



Puerto Rico Medicaid Management Information System

DEL_PRMMIS_Final_User_Documentation_PEP_Enrollment_Facility_Ref_Guide

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

Version 4.0

Change History

Version #	Date	Modified By	Description
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1 Acronyms

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

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

Table 1 – Acronyms

Acronyms	Definition
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ATN	Application Tracking Number
CLIA	Certified Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Agency
EIN	Employee Identification Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
ID	Identifier
LMS	Learning Management System
MCD	Medicaid ID
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 – Facility 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 a Facility 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 – Facility 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 Facility Enrollment Type applies to facilities that provide medical services and submit encounter claims for those services to Medicaid.

The Enrollment process for a Facility consists of multiple steps that must be completed in order to accept and submit an enrollment application for review.

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

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 select Facility.	a. Pop-up window displays, indicating that once the application is saved the Enrollment Type cannot be changed. b. The required enrollment steps for a Facility and a progress bar display at the top of the page.
2	Select Provider Type.	Click the drop-down list under Provider Type and select 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

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

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

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

The steps required to complete the enrollment for a Facility display at the top of the page, along with a progress bar to show your current progress.

PROGRESS

1 General Information 2 Specialties 3 Service Location 4 Addresses 5 Organization

6 Associations 7 Credentials 8 Provider Type 9 Other 10 Disclosures

11 Background Check 12 Attachments 13 Agreement / Submit



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.

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

*** Provider Type**

select a value...

select a value...

Ambulance

Ambulatory Surgical Center

Blood Bank

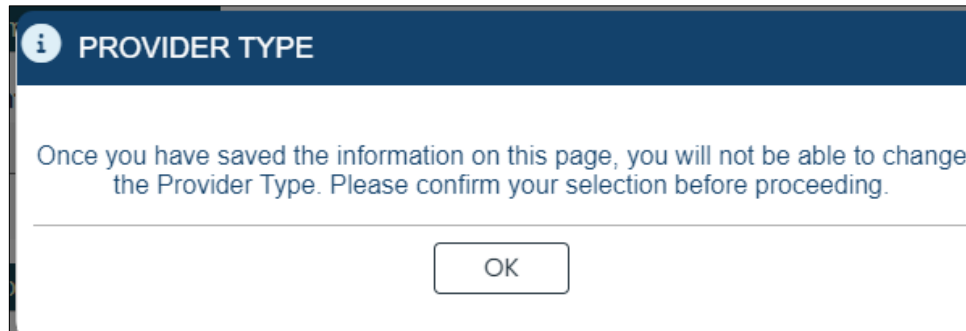
Center for Diagnosis and Treatment

Comprehensive Outpatient



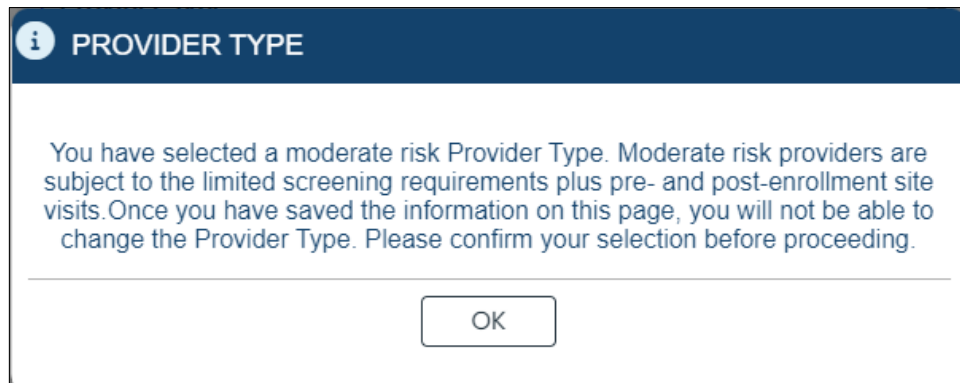
PROVIDER TYPE: The Provider Type drop-down list is dynamic based on the Enrollment Type selected. If you do not see your Provider Type in this list, verify that you have selected the correct Enrollment Type.

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

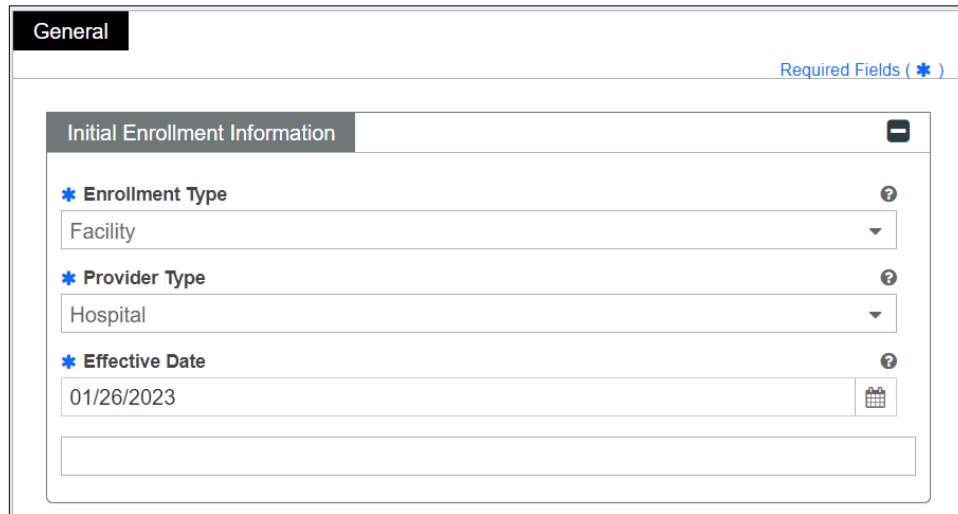


PROVIDER RISK: Depending on the Provider Type chosen, the provider's risk level (limited, moderate, or high) and the additional steps the provider must take in addition to the enrollment will be displayed in the generated pop-up window.

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



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




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

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

For a Facility, this section displays business-related fields.

Provider Information

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

* Legal Name on ... ?

Tax Name ?

Doing Business A... ?

* NPI ?

EIN ?

* Preferred Comm... ?



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

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

i. New Enrollment:

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

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

Are you currently enrolled as a Provider? ?

☐ Yes
 ☒ No

Were you previously enrolled as a Provider? ?

☐ Yes
 ☒ No

ii. Additional Enrollment:

- If you have been approved for enrollment in PRMP through PEP,
AND

- If you are currently active in the PRMP,

These steps are most common if you are:

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

OR

- Applying with a different Enrollment Type.

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

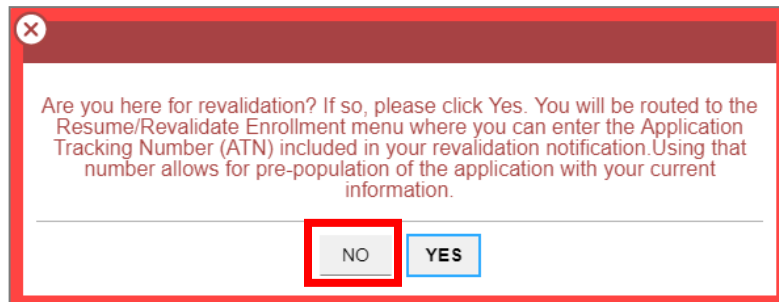
Select **Yes** for the currently enrolled question.



Are you currently enrolled as a Provider?

☒ Yes ☐ No

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



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

NO YES

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

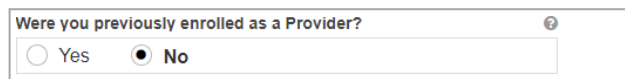


Are you currently enrolled as a Provider?

☒ Yes ☐ No

Current Provider Identifier

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



Were you previously enrolled as a Provider?

☐ Yes ☒ No

iii. **Revalidation (Currently Active):**

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

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

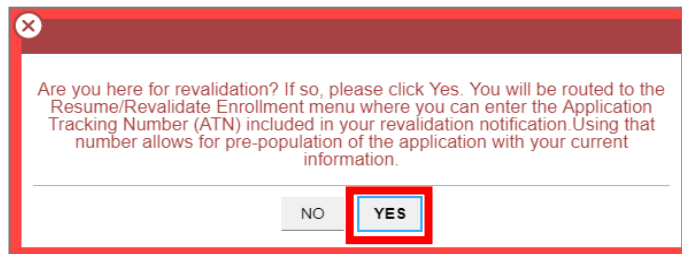
Select **Yes** for the currently enrolled question.



Are you currently enrolled as a Provider?

☒ Yes ☐ No

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



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

NO YES



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

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

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

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



Are you currently enrolled as a Provider?

☐ Yes ☒ No

Were you previously enrolled as a Provider?

☒ Yes ☐ No

Previous Provider Identifier

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

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

Are you Medicare enrolled?

☐ Yes ☒ No

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

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 *

* Phone Type * Telephone Number * Telephone Number Ext... * Fax Number *

Email Address * Confirm Email *

* Preferred Communication *

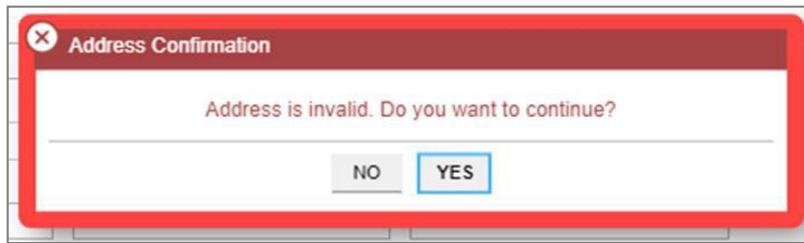


VALID ADDRESS: The PEP system will validate the address entered. If there is an updated variation, select that address from the pop-up window that displays.

Search Address

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

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



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

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

Torre Hospital Auxilio Mutuo

San Juan PR 00917-5030

Example of an invalid address: Torre Hospital Auxilio Mutuo

735 Ave Ponce de León Suite 710

San Juan PR 00917-5030

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

* Phone Type

* Telephone Number

Telephone Number Ext...

Fax Number

Email Address

Confirm Email

* Preferred Communication

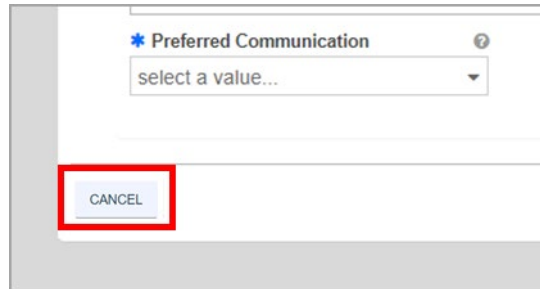
CANCEL

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.



3.1 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

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

Specialties

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

Provider Type
Hospital

Create New

Specialty	Taxonomy	Primary	Effective Date	Edit

- 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.

Create New

Specialty	Taxonomy	Primary	Effective Date	Edit

New Specialty

Required Fields (*)

☒ Make Primary

* Specialty select a value...

* Taxonomy select a value...

* Effective Date

Cancel Save

Once saved, the specialty will be displayed.

Specialties

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

Provider Type
Hospital

Create New

Specialty	Taxonomy	Primary	Effective Date	Edit
901-General Hospital	282E00000X-Long Term Care Hospital	x	10/13/2023	



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.

☒ **Make Primary**

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

Specialty	Taxonomy	Primary	Effective Date	Edit
901-General Hospital	282E0000X-Long Term Care Hospital		10/13/2023	<div> </div>

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

- c. 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.

Taxonomy

Create New

New Taxonomy

Required Fields (*)

* Taxonomy

select a value...

CANCEL

SAVE

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

Additional Taxonomies

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

Taxonomy

2865C1500X-Community Health


Create New

Edit

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

Additional Taxonomies

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

Taxonomy	Edit
2865C1500X-Community Health	


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

Puerto Rico Medicaid Program
PROVIDER ENROLLMENT PORTAL

PRMP CONTACT US LOGIN


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


Provider Type
Hospital

Specialty	Taxonomy	Primary	Effective Date	Edit
901-General Hospital	282E00000X-Long Term Care Hospital		10/13/2023	

Additional Taxonomies

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

Taxonomy	Edit
2865C1500X-Community Health	

Cancel Previous **Save and Continue** 

3.2 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.		

Step	Task	Action	Result
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.

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

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

New Service 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.

*** Location Name**

Contact Information

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

*** Address Line 1** **Address Line 2** *** City**

*** State** *** ZIP Code/ Post...** **Location Code** **County** *** Country**

select a value...

select a value...

select a value...

Email **Confirm Email**

Phone Number

At least one Phone Number must be provided.

Create New

Phone Type	Telephone Number	Extension	Edit



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 at the top of the panel when adding a new Service Location to mark it as your primary location.

☐ Make Primary

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



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

Search Address						
Number	Street	City	County	State	Country	ZIP Code
	NICHOLASVILLE CENTRE DR	LEXINGTON	FAYETTE	KY	UNITED STATES	40503-3344

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 window.

☰
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 ?

select a value...


* Telephone Number ?

Telephone Number Extension ?


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		 Edit

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 Number Extension

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

☒ Hours of Operation

Hours of Operation

Create New

Day	From Hour	To Hour	Edit

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

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		<input checked="" type="checkbox"/>

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

New Hours Of Operation

Required Fields (*)

* Day

?

* From Hour

?

* To Hour

?

select a value...

select a value...

select a value...

Cancel

Save

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

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

- 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

Accepting New Patients

* Preferred Patient Gender

No Preference

Cancel

Save

Once the information is saved, the service location displays.

Service Location

Service Location

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	1740 NICHOLASVILLE RD		Lexington	Kentucky	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						
Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	1740 NICHOLASVILLE RD		Lexington	Kentucky	x	

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

Service Location

Service Location

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	1740 NICHOLASVILLE RD		Lexington	Kentucky	x	

Cancel

Previous

Save and Continue

3.3 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. c. 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

Addresses Required Fields (*)

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

* ZIP Code/ Postal Code

* Country

☐ Same as Service Location

Email

Confirm Email



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

Pay To

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

☐ Same as Service Location

For some Address types, you could see a drop-down list at the beginning labeled “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.

A second Same as drop-down list will automatically populate the Email fields.

Same as

select a value...

select a value...
Service Location
Pay To

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

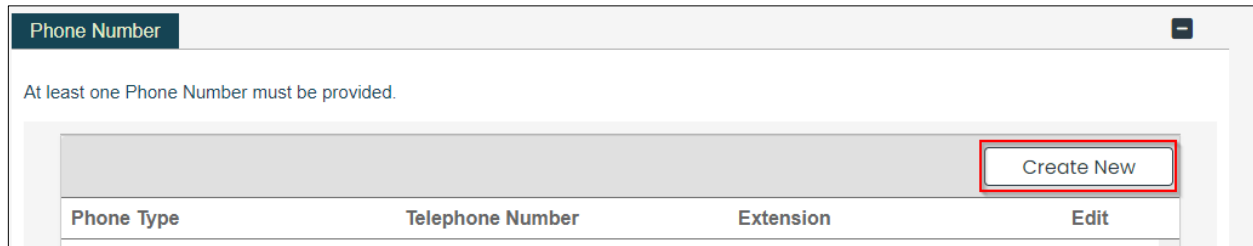
Phone Number

At least one Phone Number must be provided.

Create New

Phone Type	Telephone Number	Extension	Edit

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

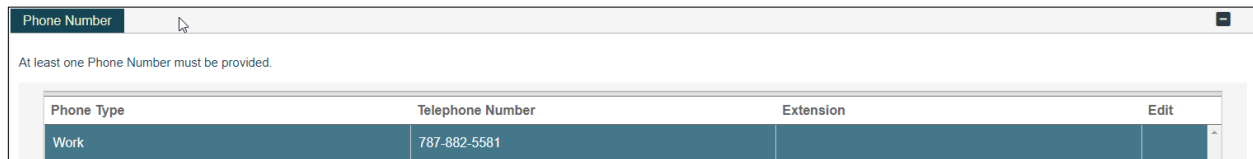


Phone Number

At least one Phone Number must be provided.

Phone Type	Telephone Number	Extension	Edit
Create New			

Once the information is saved, the phone number information is displayed.

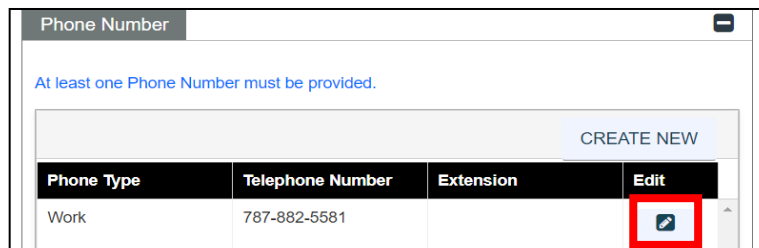


Phone Number

At least one Phone Number must be provided.

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


- b. To edit an added address 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		



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

☐ Same as Service Location 

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

Phone Number

At least one Phone Number must be provided.

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

Cancel Previous **Save and Continue**

3.4 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>c. 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 is displayed. A capacity is the maximum Medicaid Member count for each of a provider's Specialties within the County and State.

The screenshot shows the 'Capacity' page with a tab for '962 - Optometrist'. Below the tab is a table with the following data:

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

Buttons at the bottom include 'CANCEL', 'PREVIOUS', and 'SAVE AND CONTINUE'. A 'CREATE NEW' button is located in the top right corner of the table area.

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

This screenshot shows the same 'Capacity' page as before, but with a red box highlighting the 'CREATE NEW' button in the top right corner of the table area. A red arrow points from this button to a larger 'CREATE NEW' button in a pop-up window.

The 'New Capacity' pop-up window displays the following fields:

- State:** A dropdown menu with the text 'select a value...'.
- County:** A dropdown menu with the text 'select a value...'.
- Maximum Medicaid Member Count:** A text input field.

Buttons at the bottom include 'CANCEL' and '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.

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

The screenshot shows the 'Capacity' panel with a filter for '962 - Optometrist'. Below the filter is a table with the following columns: State, County, Waiver/Entitlement Type, Maximum Medicaid Member Count, and Edit. The first row shows 'Puerto Rico' for State and 'Isabela Municipio' for County. The 'Edit' button in the first row is highlighted with a red box. At the bottom right, there are buttons for 'PREVIOUS' and 'SAVE AND CONTINUE'.

The screenshot shows the 'Edit Capacity' form. It has three required fields: State (set to 'Puerto Rico'), County (set to 'select a value...'), and Maximum Medicaid Member Count (an empty text box). At the bottom left is a 'REMOVE' button, and at the bottom right are 'CANCEL' and 'SAVE' buttons. The 'SAVE' button is highlighted.

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

The screenshot shows the 'Capacity' panel with the same table as before. A large red arrow points from the 'SAVE AND CONTINUE' button at the bottom center to the 'SAVE AND CONTINUE' button at the bottom right, which is highlighted with a red box.

3.5 Organization

Quick Reference – Organization

Table 7 – Organization

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

Detailed Steps

The Organization step is displayed.

- 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

3.6 Associations

NOTE: The Associations page displays based on the Provider Type and Specialty disclosed in previous steps. If you intend to add Individual associations to your Facility enrollment application, you will need their Puerto Rico Medicaid Program (PRMP) Provider Location ID or their National Provider Identifier (NPI) in order to complete this step. If needed, see the instructions in **Section 2.4** of the **Provider Enrollment Portal (PEP) Navigation Reference Guide** for resuming your enrollment application after it has started.

If the Associations page does not display in your enrollment application, it is not required for your Provider Type. You can continue to [Section 3.8 Credentials](#) to see the instructions for your next required step.

Quick Reference – Associations

Table 8 – Associations

Step	Task	Action	Result
Start from the Associations page. This page displays after clicking Save and Continue from the previous page.			
1	Add Individual Associations	<ol style="list-style-type: none"> Click Create New at the top-right of the Individual Association section. Type in the desired association's Provider Location ID or NPI in the pop-up screen and click Search. Click the desired Association from the Search Results. Once the information is saved, the association information will be displayed. Click Save and Continue. 	<p>Associations are saved.</p> <p>Progress bar advances to the next available page.</p>

Detailed Steps

1. The Associations page is displayed. **Facility** enrollment is presented with an **Individual** Associations panel, which allows Facilities to associate with already-enrolled OPR providers.

Associations

Required Fields (*)

Individual Association

Download Template >

Bulk Uploads View Uploads > Create New

<input type="checkbox"/>	Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
There are no records found.							

Export to Excel Export to PDF

0 10 Items per page No items to display

Cancel Previous Save and Continue

- a. To add a new Association, click **Create New** at the top right corner of the **Individual Association** section.

Individual Association

Download Template >

Bulk Uploads View Uploads > Create New

<input type="checkbox"/>	Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
--------------------------	----------------------	------------	-------------	-----------	----------------	----------	------

- b. Type in the desired association's Medicaid ID (MCD) in the Provider Location ID field or their NPI in the pop-up screen and click **Search**.

New Individual Association

Required Fields (*)

* Provider Location ID ? NPI ? Search

Title Last Name First Name Middle Name Suffix

Reset Cancel Save



ADDING ASSOCIATIONS: Associations are limited to providers that are **already enrolled** in the Medicaid program. If a provider is not found with the entered search criteria, an error message displays indicating an invalid provider number was entered.

If the provider you want to associate with is not enrolled, please contact that provider directly.

- c. Select the desired association from the Search Results. This will populate the New Individual Association pop-up window with data from the selected association. Save the information once finished.

New Individual Association

Search Criteria

Search By

Provider Location ID

Service Location ID

01

Cancel

Clear

Search

Search Results

NPI	Provider Location ID	Last Name	First Name
	12345656730001	Adams	A
3534937297	12346666950001	Baker	B
4966811331	12346666950001	Banks	C
	12346668950001	Cox	D
	12393236150001	Davis	E
	12456612970001	Gray	F

1

10

Items per page

No Items to display

Cancel

- d. Once saved, the association information is displayed in the panel, and the options to **Export to Excel** or **Export to PDF** are activated.

Associations

Individual Association

CREATE NEW

Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
035558507	George		Strait	3/13/2023	12/31/9999	

10

Items per page

1 - 1 of 1 items

EXPORT TO EXCEL

EXPORT TO PDF

CANCEL

PREVIOUS

SAVE AND CONTINUE

Click the **Save and Continue** button at the bottom right to save the Associations page.

Associations

Individual Association

CREATE NEW

Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
035558507	George		Strait	3/13/2023	12/31/9999	

10

Items per page

1 - 1 of 1 items

EXPORT TO EXCEL

EXPORT TO PDF

CANCEL

SAVE AND CONTINUE

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 9 – 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.	<p>Complete the required information for any of the following sections that are presented:</p> <ul style="list-style-type: none"> a. License b. Medicaid Program c. DEA d. Puerto Rico Controlled Substance Certificate <p>Click Save and Continue.</p>	<p>Credentials are successfully added and saved.</p> <p>Progress bar advances to the next available page.</p>

Detailed Steps

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

Credentials

Required Fields (*)

License

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

Create New

License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit



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

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

License

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

Create New

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

New License

Required Fields (*)

* License Number

* Issuing State

* Issuing Board

* Effective Date

* 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

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

Create New

License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit
8685747645	Puerto Rico	OTHER - OTHER	10/16/2023	10/16/2028	



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 any other state Medicaid Program 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.

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

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

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

New Medicaid Program

Required Fields (*)

* Program ?
 * State ?
 * Effective Date ?
 * End Date ?

Once the information is saved, the credentials will 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	10/16/2023	10/16/2028	



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

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

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

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

Create New

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

New DEA

Required Fields (*)

* DEA Number ?

* Effective Date ?

* End Date ?

CANCEL

SAVE


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

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

DEA

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

Create New

DEA Number	Effective Date	End Date	Edit
AD0865937	10/16/2023	10/16/2028	

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

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?

☐ Yes
 ☐ No

Do you dispense controlled substances in Puerto Rico?

☐ Yes
 ☐ No

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

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?

☒ Yes
 ☐ No

Create New

Registration Number	Effective Date	End Date	Edit
---------------------	----------------	----------	------

Do you dispense controlled substances in Puerto Rico?

☒ Yes
 ☐ No

Create New

Registration Number	Effective Date	End Date	Edit
---------------------	----------------	----------	------

Cancel

Previous

Save and Continue

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

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?

☒ Yes ☐ No

Create New

Registration Number	Effective Date	End Date	Edit

Puerto Rico Controlled Substance Certificate

Required Fields (*)

* Registratio... ? * Effective D... ? * End Date ?

Registration Number: [] Effective Date: [] End Date: []

CANCEL SAVE

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

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

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?

☒ Yes ☐ No

Create New

Registration Number	Effective Date	End Date	Edit
AB123467	10/16/2023	10/16/2028	



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.


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	10/16/2023	10/16/2028	

Do you dispense controlled substances in Puerto Rico?

☐ Yes ☒ No

Cancel

Previous

Save and Continue

3.8 Provider Type

The information displayed on this page will be a different combination of panels, depending on the Provider Type and specialty chosen in previous enrollment steps.

Quick Reference – Provider Type

Table 10 – Provider Type

Step	Task	Action	Result
Start from Provider Type page displayed. This page displays after clicking Save and Continue from the previous page.			
1	Add Provider Type information.	Complete the required information for the panels displayed: a. CLIA b. Bed Information c. Level of Maternal Care Click Save and Continue.	Provider Type information is added and saved. Progress bar advances to the next available page.

Detailed Steps

1. The Provider Type page displays. Below are the Provider Type credentials that can be displayed for Facility enrollments.

- a. **CLIA (Certified Laboratory Improvement Amendments)** - Required for Providers who bill laboratory services.

Provider Type

Required Fields (*)

CLIA

Create New

CLIA Number	CLIA Type	Effective Date	End Date	Edit

To add a new CLIA entry, click **Create New** in the CLIA panel and complete the required fields in the displayed pop-up screen.

Provider Type

Required Fields (*)

CLIA

Create New

CLIA Number	CLIA Type	Effective Date	End Date	Edit

New CLIA

Required Fields (*)

* CLIA Number ? * CLIA Type ? * Effectiv... ? * End Date ?


CANCEL SAVE

Once saved, the information will display in the CLIA panel.

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

CLIA

Create New

CLIA Number	CLIA Type	Effective Date	End Date	Edit
19D8675309	3 - Accreditation	10/16/2023	10/16/2028	

- b. **Bed Information** - Hospitals and Custodial Care facilities are required to enter information about the type and number of available beds.

To add new bed information, click **Create New** in the Bed Information panel and complete the required fields in the displayed pop-up screen.

Bed Information

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

Create New

Bed Type	Number Of Beds	Effective Date	End Date	Edit

Edit Bed Information

Required Fields (*)

* Bed Type

Intermediate Care

* Number Of Beds

120

* Effective Date

10/16/2023

* End Date

10/16/9999

Delete

Cancel

Save

Once saved, the information will display in the Bed Information panel.

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

Bed Information

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

Create New

Bed Type	Number Of Beds	Effective Date	End Date	Edit
Intermediate Care Facility Beds	120	10/16/2023	10/16/9999	

Level of Maternal Care - Required for birth center Providers.

Level of Maternal Care

Create New

Level Of Maternal Care	Effective Date	End Date	Edit

To add a new level of maternal care, click **Create New** in the Level of Maternal Care panel and complete the required fields in the displayed pop-up screen.

The screenshot shows a panel titled "Level of Maternal Care". At the top right, there is a "Create New" button highlighted with a red rectangle. Below this is a table with the following columns: "Level Of Maternal Care", "Effective Date", "End Date", and "Edit".

The screenshot shows a pop-up form titled "New Level Of Maternal Care". It contains three required fields, each marked with a blue asterisk and a question mark icon: "Level Of Mate...", "Effective Date", and "End Date". The "Level Of Mate..." field has a dropdown menu showing "select a value...". The "Effective Date" and "End Date" fields have calendar icons. At the bottom right, there are "CANCEL" and "SAVE" buttons.

Once saved, the information will display in the Level of Maternal Care panel.

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

The screenshot shows the "Level of Maternal Care" panel with a table containing one entry. The "Edit" button for this entry is highlighted with a red rectangle.

Level Of Maternal Care	Effective Date	End Date	Edit
Specialty Care	10/16/2023	10/16/9999	

Once all sections are completed in the page, click **Save and Continue** at the bottom-right to save the Provider Type page.

The screenshot shows the "Level of Maternal Care" panel with the table from the previous screenshot. At the bottom right, the "Save and Continue" button is highlighted with a red rectangle.



SAVE AND CONTINUE BUTTON LOCATION: *The panel or section under which the Save and Continue button is found will differ based on the Provider Type chosen.*

3.9 Other

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

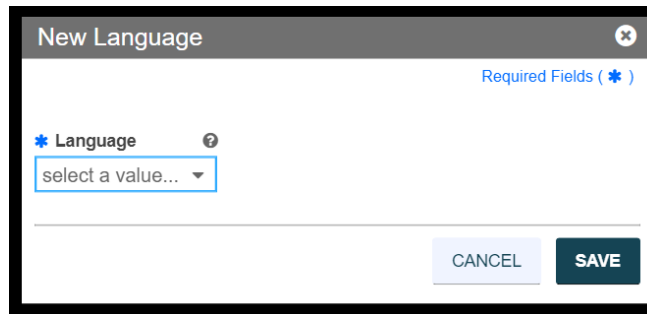
Quick Reference – Other

Table 11 – Other

Step	Task	Action	Result
Start from the Other page. This page displays after clicking Save and Continue from the previous page.			
1	Add Other information.	Complete the required information for the panels displayed: <ol style="list-style-type: none"> Languages Certifications Facility Accreditations Additional Information Malpractice Carrier Information Malpractice Suit Information Click Save and Continue.	Other information is added and saved. Progress bar advances to the next available page.

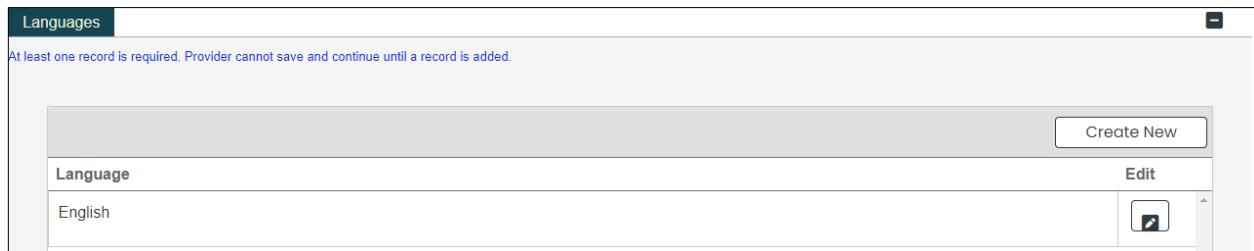
Detailed Steps

- The Other page is displayed. The other information that may be collected for Facility enrollments are shown below.
 - 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.



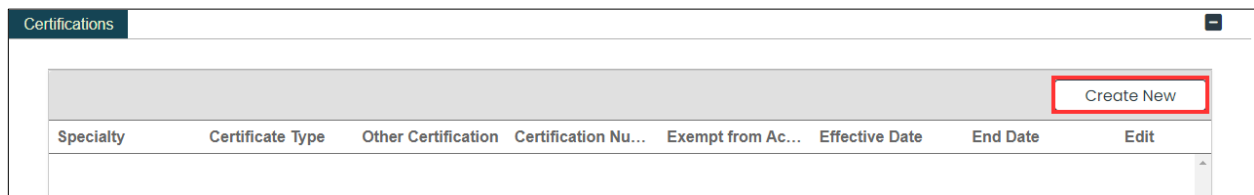
A pop-up window titled "New Language" with a close button (X) in the top right corner. It contains a "Required Fields (*)" label in blue. Below this is a required field labeled "* Language" with a question mark icon, featuring a dropdown menu with "select a value..." text. At the bottom right are "CANCEL" and "SAVE" buttons.

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

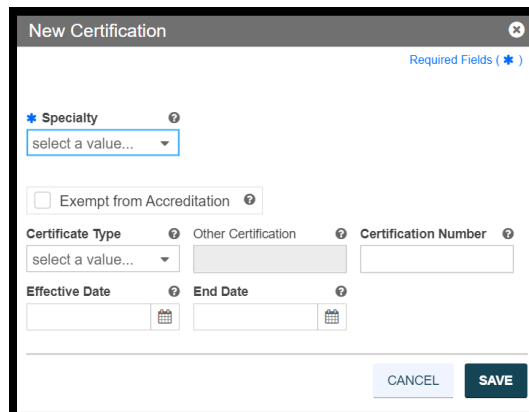


A screenshot of the "Languages" section. At the top, a message states: "At least one record is required. Provider cannot save and continue until a record is added." Below this is a table with one row: "English". To the right of the table is an "Edit" button and a plus icon. Above the table is a "Create New" button.

- 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 features a table with columns: "Specialty", "Certificate Type", "Other Certification", "Certification Nu...", "Exempt from Ac...", "Effective Date", "End Date", and "Edit". Above the table is a "Create New" button, which is highlighted with a red rectangle.




A pop-up window titled "New Certification" with a close button (X) in the top right corner. It contains a "Required Fields (*)" label in blue. The form includes:

- A required field labeled "* Specialty" with a question mark icon and a dropdown menu with "select a value..." text.
- An "Exempt from Accreditation" checkbox with a question mark icon.
- Fields for "Certificate Type" (dropdown with "select a value..."), "Other Certification" (text input), and "Certification Number" (text input).
- Fields for "Effective Date" and "End Date", each with a calendar icon.

 At the bottom right are "CANCEL" and "SAVE" buttons.

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

Certifications							
Create New							
Specialty	Certificate Type	Other Certification	Certification Nu...	Exempt from Ac...	Effective Date	End Date	Edit
901-General Hospital	Joint Commission on Accreditation of Healthcare Organizations		7589632		10/16/2023	10/16/2028	

- c. **Facility Accreditations** - Select the answer (Yes, No, Pending) that reflects your facility's current accreditation.

Facility Accreditations

Is your facility accredited ?

☐ Yes
☒ No
☐ Pending

No Facility Accreditation: Select **No** and no further information is required.

Facility Accreditations

Is your facility accredited ?

☐ Yes
☒ No
☐ Pending

Active Facility Accreditation: Select **Yes**.

Facility Accreditations

Is your facility accredited ?

☒ Yes
☐ No
☐ Pending

A Facility Accreditations panel displays underneath. To add the accreditation, click **Create New** and complete the required fields in the displayed pop-up window.

Facility Accreditations

Is your facility accredited ?

☒ Yes
☐ No
☐ Pending

Create New

Accrediting Organization
Expiration Date
Edit

New Facility Accreditation

Required Fields (*)

* Accrediting Organization

select a value...

* Expiration Date

Cancel

Save

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

Facility Accreditations

Is your facility accredited ?

☒ Yes
 ☐ No
 ☐ Pending

Create New

Accrediting Organization	Expiration Date	Edit
American Association for Accreditation of Ambulatory Surgery Facilities	10/16/2223	

Facility Accreditations

Is your facility accredited ?

☒ Yes
 ☐ No
 ☐ Pending

CREATE NEW

Accrediting Organization	Expiration Date	Edit
American Association for Accreditation of Ambulatory Surgery Facilities	3/14/2025	

SAVE

Pending Facility Accreditation: Select **Pending**. Select **Yes** or **No** to answer the new question displayed regarding whether the survey has been scheduled.

Facility Accreditations

Is your facility accredited ?

☐ Yes
 ☐ No
 ☒ Pending

Has the survey been scheduled ?

☐ Yes
 ☒ No

If **No** is selected, no additional action is necessary.

If **Yes** is selected, enter the date of the survey in the field that displays underneath.


Facility Accreditations


Is your facility accredited ?

☐ Yes
 ☐ No
 ☒ Pending

Has the survey been scheduled ?

☒ Yes
 ☐ No


* Survey Date 



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

Additional Information

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

Provider Website URL 

- e. **Malpractice Carrier Information** – To add 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

Type of Carrier	Name of Carrier	Coverage Amount Aggre...	Coverage Amount Per Oc...	Policy Number	Effective Date	End Date	Edit
Create New							

New Malpractice Carrier Information

Required Fields (*)

* Type of Carrier * 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 is displayed.

Malpractice Information

Please complete the malpractice information below

Type of Carrier	Name of Carrier	Coverage Amount Ag...	Coverage Amount Per...	Policy Number	Effective Date	End Date	Edit
Comprehensive General Liability	Triple S	1000000	2500	387648326	3/14/2019	3/14/2025	Edit

[CREATE NEW](#)

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

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

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

☐ Yes ☒ No

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

Are you currently or have you within the last 5 years been involved in a malpractice suit or claim in which your care and treatment of a patient was 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 Case	Claimant / Plaintiff filed...	Status Claim	Edit

New Malpractice Information

Required Fields (*)

* Patient/Plaintiff Name ?
☒ Patient Name ☐ Plaintiff Name

* Patient Name ?

* Your Involvement in t... ? * 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 to save the Other page.

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 Amount Aggr...	Coverage Amount Per ...	Policy Number	Effective Date	End Date	Edit
Comprehensive General Liability	Triple Rx Insurance	2000000000	300000	75395146	10/01/2023	10/01/2024	

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.

Cancel

Previous

Save and Continue

3.10 Disclosures

Quick Reference – Disclosures

Table 12 – 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.	a. Complete the disclosure forms displayed by clicking Create New next to each form. b. To edit or delete a form, click the desired form's name and then the Edit button in the displayed pop-up window. c. Click Save and Continue once all forms are completed.	Disclosures are completed. Progress bar advances to the next available page.

Detailed Steps

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

Disclosure Details

PRIVACY NOTICE STATEMENT

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

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

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

OWNERSHIP/CONTROLLING INTEREST

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

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

DISCLOSURE FORMS

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

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

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

CANCEL
PREVIOUS
SAVE AND CONTINUE

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

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

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

DISCLOSURE FORMS

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

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

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

CANCEL
PREVIOUS
SAVE AND CONTINUE

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

Example: Provider Self Disclosure



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**.

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

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

DISCLOSURE FORMS

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


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

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

CANCEL
PREVIOUS
SAVE AND CONTINUE

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

View Provider Self Disclosure

Disclosure Name	Edit
Last, First	

CLOSE

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

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

Edit Provider Self Disclosure

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

Required Fields (★)

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

Suffix SSN Birth Date

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

Affiliations

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

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

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.

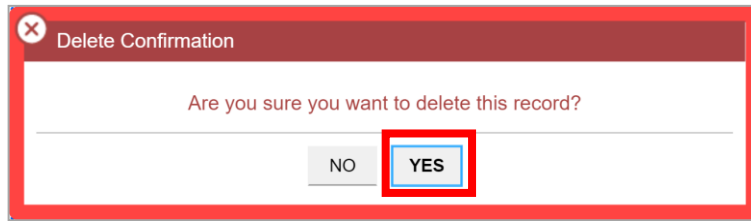
Convictions Of Criminal Offense

★ 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

Delete Cancel Save

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

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

The screenshot shows the "DISCLOSURE FORMS" section. It includes a table with the following data:

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

Below the table, there are three buttons: "CANCEL", "SAVE AND CONTINUE", and "PREVIOUS". A red arrow points from the "SAVE AND CONTINUE" button to a red-bordered "SAVE AND CONTINUE" button located further to the right.



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.

3.11 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 Individual Provider Type. If this is the case, go to [Section 3.13 Attachments](#) to view the instructions for your next required step.

Quick Reference – Background Check

Table 13 – Background Check

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

Detailed Steps

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 go back to the Disclosures step in your enrollment (discussed in [Section 3.11](#)), update and save the information.

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.

NOTE: If no fingerprints have been submitted in the past five 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.

Background Check

Background Check Details

The Affordable Care Act requires that providers with an ownership of 5% or more and are considered a high category of risk, submit fingerprint and 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	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	File
Sanz	Carlos	333-22-1212	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 *

* 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
06/16/2020


CANCEL **SAVE**

- b. 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**

3.12 Attachments

Quick Reference – Attachments

Table 14 – 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>b. 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.

Puerto Rico Medicaid Program
PROVIDER ENROLLMENT PORTAL

Attachments

Provider Type: Hospital
Specialty: General Hospital

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.

You may provide a copy of one of the following accreditations in lieu of the CMS Certification letter: American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), The Joint Commission (JC) or Det Norske Veritas (DNV) CMS-recognized deemed status certifications.

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
CMS Certification Letter	NO
DEA Certification	NO
Hospital License	NO
Malpractice/Liability Insurance	NO

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

Example: Copy of Provider Consent Form, Malpractice Insurance, and Change of Ownership

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.

You may provide a copy of one of the following accreditations in lieu of the CMS Certification letter: American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), The Joint Commission (JC) or Det Norske Veritas (DNV) CMS-recognized deemed status certifications.

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
CMS Certification Letter	NO
DEA Certification	NO
Hospital License	NO
Malpractice/Liability Insurance	NO

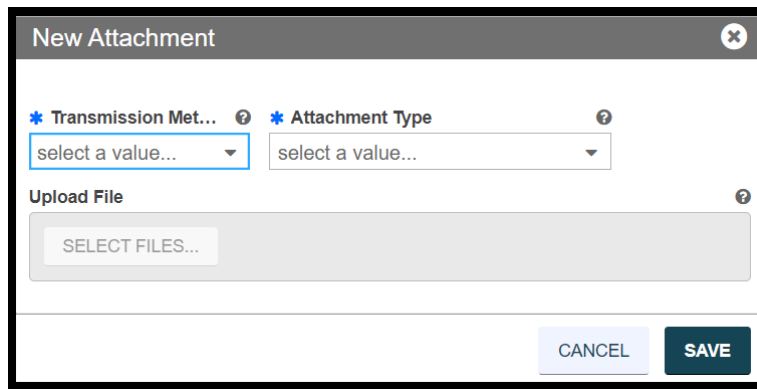
- Click **Create New** at the top-right of the Attachment Details panel to add a new attachment.

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.





The 'New Attachment' pop-up window contains the following elements:

- Transmission Met...**: A dropdown menu with 'select a value...' as the placeholder.
- Attachment Type**: A dropdown menu with 'select a value...' as the placeholder.
- Upload File**: A section with a 'SELECT FILES...' button.
- Buttons**: 'CANCEL' and 'SAVE' buttons at the bottom right.



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	License Add.png	
Electronic Only	Physician's board certification: Evidence of current board certification by ABMS, AOA, ABOMS, ABPS, ABOPPM, RCPSPG, CFPC or RCPCS	License Add.png	

In the Required Attachments panel, the Requirement Met column of an attachment changes from “No” to “Yes” once the attachment has 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
Malpractice/Liability Insurance	Yes
Federal W-9 Form	Yes
CLIA	Yes
Controlled Substance Prescribing Certificate of Registration	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	License Add.png	
Electronic Only	Physician's board certification: Evidence of current board certification by ABMS, AOA, ABOMS, ABPS, ABOPPM, RCPSPG, CFPC or RCPCS	License Add.png	

Cancel

Previous

Save and Continue



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

3.13 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 3.15 Agreement/Submit](#) to view the instructions for your next required step.

Quick Reference – Fees

Table 15 – Fees

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

Detailed Steps

1. The Fees page is displayed.

Application Fee

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

- a. 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 locatio...

☐ 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

Total Amount Due

No Fee

Cancel

Previous

Save and Continue

If you answer “Yes” to the first Application Fee question a follow up question displays.

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

If you answer “Yes” to the second Application Fee question a follow up question displays

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

* Payment Date

select a value...

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- b. 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 \$XXX.XX

Total Amount Due \$XXX.XX



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

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

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

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 \$XXX.XX

Total Amount Due \$XXX.XX

3.14 Agreement/Submit


Quick Reference – Agreement/Submit

Table 16 – 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 display under the Terms of Agreement.



Puerto Rico Medicaid Program
 PROVIDER ENROLLMENT PORTAL

[PRMP](#)
[CONTACT US](#)
[LOGIN](#)

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
NPI	Tax ID Type	Tax ID Number
1396848321	EIN	12-3456789
		Service Location

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.

Cancel

Proceed

Previous

Finish Later

Submit

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

ate and true. I understand that the filing of
Puerto Rico Medicaid Program.

otify the Puerto Rico Medicaid Program of
tion number, or NPI.

tracted MCO/MAOs.

Proceed

Previous

Finish Later

Submit

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

I understand that should I be approved as a provider or 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


Form

Please read the Provider Agreement document below.

LoadAgreementPdf

1 / 8 | - 121% + | [Icon] [Icon]

1



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 duly 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.

Required Fields (*)
I Accept ☐

Cancel Previous Finish Later Submit



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 / 8 121%

 **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 duly 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 ☒

Cancel Previous Finish Later Submit

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

The **I Accept** checkbox turns into a word answer.

4. The **Signature** section displays.

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

Signature

The Provider Agreement is fully electronic. By selecting the "I Accept" button, you agree to the terms of the agreement.

* I Accept

☒

Title

?

* Last Name

- b. 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	10/17/2023
---------------------------	-------------------	-----------------	------------

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

i

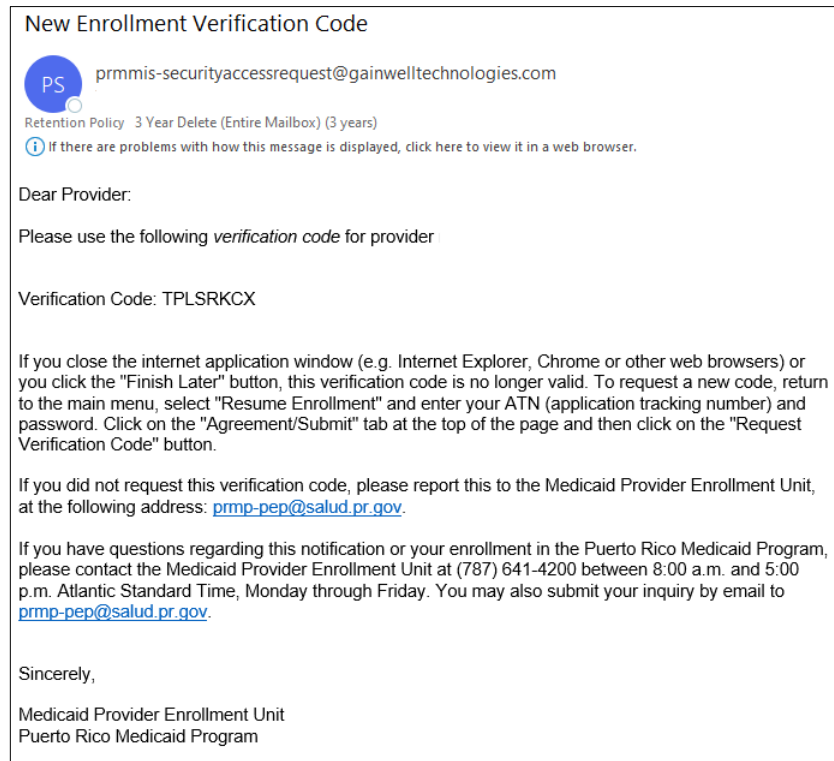
Email Verification Code

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

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.*

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

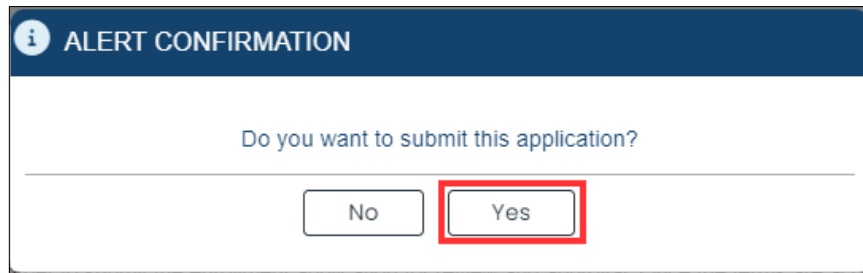
DO NOT NAVIGATE AWAY FROM PAGE

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

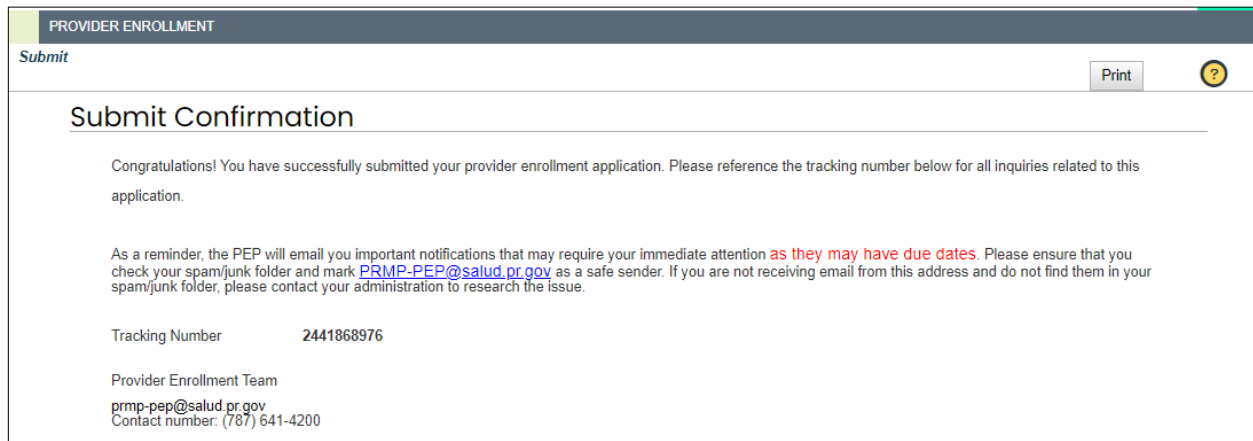
Request Verification Code	Verification Code	TPLSRKCX	Submission Date	10/17/2023
---------------------------	-------------------	----------	-----------------	------------

Cancel
Previous
Finish Later
Submit

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



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



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

New Enrollment Complete Notification



prmmis-securityaccessrequest@gainwelltechnologies.com

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: 2441868976

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 prmmis-securityaccessrequest@gainwelltechnologies.com.

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 enrolled 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.