MISSISSIPPI MEDICAID ENROLLMENT APPLICATION
(ORDERING/REFERRING/PRESCRIBING PROVIDER)

This application is for the sole purpose of ordering/referring/prescribing items and services for MS Medicaid beneficiaries. This type of enrollment does not allow MS Medicaid to reimburse the applicant/provider for services provided. If the applicant/provider wishes to be reimbursed for services performed, he/she must submit a full application package as required by MS Medicaid.

Section A - Individual Information (Your name, date of birth & social security number must match your social security record)		
Last Name	First Name	Middle Initial
Suffix (Jr., Sr., M.D., D.O., etc.)	SSN	
Date of Birth (MM/DD/YYYY):	Gender of Provider (M/F):	
National Provider ID (NPI)		
	[redacted]	

Section B - Provider Address Information	
Servicing Address	
Street Address (P.O. Box is Not Acceptable)	
City, State and Zip Code	County
Telephone Number	Fax Number (if applicable)
Mail Other Address (The address below will be used by Medicaid if it needs to contact you directly. This should be your direct contact information and not that of a 3rd party.)	
P. O. Box/Street Address	
City, State and Zip Code	
Telephone Number	Fax Number (if applicable)
Email Address (if applicable)	

NOTE: The Contact Person reported in this section will only be authorized to discuss issues concerning the enrollment application.

Section C – Alternate Contact Information			
(If questions arise during the processing of this application and you are not available, you may designate an alternate person below.)			
First Name	Middle Initial	Last Name	Suffix (Jr., Sr., e.g.)
Telephone Number		Fax Number (if applicable)	
Email Address (if applicable)		Relationship or Affiliation to Applicant	

Section D- Licensure/Specialty/Certification Information		
Servicing State License/Certification Information		
License/Certification Number	Board Name	
State	Effective Date	Expiration Date

Do you currently hold (or have you in the past held) a professional license in any other state? If **Yes**, list state(s), type of license, license number, and applicable dates. [ ] Yes [ ] No

License Number	Type of License	Issuing State	Effective Date	End Date

If you have a Drug Enforcement Administration (DEA) Number on file with the DEA, please provide it.	DEA Number

AREA OF PRACTICE

A. Non-Physician/Practitioner

If you are a non-physician practitioner, check the appropriate box to indicate your area of practice. All non-physician practitioners must meet specific licensing, certification, educational and work experience requirements.

Check only one of the following:

- ☐ Audiologist
- ☐ Certified Nurse Midwife
- ☐ Certified Registered Nurse Anesthetist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Dietician
- ☐ Hearing Aid Dealer
- ☐ Licensed Certified Social Worker
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician Assistant
- ☐ Podiatrist
- ☐ Psychologist
- ☐ Speech Therapist
- ☐ Unlisted Non-Physician Practitioner Type

Specify: _____

B. Physician/Practitioner

Check only one of the following:

- ☐ Doctor of Osteopathy (D.O)
- ☐ Medical Doctor (M.D.)

C. Physician/Practitioner Specialty *(Only D.O.s and M.D.s should complete this section)*

Check your primary specialty below. Physicians must meet all State requirements for the type of specialty checked.

- ☐ Addiction Medicine
- ☐ Aerospace Medicine
- ☐ Allergy
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac Surgery
- ☐ Cardiology
- ☐ Cardiovascular Disease
- ☐ Clinical Cytogeneticist
- ☐ Clinical Genetics
- ☐ Critical Care
- ☐ Cytopathology
- ☐ Dermatology
- ☐ Diabetes
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Eye, Ear, Nose, Throat
- ☐ Family Practice
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Preventive Medicine
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Gynecological Oncology
- ☐ Hematology-Internal Medicine
- ☐ Hematology/Oncology
- ☐ Hospice/Palliative Care
- ☐ Hyperbaric Medicine
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Interventional Pain Management
- ☐ Interventional Radiology
- ☐ Laryngology
- ☐ Legal Medicine
- ☐ Medical Oncology
- ☐ Neonatal-Perinatal Medicine
- ☐ Nephrology
- ☐ Neurological Surgery
- ☐ Neurology
- ☐ Neurology, Child
- ☐ Neuropathology
- ☐ Neuropsychiatry
- ☐ Nuclear Medicine
- ☐ Nuclear Radiology
- ☐ Obstetrics & Gynecology
- ☐ Occupational Medicine
- ☐ Oncology
- ☐ Ophthalmology
- ☐ Oral & Maxillofacial Surgery
- ☐ Orthopedic Surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Otology
- ☐ Otorhinolaryngology
- ☐ Pain Management, Anesthesiology
- ☐ Pathology
- ☐ Pathology, Anatomic
- ☐ Pathology, Anatomic, & Clinical
- ☐ Pathology, Clinical

- ☐ Pathology, Forensic
- ☐ Pediatric Allergy & Immunology
- ☐ Pediatric Cardiology
- ☐ Pediatric Dentistry
- ☐ Pediatric Gastroenterology
- ☐ Pediatric Hematology-Oncology
- ☐ Pediatric Pathology
- ☐ Pediatrics
- ☐ Peripheral Vascular Disease
- ☐ Pharmacology, Clinical
- ☐ Physical Medicine and Rehab
- ☐ Plastic Surgery
- ☐ Preventive Medicine
- ☐ Proctology
- ☐ Prosthodontics
- ☐ Psychiatry
- ☐ Psychiatry, Child, Adolescent
- ☐ Public Health
- ☐ Pulmonary Disease
- ☐ Pulmonary Medicine
- ☐ Radiation Therapy
- ☐ Radiology
- ☐ Radiology, Diagnostic
- ☐ Radiology, Pediatric
- ☐ Radiology, Therapeutic
- ☐ Rheumatology
- ☐ Roentgenology
- ☐ Roentgenology, Diagnostic
- ☐ Sleep Laboratory/Medicine
- ☐ Sports Medicine
- ☐ Surgical Oncology
- ☐ Surgery, Abdominal
- ☐ Surgery, Cardiovascular
- ☐ Surgery, Colon & Rectal
- ☐ Surgery, Critical Care
- ☐ Surgery, Hand
- ☐ Surgery, Head & Neck
- ☐ Surgery, Obstetric & Gynecological
- ☐ Surgery, Pediatric
- ☐ Surgery, Traumatic
- ☐ Surgery, Urological
- ☐ Surgery, Vascular
- ☐ Thoracic Surgery
- ☐ Urology

If you need information concerning the specific requirements for your specialty, contact Provider Enrollment at (800) 884-3222.

Section E – Provider Disclosure (Final Adverse Actions/Convictions)

Per Federal Regulation 42 CFR §§ 455.100 and 455.106, this section gathers required information on final adverse actions, such as convictions, exclusions, revocations, and suspensions. All applicable final legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

If "yes" is marked for any of the questions in this section, please provide additional information in the chart at the end of this section and attach supporting documentation.

A. Licensure

1) Is your license currently suspended or restricted? If yes, please fully explain the details including dates, the state(s) where the incident occurred and any adverse action against your license.
☐ Yes ☐ No
2) Has any action ever been taken against your license or certification, by any state or Licensure and/or Certification Board?
☐ Yes ☐ No

B. Affiliation

1) Has any action ever been taken against your medical privileges or any other associations, by any hospital, healthcare institution or governing board?
☐ Yes ☐ No
2) Have you ever voluntarily withdrawn your privileges based on any action by a hospital, healthcare institution or governing board?
☐ Yes ☐ No
3) Have you ever been terminated or subject to any disciplinary action by any healthcare organization or licensing and/or certification board(s)?
☐ Yes ☐ No

C. Education

1) Have you ever been disciplined in any manner during your medical education?
☐ Yes ☐ No
2) Have you ever voluntarily withdrawn or terminated your medical education due to an investigation?
☐ Yes ☐ No
3) Has your board certification ever been suspended or terminated?
☐ Yes ☐ No
4) Have you ever chosen to terminate your board certification while under investigation?
☐ Yes ☐ No

D. Substance Registration

Has any action ever been taken against your federal or state controlled substance certifications or authorizations?
☐ Yes ☐ No

E. Governmental Programs

Has any action ever been taken against you during your participation in, or have you ever been excluded, suspended, sanctioned, or debarred from any federal or state governmental healthcare program? If yes, please fully explain the details including dates, the state(s) where the incident occurred and any adverse action.
☐ Yes ☐ No

F. Investigations

1) Have you ever been the subject of an investigation by any healthcare organization or military agency, related to your performance of medical services, for any action that qualifies as fraudulent activities?
☐ Yes ☐ No
2) Are you aware of any information being reported regarding your performance as a medical practitioner to any public medical malpractice reporting agency?
☐ Yes ☐ No

3) Have you ever been under investigation by any state or federal regulatory agencies?
☐ Yes ☐ No

4) Have you ever been convicted, or are you currently under investigation, by any licensing authority, law enforcement agency or any other entity for any legal misconduct?
☐ Yes ☐ No

Final Adverse Action	Date	Taken By	Resolution

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Section F – Provider Signature/Attestation	
The undersigned individual ("Provider") agrees to participate as a Provider in the Mississippi Medicaid program for the sole purpose of ordering, prescribing, or referring services to Mississippi Medicaid beneficiaries. As a Mississippi Medicaid Provider, I attest that I will not knowingly order and/or refer an item and/or service that allows for a false or fraudulent claim to be presented for payment by the Mississippi Division of Medicaid ("Medicaid"). I further certify that I am the individual practitioner who is applying for the sole purpose of providing said services to Medicaid beneficiaries. By signing this application, I certify that all statements made herein and on any attached documentation are true and complete to the best of my knowledge. Further, I will take immediate action to correct or complete any error or omission provided on this application or any attached documentation. I authorize the verification of this information by Medicaid and agree to notify Medicaid of any changes to the information provided herein within thirty (30) days of the effective date of any change. I fully understand that any misrepresentation, omission or falsification made in connection with this application may lead to the rejection of my application, dismissal from the Mississippi Medicaid program, and/or any further legal action.	
Legal Name of Provider (please print):	
Date:	Provider Signature: