

DEPARTAMENTO DE  
**SALUD**



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# Puerto Rico Medicaid Management Information System

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 5.0

## Change History

Version #	Date	Modified By	Description
5.0	11/10/2023	Gainwell Technologies	R23-R26 Updates
4.0	04/05/2023	Gainwell Technologies	R19-R22 Updates
3.0	03/15/2021	Gainwell Technologies	R17/R18 Updates
2.0	10/28/2020	Gainwell Technologies	Gainwell Rebranding
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## Contents

1	Acronyms .....	1
2	Overview .....	2
3	New Enrollment Application .....	3
3.1	General Information.....	3
3.2	Specialties .....	14
3.3	Service Location .....	19
3.4	Addresses.....	28
3.5	Capacities .....	32
3.6	Organization .....	35
3.7	Credentials .....	37
3.8	Other.....	44
3.9	Disclosures .....	50
3.10	Background Check.....	56
3.11	Attachments.....	59
3.12	Fees.....	63
3.13	Agreement/Submit.....	68
4	Notifications.....	75
4.1	Fingerprints Required .....	75
4.2	Return to Provider.....	75
4.3	Enrollment Approval .....	75
4.4	Enrollment Denial .....	75

## Tables

Table 1 – Acronyms.....	1
Table 2 – General Information .....	3
Table 3 – Specialties .....	14
Table 4 – Service Location .....	19
Table 5 – Addresses.....	28
Table 6 – Capacities .....	32
Table 7 – Organization .....	35

Table 8 – Credentials.....	37
Table 9 – Other .....	44
Table 10 – Disclosures .....	50
Table 11 – Background Check.....	56
Table 12 – Attachments.....	59
Table 13 – Fees .....	63
Table 14 – Agreement/Submit.....	68

## 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.prmis.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.	Pop-up window displays, indicating that once the application is saved, the Enrollment Type cannot be changed. 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: 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

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

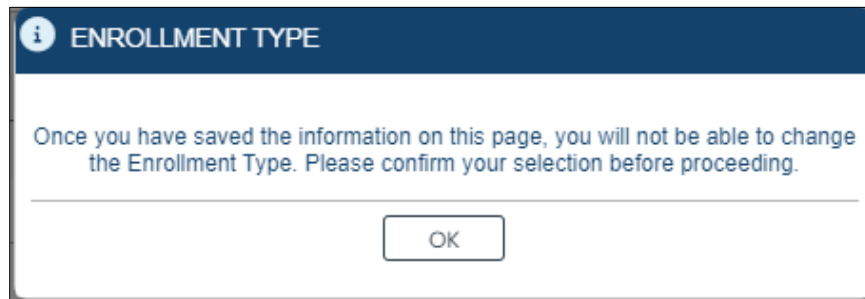
The screenshot shows the 'General Information' page of the Puerto Rico Medicaid Program Provider Enrollment Portal. At the top, there is a header with the program name and a 'PROVIDER ENROLLMENT' tab. Below the header, a 'Tracking Number: 8057465962' is displayed with a help icon. The main section is titled 'General' and contains an 'Initial Enrollment Information' section. This section has three fields: 'Enrollment Type' (a dropdown menu with 'select a value...' text), 'Provider Type' (a dropdown menu with 'select a value...' text), and 'Effective Date' (a date field with '11/03/2023' and a calendar icon). Below this section is a 'Provider Information' section.

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

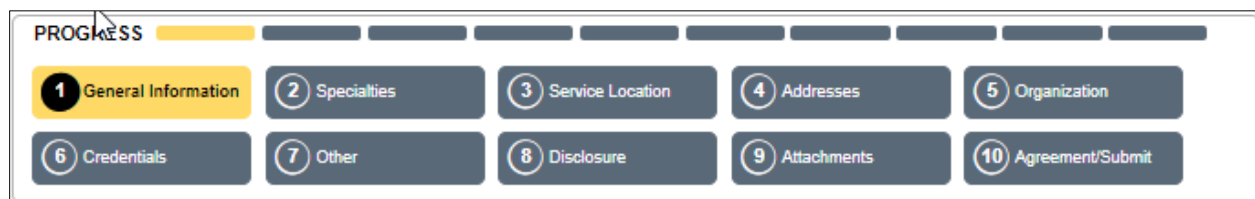
This screenshot shows the 'Enrollment Type' dropdown menu from the 'Initial Enrollment Information' section. The dropdown is open, showing a list of options: 'select a value...', 'select a value...', 'Individual or Sole Proprietor', 'Facility', 'Group or Clinic', 'Individual Within A Group', 'Atypical Providers', and 'Ordering, Prescribing, Referring'. The 'Atypical Providers' option is highlighted with a red rectangular box.



- 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.



- 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.

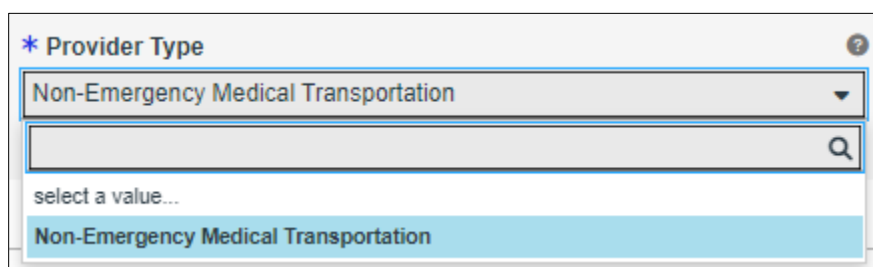


**DIFFERENT ENROLLMENT STEPS DISPLAYED:** The steps displayed at the top of the screen may continue to change during the enrollment process as more information is entered in the application that dictate the remaining steps that are required.



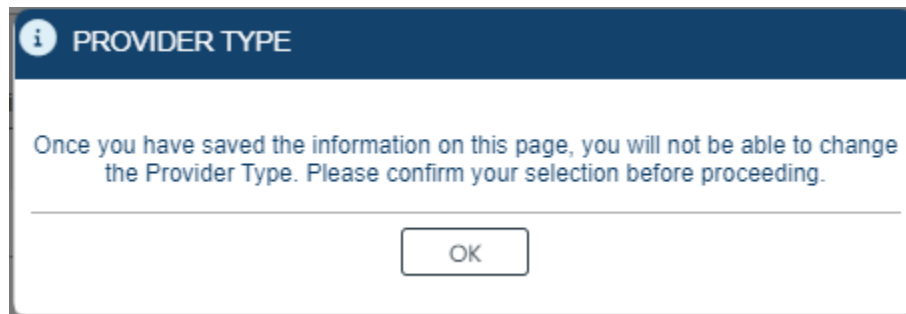
Steps are determined to be required, optional, or non-applicable based on the Provider Type, Specialties, and other related information.

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.



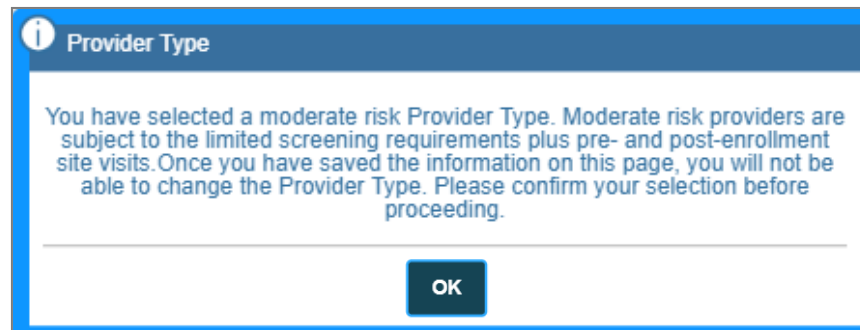
**PROVIDER TYPE:** The Provider Type drop-down list is dynamic based on the Enrollment Type selected. If you do not see your Provider Type in this list, verify that you have selected the correct Enrollment Type.

- a. 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.

Initial Enrollment Information			
* Enrollment Type	* Provider Type	* Effective Date	
<input type="text" value="select a value..."/>	<input type="text" value="select a value..."/>	<input type="text" value="11/07/2023"/>	



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

- 1) 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**.

The screenshot shows a form titled "Provider Information". Below the title is a question: "Are you an Individual or Sole Proprietor (SP) or Busin...". There are two radio button options: "Individual or SP with SSN" (which is selected) and "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:

The screenshot shows the "Provider Information" form with "Individual or SP with SSN" selected. Below the selection, there is a note: "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." The form includes the following fields: Title, Last Name on..., First Last Name, Second Last Name, First Name, Middle Name, Suffix, Gender (dropdown), What is your ethnicity? (dropdown), Birth Date (calendar icon), SSN (masked field), and Preferred Communication... (dropdown).

**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:

The screenshot shows the "Provider Information" form with "SP or Business with EIN" selected. Below the selection, there is a note: "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." The form includes the following fields: Legal Name on your Tax ID..., Tax Name, Doing Business As Name, EIN (masked field), and Preferred Communication... (dropdown).



**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.

4. 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.

a. New Enrollment:

- If you have never been approved for enrollment in PRMP through PEP. Answer **No** to the currently enrolled and previously enrolled questions.

The screenshot shows two questions in a form. The first question is "Are you currently enrolled as a Provider?" with radio buttons for "Yes" and "No", where "No" is selected. The second question is "Were you previously enrolled as a Provider?" with radio buttons for "Yes" and "No", where "No" is selected. Both questions have a help icon (question mark) to the right.

b. 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

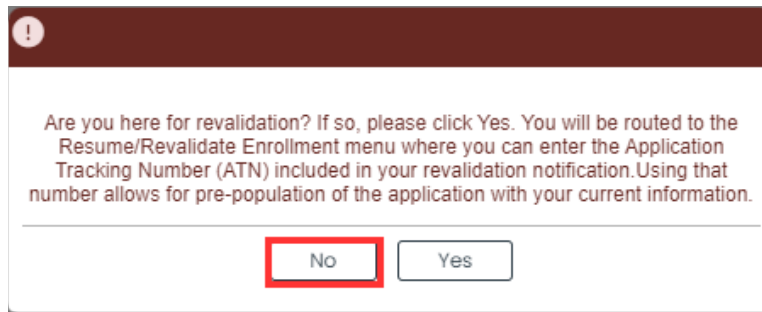
- Applying with a different Enrollment Type.

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.


- i) Select **Yes** for the currently enrolled question.

The screenshot shows the question "Are you currently enrolled as a Provider?" with radio buttons for "Yes" and "No", where "Yes" is selected. There is a help icon (question mark) to the right of the question.

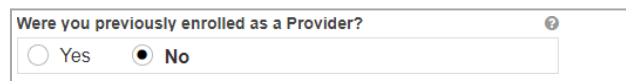
- ii) Click **No** in the displayed revalidation pop-up window.

A revalidation pop-up window with a dark red header bar containing a white exclamation mark icon. The main text area is white with red text that reads: "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." At the bottom, there are two buttons: "No" and "Yes". The "No" button is highlighted with a red rectangular border.

- iii) 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.

A form titled "Are you currently enrolled as a Provider?" with a question mark icon. It features two radio buttons: "Yes" (selected) and "No". To the right, there is a text input field labeled "Current Provider Identifier" with a question mark icon.

- iv) Select **No** for the previously enrolled question.

A form titled "Were you previously enrolled as a Provider?" with a question mark icon. It features two radio buttons: "Yes" and "No" (selected).

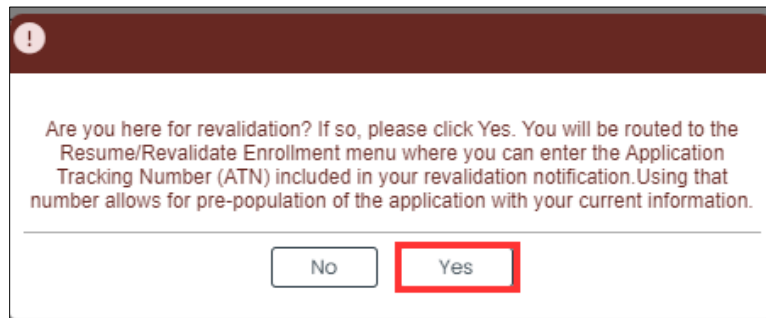
c. Revalidation (Currently Active):

- 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.

A form titled "Are you currently enrolled as a Provider?" with a question mark icon. It features two radio buttons: "Yes" (selected) and "No".

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



**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**.

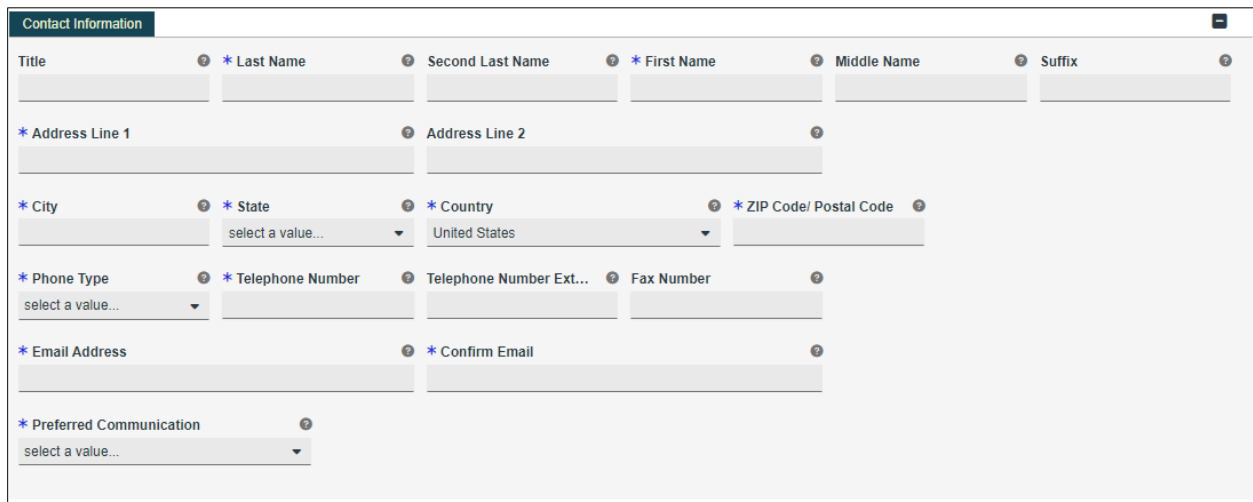
- d. Reenrollment (Currently Inactive):

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

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

- iii) 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.
- iv) Answer the remaining question that asks if you are Medicare enrolled.

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

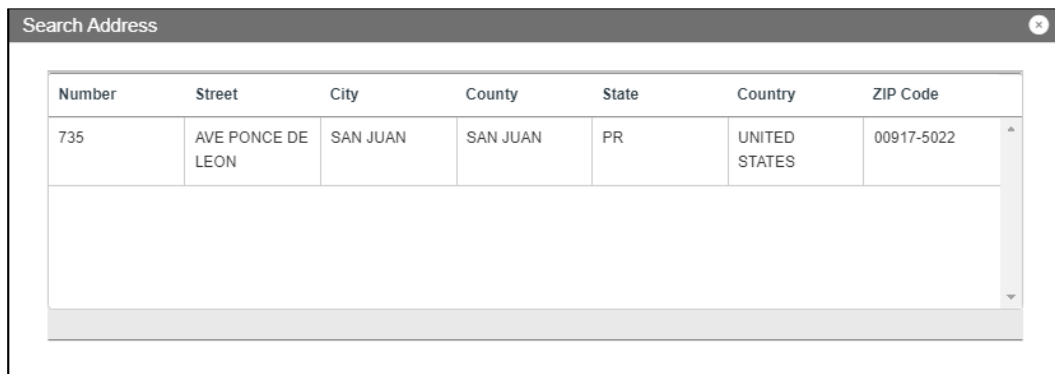


The Contact Information form contains the following fields:

- Title
- \* Last Name
- Second Last Name
- \* First Name
- Middle Name
- Suffix
- \* Address Line 1
- Address Line 2
- \* City
- \* State (dropdown menu)
- \* Country (dropdown menu, currently showing United States)
- \* ZIP Code/ Postal Code
- \* Phone Type (dropdown menu)
- \* Telephone Number
- Telephone Number Ext...
- Fax Number
- \* Email Address
- \* Confirm Email
- \* Preferred Communication (dropdown menu)



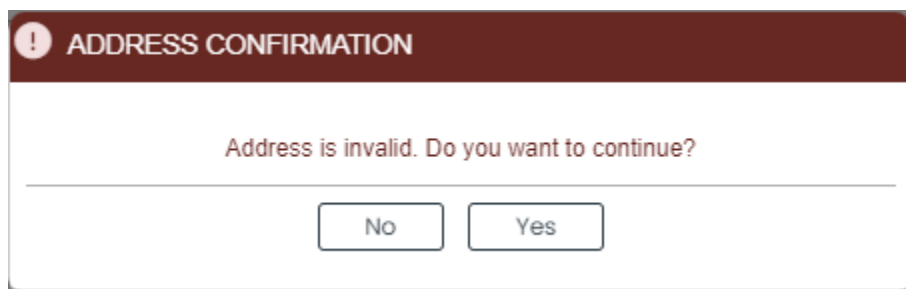
**VALID ADDRESS:** The PEP system will validate the address entered. If there is an updated variation, select that address from the pop-up window that displays.



The Search Address pop-up window displays a table with the following data:

Number	Street	City	County	State	Country	ZIP Code
735	AVE PONCE DE LEON	SAN JUAN	SAN JUAN	PR	UNITED STATES	00917-5022

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



The Address Confirmation pop-up window displays the following message:

**! ADDRESS CONFIRMATION**

Address is invalid. Do you want to continue?

Buttons: 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.

**Contact Information**

Title \* Last Name \* Second Last Name \* First Name \* Middle Name \* Suffix \*

\* Address Line 1 \* Address Line 2 \*

\* City \* State \* Country \* ZIP Code/ Postal Code \*

SAN JUAN Puerto Rico United States 00917-5030

\* Phone Type \* Telephone Number \* Telephone Number Exten... \* Fax Number \*

Work

\* Email Address \* Confirm Email \*

\* Preferred Communication \*

select a value...

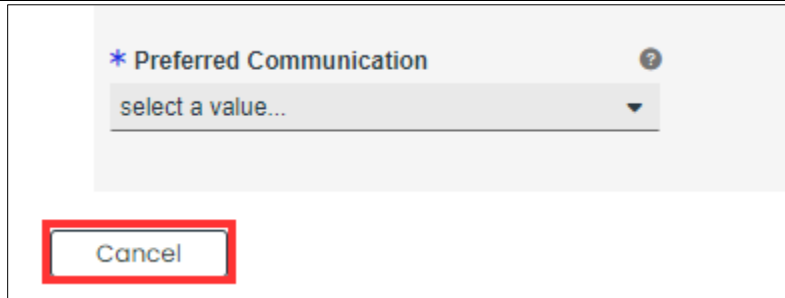
Cancel Save and Continue




**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.*





\* Preferred Communication 

select a value... 

Cancel

## 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.  b. To edit a specialty, click the Edit button next to the desired specialty and save the changes.	Specialties are added.
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

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

Specialties

Required Fields ( \* )

**Specialties**

The provider type selected on the previous page determines the specialties available. One specialty must be named as primary.

Provider Type  
Non-Emergency Medical Transportation

Create New

Specialty	Taxonomy	Primary	Effective Date	Edit
-----------	----------	---------	----------------	------

1. 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.

Specialties

The provider type selected on the previous page determines the specialties available. One specialty must be named as primary.

Provider Type

Non-Emergency Medical Transportation

Create New

Specialty	Taxonomy	Primary	Effective Date	Edit
-----------	----------	---------	----------------	------

New Specialty

☐ Make Primary

\* Specialty

select a value...

\* Taxonomy

select a value...

\* Effective Date

Cancel

Save

Once saved, the specialty displays in the window.

<div>Create New</div>				
Specialty	Taxonomy	Primary	Effective Date	Edit
941-Non-Emergency Medical Transportation	343900000X-Non-emergency Medical Transport (VAN)	x	11/07/2023	




**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.

New Specialty

☒ Make Primary
 ?

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

Specialty	Taxonomy	Primary	Effective Date	Edit
941-Non-Emergency Medical Transportation	343900000X-Non-emergency Medical Transport (VAN)	x	11/07/2023	

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

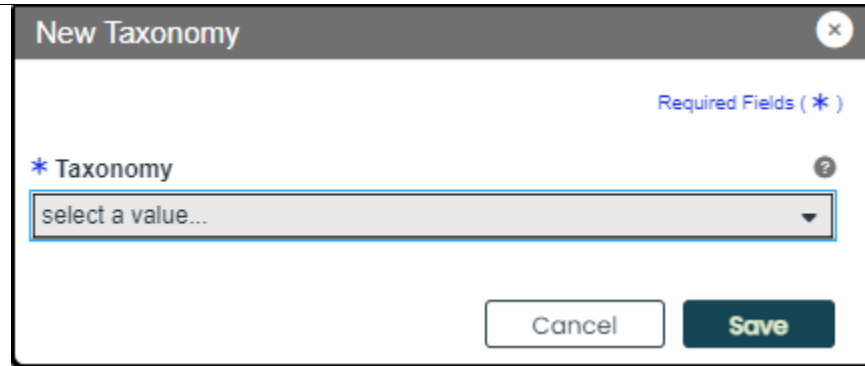
- a. To add a new taxonomy, click Create New at the top-right of the Additional Taxonomies panel.

Additional Taxonomies

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

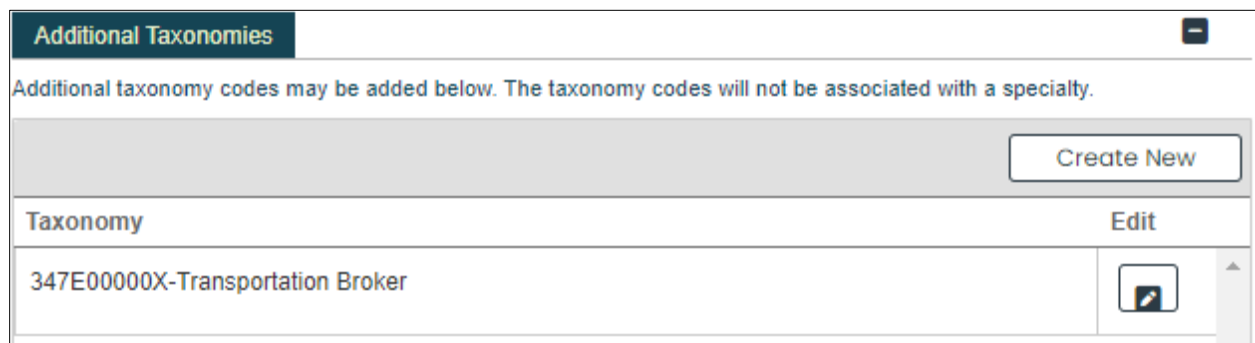
Create New

Taxonomy
Edit



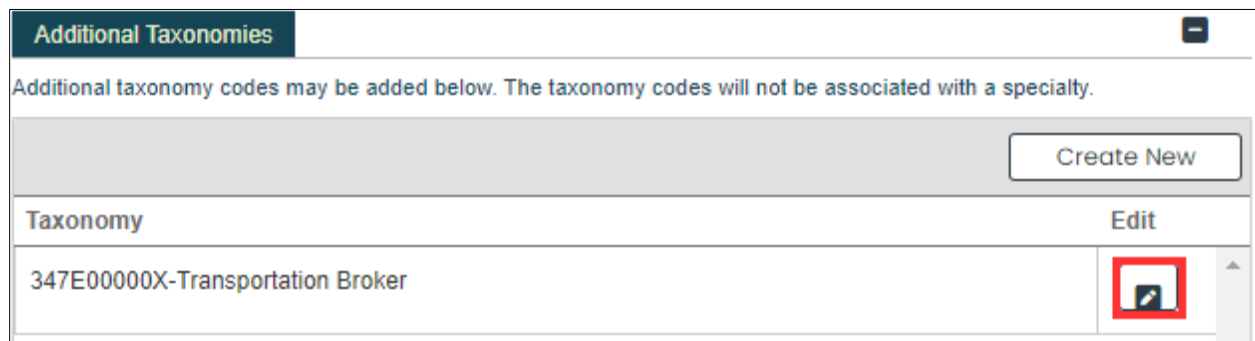
A dialog box titled "New Taxonomy" with a close button (X) in the top right corner. It contains a label "Required Fields ( \* )" in blue. Below this is a required field labeled "\* Taxonomy" with a question mark icon. The field is a dropdown menu showing "select a value...". At the bottom are "Cancel" and "Save" buttons.

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



A panel titled "Additional Taxonomies" with a minus icon in the top right. Below the title is a message: "Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty." Below this is a "Create New" button. A table follows with two columns: "Taxonomy" and "Edit". The table contains one row with the value "347E00000X-Transportation Broker" and an edit icon (pencil) in the "Edit" column.

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




The same "Additional Taxonomies" panel as above, but with a red rectangle highlighting the edit icon (pencil) in the "Edit" column next to the "347E00000X-Transportation Broker" entry.

Click **Save and Continue** at the bottom-right to save 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
347E00000X-Transportation Broker	

Cancel

Previous

Save and Continue

### 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.	<p>a. To add a new Service Location, click Create New and complete the required address fields in the displayed pop-up window.</p> <p>b. Click Save to add this information.</p> <p>c. To edit an added Service Location, click the Edit button next to the desired taxonomy and save the changes.</p> <p>Click Save and Continue.</p>	<p>Service Location page is saved.</p> <p>Progress bar advances to the next available page.</p>

#### Detailed Steps

1. Service Location page is displayed.

Service Location

Required Fields (\*)

Service Location

Create New

Location ...	Address L...	Address L...	City	State	Primary	Edit

Cancel Previous Save and Continue

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

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





**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.

Required Fields ( \* )

☒
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.

Search Address
✕

Number	Street	City	County	State	Country	ZIP Code
735	AVE PONCE DE LEON	SAN JUAN	SAN JUAN	PR	UNITED STATES	00917-5030
<div style="border: 1px solid #ccc; height: 100%; width: 100%;"></div>						

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

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

Phone Number

At least one Phone Number must be provided.

Create New

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

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.

Create New

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

New Phone Number


Required Fields ( \* )

\* Phone Type ? \* Telephone Number ? Telephone Number Exten... ?


select a value...

Cancel Save

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

Phone Number			
At least one Phone Number must be provided.			
			Create New
Phone Type	Telephone Number	Extension	Edit
Work	787-882-5581		

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

Phone Number			
At least one Phone Number must be provided.			
			Create New
Phone Type	Telephone Number	Extension	Edit
Work	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

☐ Yes ☒ No

☐ Yes ☒ No

Phone Type Emergency Phone ... 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** -

Create New

Day	From Hour	To Hour	Edit
-----	-----------	---------	------

**New Hours Of Operation** x

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
EveryDay	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
EveryDay	24 Hours		

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

Version 5.0 Page 25

- 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

☐ Age Restrictions

\* Accepting New Patients  
select a value...

\* Preferred Patient Gender  
select a value...

Cancel Save

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

**Service Location**

Required Fields (\*)

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	735 AVE PONCE DE LEON		SAN JUAN	Puerto Rico	x	

Cancel Previous Save and Continue



**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.


Service Location Required Fields ( \* )

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	735 AVE PONCE DE LEON		SAN JUAN	Puerto Rico	x	

Cancel Previous Save and Continue

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

Service Location Required Fields ( \* )

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	735 AVE PONCE DE LEON		SAN JUAN	Puerto Rico	x	

Cancel Previous Save and Continue

## 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.	a. Click Create New to add at least one phone number. b. To edit an existing phone number, click the Edit button next to the desired number and save the changes. Click Save and Continue.	A phone number is added to each Address type. Address information is saved. Progress bar advances to the next available page.

### 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

\* Address Line 1

Address Line 2

\* City

\* State

select a value...

\* ZIP Code/ Postal C...

\* Country

select a value...

☐ Same as Service Location

Email

Confirm Email



**Example: Mail To Address**



**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.

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.

Add phone numbers to the Address step of your enrollment.


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.

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



*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 

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

Phone Number

At least one Phone Number must be provided.

Create New

Phone Type	Telephone Number	Extension	Edit
Work	787-882-5581		

Cancel

Previous

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.	<p>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.</p> <p>b. To edit added capacity information, click the Edit button next to the desired capacity entry and save the changes.</p> <p>Click Save and Continue.</p>	<p>Capacity information is added and saved.</p> <p>Progress bar advances to the next available page.</p>

#### 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.

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

Capacity

Capacity By Specialty

962 - Optometrist

State	County	Waiver/Entitlement Type	Maximum Medicaid Member Count	Edit
Puerto Rico	Isabela Municipio			

CANCEL PREVIOUS SAVE AND CONTINUE

New Capacity

Required Fields ( \* )

\* State select a value... \* County select a value... \* Maximum Medicaid Member Count

CANCEL SAVE

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.

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

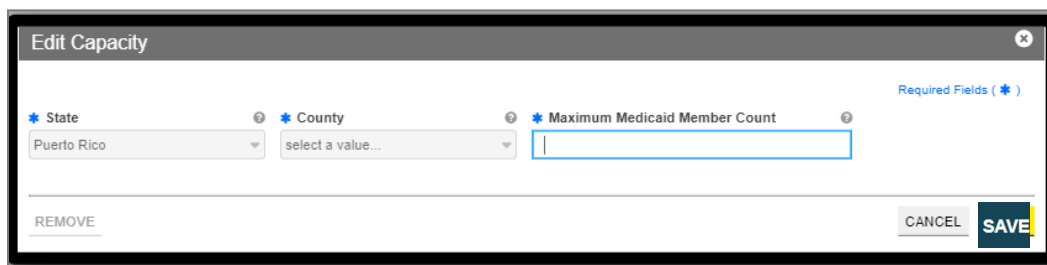
Capacity

Capacity By Specialty

962 - Optometrist

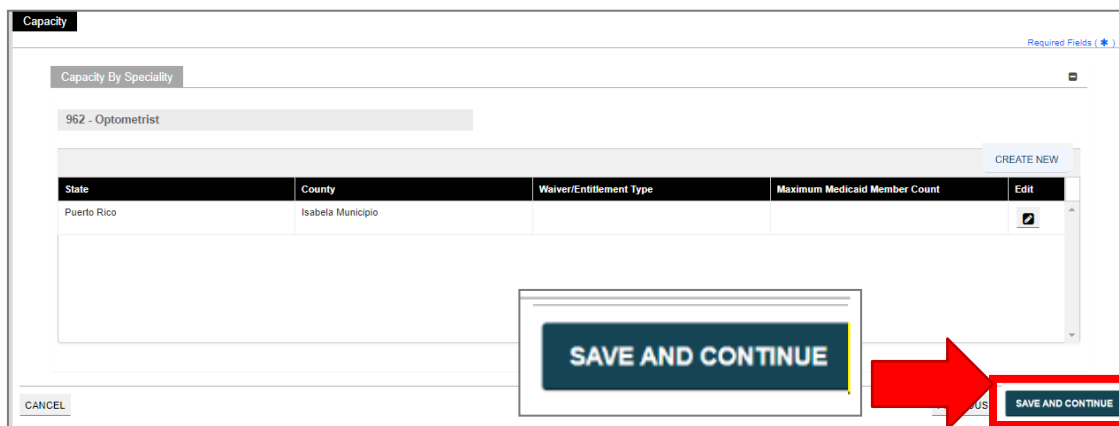
State	County	Waiver/Entitlement Type	Maximum Medicaid Member Count	Edit
Puerto Rico	Isabela Municipio			

CANCEL PREVIOUS SAVE AND CONTINUE



The 'Edit Capacity' modal form contains three required fields: 'State' (a dropdown menu with 'Puerto Rico' selected), 'County' (a dropdown menu with 'select a value...' displayed), and 'Maximum Medicaid Member Count' (a text input field). At the bottom of the modal are three buttons: 'REMOVE', 'CANCEL', and 'SAVE'.

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



The 'Capacity' page shows a table titled 'Capacity By Specialty' with a filter for '962 - Optometrist'. The table has columns for 'State', 'County', 'Waiver/Entitlement Type', 'Maximum Medicaid Member Count', and 'Edit'. A red box highlights the 'SAVE AND CONTINUE' button at the bottom right of the page, with a red arrow pointing to it from a larger 'SAVE AND CONTINUE' button located in the center of the page.

State	County	Waiver/Entitlement Type	Maximum Medicaid Member Count	Edit
Puerto Rico	Isabela Municipio			

## 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.	<p>a. Complete the required and relevant fields in the Organizational Details section.</p> <p>Click Save and Continue.</p>	<p>Organizational Details are saved.</p> <p>Progress bar advances to the next available page.</p>

### 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.

### 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



## 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

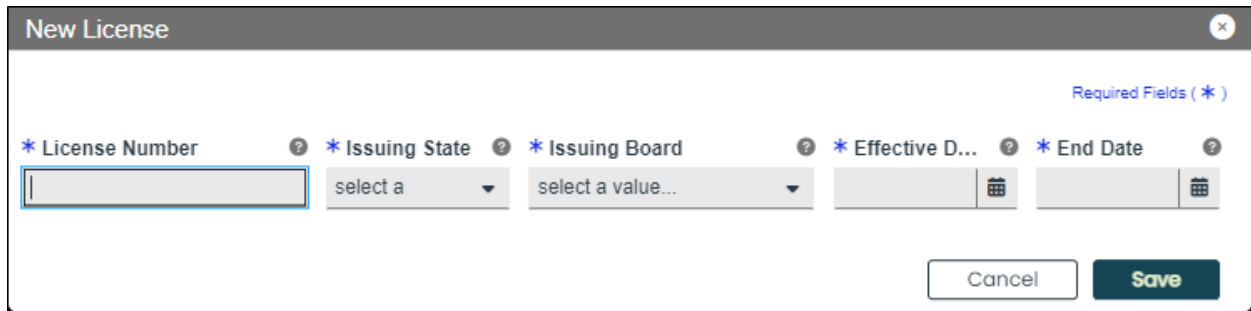
1. The Credentials page displays. The credential information that may be collected for Atypical Provider enrollments are shown below:
  - a. **License** – Add a license, in good standing, in the same state as the service location.



**LICENSE:** 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 D... ? \* End Date ?

select a select a value...


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.

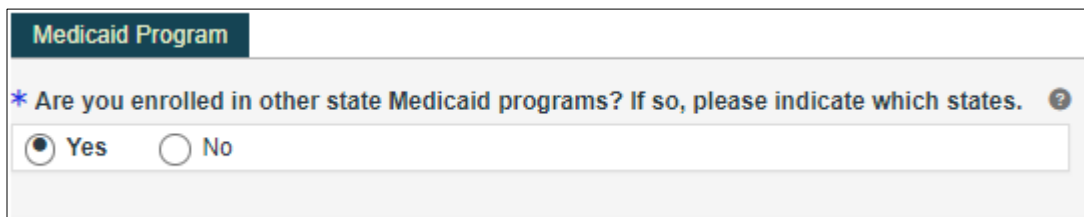
License					
					Create New
License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit
8685747645	Puerto Rico	OTHER - OTHER	11/08/2023	11/08/2033	



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



**Medicaid Program**

\* Are you enrolled in other state Medicaid programs? If so, please indicate which states. ?

☒ Yes ☐ No

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

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.

**Medicaid Program**

\* Are you enrolled in other state Medicaid programs? If so, please indicate which states. ?

☒ Yes ☐ No

Create New

Program	State	Effective Date	End Date	Edit
TEST	Puerto Rico	11/08/2023	11/08/2028	



**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.

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

**DEA**

CREATE NEW

DEA Number	Effective Date	End Date	Edit
------------	----------------	----------	------

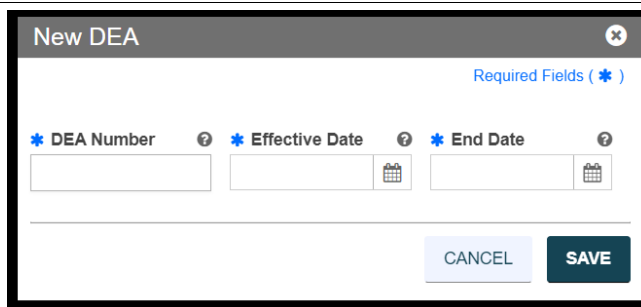
To add a new DEA number, click Create New at the top-right of the DEA section and complete the required fields in the displayed pop-up window.

**DEA**

CREATE NEW

DEA Number	Effective Date	End Date	Edit
------------	----------------	----------	------

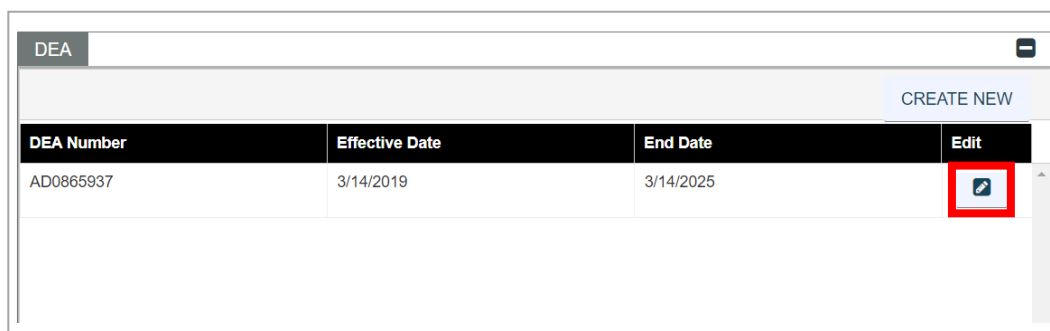
CREATE NEW




The 'New DEA' form is a modal window with a title bar containing a close button. It features a 'Required Fields (\*)' label in blue. Below this, there are three required fields: 'DEA Number', 'Effective Date', and 'End Date'. Each field has a blue asterisk icon and a help icon. The 'Effective Date' and 'End Date' fields include calendar icons. At the bottom right, there are 'CANCEL' and 'SAVE' buttons.

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.



The 'DEA' panel shows a table of DEA licenses. The table has columns for 'DEA Number', 'Effective Date', 'End Date', and 'Edit'. The first row contains the values 'AD0865937', '3/14/2019', '3/14/2025', and an 'Edit' button. The 'Edit' button is highlighted with a red square. Above the table, there is a 'CREATE NEW' button. The panel also has a 'DEA' tab and a minus icon in the top right corner.

DEA Number	Effective Date	End Date	Edit
AD0865937	3/14/2019	3/14/2025	

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



The 'Puerto Rico Controlled Substance Certificate (previously ASSMCA)' form contains two questions. The first question is 'Do you prescribe controlled substances in Puerto Rico?' with radio buttons for 'Yes' and 'No'. The second question is 'Do you dispense controlled substances in Puerto Rico?' with radio buttons for 'Yes' and 'No'. Each question has a help icon.

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

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

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.



**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	3/14/2019	3/14/2025	

Do you dispense controlled substances in Puerto Rico?

☒ Yes ☐ No

CREATE NEW

Registration Number	Effective Date	End Date	Edit
BB962151	3/14/2019	3/14/2025	

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

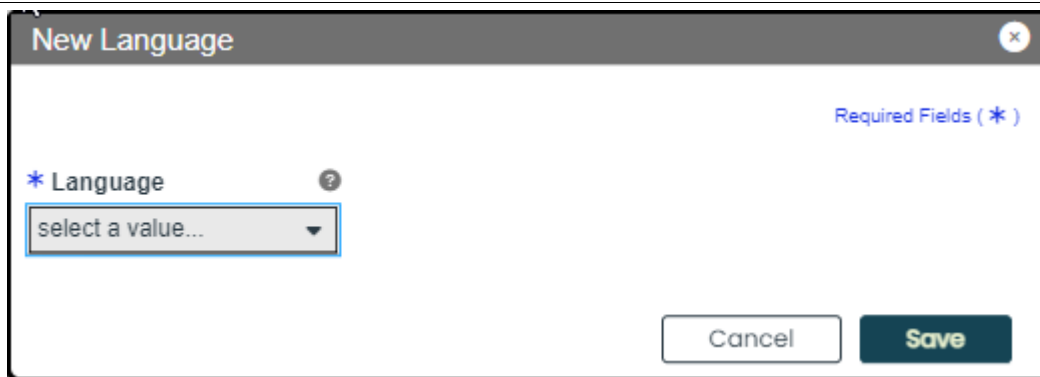
Table 9 – Other

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.	<p>Complete the required information for any of the following sections that are presented:</p> <ul style="list-style-type: none"> <li>a. Languages</li> <li>b. Certifications</li> <li>c. Additional Information</li> <li>d. Malpractice Carrier Information</li> <li>e. Malpractice Suit Information</li> </ul> <p>Click Save and Continue.</p>	<p>Other information is added and saved.</p> <p>Progress bar advances to the next available page.</p>

### 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.





A pop-up window titled "New Language" with a close button in the top right corner. It contains a label "\* Language" with a question mark icon, followed by a dropdown menu showing "select a value...". In the top right corner, it says "Required Fields ( \* )". At the bottom right, there are "Cancel" and "Save" buttons.

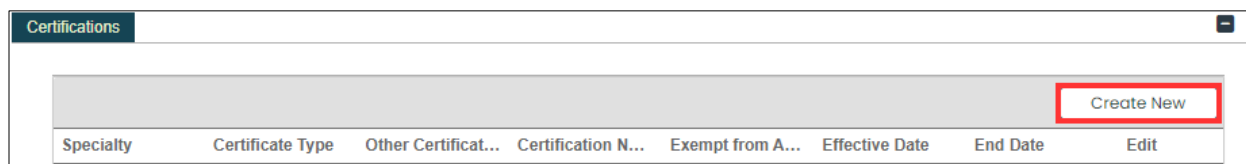
Once the information is saved, the language information is displayed.



A screenshot of the "Languages" section in the application. It features a table with one row containing "English". Above the table is a "Create New" button. Below the table is an "Edit" button. A message at the top states: "At least one record is required. Provider cannot save and continue until a record is added."

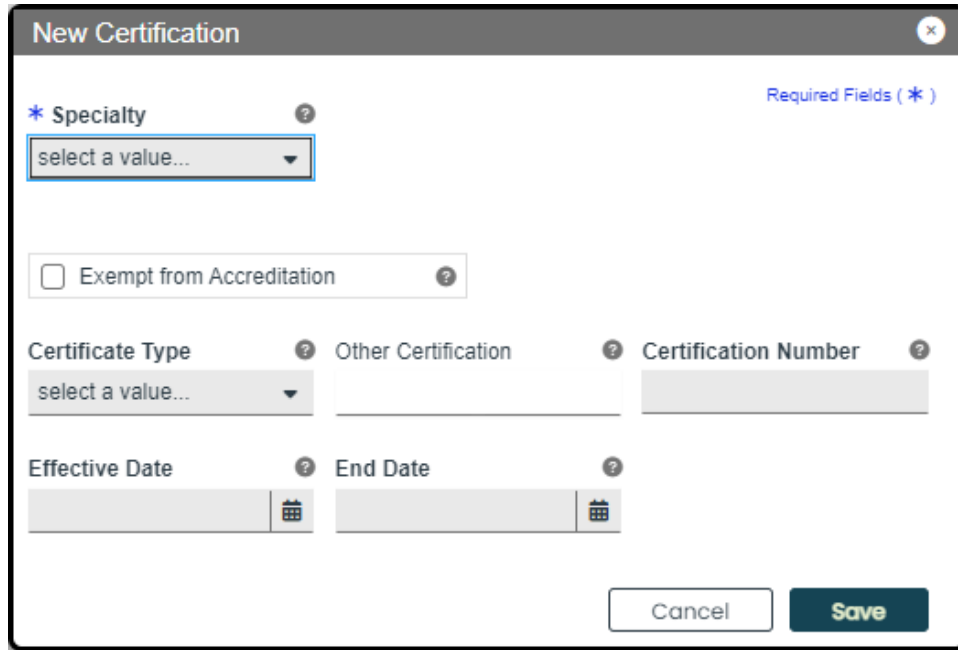
Language
English

- 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.



A screenshot of the "Certifications" section. It shows a table with columns: "Specialty", "Certificate Type", "Other Certificat...", "Certification N...", "Exempt from A...", "Effective Date", "End Date", and "Edit". A "Create New" button is located at the top right of the table area.

Specialty	Certificate Type	Other Certificat...	Certification N...	Exempt from A...	Effective Date	End Date	Edit
-----------	------------------	---------------------	--------------------	------------------	----------------	----------	------



**New Certification**

\* Specialty ? Required Fields ( \* )  
 select a value... ▼

☐ Exempt from Accreditation ?

Certificate Type ? Other Certification ? Certification Number ?  
 select a value... ▼

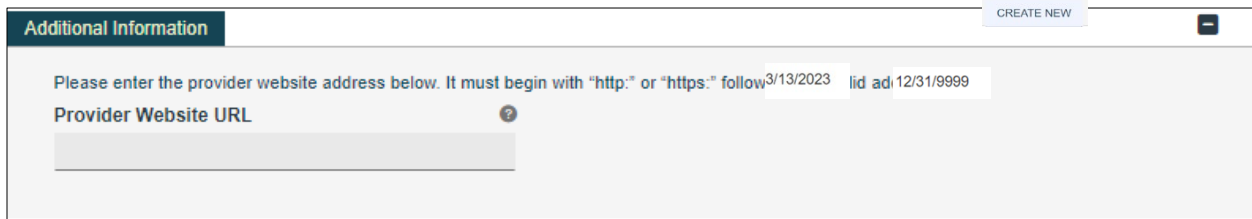
Effective Date ? End Date ?  
 [Calendar Icon] [Calendar Icon]

Cancel Save

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

Certifications							
							Create New
Specialty	Certificate Type	Other Certificat...	Certification N...	Exempt from A...	Effective Date	End Date	Edit
941-Non	Other	Medical Transport	5551234		11/08/2023	11/08/2033	[Edit Icon]

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



**Additional Information** CREATE NEW

Please enter the provider website address below. It must begin with "http:" or "https:" followed by 3/13/2023 lid ad 12/31/9999

Provider Website URL ?  
 [Text Input Field]

- 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

At least one record is required. Provider cannot save and continue until a record is added.

Please complete the malpractice information below

Create New

Type of Carrier	Name of Carrier	Coverage Amo...	Coverage Amo...	Policy Number	Effective Date	End Date	Edit
-----------------	-----------------	-----------------	-----------------	---------------	----------------	----------	------

New Malpractice Carrier Information

Required Fields ( \* )

\* Type of Carrier

select a value...

\* Name of Carrier

\* Policy Number

\* 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

At least one record is required. Provider cannot save and continue until a record is added.

Please complete the malpractice information below

Create New

Type of Carrier	Name of Carrier	Coverage Amo...	Coverage Amo...	Policy Number	Effective Date	End Date	Edit
Comprehensive General Liability	Triple M	2000000	500000	3675643205	11/08/2023	11/08/2025	

**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 an 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**, it is then necessary to provide information regarding current and previous malpractice suits. To add the suit information, click **Create New** at the top-right of the **Malpractice Suit** section.

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 an issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit? ?

☒ Yes ☐ No

**Note:** Enter all information in this panel, however, if you have a large volume of cases or claims, you may enter the most recent case in this section and then must include a detail document with a list of all other cases or claims within the 5-year period in the additional information tab / attachment section.

**Create New**

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

Complete the required fields in the displayed pop-up window.

**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 ?  
select a value...  select a value...

\* 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 ?  
 select a value... select a value...

Federal Court Case Number ? District ?

\* Status Claim ?  
select a value...


**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.

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

Create New

Patient Name	Policy Number	Your status in the Case	Claimant / Plaintiff filed suit...	Status Claim	Edit
Tropical Punch	387648326	Co-Defendant	Yes	Pending	

Cancel

Previous

Save and Continue

## 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.	<p>a. Complete the disclosure forms displayed by clicking Create New next to each form.</p> <p>b. To edit or delete a form, click the desired form's name and then the Edit button in the displayed pop-up window.</p> <p>Click Save and Continue once all forms are completed.</p>	<p>Disclosures are completed.</p> <p>Progress bar advances to the next available page.</p>

### Detailed Steps

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

### Disclosures

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 local 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		
<p>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.</p> <p>Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you answer "Yes" to any question, please provide the additional information that may be requested.</p>		
Disclosure Form	Status	Create New
Provider Self Disclosure	New	<a href="#">Create New</a>
Sub-Contractor Disclosure	New	<a href="#">Create New</a>
Ownership and Control Interest	New	<a href="#">Create New</a>
Managing Employees	New	<a href="#">Create New</a>
Business Transaction	New	<a href="#">Create New</a>

- 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.

Disclosure Form	Status	Create New
Provider Self Disclosure	New	<a href="#">Create New</a>
Sub-Contractor Disclosure	New	<a href="#">Create New</a>

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 Last Last First Last N... Second Las... First Name Middle Name

Suffix Birth Date 11/07/1993 SSN 123-45-6789

**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**.

**Convictions Of Criminal Offense**

\* 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? ☐ Yes ☒ No

SAVE

Delete 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 Form	Status	Create New
Provider Self Disclosure	Completed	<a href="#">Create New</a>
Sub-Contractor Disclosure	Completed	<a href="#">Create New</a>
Ownership and Control Interest	New	<a href="#">Create New</a>

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.

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.

**Edit SubContractor Disclosure**

[Required Fields \(\\*\)](#)

Sub-contractor disclosure form collects information of any subcontractor entity/individual with which the provider has had any business transactions totaling more than \$25,000 during the preceding 12 month period.

Provide the following information for each entity/individual as described above:

\* Has the provider had business transactions with any subcontractor totalling more than \$25,000 during the preceding 12 month period?

☒ Yes ☐ No

\* Is this entity an individual or a corp...

☒ Individual ☐ Corporation

Title Last Name o... First Last Na... Second Last N...

Last Also

\* First ... Middle ... Suffix \* SSN \* Birth Date

First

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

\* If the SubContractor is a corporation, select 'yes' and provide the owner information below by clicking 'create new'. If the SubContractor is an individual, select 'no'.

☐ Yes ☒ No

Delete Cancel **Save**

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

\* If the SubContractor is a corporation, select 'yes' and provide the owner information below by clicking 'create new'. If the SubContractor is an individual, select 'no'.

☐ Yes ☒ No

**Delete** Cancel Save

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

**Delete Confirmation**

Are you sure you want to delete this record?

NO **YES**

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.

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**



**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.	<p>a. Verify that all names displayed in the Background Check Details panel are correct.</p> <p>b. Check the box in the final column of the panel if the person has submitted fingerprints to Medicaid within the past five years.</p> <p>Click Save and Continue.</p>	<p>Background check is reviewed.</p> <p>Progress bar advances to the next available page.</p>

### 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.



**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	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Sancz				<input type="checkbox"/> Check if Yes	Completed	

**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.

Select “Yes” for both questions and complete the required data. Use Calendar feature to complete the dates. Click **Save**.

To edit Fingerprints Submission, click the **Edit** button next to the desired.

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Sancz	Carla	333-00-1212	4/22/1982	<input type="checkbox"/> Check if Yes	Completed	

Enter Fingerprints Submission details and click Save to save the changes

Medicare/Medicaid Fingerprints Submission

Required Fields (4)

1. Have you submitted prints to Medicare within the last five years?  
☒ Yes ☐ No

Submitted Date  
01/04/2021

2. Have you submitted prints to another state Medicaid agency within the last five years?  
☒ Yes ☐ No

State  
Louisiana

Submitted Date  
06/16/2029

CANCEL SAVE

- 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				<input type="checkbox"/>
Long				<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.	<p>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.</p> <p>Click Save and Continue.</p>	<p>Attachments are added and saved.</p> <p>Progress bar advances to the next available page.</p>

### Detailed Steps

The Attachments page is displayed.

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

## Attachments

Required Fields ( \* )

Provider Type
Non-Emergency Medical Transportation

Specialty
Non-Emergency Medical Transportation

### Additional Information

Your provider type and specialty may require additional information.

If you are required to attach the Provider Consent Form, please click [Here](#) to download form.

If you have a large volume of malpractice cases or claims, please provide a detail document with a list of the other cases or claims within the 5-year period using the **malpractice suit or claim list** attachment type.

If this is a Change of Ownership (CHOW), please attach the purchase/sale contract and a letter that explains this is a CHOW and includes the old owner's NPI, Medicaid ID, and effective date of the new ownership. Use the **Change of Ownership (CHOW)** Attachment Type.

If you're enrolling as business with an Employer Identification Number (EIN) selecting an enrollment type of any of the following; Facility, Group or Atypical provider, the consent form is not required. Please upload a statement that you are enrolling as a group or facility and that an individual provider's consent is not required.

### 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
Provider Enrollment Consent Form	NO
General Liability Insurance	NO
Transportation Department Certification – Public Services Commission Certification for each unit (ambulance)	NO

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
Provider Enrollment Consent Form	NO
General Liability Insurance	NO
Transportation Department Certification – Public Services Commission Certification for each unit (ambulance)	NO

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



Attachment Details			
			Create New
Transmission Method	Attachment Type	File Name	Edit
There are no records found.			

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

New Attachment

Required Fields ( \* )

\* Transmission Method

select a value...

\* Attachment Type

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	Federal W-9 Form	Sample File.pdf	
Electronic Only	Physician's board certification: Evidence of current board certification by ABMS, AOA, ABOMS, ABPS, ABOPPM, RCPSG, CFPC or RCPCS	Sample File.pdf	

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

CREATE NEW

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
Provider Enrollment Consent Form	Yes
General Liability Insurance	Yes
Transportation Department Certification – Public Services Commission Certification for each unit (ambulance)	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	Sample File.pdf	
Electronic Only	Physician's board certification: Evidence of current board certification by ABMS, AOA, ABOMS, ABPS, ABOPPM, RCPSC, CFPC or RCPSC	Sample File.pdf	

Cancel

Previous

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.  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

Required Fields ( \* )

**Important Revalidation Fees:** If you have paid Fees during revalidation for another service location in Puerto Rico, please answer 'Yes' to Question 2 below to request application fee waiver for this service location. (Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prosthesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.)

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).

**\*Fee Update effective January 1, 2023\***

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 2023 is \$688.00. 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)

Checks should be made payable to: Secretario de Hacienda

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.

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

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

**APPLICATION FEE QUESTIONS**

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

1. Is the service location enrolled in Medicare?

☐ Yes ☐ No

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

Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prosthesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.

2. Has the application Fee for the Service location been paid to another state's Medicaid program or paid during revalidation for another service location in Puerto Rico?

☐ Yes ☐ No

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

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

If you answer “Yes” to the first Application Fee question, an enrollment date is required.

**APPLICATION FEE QUESTIONS**

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

1. Is the service location enrolled in Medicare?

☒ Yes ☐ No

\* Date Enrolled

11/09/2023

If you answer “Yes” to the second Application Fee, the state and date of payment are required fields.

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

Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prosthesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.

2. Has the application Fee for the Service location been paid to another state's Medicaid program or paid during revalidation for another service location in Puerto Rico?

☒ Yes ☐ No

\* State

Florida

\* Payment Date

11/09/2023

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

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

**APPLICATION FEE QUESTIONS**

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

1. Is the service location enrolled in Medicare? ?

☐ Yes ☒ No

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

Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prosthesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.

2. Has the application Fee for the Service location been paid to another state's Medicaid program or paid during revalidation for another service location in Pue... ?

☐ Yes ☒ No

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

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

Enrollment Application Fee \$688.00

Total Amount Due \$688.00



**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.

PAY APPLICATION FEE

Welcome to the the Online Bill Pay Process

Please complete each section of the online bill pay process to make a one-time payment for your Colorado Medicaid bill.

The following forms of payment are accepted:

Account Information

Account Information

☐ Personal ☐ Business

Last Name

First Name

Address

City

State

ZIP Code

Telephone Number

Payment Information

\* Payment Method

select a value...

\* Card Number

\* Verification Code

\* M.

\* Y.

\* Billing Address ZIP ...

Payment Amount

\* Email Address

\* Email Address Confirmation

Authorize Payment

Please verify your payment above and make any necessary changes. When verification is complete,click the "Authorize Payment" button below to submit your payment.

Your payment will not be processed until you click the "Authorize Payment" button below. Only click once to avoid duplicate payments. Once your payment has processed,you will receive a confirmation number that you can print for your records. Click the "Cancel" button below to stop this payment process and exit. Do not use your browser Back button.

Cancel

Authorize Payment

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

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

Enrollment Application Fee	\$688.00
<hr/>	
Total Amount Due	\$688.00

### 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** Required Fields ( \* )

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 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 on your Tax ID/SSN	Contact Name	Contact Email	Tax ID Type
			SSN

Tax ID Number	Service Location
123-45-6789	735 AVE PONCE DE LEON SAN JUAN PR, 009175030

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**

**Cancel** **Previous** **Finish Later** **Submit**

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

responsibility to notify the Puerto Rico  
ation, change of ownership, tax

nation with all contracted MCO/MAOs.

**Proceed**

**Finish Later** **Submit**

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



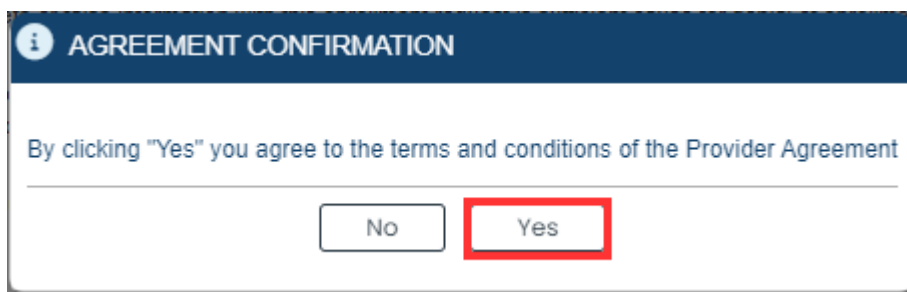
GOVERNMENT OF PUERTO RICO  
Department of Health  
Medicaid Program

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 a individual applying to bind such person to

☒ I Accept ☐  ☒ I Accept ☐

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



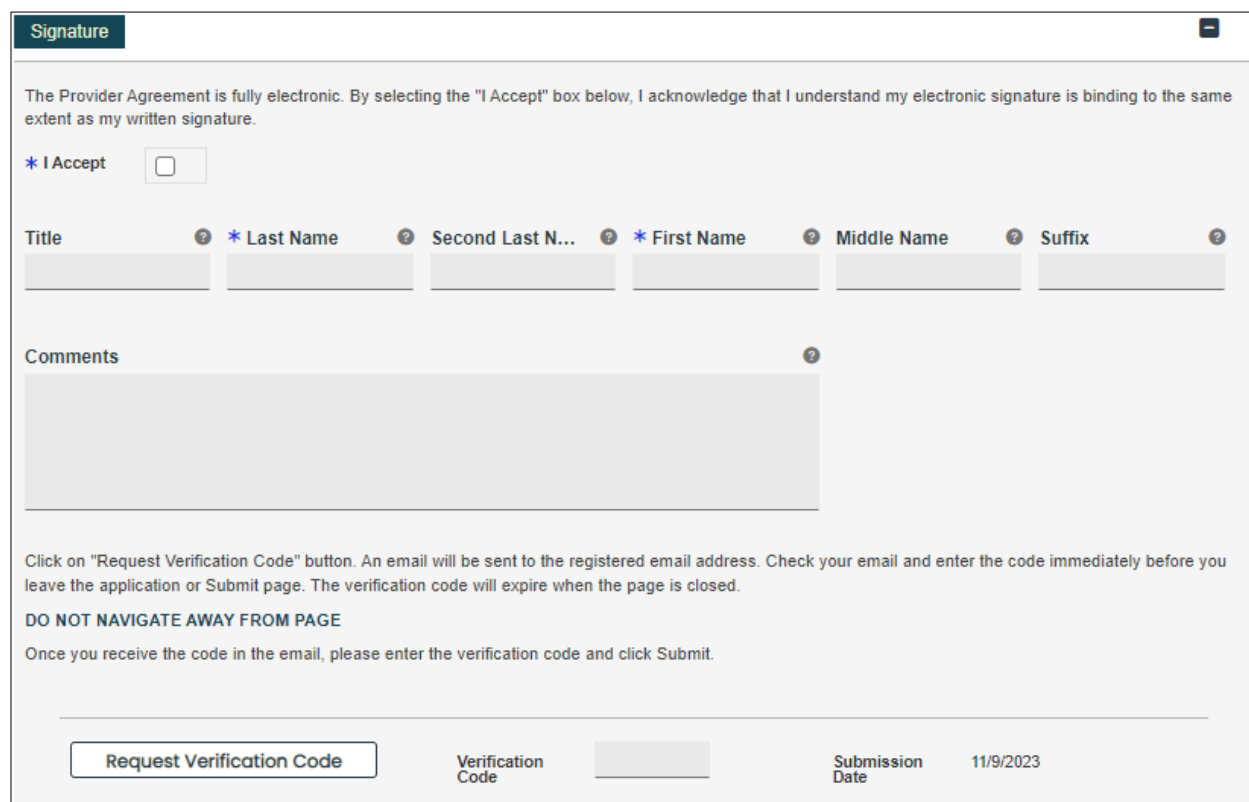
The image shows a pop-up window titled "AGREEMENT CONFIRMATION" with an information icon on the left. Below the title, it says "By clicking 'Yes' you agree to the terms and conditions of the Provider Agreement". At the bottom, there are two buttons: "No" and "Yes". The "Yes" button is highlighted with a red rectangular border.

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



The image shows a small rectangular box containing the text "Required Fields ( \* )" in blue, followed by "I Accept" in bold black, and "Yes" in bold black below it.

3. The **Signature** section displays.



The image shows a "Signature" section form. At the top, it says "The Provider Agreement is fully electronic. By selecting the 'I Accept' box below, I acknowledge that I understand my electronic signature is binding to the same extent as my written signature." Below this is a checkbox labeled "\* I Accept". Underneath the checkbox are six input fields: "Title", "\* Last Name", "Second Last N...", "\* First Name", "Middle Name", and "Suffix". Each field has a question mark icon to its right. Below these fields is a "Comments" section with a large text area and a question mark icon. At the bottom, there is a "Request Verification Code" button, a "Verification Code" input field, and a "Submission Date" field showing "11/9/2023". Above the submission date, it says "DO NOT NAVIGATE AWAY FROM PAGE" and "Once you receive the code in the email, please enter the verification code and click Submit."

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

**Signature**

The Provider Agreement is fully electronic. By selecting the "I Accept" box below, same extent as my written signature.

\* I Accept ☒

Click Request Verification Code.

Click on "Request Verification Code" button. An email will be sent to the registered email address. 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

Submission Date 11/9/2023

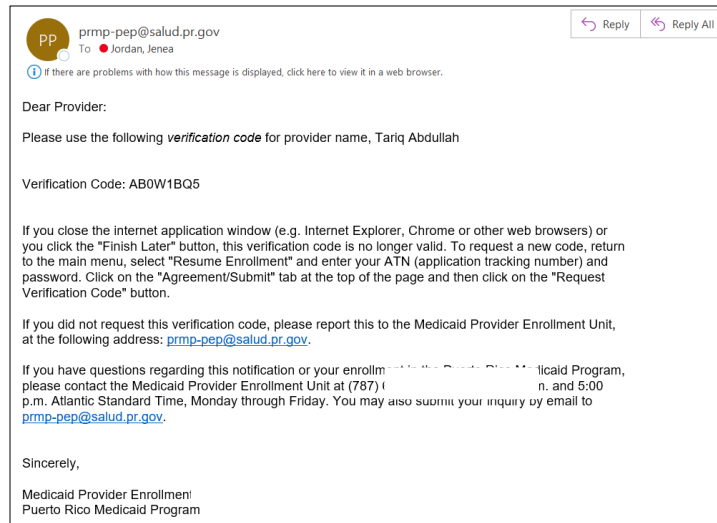
The verification code will be sent to the email address confirmed in the required fields.

**Email Verification Code**

Your Verification Code has been sent to **sample@abc.com**. Please check your email and promptly enter the code before you navigate away from the application.

OK

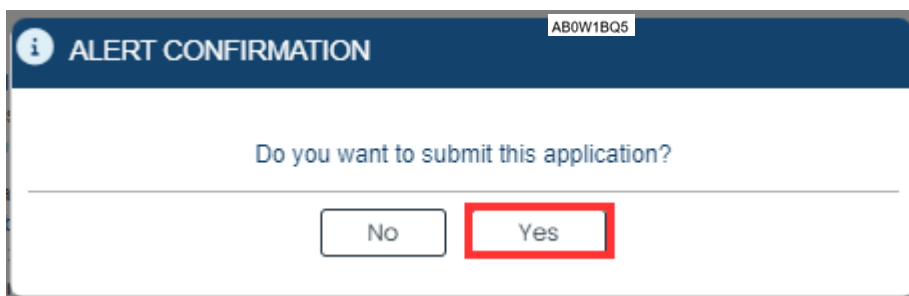
*Example of email received with verification code:*



**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.*

4. Enter the verification code in the **Verification Code** field and click **Submit**.
5. Confirm the submission by clicking **Yes** in the pop-up screen.



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

The screenshot shows the 'Submit Confirmation' page of the Puerto Rico Medicaid Program Provider Enrollment Portal. The header includes the program name and a 'Submit' button. The main content area contains a congratulatory message, a reminder to check email for important notifications, and the tracking number 8057465962. It also lists the Provider Enrollment Team contact information: prmp-pep@salud.pr.gov and (787) 641-4200. A footer bar contains links for Disclaimer, Website Requirements, and Privacy Policy.

Puerto Rico Medicaid Program  
PROVIDER ENROLLMENT PORTAL

PROVIDER ENROLLMENT Submit

Print ?

### Submit Confirmation

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

As a reminder, the PEP will email you important notifications that may require your immediate attention **as they may have due dates**. Please ensure that you check your spam/junk folder and mark [PRMP-PEP@salud.pr.gov](mailto:PRMP-PEP@salud.pr.gov) as a safe sender. If you are not receiving email from this address and do not find them in your spam/junk folder, please contact your administration to research the issue.

Tracking Number 8057465962

Provider Enrollment Team  
[prmp-pep@salud.pr.gov](mailto:prmp-pep@salud.pr.gov)  
Contact number: (787) 641-4200

DISCLAIMER | WEBSITE REQUIREMENTS | PRIVACY POLICY

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

The screenshot shows an email notification titled 'New Enrollment Complete Notification' from prmp-pep@salud.pr.gov. The email body includes a greeting 'Dear Provider:', a message about the successful submission of the provider enrollment application, the application tracking number 1426435421, and a password. It also provides instructions on how to check the status of the application and contact the Medicaid Provider Enrollment Unit for additional questions. The email is signed 'Sincerely, Medicaid Provider Enrollment Unit, Puerto Rico Medicaid Program'.

New Enrollment Complete Notification

pp prmp-pep@salud.pr.gov

Reply Reply All

If there are problems with how this message is displayed, click here to view it in a web browser.

Dear Provider:

Your provider enrollment application with the Puerto Rico Medicaid Program (PRMP) has been received. The Medicaid Provider Enrollment Unit will be evaluating your enrollment application. You will receive an approval notification via email, and if necessary, additional instructions to complete the process. Below is your tracking number that has been associated with your enrollment application.

Application Tracking Number: 1426435421  
Password: \*\*\*\*\*

You may check the status of your application by going to 'Enrollment Status' in PEP and entering your ATN and password.

If you have additional questions regarding your enrollment in the Puerto Rico Medicaid Program, please contact the Medicaid Provider Enrollment Unit at (787) 641-4200 between 8:00 a.m. and 5:00 p.m. Atlantic Standard Time, Monday through Friday. You may also submit your inquiry by email to [prmp-pep@salud.pr.gov](mailto:prmp-pep@salud.pr.gov).

Sincerely,  
Medicaid Provider Enrollment Unit  
Puerto Rico Medicaid Program

## **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.