ODP PROMISe™ Provider Enrollment Readiness Packet

This packet contains information that will help guide MR providers through the PROMISe™ Provider Enrollment Process.

Use the following links to go directly to the document you would like to view:

PROMISe™ Provider Enrollment Base Application Instructions

Print the Provider Enrollment Base Application from the DPW web site at: http://www.dpw.state.pa.us. To download the application:

1. Click the Provider Information hyperlink (on the left side of the screen);
2. Click the PROMISe™ hyperlink;
3. Click the Provider Enrollment Information hyperlink;
4. Navigate to your appropriate provider type;
5. Click the Enrollment Application and Requirements hyperlink.

IMPORTANT NOTES:

- **Applications must be typed or completed by hand using black ink.**
- **Complete ALL SPACES as required on the application with either your correct information, or N/A.**
- **The application must be printed and submitted as a single-sided document.**
- **Out-of-state providers must submit proof of participation in that state's Medicaid program.**

Specific Field Completion Instructions

Field	Description and Completion Notes
1.	Enter the complete name of the individual or the facility. **NOTE:** The facility name cannot include a street address.
2a.	Select **Initial Enrollment**. Select **Individual** or **Facility**. Write the MPI and service location on the right side of this line. **NOTE:** For each unique service location, a new application must be completed.
2b.	If you are re-activating a closed service location that was enrolled in PROMISe™ in the past, check this box and enter your nine (9) digit **MPI number** and four (4) digit **service location code**.
2c.	If this is a name change, indicate both the old name and the new name. **NOTE:** To verify your new name, a copy of your Social Security card or IRS FEIN documentation must accompany your application.
2d.	Do not complete this section.
3.	**IMPORTANT:** This cell **must be completed** for all healthcare provider types 05, 16, 17, 19, 21, or 52 (with specialties 456 or 520). Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the health care provider applying for enrollment. Enter your ten (10) digit NPI number, and ten (10) digit taxonomy code(s). If you have more than four (4) taxonomy codes, please attach an additional sheet noting the additional codes. **NOTE FOR PROVIDER TYPE 26, 51, 52 (for specialties, 521, 522, and 524), 53, 54 and 55:** These provider types are considered an atypical (non-healthcare) provider type; therefore, no NPI is needed. **NOTE FOR PROVIDER TYPE 21:** This provider type needs to coordinate changes with the ODP Case Management lead when providing this service for the Office of Developmental Programs. There are changes that **must** take place in HCSIS for claims to process correctly.
4.	Enter the requested effective date for your action request. Check with your County on what

Field	Description and Completion Notes
	date should appear here**.** **NOTE:** If claims are submitted in PROMISe™ using a date prior to the Requested Effective Date, they will be denied.
5.	Enter your provider type number and description. Refer to the Provider Type/Specialty Codes list, available within this document, for assistance.
6.	Enter your specialty name and code number. Refer to the Provider Type/Specialty Codes list, available within this document, for assistance. **NOTE:** Separate applications are *not* required for different specialties, only for separate service locations. You may enter multiple specialty names and codes in this field.
7.	Enter **N/A**.
8.	Enter your Social Security Number (SSN) if you are enrolling as an individual. **NOTES:** • A copy of your Social Security card, W-2, or document from the IRS containing your Social Security Number must accompany your application. • If you complete this field, do not complete #9.
9.	Enter your Federal Tax ID Number (FEIN) if you are enrolling as a facility. **NOTES:** • A copy of the FEIN label or document from the IRS containing your FEIN number must accompany this application. A W-9 form will not be accepted. • If you complete this field, do not complete #8.
10.	Enter your legal name as it is filed with the IRS and as it appears on the attached IRS documentation. It is not necessary that **Facility Name** in #1 and **Legal Name** in #10 match; *however*, the Legal Name in #10 MUST match the name on the IRS documentation.
11a.	Indicate whether the provider participates with any PA MCOs.
11b.	If 'Yes' is checked, please list the MCO(s).
12a.	Indicate whether the provider operates under a fictitious business or “doing business as” (d/b/a) name.
12b.	If applicable, enter the statement/permit number and the name. **NOTE:** Attach a legible copy of the recorded/stamped fictitious business name statement/permit.
13.	For Individuals Only: Enter your date of birth.
14.	For Individuals Only: Enter your gender.
15.	For Individuals Only: Enter the title/degree you currently hold.
16a.	Enter your legal entity address. The address must be a physical location; a post office box is not a valid legal entity address. The zip code **must** contain nine (9) digits.
16b.	Enter the name of the CEO, President or Owner of the organization.
16c.	Enter the e-mail address for the contact person listed in # 16b, if applicable.
16d.	Enter the business phone for the contact person listed in # 16b.
16e.	Enter the toll free business phone for the contact person listed in # 16b, if applicable.
16f.	Enter the fax number for the contact person listed in # 16b, if applicable.
17.	Select the appropriate box for your business type. Check only one box.
18.	If you are enrolling to provide a licensed service, enter your license number, issuing state,

Field	Description and Completion Notes
	issue date, and expiration date. **NOTES:** • A copy of your license or certificate of compliance must accompany your application. Attach the page of the license that pertains to the service location..
19.	Enter **N/A**.
20a.	Enter a valid service location address. This address should already be entered in HCSIS and the addresses should match. Select **Pay-to, Mail-to** and/or **Home Office**, if applicable **NOTES:** • The address must be a physical location, not a post office box. • The zip code MUST contain nine (9) digits. • For **Pay-to, Mail-to,** and/or **Home Office** locations different from the Service Location address entered in # 20a, complete the additional Home Office/Mail-To/Pay-To page within the application. If the **Pay-to, Mail-to** and/or **Home Office** are all the same as the Service Location address, write **N/A** on the additional page.
20b.	Indicate whether you want to receive electronic or paper bulletin notifications.
20c.	Indicate whether you want to receive electronic or paper RAs from PROMISe™.
20d.	Enter **N/A**.
20e.	Enter the PROMISe™ billing contact for your organization.
20f.	Enter the toll free business phone for the contact person listed in # 20e, if applicable.
20g.	Enter the fax number for the contact person listed in # 20e, if applicable.
20h.	Enter the e-mail address for the contact person listed in # 20e.
20i.	Select whether you or your staff are able to communicate in any language other than English. **NOTE:** American Sign Language (ASL) is considered another language.
20j.	List the language(s), other than English, in which you or your staff are able to communicate.
20k.	Answer the questions pertaining to the Americans with Disabilities Act (ADA). These questions refer to the Service Location Address entered in # 20a.
20l.	Enter the appropriate Provider Eligibility Program(s) (PEP) in which you participate. Follow the instructions below: • Enter Consolidated, P/FDS and MR Base for all Provider Types. • If you do not provide waiver services, **enter MR Base only**.
21a-e.	Complete ALL confidential information questions in this section. **NOTE:** If you answer **Yes** to any of the questions, provide a detailed explanation (on a separate piece of paper) and attach it to your application Please allow extra time for the application to be enrolled in PROMISe.
21f.	Include full details on any **Yes** responses to the proceeding questions.
22.	A CEO/President/Owner is required to sign the application and indicate their name, title and date. **NOTE:** ***BLACK*** ink must be used for the signature.
23.	Use this page **only** to add a **Mail-to, Pay-to** and/or **Home Office** address to the **previously defined** service location entered in # 20a. **NOTES:**

Field	Description and Completion Notes
	• Use as many fields as necessary to list details for all applicable locations. • This sheet cannot be used to add a service location. You must complete a new application to add a service location.

Additional Notes:

- Review the PROMISe™ Provider Enrollment Packet Checklist before submitting your application.
- **Page 13 should be omitted** when submitting your application. It cannot be used to enroll additional service locations.
- **All providers MUST sign and date Page 14**, the Provider Agreement for Outpatient Providers.
- Return your application and other documentation to:

ODP Provider Enrollment
Room 413
Health & Welfare Building
Harrisburg, PA 17101

Contact Information	
Phone Number:	**1-888-565-9435**
Fax Number:	**717-783-5141**
E-Mail Address:	**ra-odpproviderenroll@state.pa.us**

ODP Provider Types and Specialty Codes

Provider Type	Description	Specialty Code	Description
03	Extended Care Facility	032	ICF/MR 8 Beds or Less
		033	ICF/MR 9 Beds or More
		038	State Mental Retardation Center
05	Home Health	051	Private Duty Nurse
16	Nurse	160	Registered Nurse
		161	Licensed Practical Nurse
17	Therapist	170	Physical Therapist
		171	Occupational Therapist
		173	Speech/Hearing Therapist
19	Psychologist	190	General Psychologist
		191	Clinical Neuropsychologist
		192	Clinical Health Psychologist
		193	Psychoanalytic Psychologist
		194	School Psychologist
		195	Clinical Psychologist
		196	Clinical Child Psychologist
		197	Counseling Psychologist
		198	Industrial Organizational Psychologist
		199	Behavioral Psychologist
		201	Forensic Psychologist
		202	Family Psychologist
		203	Biofeedback: Applied Psychophysiologist
		204	Clinical Geropsychologist
		205	Psychopharmacologist
		206	Trtmt of Alcol and other Psycav Sbstc Use Dsordrs
		207	Cognitive Therapist
		208	Behavioral Therapist Consultant
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
21	Case Management	218	Supports Coordination
26	Transportation	267	Non-emergency
51	Home & Community Habilitation	410	Adult Day Services
		510	Home & Community Habilitation
		511	Respite Care – Institutional

ODP Provider Types and Specialty Codes (Continued)

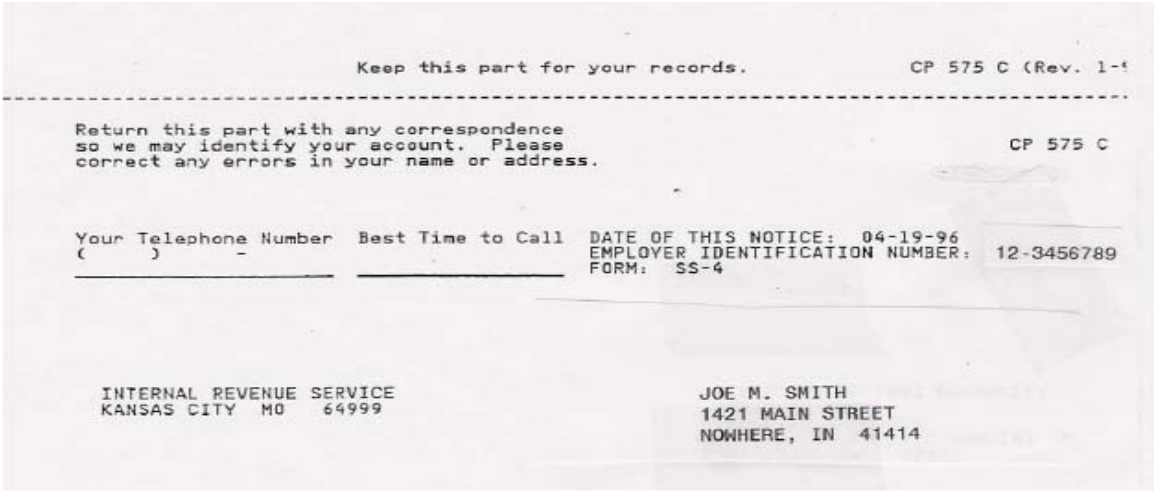
Provider Type	Description	Specialty Code	Description
51	Home & Community Habilitation	512	Respite Care - Home Based
		513	Respite Care - Out of Home
		514	Adult Training - 2380
		515	Pre-Vocational - 2390
		516	Transitional Work Services
		517	Visual & Mobility Therapy
		518	Recreation
		533	Educational Service
		571	Home Finding
52	Community Residential Rehabilitation	456	CRR - Adult
		520	Child Residential Services - 3800
		521	Adult Residential - 6400
		522	Family Living Homes - 6500
		524	Unlicensed
53	Employment-Competitive	530	Job Finding
		531	Job Support
54	Intermediate Service Organization	540	ISO - Agency with Choice
		541	ISO - Fiscal/Employer Agent
55	Vendor	267	Non-emergency
		430	Homemaker Agency
		431	Homemaker/Chore Services
		543	Environmental Accessibility Adaptations
		552	Adaptive Appliances/Equipment
		553	Habilitation Supplies
		554	Respite, Overnight Camp
		555	Respite, Day Camp

Examples of Acceptable Documentation to Verify IRS Numbers

The following documents are acceptable as verification of the FEIN/SSN number:

NOTE: Only the applicable portions of the documents have been included.

- **IRS Form CP575**



Keep this part for your records. CP 575 C (Rev. 1-

Return this part with any correspondence so we may identify your account. Please correct any errors in your name or address.

CP 575 C

Your Telephone Number ( ) -

Best Time to Call

DATE OF THIS NOTICE: 04-19-96
EMPLOYER IDENTIFICATION NUMBER: 12-3456789
FORM: SS-4

INTERNAL REVENUE SERVICE
KANSAS CITY MO 64999

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

- **Form 8109 – Federal Tax Deposit Coupon**

Mark the "X" in this box only if there is a change to Employer Identification Number (EIN) or Name.

See instructions on page 1.

BANK NAME/ DATE STAMP

EIN 12-3456789

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

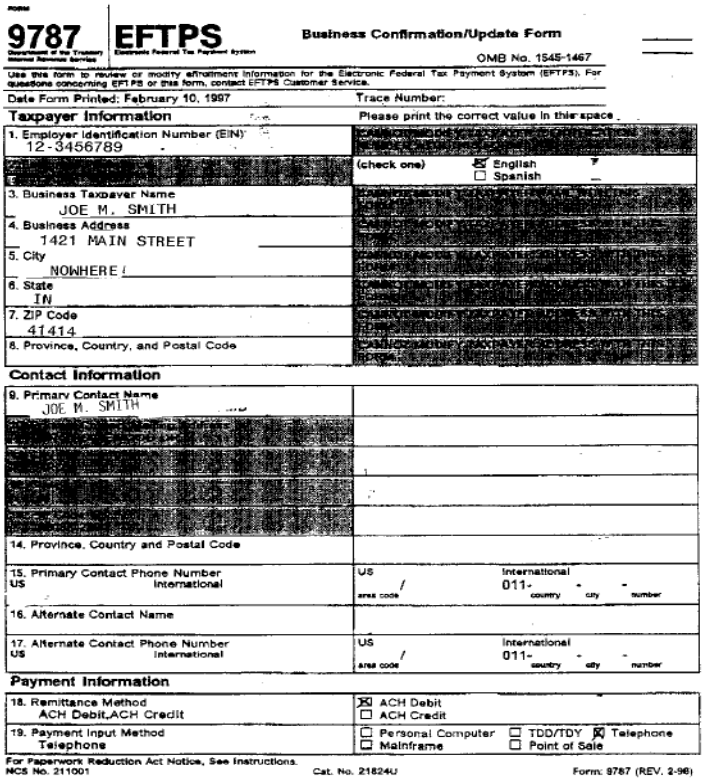
Telephone number ( )

Federal Tax Deposit Coupon
Form 8109 (Rev. 10-96)

941	945	1st Quarter
990-C	1120	2nd Quarter
943	990-T	3rd Quarter
720	990-PF	4th Quarter
CT-1	1042	
940		

FOR BANK USE IN MICR ENCODING

- **Form 9787 Electronic Federal Tax Payment System**



9787 EFTPS Business Confirmation/Update Form

OMB No. 1545-1467

Use this form to review or modify enrollment information for the Electronic Federal Tax Payment System (EFTPS). For questions concerning EFTPS or this form, contact EFTPS Customer Service.

Date Form Printed: February 10, 1997 Trace Number:

Please print the correct value in this space.

Taxpayer Information

1. Employer Identification Number (EIN): 12-3456789
(check one) ☒ English ☐ Spanish
3. Business Taxpayer Name: JOE M. SMITH
4. Business Address: 1421 MAIN STREET
5. City: NOWHERE
6. State: IN
7. ZIP Code: 41414
8. Province, Country, and Postal Code

Contact Information

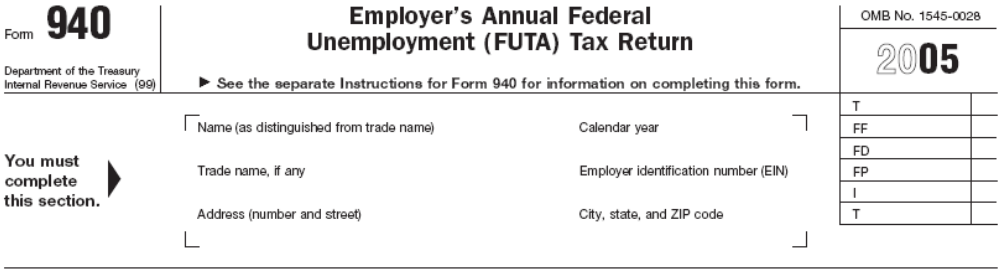
9. Primary Contact Name: JOE M. SMITH
14. Province, Country and Postal Code
15. Primary Contact Phone Number — US / International 011- - - (area code / country city number)
16. Alternate Contact Name
17. Alternate Contact Phone Number — US / International 011- - - (area code / country city number)

Payment Information

18. Remittance Method: ACH Debit,ACH Credit — ☒ ACH Debit ☐ ACH Credit
19. Payment Input Method: Telephone — ☐ Personal Computer ☐ TDD/TDY ☒ Telephone ☐ Mainframe ☐ Point of Sale

For Paperwork Reduction Act Notice, See Instructions.
NCS No. 211001 Cat. No. 21824U Form: 9787 (REV. 2-98)

- **940 Social Security Tax Form**



Form 940

Department of the Treasury
Internal Revenue Service (99)

Employer's Annual Federal Unemployment (FUTA) Tax Return

▶ See the separate Instructions for Form 940 for information on completing this form.

OMB No. 1545-0028

2005

You must complete this section.

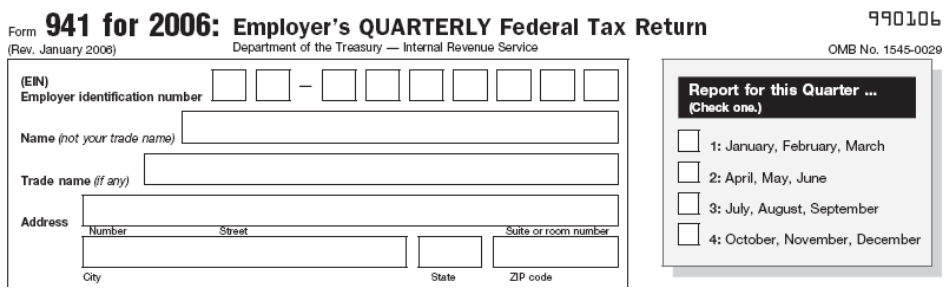
Name (as distinguished from trade name) Calendar year

Trade name, if any Employer identification number (EIN)

Address (number and street) City, state, and ZIP code

T
FF
FD
FP
I
T

- **941 Federal Unemployment Tax Form**



Form **941 for 2006:** Employer's QUARTERLY Federal Tax Return

(Rev. January 2006) Department of the Treasury — Internal Revenue Service

990106

OMB No. 1545-0029

(EIN) Employer identification number

Name *(not your trade name)*

Trade name *(if any)*

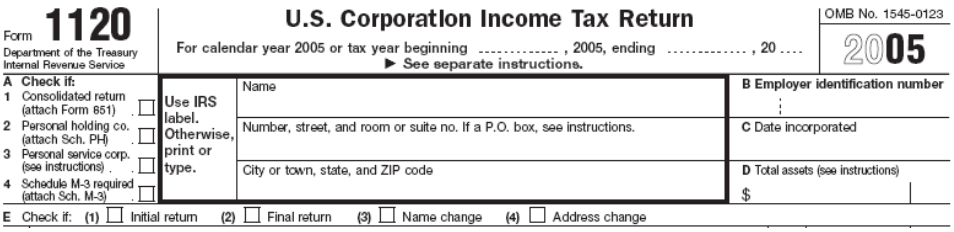
Address — Number Street Suite or room number

City State ZIP code

Report for this Quarter ... (Check one.)

- 1: January, February, March
- 2: April, May, June
- 3: July, August, September
- 4: October, November, December

- **1120 Federal Income Tax Form**



Form **1120**
Department of the Treasury
Internal Revenue Service

U.S. Corporation Income Tax Return

For calendar year 2005 or tax year beginning ..... , 2005, ending ..... , 20 ....
► See separate instructions.

OMB No. 1545-0123
2005

A Check if:
1 Consolidated return (attach Form 851) ☐
2 Personal holding co. (attach Sch. PH) ☐
3 Personal service corp. (see instructions) ☐
4 Schedule M-3 required (attach Sch. M-3) ☐

Use IRS label. Otherwise, print or type.

Name

Number, street, and room or suite no. If a P.O. box, see instructions.

City or town, state, and ZIP code

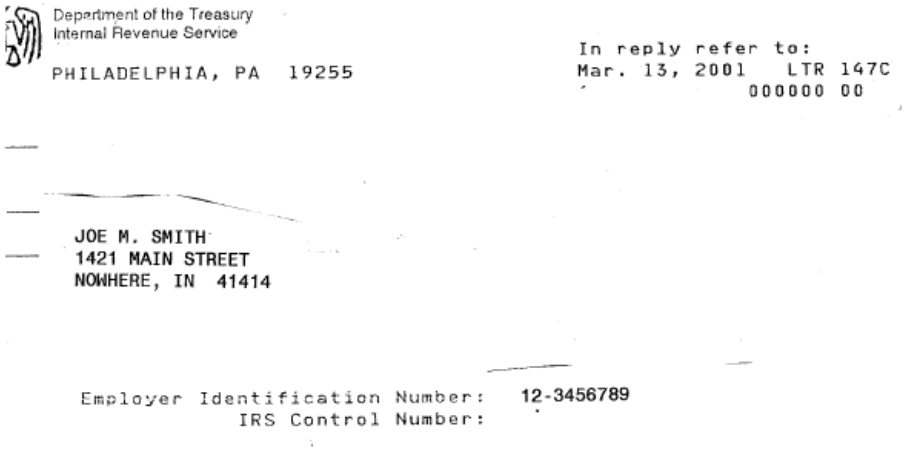
B Employer identification number

C Date incorporated

D Total assets (see instructions)
$

E Check if: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change

- **IRS Letter 147C**



Department of the Treasury
Internal Revenue Service

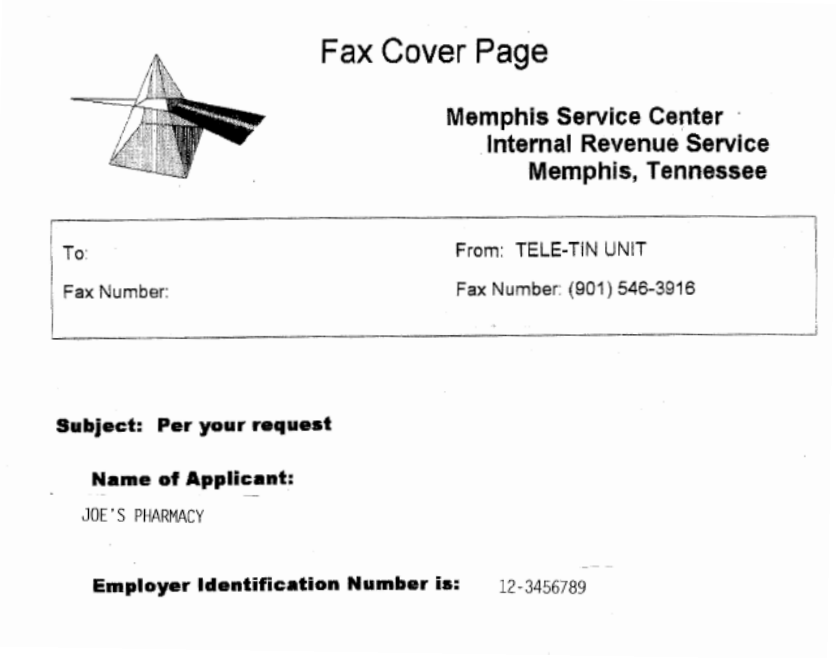
PHILADELPHIA, PA 19255

In reply refer to:
Mar. 13, 2001 LTR 147C
000000 00

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

Employer Identification Number: 12-3456789
IRS Control Number:

- **IRS Fax Cover Page**



Fax Cover Page

Memphis Service Center
Internal Revenue Service
Memphis, Tennessee

To:
Fax Number:

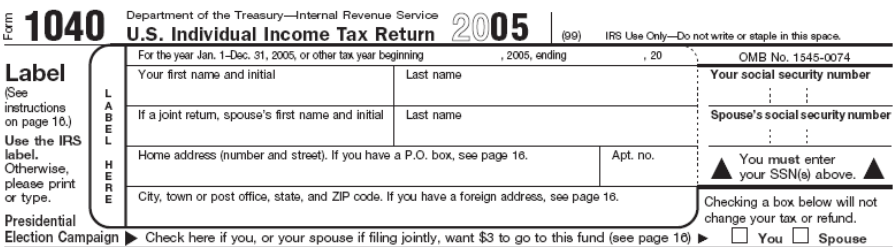
From: TELE-TIN UNIT
Fax Number: (901) 546-3916

Subject: Per your request

Name of Applicant:
JOE'S PHARMACY

Employer Identification Number is: 12-3456789

- **IRS Form 1040 (1040 A & 1040 EZ are also acceptable)**



Form **1040** Department of the Treasury—Internal Revenue Service **U.S. Individual Income Tax Return** 2005 (99) IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2005, or other tax year beginning , 2005, ending , 20 OMB No. 1545-0074

Label (See instructions on page 16.) Use the IRS label. Otherwise, please print or type. LABEL HERE

Your first name and initial | Last name | Your social security number

If a joint return, spouse's first name and initial | Last name | Spouse's social security number

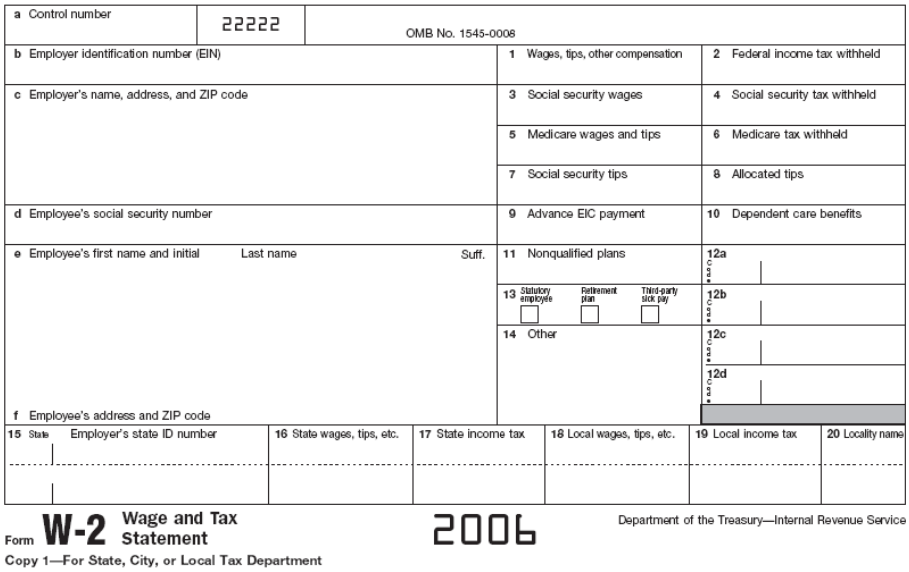
Home address (number and street). If you have a P.O. box, see page 16. | Apt. no. | You must enter your SSN(s) above.

City, town or post office, state, and ZIP code. If you have a foreign address, see page 16. | Checking a box below will not change your tax or refund.

Presidential Election Campaign ▶ Check here if you, or your spouse if filing jointly, want $3 to go to this fund (see page 16) ▶ ☐ You ☐ Spouse

- **Social Security Card**

- **Form W-2**



a Control number 22222 OMB No. 1545-0008

b Employer identification number (EIN) | 1 Wages, tips, other compensation | 2 Federal income tax withheld

c Employer's name, address, and ZIP code | 3 Social security wages | 4 Social security tax withheld | 5 Medicare wages and tips | 6 Medicare tax withheld | 7 Social security tips | 8 Allocated tips

d Employee's social security number | 9 Advance EIC payment | 10 Dependent care benefits

e Employee's first name and initial Last name Suff. | 11 Nonqualified plans | 12a | 13 Statutory employee Retirement plan Third-party sick pay | 12b | 14 Other | 12c | 12d

f Employee's address and ZIP code

15 State Employer's state ID number | 16 State wages, tips, etc. | 17 State income tax | 18 Local wages, tips, etc. | 19 Local income tax | 20 Locality name

Form **W-2** Wage and Tax Statement 2006 Department of the Treasury—Internal Revenue Service

Copy 1—For State, City, or Local Tax Department

- **Social Security Statement (MUST include BOTH pages 1 & 2)**

Page 1:

Prevent identity theft—protect your Social Security number

Your Social Security Statement

Prepared especially for Wanda Worker

January 6, 2006

See inside for your personal information →

WANDA WORKER
456 ANYWHERE AVENUE
MAINTOWN, USA 11111-1111

What's inside…

Page 2:

***Your estimated benefits are based on current law. Congress has made changes to the law in the past and can do so at any time. The law governing benefit amounts may change because, by 2041, the payroll taxes collected will be enough to pay only about 74 percent of scheduled benefits.**

We based your benefit estimates on these facts:

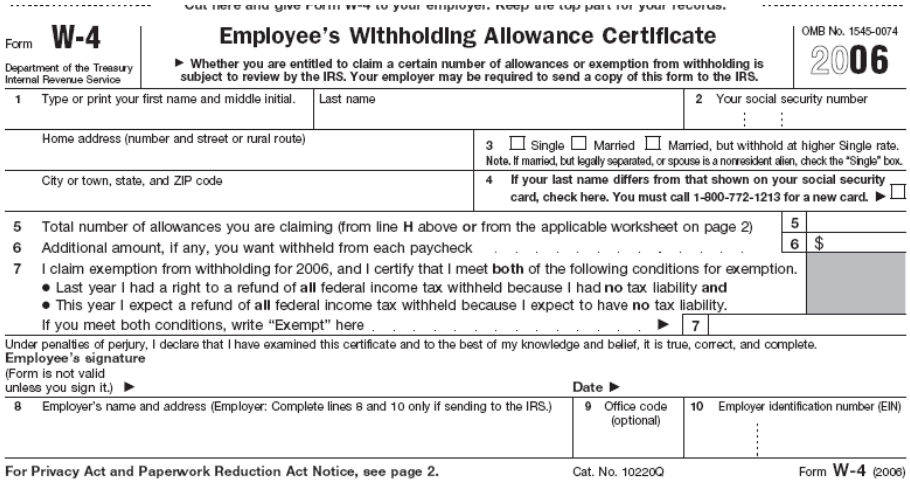
Your date of birth	May 5, 1965
Your estimated taxable earnings per year after 2005	$37,276
Your Social Security number (only the last four digits are shown to help prevent identity theft)	XXX-XX-1234

Examples of Unacceptable Documentation to Verify IRS Numbers

The following documents are **NOT** acceptable as verification of the IRS/SSN number:

NOTE: Only the applicable portions of the documents have been included.

- **Form W-4**



Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074 — 2006

1 Type or print your first name and middle initial. | Last name | 2 Your social security number

Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ► ☐

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) — 5

6 Additional amount, if any, you want withheld from each paycheck — 6 $

7 I claim exemption from withholding for 2006, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here ► 7

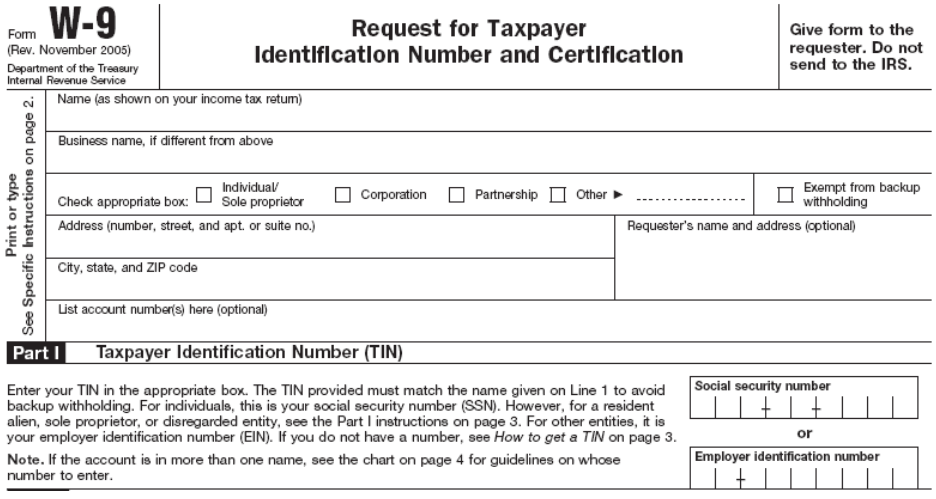
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ► Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form W-4 (2006)

- **Form W-9**



Form **W-9** (Rev. November 2005) — Department of the Treasury, Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type — See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

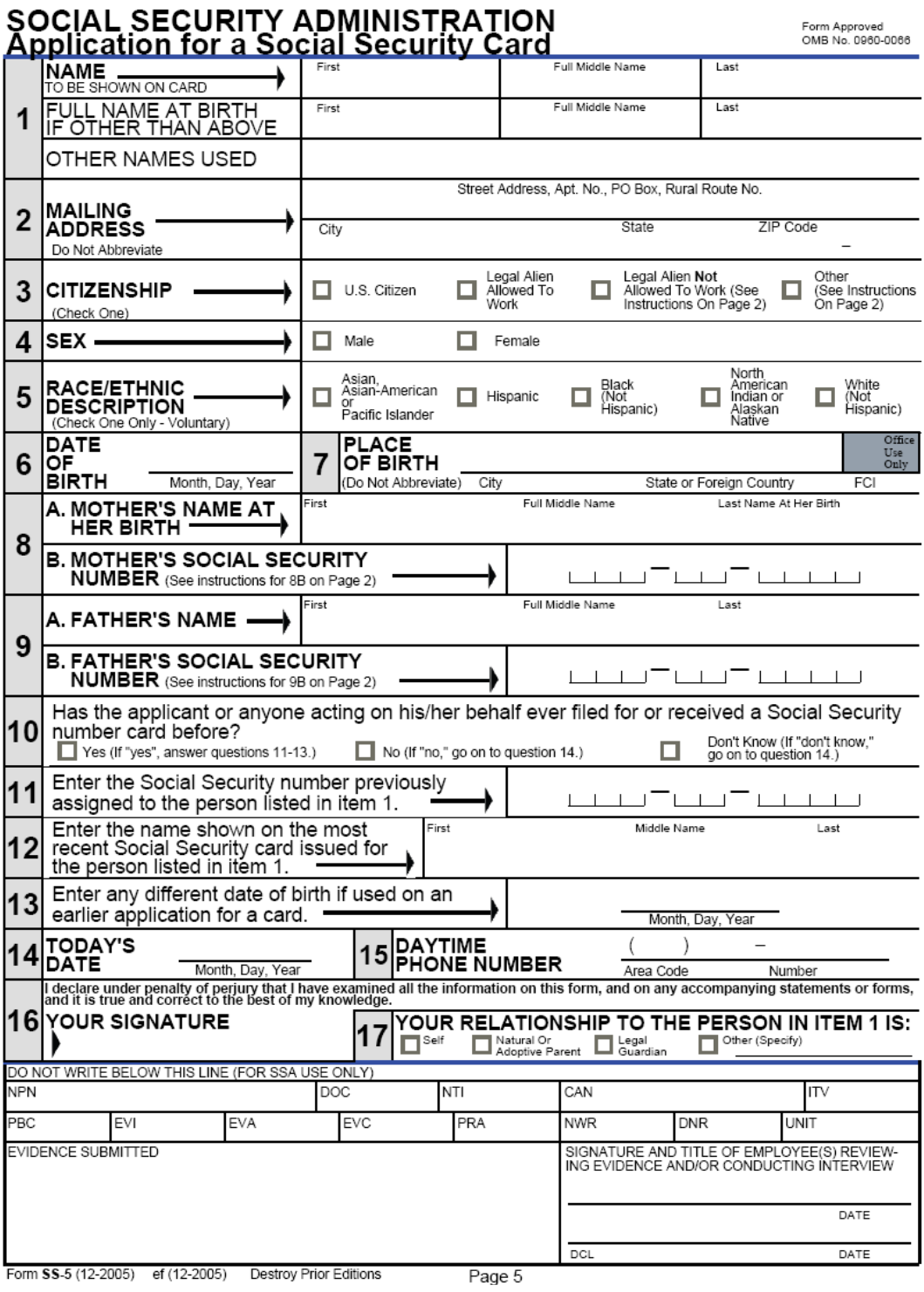
Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number — or — **Employer identification number**

- **Form SS-5 (Application for a Social Security Card)**



SOCIAL SECURITY ADMINISTRATION
Application for a Social Security Card

Form Approved
OMB No. 0960-0066

1	NAME TO BE SHOWN ON CARD	First	Full Middle Name	Last
	FULL NAME AT BIRTH IF OTHER THAN ABOVE	First	Full Middle Name	Last
	OTHER NAMES USED			
2	MAILING ADDRESS (Do Not Abbreviate)	Street Address, Apt. No., PO Box, Rural Route No.		
		City	State	ZIP Code –
3	CITIZENSHIP (Check One)	☐ U.S. Citizen	☐ Legal Alien Allowed To Work	☐ Legal Alien **Not** Allowed To Work (See Instructions On Page 2) ☐ Other (See Instructions On Page 2)
4	SEX	☐ Male	☐ Female	
5	RACE/ETHNIC DESCRIPTION (Check One Only - Voluntary)	☐ Asian, Asian-American or Pacific Islander	☐ Hispanic	☐ Black (Not Hispanic) ☐ North American Indian or Alaskan Native ☐ White (Not Hispanic)
6	DATE OF BIRTH	Month, Day, Year		
7	PLACE OF BIRTH (Do Not Abbreviate)	City	State or Foreign Country	FCI (Office Use Only)
8	A. MOTHER'S NAME AT HER BIRTH	First	Full Middle Name	Last Name At Her Birth
	B. MOTHER'S SOCIAL SECURITY NUMBER (See instructions for 8B on Page 2)	___ – ___ – ____		
9	A. FATHER'S NAME	First	Full Middle Name	Last
	B. FATHER'S SOCIAL SECURITY NUMBER (See instructions for 9B on Page 2)	___ – ___ – ____		
10	Has the applicant or anyone acting on his/her behalf ever filed for or received a Social Security number card before?	☐ Yes (If "yes", answer questions 11-13.)	☐ No (If "no," go on to question 14.)	☐ Don't Know (If "don't know," go on to question 14.)
11	Enter the Social Security number previously assigned to the person listed in item 1.	___ – ___ – ____		
12	Enter the name shown on the most recent Social Security card issued for the person listed in item 1.	First	Middle Name	Last
13	Enter any different date of birth if used on an earlier application for a card.	Month, Day, Year		
14	TODAY'S DATE	Month, Day, Year		
15	DAYTIME PHONE NUMBER	( ) –	Area Code	Number
16	I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. YOUR SIGNATURE			
17	YOUR RELATIONSHIP TO THE PERSON IN ITEM 1 IS:	☐ Self	☐ Natural Or Adoptive Parent	☐ Legal Guardian ☐ Other (Specify)

DO NOT WRITE BELOW THIS LINE (FOR SSA USE ONLY)

NPN			DOC	NTI	CAN			ITV
PBC	EVI	EVA	EVC	PRA	NWR	DNR	UNIT	

EVIDENCE SUBMITTED	SIGNATURE AND TITLE OF EMPLOYEE(S) REVIEWING EVIDENCE AND/OR CONDUCTING INTERVIEW DATE DCL DATE

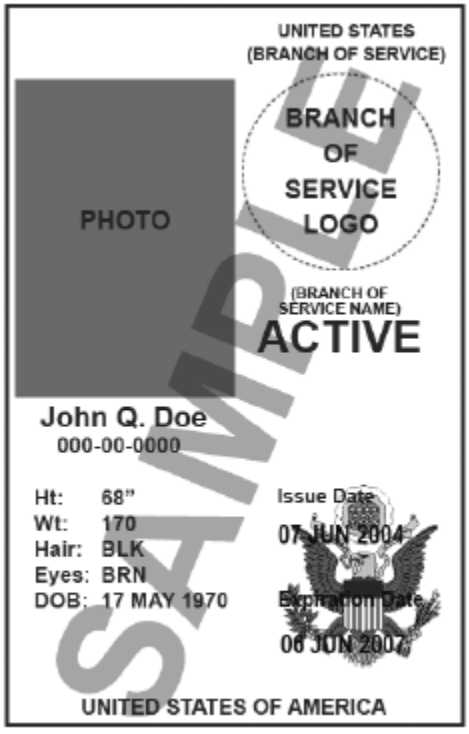
Form SS-5 (12-2005) ef (12-2005) Destroy Prior Editions Page 5

- **State Driver's License**

- **Military ID**

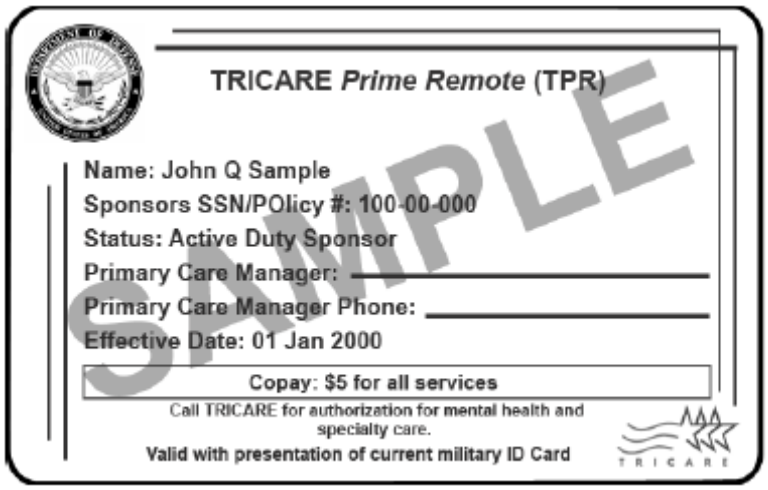
Uniformed Services Identification Card - Active Duty

Uniformed Services Identification Card - Active Duty Family Member



Common Access Card

- **Health Insurance Card**



- **State Corporation Papers**
- **State Tax Papers**

PROMISe™ Provider Enrollment Packet Checklist

The following checklist contains the most common reasons enrollment applications are returned. Please review the checklist for each enrollment application. Incomplete enrollment packets will result in longer processing time.

Did you remember to…

- ☐ Use black ink.
- ☐ Complete all fields as required on the application with either your correct information or N/A.
- ☐ Verify you have entered the correct number of digits where specified.
- ☐ Indicate one or more provider specialty codes. (Box 6)
- ☐ Enter at least one Provider Eligibility Program (PEP). (Box 20l)
- ☐ Sign and date the provider enrollment application.
- ☐ Write in your MPI# and Service Location Code next to 2a.

Did you remember to attach…

- ☐ For individual enrollment, a copy of your Social Security card or W-2. (Box 8)
- ☐ For agency enrollment, documentation from the IRS for tax identification purposes (a copy of your Federal Tax Identification Number label or document). Remember, a W-9 is not acceptable.
- ☐ If applicable, Corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- ☐ If applicable, a copy of your:
  - ☐ Professional License
  - ☐ Any other certification, license or permit that applies.
- ☐ Your signed and dated provider agreement
- ☐ All application pages specific to your provider type.