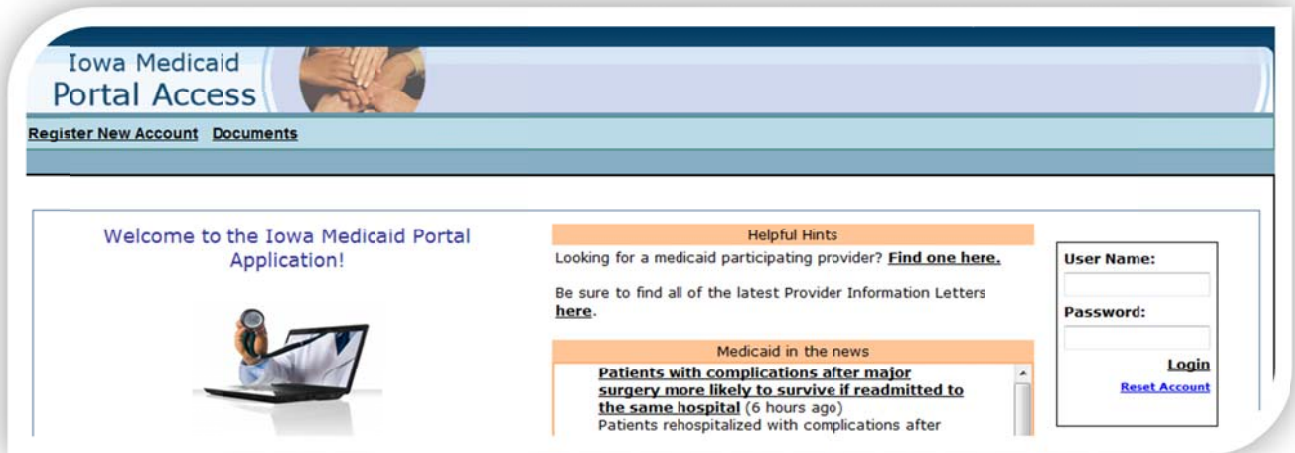


Iowa Medicaid Portal Access (IMPA) Provider-User Guide



Reenrollment Application

Ownership and Control Disclosure (OCD) Application

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Note: When completing the OCD application in IMPA refer to Section 4 instructions.

Getting Started

If you are already a registered user of IMPA, log into IMPA as you normally would.

If you are not a registered user of IMPA, go to <https://secureapp.dhs.state.ia.us/imp/> and choose: **Click here for the User Registration Guide:**

Iowa Medicaid Portal Access

Register New Account Documents

Welcome to the Iowa Medicaid Portal Application!

Helpful Hints

Looking for a medicaid participating provider? [Find one here.](#)

Be sure to find all of the latest Provider Information Letters [here.](#)

Medicaid in the news

Patients with complications after major surgery more likely to survive if readmitted to the same hospital (7 hours ago)
Patients rehospitalized with complications after major surgery are 26% more likely to survive if the...

Prescription drug benefit doesn't save money for Medicare (Yesterday)
Researchers conclude that Medicare Part D did not save the (Medicare) program any money overallFor...

Study finds high Medicare Advantage copays for hospital, nursing care (6/9/2015)
Millions of seniors with Medicare Advantage plans, including more than a million with low incomes, w...

For-profit health: some US hospitals mark up costs by 1,000% (6/9/2015)

User Name:
Password:
Login
[Reset Account](#)

Click here for the User Registration Guide

Featured Functionality

- **ICD-10 is coming. Are you ready?** Registration for the IME ICD-10 Volunteer Testing is now open. To register for testing, please contact the IME Provider Services Unit at 1-800-338-7909, or locally in Des Moines at 515-256-4609 or by email at ICD-10project@dhs.state.ia.us
- The Centers for Medicare and Medicaid (CMS) published the Outpatient Prospective Payment System (OPPS) Final Rule Nov. 27, 2013, established a new alphanumeric HCPCS code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for hospital use only. The new HCPCS code will be representative of any clinic visit under the

Each person logging into an application within IMPA must create their own IMPA account. At the top of the left hand corner under Iowa Medicaid Portal Access is a link to Register New Account.

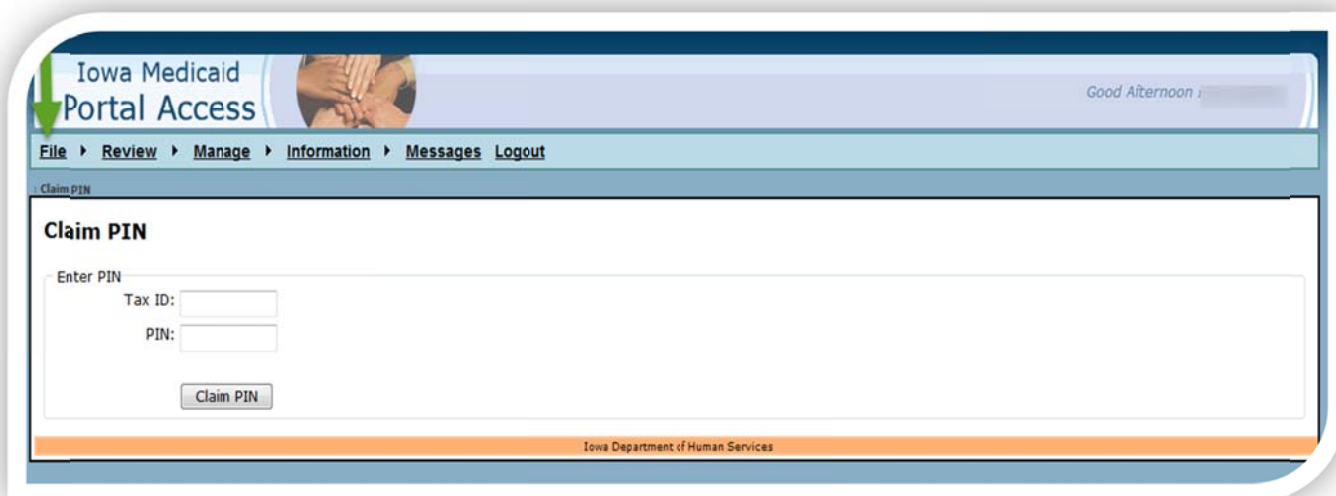
Create a username and password for each user that will complete reenrollment or the OCD application within IMPA. The user name is not case sensitive but the password must be 8 characters (one lowercase letter, one uppercase letter, a symbol and a number).

Log into IMPA with the user name and password created. Click on “I Accept to Enter the System.”

Claim a Personal Identification Number (PIN)

You must claim a security PIN to access your reenrollment application or the OCD application.

Your Designated Contact Person (DCP) will have provided to you a PIN for accessing the appropriate Tax ID (s). The user must “Claim PIN” before they can proceed to the Reenrollment application or OCD application. You only need to claim the PIN once.



The screenshot shows the 'Iowa Medicaid Portal Access' interface. At the top, there is a navigation menu with 'File', 'Review', 'Manage', 'Information', 'Messages', and 'Logout'. Below the menu, the page title is 'Claim PIN'. The main content area contains a form with the following fields and buttons:

- A large text input field labeled 'Enter PIN'.
- A 'Tax ID:' label followed by a small text input field.
- A 'PIN:' label followed by a small text input field.
- A 'Claim PIN' button.

The footer of the page reads 'Iowa Department of Human Services'.

Hover over File, from the drop down click on “Claim PIN”.

Enter your “Tax ID” number and “PIN” and click on the button Claim PIN.

Once the PIN has been successfully claimed proceed to the application (reenrollment or OCD application).

Reenrollment application:

Hover over File, and click on Reenrollment in the drop down.

OCD application:

Hover over Review, and click on OCD in the drop down.

Roles

Reenrollment:

The reenrollment application may be entered by either the enrollment user or the signatory. The enrollment user is not allowed to accept the provider agreement. Only the signatory is allowed to accept the provider agreement. The user is required to have a PIN prior to starting the reenrollment application.

There are two roles defined for users for the reenrollment application:

- **Enrollment User**- this role can update all sections except the agreement and acceptance.
- **Signatory User**- this role can update all sections including the agreement and acceptance.

The Tax ID and the application status will appear on each section.

OCD:

The OCD user role allows the creation of or update to an already completed OCD application.

Each Tax ID enrolled into the Medicaid Program is required to complete the OCD application prior to enrollment.

Other Roles:

- Health Information Technology (HIT) - this user role allows the completion of the HIT survey after reenrollment has been completed.

Reenrollment Application

Providers are required to complete the reenrollment application process every five years, unless otherwise required by applicable state and federal law. Reenrollment includes, but is not limited to: legally accept the provider agreement, verify a listing that identifies each professional and institutional component of your organization and structure, complete the OCD and collect individual Social Security Numbers (SSN). The SSN is required in order for the IME to check against the Office of Inspector General's (OIG) list of Excluded Individuals and Entities (LEIE) and the Centers for Medicare and Medicaid Services (CMS) Medicare Exclusions Database (MED). The individual SSN is required for screening purposes only. It does not pertain to claims processing or payment.

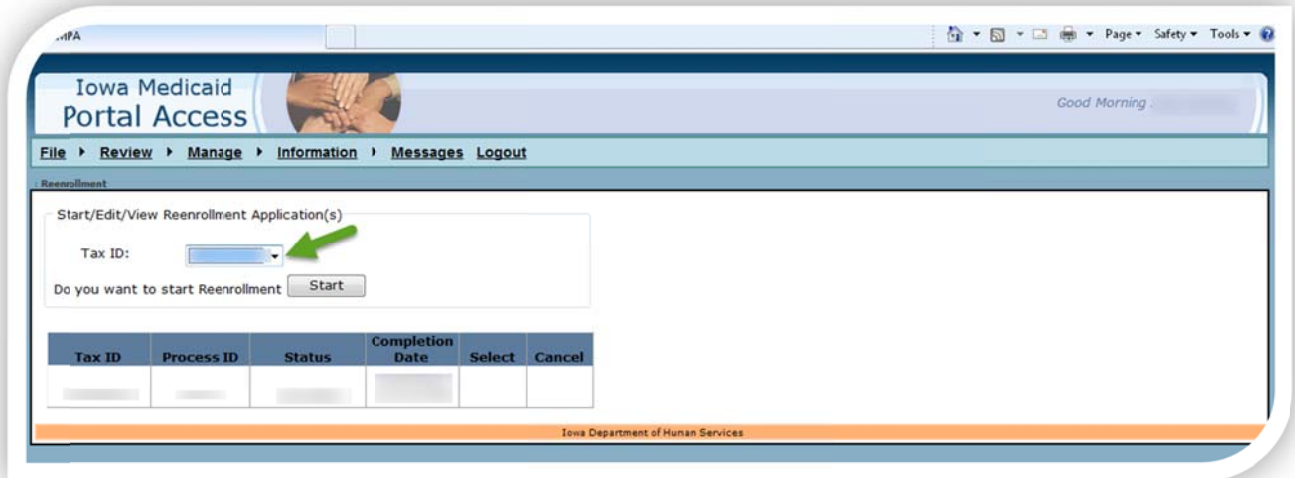
To start the reenrollment process, simply complete and return the DCP form. A contact person must be designated for the coordination of the provider reenrollment process (Form number 470-5112, can be found on the DHS website at: <http://dhs.iowa.gov/ime/providers/forms>).

Upon receipt of the DCP form, a unique PIN associated with the Tax Identification (ID) will be assigned. The DCP will receive and email containing the PIN number (s).

Once you have logged into IMPA and have claimed PIN you are ready to get started.

Start Reenrollment Application

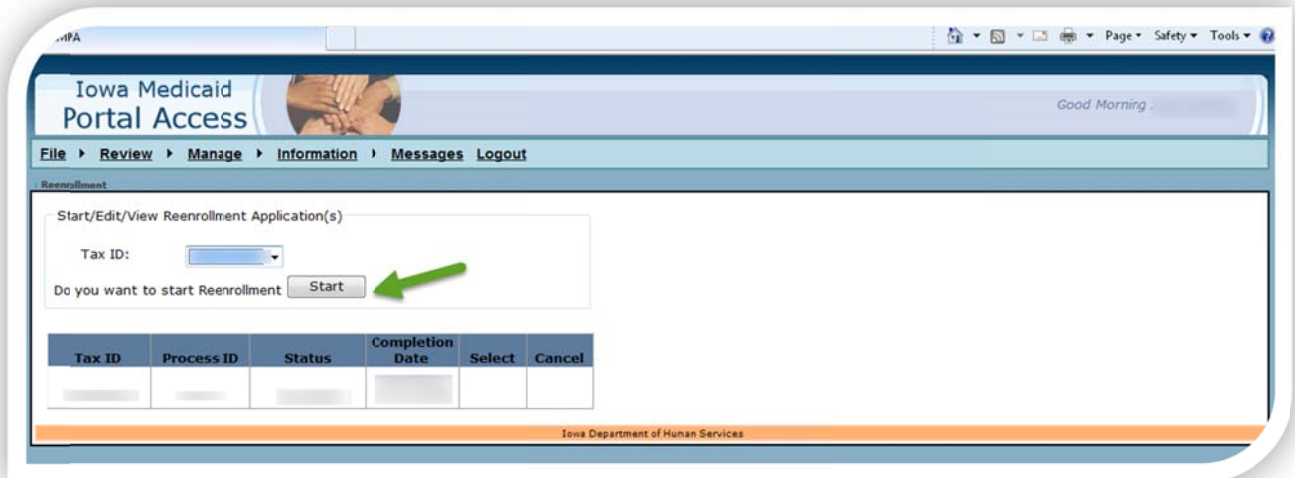
Hover over File and select “Reenrollment.”



Select the Tax ID from the drop down list.

The lists of Tax ID's are based on the PIN (s) you have claimed.

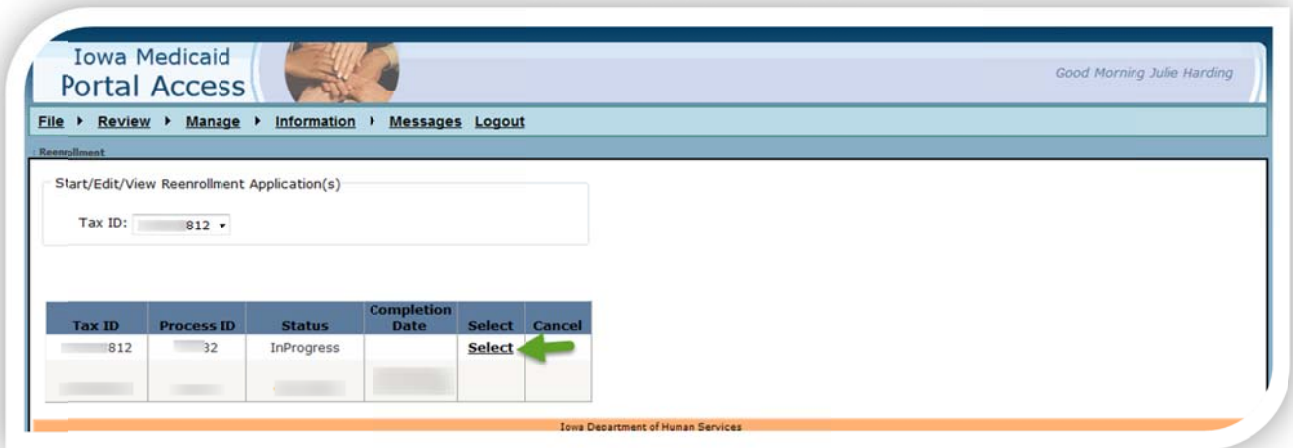
If you do not see the appropriate Tax ID please contact your DCP.



Click on Start button

Note: If you have completed Reenrollment on IMPA in the past you will see a line in the grid with a completed status and completion date.

Select the line with a status of “In Progress” to continue with this reenrollment.



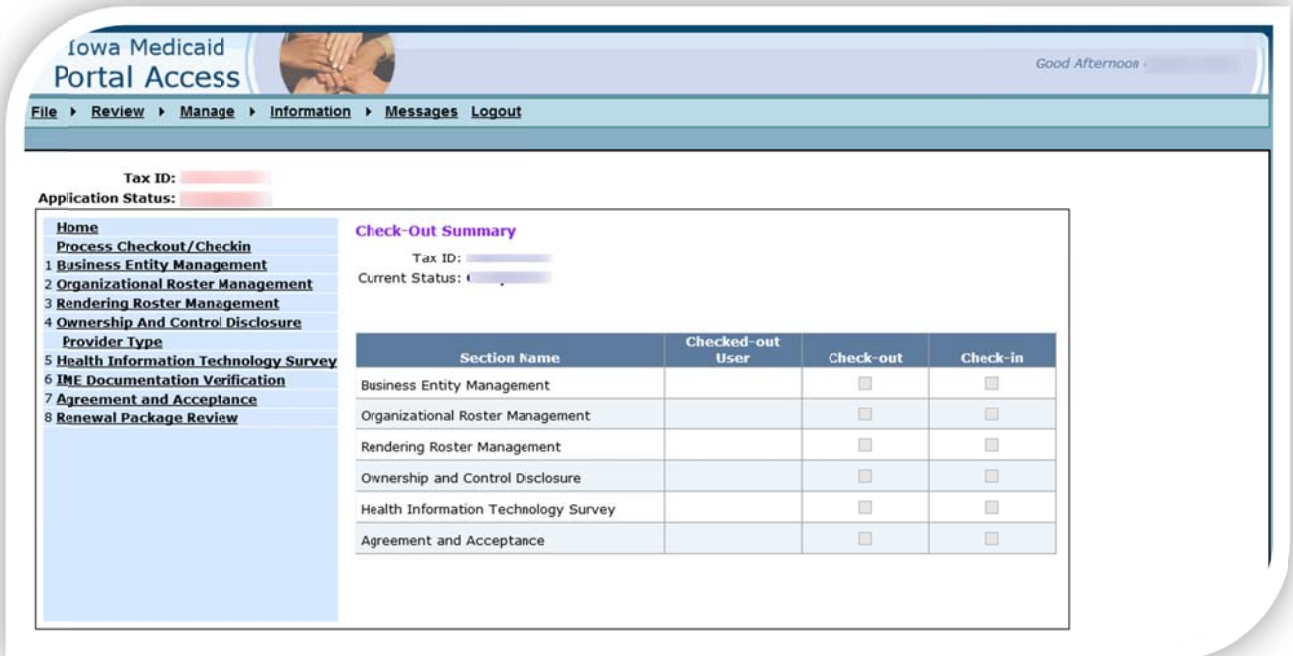
Click on Select in the grid as shown above.

The initial page displayed is Check-Out Summary.

On the left side of the page are the navigation links (in blue, under Home).

This page will display:

- Tax ID Number.
- Application Status.
- Check-Out status.



Process Check-out/Check-in

- Check-Out (Selected)
 - If you, as an Enrollment user can check-out any section except Agreement and Acceptance, click on the Check-Out box next to the section and click “Check-Out (Selected).
- Check-In (Selected)
 - After all required information has been entered click on check-in next to that section and click the Check-In Selected button.

The screenshot shows the Iowa Medicaid Portal Access interface. The top navigation bar includes 'File', 'Review', 'Manage', 'Information', 'Messages', and 'Logout'. The main content area displays 'Tax ID: 812' and 'Application Status: InProgress'. A 'Check-Out Summary' section is visible, containing a table with columns for 'Section Name', 'Checked-out User', 'Check-out', and 'Check-in'. The table lists several sections, including 'Business Entity Management', 'Organizational Roster Management', 'Rendering Roster Management', 'Ownership and Control Disclosure', 'Health Information Technology Survey', and 'Agreement and Acceptance'. The 'Organizational Roster Management' row shows a checked 'Check-in' box. Below the table are buttons for 'Check-Out ALL', 'Check-Out (Selected)', and 'Check-In (Selected)'. A red message states 'Checked-in the selected processes successfully.' Green arrows highlight the 'Check-In (Selected)' button and the 'Check-in' checkbox for 'Organizational Roster Management'.

Section Name	Checked-out User	Check-out	Check-in
Business Entity Management		<input type="checkbox"/>	<input type="checkbox"/>
Organizational Roster Management	rh	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Rendering Roster Management		<input type="checkbox"/>	<input type="checkbox"/>
Ownership and Control Disclosure		<input type="checkbox"/>	<input type="checkbox"/>
Health Information Technology Survey		<input type="checkbox"/>	<input type="checkbox"/>
Agreement and Acceptance		<input type="checkbox"/>	<input type="checkbox"/>

The purpose of Check-out and Check-in, allows multi users to be working on the same Tax ID. When a user has a section checked out another user will not be able to work in the same section until that user checks that section in.

For example:

User 1 has Check-out: Business Entity Management.

User 2 has Check-out: Organizational Roster Management.

User 1 cannot enter data in the Organizational Roster Management section when it is in a checked out status by user 2.

Section 1: Business Entity Management

The purpose of the Business Entity Management section is to define the entity defined for tax purposes.

In the left navigation click on: 1. Business Entity Management.

You can either check out from the Process Check-out/Check-in page or Click the “Check Out for Edit” button on the business Entity Management page.

Iowa Medicaid Portal Access

Good Morning

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: 812
Application Status: InProgress

Home
Process Checkout/Checkin
1 Business Entity Management
2 Organizational Roster Management
3 Rendering Roster Management
4 Ownership And Control Disclosure
Provider Type
5 Health Information Technology Survey
6 IME Documentation Verification
7 Agreement and Acceptance
8 Renewal Package Review

Business Entity Management Check-out History

Check Out for Edit Check In

Tax ID: 812
Current Status: InProgress

1099 Name: LLC
Business Email: .com
Phone Number: 2
Fax Number: :6
Headquarter Address: Drive
City:
State:
Zip: -
Ownership Type: LLC - Limited Liability Company

Save

Iowa Department of Human Services

- 1099 Name: pre populated with 1099 Name on file. If there are multi names on file select correct name from in the drop down. If the name (s) is not correct, please submit a new W-9 form to the IME Provider Services Enrollment Unit.
- Enter Business Email.
- Enter Phone Number.
- Enter Fax Number.
- Enter Headquarter Address.
- Enter City, State, Zip.
- Ownership Type: Select the type of ownership from the drop down.
- Click on Save.
- Click on Check-In.

Section 2: Organizational Roster Management

The purpose of the Organizational Roster Management is to confirm your organization's payment structure.

In the left navigation click on: 2. Organizational Roster Management.

This page will contain all of the payment/billing NPI's. You will need to confirm the information related to each NPI. You will work through each NPI in the select NPI dropdown list. As you complete each NPI, the dropdown list will have the status before the NPI.

The screenshot shows the Iowa Medicaid Portal Access interface. At the top, it says "Iowa Medicaid Portal Access" and "Good Afternoon". Below the navigation bar, the user's Tax ID is 812 and the Application Status is InProgress. The main content area is titled "Organizational Roster Management" and includes a "Check-out History" link. A "Select NPI:" dropdown menu is highlighted with a green arrow, showing "12" as the selected option. Below this is a table with the following data:

NPI	Name/Address	Taxonomy	Provider Type	State License Number	License Expiration Date	Confirmed AI
12		3336H0001X			1/1/2018	

Below the table is a "Save Current Selections" button. A message states "0 NPI(s) information completed out of 1 NPI(s)".

- Select the NPI from the dropdown list. Review all the data in grid. Name, Address, Taxonomy code, license number, license expiration date.
 - Note: if enrolled under multiple addresses, each address will appear in the grid.

The screenshot shows the 'Organizational Roster Management' page in the Iowa Medicaid Portal. The page header includes 'Iowa Medicaid Portal Access' and a greeting 'Good Afternoon'. A navigation menu on the left lists various options like 'Home', 'Process Checkout/Checkin', and 'Business Entity Management'. The main content area displays the 'Organizational Roster Management' section for Tax ID: 812, with an application status of 'InProgress'. A table lists NPI information, including columns for NPI, Name/Address, Taxonomy, Provider Type, State License Number, and License Expiration Date. A dropdown menu next to the table is highlighted with a green arrow, and a 'Save Current Selections' button is located below the table.

From the dropdown next to each row select from the dropdown:

- **Confirmed** - indicates that the information for the NPI is accurate.
 - **TIP:** If all the information in all the grids below is correct, you can select Confirmed All and it will change the value to Confirmed for each address for that NPI in the list.
- **Confirmed with Address Change** - indicates that there is a change in the address. This will require an address change form to be completed and mailed to the IME. The address change form will be available to print under step #6
- **Request Termination** - indicates that this particular NPI is no longer practicing at this address. Once the IME receives this information the provider will be terminated.
- Click on Save Current Sections- Once this is successfully saved the dropdown list will move to the next NPI automatically. After completing an NPI it will move to the bottom of the list with a completed status. All NPIs must be completed before the application can be submitted.

IMPORTANT NOTE:

Any other changes to displayed data must be submitted in writing to the IME Provider Services Enrollment Unit. The data displayed on IMPA will not change.

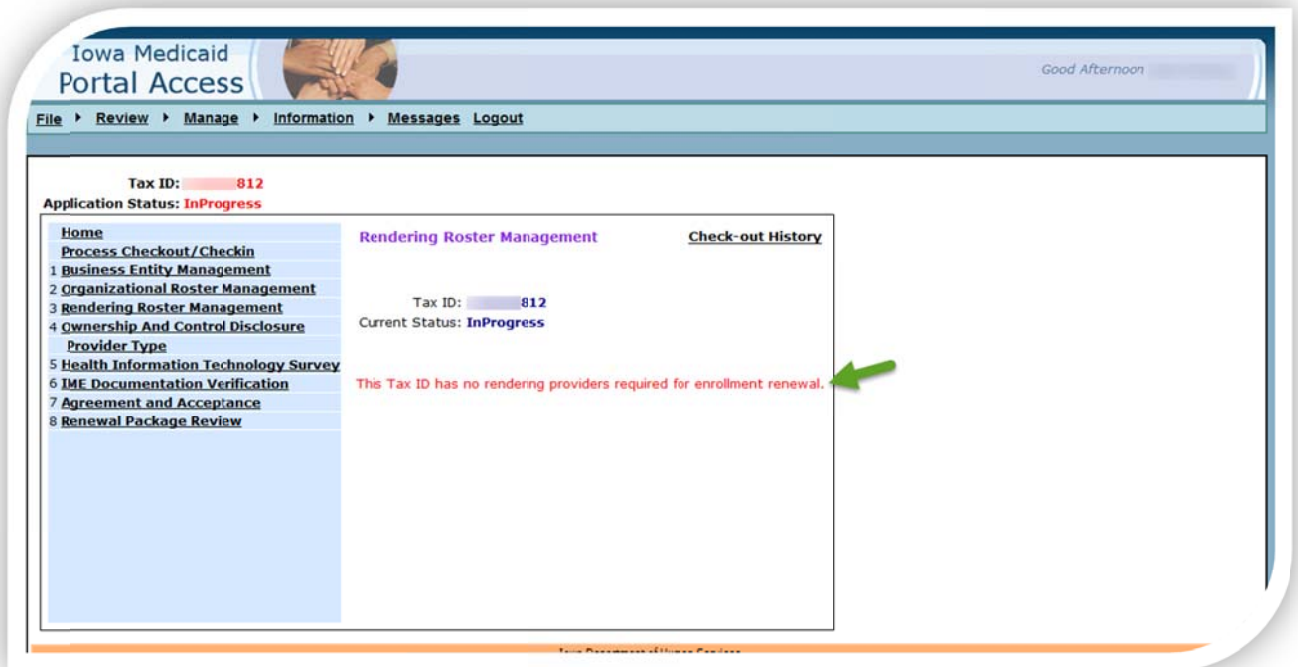
After all NPI's have been completed, click on Check In move to next section.

Section 3: Rendering Roster Management

The purpose of the Rendering Roster Management is to confirm your organization's treating provider structure as known to the IME.

On the navigation to the left of the screen click on: 3. Rendering Roster Management.

If the Tax ID has no treating/rendering NPI associated with it, a message in red will appear on the screen: "This Tax ID has no rendering providers required for enrollment renewal" No action is needed.



This page will contain all of the rendering NPI's. You will need to confirm the information related to each NPI. You will work through each NPI in the select NPI dropdown list. As you complete each NPI the dropdown list will have the status before the NPI.

Iowa Medicaid Portal Access Good Afternoon

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: [REDACTED]
Application Status: **InProgress**

Home

- Process Checkout/Checkin
- 1 Business Entity Management
- 2 Organizational Roster Management
- 3 **Rendering Roster Management**
- 4 Ownership And Control Disclosure
- Provider Type
- 5 Health Information Technology Survey
- 6 IME Documentation Verification
- 7 Agreement and Acceptance
- 8 Renewal Package Review

Rendering Roster Management [Check-out History](#)

Check Out for Edit Check In

Tax ID: [REDACTED]
Current Status:

Select NPI: [58 ▼] 0 NPI(s) information completed out of 224 NPI(s).

SSN:
SSN (Confirmation):

Note: If you have more than one specialty per address, selecting Confirmed, Confirmed with Address Change or Terminate, will apply to all specialties. If you have a change for one specialty, but not the other then select IME Review. This will notify IME Provider Services that additional consideration is required to complete your enrollment renewal packet.

NPI	Name/Address	Taxonomy	Provider Type	State License Number	License Expiration Date	Specialty Type Code	Confirmation
3636363636	LOUISIANA COLLEGE OF OPTOMETRY 1 MADISON CITY, TN 37041-2600		opt	63326	12/31/2014		[Confirmation Dropdown]

Save Current Selections

Iowa Department of Human Services

- Select the NPI from the dropdown list. Review all the data in grid. Name, Address, Taxonomy code, license number, license expiration date.
 - Note: if enrolled under multiple addresses, each address will appear in the grid.

From the dropdown next to each row select from the dropdown:

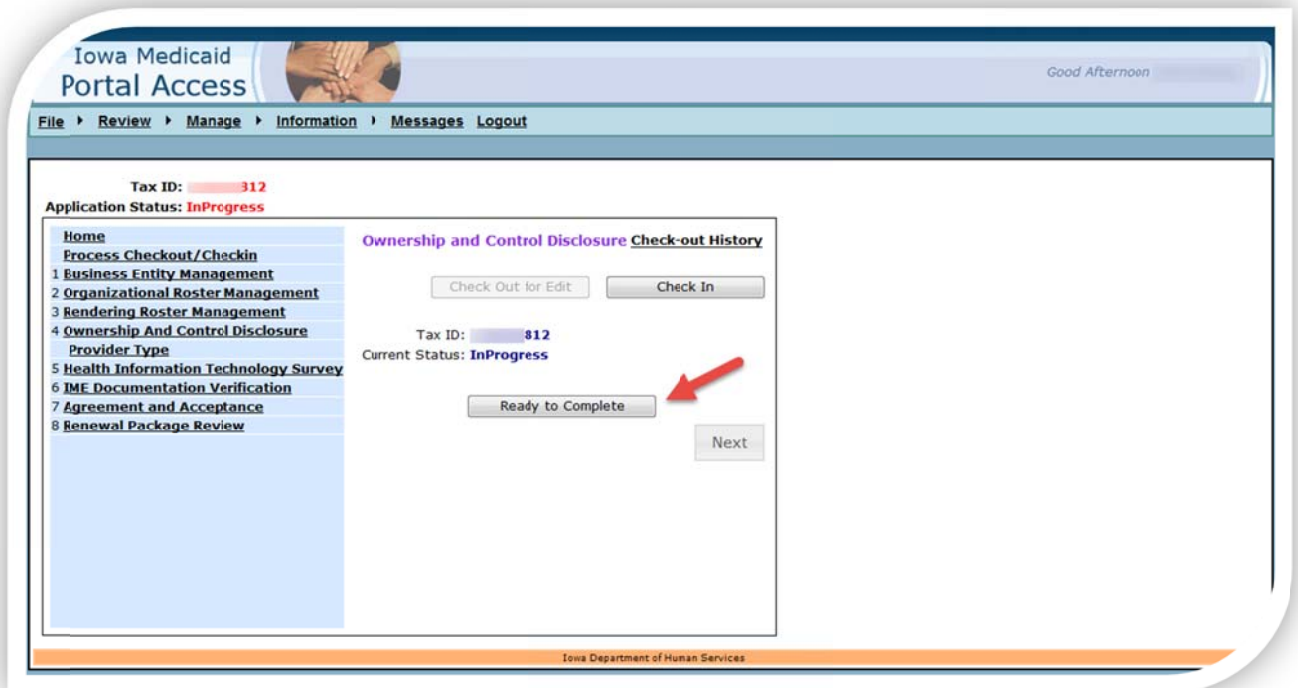
- **Confirmed** - indicates that the information for the NPI is accurate.
 - **TIP:** If all the information in all the grids below is correct, you can select Confirmed All and it will change the value to Confirmed for each address for that NPI in the list.
- **Confirmed with Address Change**- indicates that there is a change in the address. This will require and Address change form to be completed and sent to IME. The address change form will be available to print under step #6
- **Request Termination** - indicates that this particular NPI is no longer practicing at this address. Once the IME receives this information the provider will be terminated.
- Enter the SSN that is tied to the selected NPI.
- Enter the SSN again for confirmation.
 - The two SSNs must match before the NPI data can be saved.
- Click on Save Current Sections- Once this is successfully saved the dropdown list will move to the next NPI automatically. After completing an NPI it will move to the bottom of the list with a completed status. All NPIs must be completed before the application can be submitted. Click on check-in and move to next section.

Section 4: Ownership and Control Disclosure (OCD)

The purpose of the OCD section is to meet Federal regulations implemented with the Patient Protection and Affordable Care Act by the Centers for Medicare & Medicaid Services (CMS).

This section will require the user to gather information as opposed to review existing data. Not all sections pertain to every entity, but due diligence and best efforts to obtain the data is highly recommended and required for some sections.

In the navigation bar click on: 4 Ownership and Control Disclosure.



This page has a Ready to complete button. This button is to be used when you have **completed** the required section and will only be enabled when the OCD is checked out.

- Click on Check-Out for Edit, if this has not already checked out. This will check out all section of the OCD.
- Click on **Provider Type** in the left navigation under number 4

Iowa Medicaid Portal Access Good Afternoon, [User Name]

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: ██████████ 812
 Application Status: **InProgress**

<ul style="list-style-type: none"> Home Process Checkout / Checkin 1 Business Entity Management 2 Organizational Roster Management 3 Rendering Roster Management 4 Ownership And Control Disclosure Provider Type 5 Health Information Technology Survey 6 IME Documentation Verification 7 Agreement and Acceptance 8 Renewal Package Review 	<p>Ownership and Control Disclosure</p> <p>Tax ID: ██████████ 812 Name: MOMENTUM MEDICAL CARE LLC</p> <hr/> <p>Provider Type</p> <p>Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.</p> <p>It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN). In the questions that follow, the Provider listed above is referred to as "You" or "Your."</p> <p>Are you an individual practitioner or a group of individual practitioners?</p> <p>Individual Practitioner: <input type="checkbox"/> Yes or <input type="checkbox"/> No Group of Individual Practitioners: <input type="checkbox"/> Yes or <input type="checkbox"/> No</p> <p>Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting. <input type="checkbox"/></p> <p style="text-align: right;"><input type="button" value="Next"/></p>
--	---

Iowa Department of Human Services

Remember that the answer to these questions are legally binding; hence the attestation on each page.

In the instructions below all sections will be covered, but might not be required for all.

Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director or board member, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information of all managing employees, title, address, date of birth (DOB), and SSN.

Iowa Medicaid Portal Access

Good Afternoon Julie Harding

File > Review > Manage > Information > Messages Logout

Tax ID: [REDACTED]:812
Application Status: InProgress

Ownership and Control Disclosure
Tax ID: [REDACTED] 812
Name: HOME MEDICAL SUPPLY LLC

Managing Employees
Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below name of all managing employees, title, address, DOB, and SSN.

All fields are required. Adverse Action where applicable

Person Name	Title	Address(es)	DOB	SSN	Adverse Actions
					New

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Next

Iowa Department of Human Services

- Click on New.

Party for Managing Employees
 You may enter a new party and then save it.

SSN:	<input type="text"/>
Title:	<input type="text"/>
First Name:	<input type="text"/>
Middle Name:	<input type="text"/>
Last Name:	<input type="text"/>
Date of Birth:	<input type="text"/>
Adverse Actions:	<input type="checkbox"/>

Save Clear Close

- Enter the required information. All fields are required except the Middle Name and Adverse Actions.
- Click on Save.

Party for Managing Employees
 Party Name was saved.

SSN:	123456789
Title:	Title
First Name:	First
Middle Name:	
Last Name:	Last
Date of Birth:	07/01/2015
Adverse Actions:	<input type="checkbox"/>

Save Clear Close

- The graphic shown above displays a message when the record is saved successfully.
- Click on Close to return to the Managing Employee main page.
- Repeat until all managing employees appear in the grid.

owa Medicaid Portal Access Good Afternoon

File | Review | Manage | Information | Messages | Logout

Tax ID: 312
Application Status: InProgress

Home

Process Checkout /Checkin

1 **Business Entity Management**

2 **Organizational Roster Management**

3 **Rendering Roster Management**

4 **Ownership And Control Disclosure**

Provider Type

Managing Employees

Ownership

Individual

Non-Individual

of Subcontractors

Relationships

Individual

Non-Individual

Other Disclosing Entities

Final Adverse Actions

Patient Protection & ACA

5 **Health Information Technology Survey**

6 **IME Documentation Verification**

7 **Agreement and Acceptance**

8 **Renewal Package Review**

Ownership and Control Disclosure

Tax ID: 812
Name: WASTE MANAGEMENT SERVICES LLC

Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below name of all managing employees, title, address, DOB, and SSN.

All fields are required. Adverse Action where applicable

Person Name	Title	Address(es)	DOB	SSN	Adverse Actions	
						New
Last , First	Title	Addresses	7/1/2015	123456789	<input type="checkbox"/>	Edit Delete

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

To edit an existing row (prior to submission) click on Edit

To delete a row, (prior to submission) click on Delete. Once you delete a row you cannot get it back.

Address information is required; The Address is shown in red font.

Addresses for [Name]

Type	Street	City	State	Zip	Zip 4	
						New

- Click on Addresses.
- Click on New or if not new, click on Edit.
- Enter the required information. All fields are required except zip4. Also there is a drop down list for the type of address.
- Click on Save, you will see a message that the record was saved successfully.
- Click on Close.

- If an additional address is needed, select New. If no additional address is needed, click Close.

After addresses have been entered for each line, complete the attestation and click on next.

Individuals

Please list all **INDIVIDUALS** with an ownership or control interest in you. Include each person's name, address, DOB, SSN, and title and, the percent of ownership.

"Persons with an ownership or control interest" means-

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- Is a partner in your organization if organized as a partnership.

Iowa Medicaid
Portal Access

Good Afternoon

File > Review > Manage > Information > Messages Logout

Tax ID: 812

Application Status: InProgress

- [Home](#)
- [Process Checkout/Checkin](#)
- [1 Business Entity Management](#)
- [2 Organizational Roster Management](#)
- [3 Rendering Roster Management](#)
- [4 Ownership And Control Disclosure](#)
- [Provider Type](#)
- [Managing Employees](#)
- [Ownership](#)
- [Individual](#)
- [Non-Individual](#)
- [of Subcontractors](#)
- [Relationships](#)
- [Individual](#)
- [Non-Individual](#)
- [Other Disclosing Entities](#)
- [Final Adverse Actions](#)
- [Patient Protection & ACA](#)
- [5 Health Information Technology Survey](#)
- [6 IME Documentation Verification](#)
- [7 Agreement and Acceptance](#)
- [8 Renewal Package Review](#)

Ownership and Control Disclosure

Tax ID: 812

Name: LLC

Individual

Please list in the table below all **individuals** with an ownership or control interest in you. Include each person's name, address(es), date of birth (DOB), and SSN, title (e.g. chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means-

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

All fields are required. Adverse Action where applicable.

Name of Individual	Title	Ownership Percentage	Address(es)	DOB	SSN	Adverse Actions
New						
No Data Found						

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

←

Next

→

If there are no individual owners then you must attest to that fact and click on Next.

Iowa Medicaid Portal Access Good Afternoon

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Tax ID: 812
Application Status: InProgress

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4 **Ownership And Control Disclosure**

 Provider Type

 Managing Employees

 Ownership

 Individual

 Non-Individual of Subcontractors

 Relationships

 Individual

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 Other Disclosing Entities

 Final Adverse Actions

 Patient Protection & ACA

5 Health Information Technology Survey

6 IME Documentation Verification

7 Agreement and Acceptance

8 Renewal Package Review

Ownership and Control Disclosure

Tax ID: 812
Name: LLC

Individual

Please list in the table below all **individuals** with an ownership or control interest in you. Include each person's name, address(es), date of birth (DOB), and SSN, title (e.g. chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

Persons with an ownership or control interest means-

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

All fields are required. Adverse Action where applicable.

Name of Individual	Title	Ownership Percentage	Address(es)	DOB	SSN	Adverse Actions
						New

No Data Found

No: applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

[Next](#)

If there are individuals that meet this requirement then click on New.

Party for Individual

You may enter a new party and then save it.

SSN:

Title:

First Name:

Middle Name:

Last Name:

Ownership Percentage:

Date of Birth:

Adverse Actions:

- Enter the required information. All fields are required except the Middle Name and Adverse Actions.
- Click on Save; you will see a message that the record was saved successfully.
- Click on Close.

Ownership and Control Disclosure

Tax ID: 312
 Name: LLC

Individual

Please list in the table below all **individuals** with an ownership or control interest in you. Include each person's name, address(es), date of birth (DOB), and SSN, title (e.g. chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

Persons with an ownership or control interest means-

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

All fields are required. Adverse Action where applicable.

Name of Individual	Title	Ownership Percentage	Address(es)	DOB	SSN	Adverse Actions
last, First	Title	100	Addresses	1/1/1900	123456789	<input type="checkbox"/> New Edit Delete

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Next

Addresses for [Name]

Type	Street	City	State	Zip	Zip 4

New

Close

Addresses information is required; as shown above the Addresses is in red font

- Click on Addresses
- Click on New or if not new, click on Edit
- Enter the required information. All fields are required except zip4. Also there is a drop down list for the type of address
- Click on Save, you will see a message that the record was saved successfully.

- Click on Close.
- If an additional address is needed select New. If no additional address is needed, click Close.

After addresses have been entered for each line, complete the attestation and click on next.

NON-INDIVIDUAL

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- Is an officer or director of you if organized as a corporation; or is a partner in you if organized as a partnership.

Tax ID:

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Ownership and Control Disclosure

Tax ID:
Name:

Non-Individual

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and P.O. Box address(es).

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of you if organized as a corporation; or is a partner in you if organized as a partnership.

All fields are required. Adverse Action where applicable.

Name of Business Entity	Ownership Percentage	Address(es)	TIN	Adverse Actions	
					New

No Data Found

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.



Next

If there are no non-individual owners then you must attest to that fact and click on next.

Iowa Medicaid Portal Access Good Afternoon

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID:

Application Status: **InProgress**

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 Other Disclosing Entities

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7 Agreement and Acceptance

8 Renewal Package Review

Ownership and Control Disclosure

Tax ID:

Name:

Non-Individual

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and P.O. Box address(es).

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of you if organized as a corporation; or is a partner in you if organized as a partnership.

All fields are required. Adverse Action where applicable.

Name of Business Entity	Ownership Percentage	Address(es)	TIN	Adverse Actions
New				

No Data Found

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Iowa Department of Human Services

- Click on New.

Party for Non-Individual

You may enter a new party and then save it.

TIN:

Business Name:

Ownership Percentage:

Adverse Actions:

- Enter the required information. All fields are required except the Adverse Actions, only if applicable.
- Click on Save. A message will be displayed in red when the record is saved.
- Click on Close to return to the Non-Individual Ownership main page.

Iowa Medicaid Portal Access Good Afternoon

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: [Redacted]
Application Status: **InProgress**

Ownership and Control Disclosure

Tax ID: [Redacted]
Name: [Redacted] LLC

Non-Individual

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and P.O. Box address(es).

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of you if organized as a corporation; or is a partner in you if organized as a partnership.

All fields are required. Adverse Action where applicable.

Name of Business Entity	Ownership Percentage	Address(es)	TIN	Adverse Actions	
[Redacted]	[Redacted]	Addresses	[Redacted]	<input type="checkbox"/>	New Edit Delete
[Redacted]	[Redacted]	Addresses	[Redacted]	<input type="checkbox"/>	Edit Delete
[Redacted]	[Redacted]	Addresses	[Redacted]	<input type="checkbox"/>	Edit Delete
[Redacted]	[Redacted]	Addresses	[Redacted]	<input type="checkbox"/>	Edit Delete

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Next

Addresses for [Redacted] LLC

Type	Street	City	State	Zip	Zip 4

New

Close

Addresses information is required; as shown above the Address is in red font.

- Click on Addresses
- Click on New or if not new click on Edit
- Enter the required information. All fields are required except zip+4. Also there is a drop down list for the type of address

- Click on Save, you will see a message that the record was saved successfully.
- Click on Close.
- If an additional address is needed select New, if no additional address click Close.

After addresses have been entered for each line, complete the attestation and click on next.

Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the Tax Identification Number (TIN) or SSN, the percent of ownership, the primary address, all business locations, and P.O. Box address.

Iowa Medicaid Portal Access Good Afternoon

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: ██████████ 812
Application Status: **InProgress**

Ownership and Control Disclosure

Tax ID: ██████████ 812
Name: ██████████ LLC

of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and P.O. Box address(es).

All fields are required. Adverse Action where applicable.

Name of Business Entity	Ownership Percentage	Address(es)	TIN	Owners	Adverse Actions
No Data Found					
New					

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

[Next](#)

Iowa Department of Human Services

If there are no subcontractor owners then you must attest to that fact and click on Next.

If there are subcontractors that meet this requirement then enter new rows as appropriate.

Iowa Medicaid Portal Access Good Afternoon

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: ██████████ 812
Application Status: **InProgress**

Ownership and Control Disclosure

Tax ID: ██████████ 812
Name: ██████████ LLC

of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and P.O. Box address(es).

All fields are required. Adverse Action where applicable.

Name of Business Entity	Ownership Percentage	Address(es)	TIN	Owners	Adverse Actions
					New

No Data Found

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Next

Iowa Department of Human Services

- Click on New.
- Enter the required information.

Party for of Subcontractors

You may enter a new party and then save it.

TIN:

Business Name:

Ownership Percentage:

Adverse Actions:

Save Clear Close

Party for of Subcontractors

Party Name was saved.

TIN:	11111111
Business Name:	Business Name
Ownership Percentage:	20
Adverse Actions:	<input type="checkbox"/>

Save Clear Close

- All fields are required except the Adverse Actions.
- Click on Save, a message will be displayed in red when the record is saved.
- Click on Close to return to the Subcontractor main page.

Iowa Medicaid Portal Access Good Afternoon

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Tax ID: ██████████ 812
Application Status: **InProgress**

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[8 Renewal Package Review](#)

Ownership and Control Disclosure

Tax ID: ██████████ 312
Name: ██████████ LLC

of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and P.O. Box address(es).

All fields are required. Adverse Action where applicable.

Name of Business Entity	Ownership Percentage	Address(es)	TIN	Owners	Adverse Actions	
Business Name	20	Addresses	:11111111	Owners	<input type="checkbox"/>	New Edit Delete

No: applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Iowa Department of Human Services

- Address information is required as with prior sections.
- Owners are required to be listed.

Ownership of Controlling Interests

for Business Name

Business Name	DOB	SSN/TIN	Adverse Actions	
				New

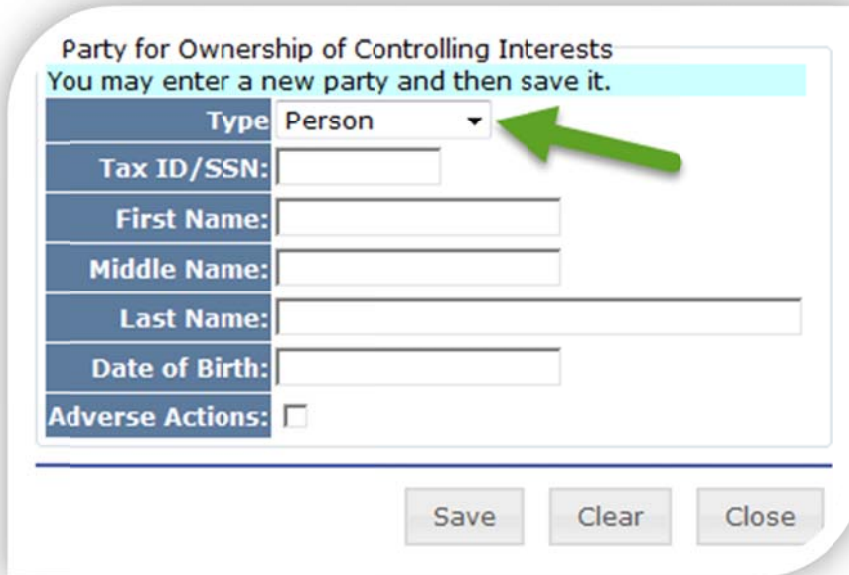
No Data Found

- Click on New

Party for Ownership of Controlling Interests
You may enter a new party and then save it.

Type	Person
Tax ID/SSN:	<input type="text"/>
First Name:	<input type="text"/>
Middle Name:	<input type="text"/>
Last Name:	<input type="text"/>
Date of Birth:	<input type="text"/>
Adverse Actions:	<input type="checkbox"/>

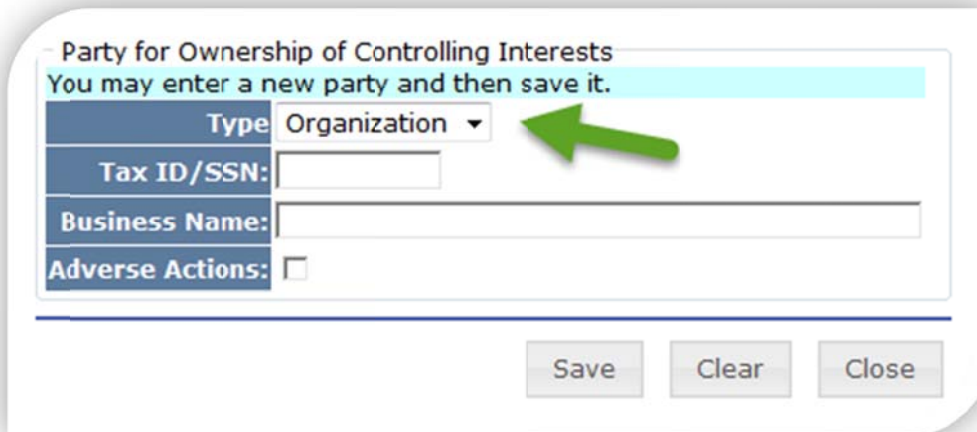
Save Clear Close



Party for Ownership of Controlling Interests
You may enter a new party and then save it.

Type	Organization
Tax ID/SSN:	<input type="text"/>
Business Name:	<input type="text"/>
Adverse Actions:	<input type="checkbox"/>

Save Clear Close



- Select Person or Organization from the drop down.
- Enter the required information, all fields are required except Adverse Actions.
- Click on Save, again you will see the message that the record was saved successfully.
- Click on Close.
- Click on Close again to return to the main record.
- If no additional information, complete the attestation and click on Next.

Relationships

If you listed any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No.

If you answered “yes” continue.

If there are no individual relationships then you must attest to that fact and click on Next.

Iowa Medicaid Portal Access Good Afternoon

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: ██████12
Application Status: **InProgress**

Ownership and Control Disclosure
Tax ID: ██████12
Name: ██████ LLC

Individual Relationships
If you listed any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling?
 Yes or No

If you answered yes: Please provide all of the following information about each individual owner in the table below.

All fields are required.

Name of Individual	Title	Relationship	DOB	SSN
				New

No Data Found

No: applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Next

Iowa Department of Human Services

- Answer the yes or no question.
- If you answer yes you must enter the name (s) in grid.
- Click on New.

Party for Individual Relationships

You may enter a new party and then save it.

SSN:	<input type="text"/>
Title:	<input type="text"/>
First Name:	<input type="text"/>
Middle Name:	<input type="text"/>
Last Name:	<input type="text"/>
Date of Birth:	<input type="text"/>

Save Clear Close

- Enter the required information; all fields are required except the Adverse Actions.
- Click on Save.
- Click on Close to return to the Individual Relationship main page.

Iowa Medicaid Portal Access Good Afternoon

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Tax ID: ██████████812
Application Status: **InProgress**

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4 **Ownership And Control Disclosure**

Provider Type

Managing Employees

Ownership

Individual

Non-Individual

of Subcontractors

Relationships

Individual

Non-Individual

Other Disclosing Entities

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5 Health Information Technology Survey

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Ownership and Control Disclosure

Tax ID: ██████████812
Name: ██████████ LLC

Individual Relationships

If you listed any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling?
 Yes or No

If you answered yes: Please provide all of the following information about each individual owner in the table below.

All fields are required.

Name of Individual	Title	Relationship	DOB	SSN	
last , First	owner	Relationships	1/1/1900	111111111	New Edit Delete

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

- Click on Relationships.


Relationship for last , First

Name of Individual	Relationship	DOB	SSN	
				New

No Data Found

- Click on New.

Party for Individual Relationships
You may enter a new party and then save it.

Type	Person ▾
Relationship:	Brother ▾ 
SSN:	<input type="text"/>
First Name:	<input type="text"/>
Middle Name:	<input type="text"/>
Last Name:	<input type="text"/>
Date of Birth:	<input type="text"/>

- Select the type of relationship from the drop down.
- Enter the required information; all is required except Middle Name.
- Click on Save, again you see the message that the record was saved successfully.
- Click on Close.
- Click on close again to return to the main record.
- If there is no additional information, complete the attestation and click Next.

Non-Individual and Subcontractor Relationships

If you listed any individual owners of you and also listed any subcontractors in which you have an ownership interest, are any of the individual owners previously listed related to any owner of any subcontractors as a spouse, parent, child or sibling?

If there are no non-individual or subcontractor relationships then you must attest to that fact and click on Next.

Iowa Medicaid Portal Access Good Afternoon

File ▶ Review ▶ Manage ▶ Information ▶ Messages Logout

Tax ID: ██████████812
Application Status: **InProgress**

Ownership and Control Disclosure

Tax ID: ██████████812
Name: ██████████ LLC

Non-Individual and Subcontractor Relationships

If you listed any individual owners of you and also listed any subcontractors in which you have an ownership interest, are any of the individual owners previously listed related to any owner of any subcontractors as a spouse, parent, child or sibling? Yes or No

If you answered yes: Please provide all of the following information about each individual owner in the table below.

All fields are required.

Name of Business Entity	Ownership Percentage	Relationship	TIN	
				New

No Data Found

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Iowa Department of Human Services

If there are individual relationships that meet this requirement then enter new rows as appropriate.

- Answer the yes or no question, if yes.
- Click on New.

Party for Non-Individual and Subcontractor Relationships

You may enter a new party and then save it.

TIN:

Business Name:

Ownership Percentage:

Adverse Actions:

Save Clear Close

- Enter the required information; all fields are required except the Adverse Actions.
- Click on Save, a message will be displayed when the record is saved.
- Click on Close.

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Tax ID: 812
Application Status: InProgress

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4 **Ownership And Control Disclosure**

 Provider Type

 Managing Employees

 Ownership

 Individual

 Non-Individual of Subcontractors

 Relationships

 Individual

 Non-Individual

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Ownership and Control Disclosure

Tax ID: 812
Name: LLC

Non-Individual and Subcontractor Relationships

If you listed any individual owners of you and also listed any subcontractors in which you have an ownership interest, are any of the individual owners previously listed related to any owner of any subcontractors as a spouse, parent, child or sibling? Yes or No

If you answered yes: Please provide all of the following information about each individual owner in the table below.

All fields are required.

Name of Business Entity	Ownership Percentage	Relationship	TIN	
Name	50	Relationships	S87654321	Edit Delete

No: applicable (N/A) - I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

[Next](#)

Iowa Department of Human Services

- Click on Relationships.

Name of Business Entity	Relationship	TIN
		New

No Data Found

Close

- Click on New.

Party for Non-Individual and Subcontractor Relationships

You may enter a new party and then save it.

Relationship: Brother

TIN:

Business Name:

Save Clear Close

- Select the Relationship from the drop down.
- Enter the required information.
- Click on Save, a message will be displayed when the record is saved successfully.
- Click on Close.
- Click on Close again to return to the main record.

If there is no additional information, complete the attestation and click Next.

Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"?

This means, do any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII):

- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "Other disclosing entity" can include entities that are not enrolled in a Medicaid program.

If this section is not applicable, please attest to that fact and click on next.

List the name of each owner of you who has such interest and the name of the other disclosing entity in which the owner has an ownership or control interest in:

- Click on New.

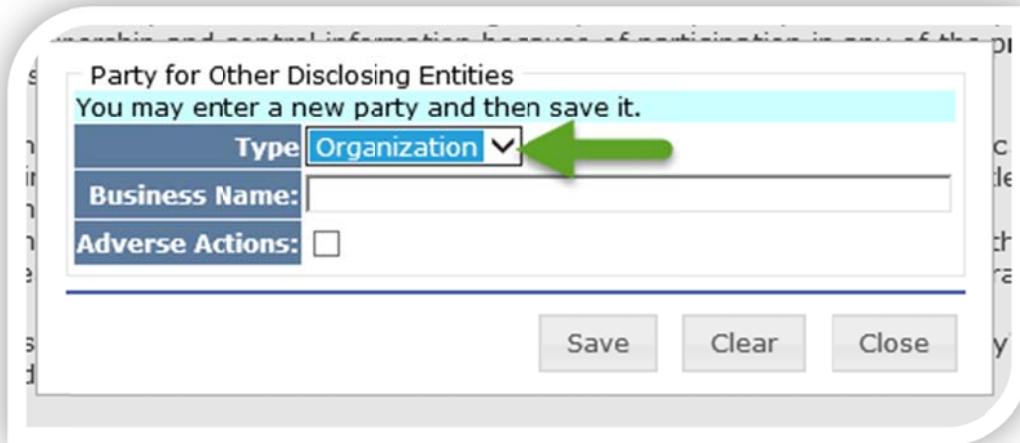
All fields are required. Adverse Action where applicable.

Business Name	Name of Other Disclosing Entity	Adverse Actions	
			New

No Data Found



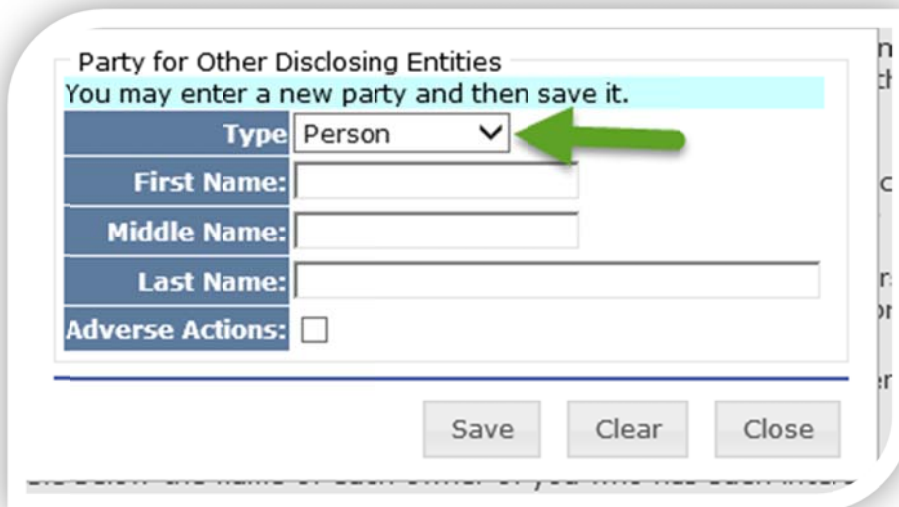
- Select type from the drop down
 - Organization or person



Party for Other Disclosing Entities
You may enter a new party and then save it.

Type	Organization
Business Name:	<input type="text"/>
Adverse Actions:	<input type="checkbox"/>

Save Clear Close



Party for Other Disclosing Entities
You may enter a new party and then save it.

Type	Person
First Name:	<input type="text"/>
Middle Name:	<input type="text"/>
Last Name:	<input type="text"/>
Adverse Actions:	<input type="checkbox"/>

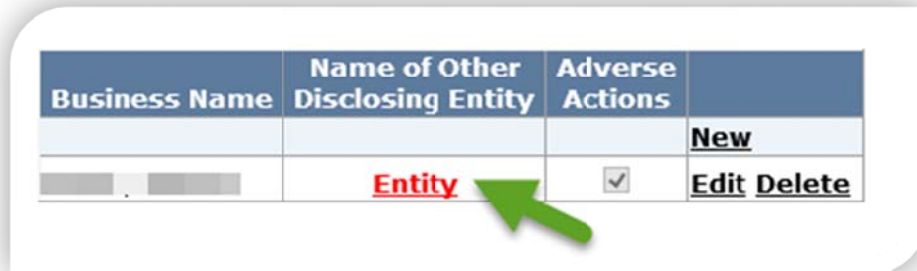
Save Clear Close

All fields are required.

- Click Save.
- Once saved, click close.

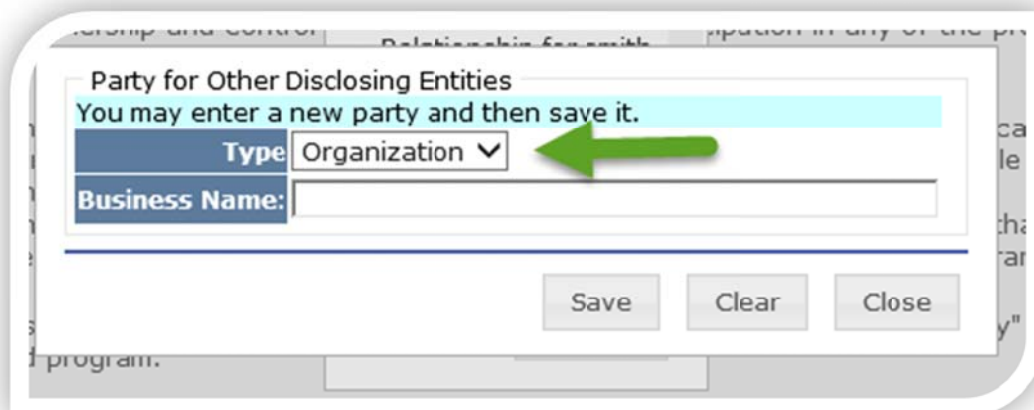
Name of other disclosing “Entity.”

- Click on Entity.



Business Name	Name of Other Disclosing Entity	Adverse Actions	
			New
	Entity	<input checked="" type="checkbox"/>	Edit Delete

- Select type from the drop down.
 - Organization or person



Party for Other Disclosing Entities
You may enter a new party and then save it.

Type: Organization ▼

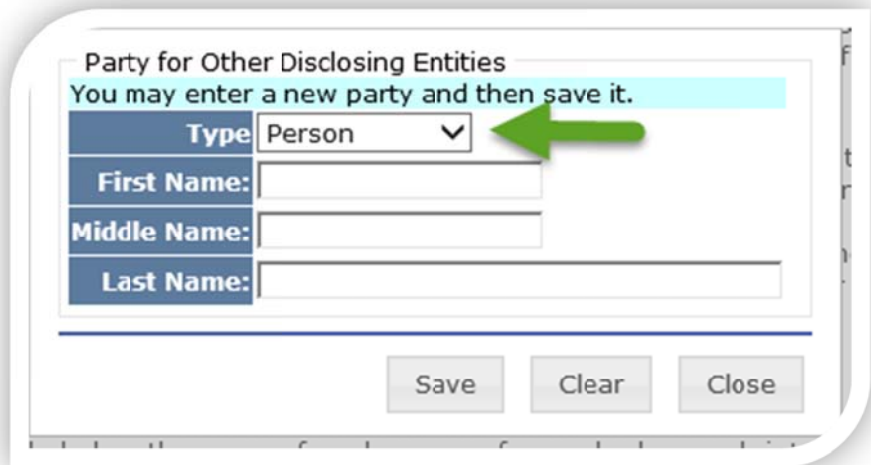
Business Name: _____

Save Clear Close

Party for Other Disclosing Entities
You may enter a new party and then save it.

Type	Person	▼
First Name:	<input type="text"/>	
Middle Name:	<input type="text"/>	
Last Name:	<input type="text"/>	

Save Clear Close



All fields are required.

- Click Save.
- Once saved, click close.

If there is no additional information, complete the attestation and click Next.


Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

All fields are required. Adverse Action where applicable.


Individual/Business	Taken By	Date of Final Adverse Action	Resolution	
[Redacted]			Resolutions	Edit
[Redacted]			Resolutions	Edit

- Click on Resolutions.

Adverse Action Detail for [Redacted]

Entity Type	Resolution
	New

No Data Found



- Click on New.

Adverse Action Detail for [redacted]

Entry Type: Resolution

Resolution: [text area]

Save Clear Close

- Type in the resolution.
- Click save.
- If more than one adverse action, click new and repeat.
- After all resolutions have been saved click on close.

Repeat for each individual/business listed in the grid.

If there is no additional information, complete the attestation and click Next.

Patient Protection and Affordable Care Act (ACA)

Please answer all five questions for each individual/business listed in the grid.

Note: *Known issue*- names are repeat multi times, each time a person or organization is entered in a previous section the name will appear in the grid. Example if you entered the same individual as managing employee, owner and relationship sections that same name will appear in the grid for each entry (3 times). You must click on the “program integrity details” for each row and answer the questions before you can complete this section.

- Click on “Program Integrity Details.”

Organization and Control Disclosure

Fax ID: 404060105
Name: [REDACTED]

Patient Protection and Affordable Care Act

Please answer all five (5) questions:

"Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with Medicaid provider?"

The term "affiliation" includes but is not limited to relationships between individuals, business entities, or a corporation. The term includes direct or indirect business relationships that involve

- (1) a compensation arrangement,
- (2) an ownership arrangement,
- (3) managerial authority over either member of the affiliation,
- (4) the ability of one member of the affiliation to control the other, or
- (5) the ability of a third party to control both members of the affiliation.

SSN/TIN	Individual/Business	Program Integrity Detail	Completed
6666666666	rineon, julius	Program Integrity Details	<input type="checkbox"/>
[REDACTED]	[REDACTED]	Program Integrity Details	<input type="checkbox"/>
[REDACTED]	[REDACTED]	Program Integrity Details	<input type="checkbox"/>
[REDACTED]	[REDACTED]	Program Integrity Details	<input type="checkbox"/>

Not applicable (N/A) - I attest that the information submitted is accurate and complete and that I have reviewed before submitting.

- Click on Attestation.

Attestation Status						
Organization/Person Name	Uncollected Debt	Payment Suspension	Billing Denied	Excluded	Shares NPI with Uncollected Debt	Attestation
	No	No	Not Answered	Not Answered	Not Answered	Attestation

Close

Answer each question (Yes, No or Not Sure) click next.

Has uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and Iowa governments,

Yes
 No
 Not Sure

Next Close

Has been or is subject to a payment suspension under a federally-funded health care program

- Yes
- No
- Not Sure

Next

Close

Has had its billing privileges denied or revoked

- Yes
- No
- Not Sure

Next

Close

Has been excluded from participation under Medicaid, Medicare, or any other federally-funded health care program

Yes

No

Not Sure

Next Close

smith desiroe Program Integrity Details

Shares a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt

Yes

No

Not Sure

Next Close

smith desiroe Program Integrity Details

- After all five questions are answered, click on Close and repeat until all lines have been checked completed.

If there is no additional information, complete the attestation and click Next.

Once all sections of the Ownership and Control Disclosure are completed return to section 4 by clicking in the navigation section.

Tax ID: [REDACTED]
Application Status: **InProgress**

Ownership and Control Disclosure [Check-out History](#)

Check Out for Edit Check In

Tax ID: [REDACTED]
Current Status: **InProgress**

Ready to Complete Next

Navigation:
Home
Process Checkout/Checkin
1 Business Entity Management
2 Organizational Roster Management
3 Rendering Roster Management
4 Ownership And Control Disclosure
Provider Type
5 Health Information Technology Survey
6 IME Documentation Verification
7 Agreement and Acceptance
8 Renewal Package Review

A green arrow points to the 'Ownership And Control Disclosure' link in the navigation menu.

Click on Ready to Complete

You must check the attest box and click Submit.

Tax ID: [REDACTED]
Application Status: **InProgress**

Ownership and Control Disclosure [Check-out History](#)

Check Out for Edit Check In

Tax ID: [REDACTED]
Current Status: **InProgress**

THE PROVIDER CERTIFIES THAT THE INFORMATION SUBMITTED ON THIS FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. THE PROVIDER ALSO UNDERSTANDS THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW

I attest that the information submitted is accurate and complete and that I have read this entire section before submitting.

Submit Next

A green arrow points to the attest checkbox.

Section 5: HIT Survey

This section is optional

Thank you for reenrolling as a provider with Iowa Medicaid. In our continuing efforts to gauge provider adoption of electronic health records (EHR), we request that you complete the following short survey regarding your usage of EHR. Your responses greatly improve our planning efforts for health information technology.

- Answer each section and click next

Do you currently use electronic health records (**EHR**)?

Yes No

[Start Over](#) [Previous](#) [Next](#)

.. .. " "

Do you intend to purchase an EHR?

No

Yes, within 1 year

Yes within 3 years

Yes within 5 years

[Start Over](#) [Previous](#) [Next](#)

The last year in which to enter the Medicaid Electronic Health Records Incentive Program is the 2016 program year. Do you plan to participate in the Electronic Health Records Incentive Program (Meaningful Use)?

- Yes
- No
- No, not eligible
- No, not enough info

[Start Over](#) [Previous](#) [Next](#)

What are your primary barriers for using an EHR (check all that apply)

- N/A
- Cost
- Confusing
- Staff does not have the training/knowledge to use an EHR
- EHR unable to interface with other systems
- Decreased productivity during implementation
- Concern that EHR will quickly become obsolete
- Lack of technical support
- Not able to find a solution that fits my data and workflow needs
- Privacy and security
- Liability
- Satisfied with current system
- Retiring within the next 3 years
- Access to broadband (high-speed internet)

Other

[Start Over](#) [Previous](#) [Next](#)

Electronic Clinical Quality Measures (eCQMs) use data from electronic health records (EHR) and/or health information technology systems to measure health care quality within the healthcare delivery system. They are defined, maintained, and updated in order to produce standardized measures to make collection, use, and comparisons easier. Measuring and reporting eCQMs helps to make sure that care is delivered safely, effectively, equitably, and timely. eCQMs are used today with several Medicare programs including MSSP (Medicare Shared Savings Program), PQRI (Physician Quality Reporting Initiative) and MU (Meaningful Use).

Would you be interested in submitting eCQMs to the IME which could be linked to payment incentives?

- Yes
- No

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Are you connected to the Iowa Health Information Network (IHIN)?

- Yes, Query functionality
- Yes, Direct Secure Messaging
- Yes, Electronic Lab Reporting (smartlab)
- Yes, Cancer Reporting (cancer registry)
- No, but plan to with 1 year
- No, but plan to within 2-3 years
- No plans to exchange information

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Are you connected to a Health Information Exchange? (excluding the IHIN)

- Yes
- No

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What can Medicaid do to assist you in the adoption and meaningful use of electronic health records? (Check all that apply)

- Identify products
- Provide technical assistance for product selection
- Provide technical assistance for implementation
- Connect me with similar providers who have adopted EHR for information
- Share best practice information

Other

[Start Over](#) [Previous](#) [Next](#)

Please select your provider type.

- | | |
|---|---|
| <input type="checkbox"/> Adult Rehab | <input type="checkbox"/> Audiologist |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Certified Nurse Midwife |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Clinical Social Worker |
| <input type="checkbox"/> CRNA | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Family Planning | <input type="checkbox"/> Habilitation Services |
| <input type="checkbox"/> Independent Speech Pathologist | <input type="checkbox"/> Indian Health Service |
| <input type="checkbox"/> Maternal Health Center | <input type="checkbox"/> SPMI SED Provider |
| <input type="checkbox"/> Medical Supplies | <input type="checkbox"/> Mental Health Substance Abuse Plan |
| <input type="checkbox"/> MEP Case Manager | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Optician | <input type="checkbox"/> Optometrist |
| <input type="checkbox"/> Other Practitioner - General | <input type="checkbox"/> Para Professional |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Physician DO |
| <input type="checkbox"/> Physician MD | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Therapeutic Treatment Service |

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What is your specialty?

- | | |
|---|--|
| <input type="checkbox"/> Addiction Medicine | <input type="checkbox"/> Allergy |
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Anesthesiologist Assistants |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Cardiac Surgery |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Endocrinology |
| <input type="checkbox"/> Endodontics | <input type="checkbox"/> Family Practice |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> General Practice |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Geriatric Medicine |
| <input type="checkbox"/> Gynecological | <input type="checkbox"/> Hand Surgery |
| <input type="checkbox"/> Hematology | <input type="checkbox"/> Independent Lab |
| <input type="checkbox"/> Indian Health Service Facility | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Maxillofacial Surgery |
| <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> Nephrology |
| <input type="checkbox"/> Neuro Surgery | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Neuropsychiatry | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> OB/GYN |
| <input type="checkbox"/> Oncology | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Optometry | <input type="checkbox"/> Oral Surgery |
| <input type="checkbox"/> Ortho Surgery | <input type="checkbox"/> Orthodontist |
| <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Pedontist | <input type="checkbox"/> Periodontics |
| <input type="checkbox"/> Physical Medicine Rehab | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Portable Xray | <input type="checkbox"/> Preventive Medicine |
| <input type="checkbox"/> Proctology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Rheumatology | <input type="checkbox"/> Thoracic Surgery |
| <input type="checkbox"/> Urology | <input type="checkbox"/> Vascular Surgery |

[Start Over](#) [Previous](#) [Next](#)

HIT Contact Person Information

Name

Address

Phone

Email

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Survey Completed

Section 6: IME Documentation Verification

This section will be completed after you complete section 7.

Section 7: Agreement and Acceptance

This section can only be completed by the signatory user. If you are only the enrollment user you will not be able to attest and accept the provider agreement.

The screenshot shows a web application interface. At the top, it displays 'Tax ID: [redacted]' and 'application Status: InProgress'. On the left is a navigation menu with items: Home, Process Checkout/Checkin, 1 Business Entity Management, 2 Organizational Roster Management, 3 Rendering Roster Management, 4 Ownership And Control Disclosure, 5 Health Information Technology Survey, 6 IME Documentation Verification, 7 Agreement and Acceptance, and 8 Renewal Package Review. The '7 Agreement and Acceptance' item is highlighted in blue, and a green arrow points to it. The main content area is titled 'Agreement and Acceptance' and shows 'Tax ID: [redacted]' and 'Current Status: InProgress'. It contains a checkbox for attesting to the accuracy of previous sections, a paragraph stating the user has read the documents and understands their responsibilities, a link to the 'Provider Agreement', and a section titled 'Electronically Sign Renewal Data and IME Provider Agreement' with two checkboxes: 'I am the Provider Signatory' and 'I accept the Provider Agreement'. At the bottom right is a 'Submit and Check-In' button. In the top right corner, there are 'Check-out History', 'Check Out for Edit', and 'Check In' buttons.

A link to the provider agreement is located in the middle of the page for review.

After review the user must attest that all pervious section are complete and accurate.

Check both boxes.

- I am the Provider Signatory.
- I accept the Provider Agreement.

Once all three boxes are checked Submit and Check-In will appear.

I attest that ALL the information in the reenrollment package section 1 through section 6 i

I have read the below document(s) and understand that by continuing, I am the responsible p
organization.

- **Provider Agreement**

Electronically Sign Renewal Data and IME Provider Agreement

I am the Provider Signatory

I accept the Provider Agreement



- Click on Submit and Check-In

Note: All pervious sections must be completed and checked-in. If not, you will receive and error message and the “I accept the Provider Agreement” will be unchecked. Once all sections have been completed and checked-in, click on the Agreement and Acceptance link. Check out of edit and re-attest, and accept the provider agreement.

Section 6: IME Documentation Verification

This section will be completed after you complete section 7.

- Click on Generate Documents.

Tax ID: [REDACTED]

Application Status: **InProgress**

IME Documentation Verification

Tax ID: 4 [REDACTED]

Current Status:

Generate Documents

- Print provider reenrollment coversheet.
- If no documentation is required as message will display.
- If documentation is required a checklist of requirements will be displayed.
- Application status will change to Submitted.
- Attach documents to coversheet and mail to the IME.

The IME will verify documents received and application status on IMPA will change to Complete.

Section 8: Renewal Package Review

This section is view only.

The screenshot displays the Iowa Medicaid Portal Access interface. At the top, there is a header with the text "Iowa Medicaid Portal Access" and a navigation menu with items: File, Review, Manage, Information, Messages, and Logout. Below the header, there is a section for "Tax ID:" and "Application Status: C". The main content area is titled "Enrollment Renewal Package Review Summary" and includes a "Tax ID:" field. On the left side, there is a navigation menu with items: Home, Process Checkout/Checkin, 1 Business Entity Management, 2 Organizational Roster Management, 3 Rendering Roster Management, 4 Ownership And Control Disclosure, 5 Health Information Technology Survey, 6 IME Documentation Verification, 7 Agreement and Acceptance, and 8 Renewal Package Review. The main content area contains two tables. The first table lists users and their roles, and the second table lists sections and their completion status.

UserID	Name	Email	Phone	RoleName
	L		2066550001	Administrator
13	S	ss	2066550001	Enrollment User
chsdhdoo		jthomas@myihsa.com	2066550001	Enrollment User
	L	t	2066550001	Signatory

Section Name	Section Status	Completed by	Completed Date
Business Entity Management	Completed		5/26/2016 11:54:49 AM
Organizational Roster Management	Completed		5/26/2016 11:54:49 AM
Rendering Roster Management	Completed		5/26/2016 11:54:49 AM
Ownership and Control Disclosure	Completed		5/26/2016 11:54:49 AM
Health Information Technology Survey	Completed		5/26/2016 11:54:49 AM
Agreement and Acceptance	Completed		5/26/2016 11:54:49 AM
IME Documentation Verification	Completed		5/26/2016 11:54:49 AM

This section allows the user to view:

- The users and the role assigned to that user.
- Each section status, completed by and completed date.