is enrolled in Medicare a fee payment is not required.

1. Is the service location enrolled in Medicare? Yes No

Medicaid Program - If the service location has paid an application fee to another Medicaid program then a fee payment is not required.

2. Have you paid an application fee to another state's Medicaid program for the service location? Yes No

Waiver Received - If you have received a waiver from the programs mentioned below a fee payment is not required.

3. Have you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship? Yes No

Financial Hardship - If you are requesting a waiver for financial hardship, please submit a letter explaining the financial hardship along with your enrollment application, including proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as a loan denial.

4. Are you requesting a waiver of the application fee because of financial hardship? Yes No

Amount Due

- b. The final amount of fees is displayed at the bottom of the screen when all questions are completed.

1. Is the service location enrolled in Medicare? Yes No

Medicaid Program - If the service location has paid an application fee to another Medicaid program then a fee payment is not required.

2. Have you paid an application fee to another state's Medicaid program for the service location? Yes No

Waiver Received - If you have received a waiver from the programs mentioned below a fee payment is not required.

3. Have you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship? Yes No

Financial Hardship - If you are requesting a waiver for financial hardship, please submit a letter explaining the financial hardship including proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as a loan denial.

4. Are you requesting a waiver of the application fee because of financial hardship? Yes No

Amount Due \$595.00



AMOUNT DUE: If “No Fee” displays next to “Amount Due” after answering all questions, you do not have to pay an application fee.

If an amount of fees displays, the instructions for paying the fee are disclosed in the top section of the Fees page. This includes the payment method accepted, the address to send the payment to, and the information required when making the payment.

- c. Click the **Save and Continue** button at the bottom right to save the Fees page.

The screenshot shows a form with two sections: 'Waiver Received' and 'Financial Hardship'. Both sections have radio buttons for 'Yes' and 'No', with 'No' selected in both. Below the sections, it says 'Amount Due \$595.00'. At the bottom, there are three buttons: 'CANCEL', 'SAVE AND CONTINUE' (highlighted in yellow), and 'PREVIOUS' (with a red arrow pointing to a 'SAVE AND CONTINUE' button highlighted in red).

3.13 Agreement/Submit

Quick Reference – Agreement/Submit

Table 14 – Agreement/Submit

Step	Task	Action	Result
Start from Agreement/Submit page. This page displays after clicking Save and Continue from the previous page.			
1	Accept Terms and Conditions.	Click Proceed to accept the terms and conditions.	Provider Agreement PDF displays.
2	Accept Provider Agreement.	Read the Provider Agreement and click the I Accept checkbox.	Confirmation pop-up window displays.
3	Confirm Provider Agreement.	Click Yes in the pop-up window to confirm agreement.	Signature section displays.
4	Complete Signature section.	a. Click the I Accept checkbox and fill in the rest of the fields. b. Click Request Verification Code.	Verification code is sent via email.
5	Add verification code.	Enter verification code sent via email and click Submit.	Enrollment submission confirmation screen displays.
6	Confirm submission of enrollment.	Click Yes to confirm submission.	Enrollment submission notification is received via pop-up screen and via email.

Detailed Steps

1. The Agreement/Submit page is displayed. This is the final step to complete and submit a new Provider Enrollment Application. Information previously entered during the other enrollment steps displays under the Terms of Agreement.

Agreement/Submit

Access the tabs above to review all data that has been entered into the application. Changes can be made, except for enrollment type and provider type, by navigating back to the appropriate screen using the tabs in the table of contents. If the enrollment type and/or provider type selected is incorrect, do not submit the application. You must complete a new application for the appropriate enrollment and/or provider type.

The terms of the enrollment are stated below. You must accept these terms in order to submit the enrollment application for review and approval. Once the terms are accepted, and the application has been confirmed and submitted, a PDF version of the application is available for saving. If terms are not accepted, the application will be saved to return later (within 30 calendar days) to complete and submit the application. If not submitted within 30 calendar days, the application will be deleted, and the application process would need to be started from the beginning.

Once the application is submitted, if there is additional documentation you wish to submit, the documents along with your Application Tracking Number (ATN) would need to be emailed to the Provider Enrollment Unit at PRMP-PEP@salud.pr.gov. A coversheet must be included in the email and can be generated by clicking Coversheet on the Print panel (located on the top right hand of the panel).

Once your application is approved, your information will be shared with the Medicaid Managed Care Organizations (MCOs)/Medicare Advantage Organizations (MAOs). Be aware that the MCO/MAO can contact you, or you may contact the MCO/MAO to pursue contracts with them. This enrollment does not automatically establish a contract with an MCO/MAO.

Terms of Agreement

Legal Name First Last	Contact Name First Last	Contact Email
NPI 1942308101	Tax ID Type SSN	Tax ID Number 569-03-0303
Service Location 605 AVE INDUSTRIAL ISABELA PR, 00662-3655		

The above provider agrees to participate in the Puerto Rico Medicaid Program.

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the Puerto Rico Medicaid Program.

I understand that should I be approved as a provider of services under the Puerto Rico Medicaid Program that it is my responsibility to notify the Puerto Rico Medicaid Program of any change to the information on this application including but not limited to address, group affiliation, change of ownership, tax identification number, or NPI.

I understand and agree that by submitting my application, Puerto Rico Medicaid Program will share my information with all contracted MCO/MAOs.

PROCEED

To accept the Terms of Agreement, click **Proceed** at the bottom of the screen.

Contact Email

Service Location
605 AVE INDUSTRIAL ISABELA PR, 00662-3655

accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the Puerto Rico Medicaid Program.

I understand that should I be approved as a provider of services under the Puerto Rico Medicaid Program that it is my responsibility to notify the Puerto Rico Medicaid Program of any change to the information on this application including but not limited to address, group affiliation, change of ownership, tax identification number, or NPI.

I understand and agree that by submitting my application, Puerto Rico Medicaid Program will share my information with all contracted MCO/MAOs.

PROCEED

PROCEED

2. A new section with a PDF form displays underneath.

Form

Please read the Provider Agreement document below.

LoadAgreementPdf 1 / 8

GOVERNMENT OF PUERTO RICO
Department of Health
Medicaid Program

Medicaid Provider Enrollment Agreement
to the Puerto Rico Government Health Plan (GHP)

I certify my signature, under penalty of perjury that I am the individual applying, or I am duty authorized by the individual applying to bind such person to the provider agreement and that I have read and understood the provider agreement & provider manuals.

* I Accept



PROVIDER AGREEMENT: The Provider Agreement is available in both English and Spanish. The first half of the document is in English and the second half is in Spanish.

Print or save a copy of the Provider Agreement now to keep for your records. Once you have completed this step, you will not be able to return to the Provider Agreement.

Read the Provider Agreement contained in the PDF document displayed and click the **I Accept** box.

Form

Please read the Provider Agreement document below.

LoadAgreementPdf 1 / 8

GOVERNMENT OF PUERTO RICO
Department of Health
Medicaid Program

Medicaid Provider Enrollment Agreement
to the Puerto Rico Government Health Plan (GHP)

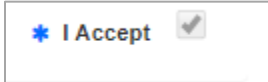
I certify my signature, under penalty of perjury that I am the individual applying to bind such person to the provider agreement and that I have read and understood the provider agreement & provider manuals.

* I Accept

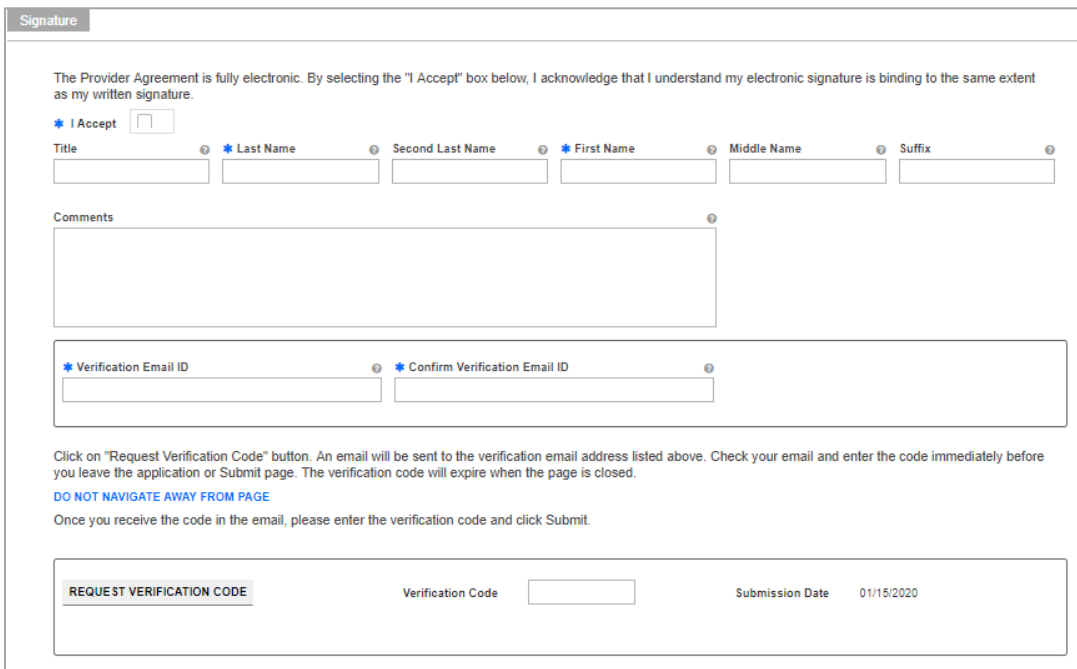
3. A pop-up window displays to confirm your agreement. Click **Yes**.



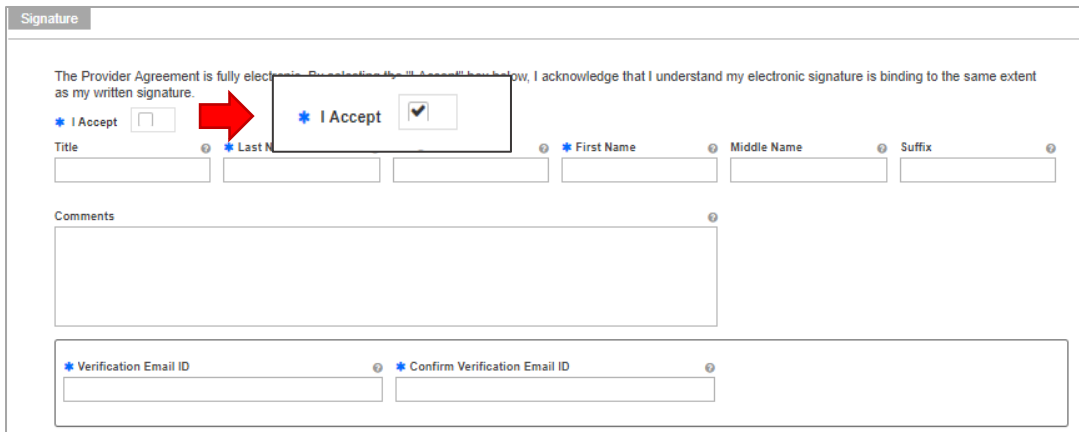
The **I Accept** checkbox is now checked.



4. The **Signature** section displays.



a. Click the **I Accept** checkbox in this section and fill in the rest of the fields.



b. Click **Request Verification Code**.

Click on "Request Verification Code" button. An email will be sent to the verification email address listed above. Check your email and enter the code immediately before you leave the application or Submit page. The verification code will expire when the page is closed.

DO NOT NAVIGATE AWAY FROM PAGE

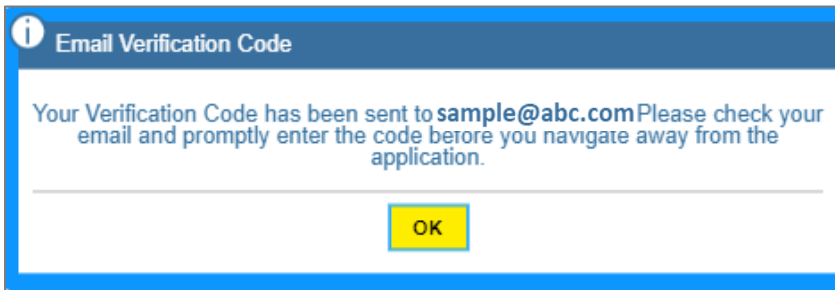
Once you receive the code in the email, please enter the verification code and click Submit.

REQUEST VERIFICATION CODE	Verification Code <input type="text"/>	Submission Date 8/1/2019
----------------------------------	--	--------------------------

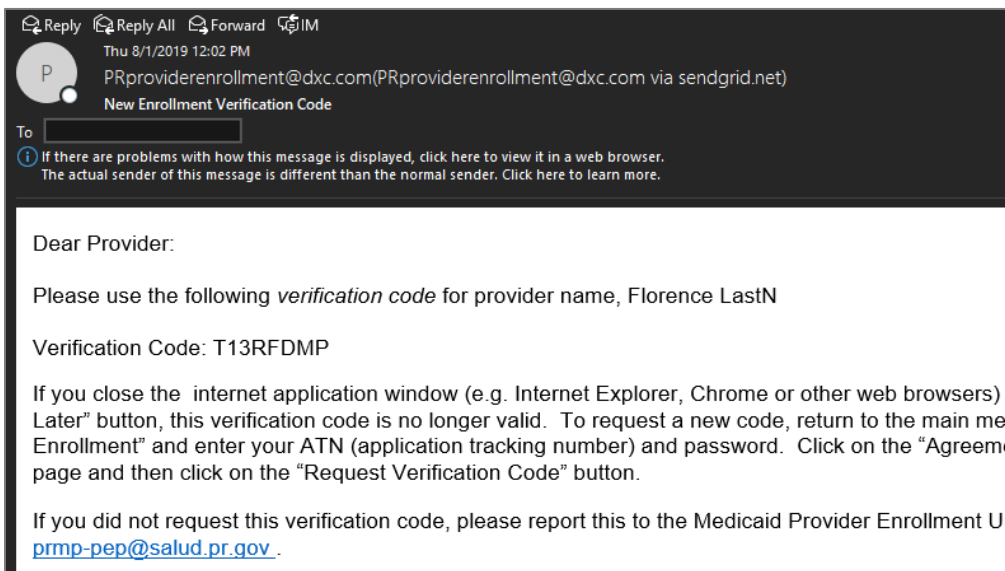
REQUEST VERIFICATION CODE

PREVIOUS **FINISH LATER** SUBMIT

The verification code will be sent to the email address confirmed in the required fields.



Example of email received with verification code:





VALID VERIFICATION CODE: If you close the internet window containing your enrollment application before entering the verification code sent to you, that verification code is no longer valid.

If this happens, resume your enrollment using your ATN and enrollment password (see **Section 2.4** in the **Provider Enrollment Portal (PEP) Navigation Reference Guide** for detailed steps), and request a new verification code.

5. Enter the verification code in the **Verification Code** field and click **Submit**.

REQUEST VERIFICATION CODE

Verification Code: T13RFD

Submission Date: 8/1/2019

CEL

SUBMIT

SUBMIT

6. Confirm the submission by clicking **Yes** in the pop-up screen.

Alert Confirmation

Do you want to submit this application?

NO YES

A message confirming your enrollment application submission is displayed on screen.

MENU Provider Enrollment Submit

Print RTP

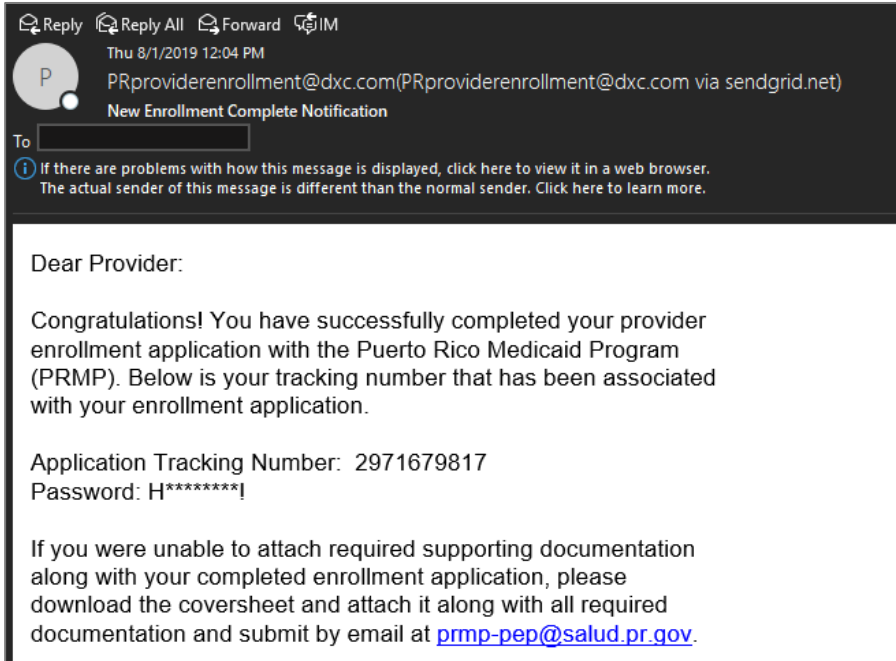
Submit Confirmation

Congratulations! You have successfully submitted your provider enrollment application. Please reference the tracking number below for all inquiries related to this application.

Tracking Number 2971679817

[Coversheet](#)

A notification will be sent via email confirming the application was successfully submitted for review:



4 Notifications

Below are the different types of notifications you can get as a provider after submitting your enrollment. Please make sure to verify your junk mail folder for any notifications from PEP.

4.1 Fingerprints Required

You may receive a Secure Communications email informing you that your enrollment requires additional screening. This includes submitting fingerprints and criminal background checks for all owners of 5% or more of the provider being enrolled.

If this screening is not completed within 30 days of receiving the email, the enrollment will be denied.

4.2 Return to Provider

You may receive a Secure Communications email informing you that your application requires corrections. The email will include the specific issues in the application that require your attention. You must access your application in the PEP (using the ATN/password used for the application registration), make the necessary updates and resubmit the application.

4.3 Enrollment Approval

You will receive a Welcome letter upon approval of your enrollment. For newly-enrolling providers, your Welcome letter will include the provider number and other important program participation information. You will get an email notification that you have a Welcome letter to view and download as a PDF at the Secure Communications site.

4.4 Enrollment Denial

You will receive written confirmation via a Secure Communications email if your new enrollment application has been denied. The notification includes the reason(s) why the enrollment was denied and information about appeal rights.