Kansas Medical Assistance Program SIA Application: Step-by-step guide

KMAP Enrollment:

Go to https://portal.kmap-state-ks.us/PublicPage

Click START, or Resume application

Kansas	Kansas	Medical Assista	ance Program ((KMAP)						Welcome
		КМАР	A	đ.	D	Ê.	D	Go Under	Contact Us Se	arch
		Home		Member Publications		Provid	er Int	Drug Manufactu	"Open" or "Closed" to re rer ers	<u>A</u>
		Disclai	mer					Ab	out	

Provider Enrollment tile

Gainwell Technologies Medicaid	
	Cont
Provider Enrollment View Enrollment	
Wecome	
Welcome to the Online Provider Enrollment System	
Is start a NEW application please click the "Start" button in the bottom right comer to begin the onrollment process. The application will automatically save each time you click "Continue".	
for RESUME an application cities there	
ie staat a HEVRLIDATION diek Hats Cy	
In check the STATUS of an application disk Here	
Ist of status descriptions:	
Partial/Started - Application has been started but net yet been submitted or a revailation" has been generated and requires the provider to complete the revailation. ("Revailation is a pre populated application that needs to be reviewed by the provider and se	domitted.)
Availing Attachments - Application has been submitted but is verifying for required effectiveness	
Submitted - Application is complete and has been submitted for review	
Pending – Application has been queued for the enrolment team for review.	
RIP (Returned to Provider) - Application requires corrections. (Applicant will receive a separate notification identifying the specific issue(s) requiring attention.)	
Approved - Application has been approved. (Applicant will receive written continuation that the application has been approved. For newly enrolling Providers, the Welcome Packet includes the Provider number and other program participation information.)	
Explined - Application was not submitted within the allowable timetrame. A new application is required in this situation	
Submitted to Managed Care - Application has been forwarded to MCOs for contracting. (This status is used for KMAP-approved applications that have also requested to participate with additional managed care organizations.)	
Pasa note that only one service location and one provider type can be enrolled per application. All attachments must be consister, legible and current. You will be notified if your application cannot be processed because it is incomplete or the information is income	d.
ulsting Group members (individuals in a Group) only need to be enrelied once for each state in which they practice. Individual in a Group providers may attiliate to multiple organizations.	
provides may need the following minimum information to complete your emotioned negrest	
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 A spectration of the spectra s per spectra spectr	
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er ganarar antolinant Fraguerth Askad Osestions, dick Hara	

Select 008 Stand alone Mental Disease hospital or 009 for a Psych Unit

				STAR
Enrollment Pre-Checklist				
Please select the below parameters to generate a checklist enlisting th	he credentials and documents requ	uired to complete an enrollment application. All the credentials that are furnished	I in the application must be current. Future dated	or expired credentials will cause your application to be returned.
* Enrollment Type	0	* Provider Type	Ø	
Facility	*	Hospital	·•	
* Specialty	0	Tax ID Type	Ø	
008-Mental Diseases (Hospital)		• EIN O SSN		
select a value	J	* I will accept patients in the following programs:	Ø	
008-Mental Diseases (Hospital)		FFS and MCO	-	
009-General Hospital with a Psychiatric Unit				
010-Acute Care				CLEAR GENERATE PRE-CHECKL
011-Psychiatric Hospital				Sec
012-Rehabilitation Hospital	7			
017-Tuberculosis Hospital				
		DISCLAIMER WEBSITE REQUIREMENTS	PRIVACY POLICY	



This page is generating your pre-check list of what you will need to complete the application

riteria	
Enrollment Type	Provider Type
Facility	Hospital
Speciality Type	Tax ID Type
008-Mental Diseases (Hospit	al) 💿 EIN 🕓 SSN
Are you Medicare enrolled	I will accept patients in the following programs
Yes No	FFS and MCO
Please find below the cree application. The requirem the enrollment application must be current. Future d	entials and documents required to complete the enrollment ents may still vary based on any other criteria that you may enter du All the credentials mentioned here that are furnished in the applica ted or expired credentials will cause your application to be returned
Please find below the creater application. The requirem the enrollment application must be current. Future data in Malpractice Information and Information details	entials and documents required to complete the enrollment ints may still vary based on any other criteria that you may enter du All the credentials mentioned here that are furnished in the applica ted or expired credentials will cause your application to be returned in details are required.
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Please find below the creater application. The requirem the enrollment application must be current. Future di Malpractice Information Bed Information details Medicare Participation Capacity details are req Application Fee details Required Attachments: Section 12 Attestation/ Federal W-9 Form details	entials and documents required to complete the enrollment ents may still vary based on any other criteria that you may enter du All the credentials mentioned here that are furnished in the applicat ted or expired credentials will cause your application to be returned a details are required. are required. details are required. Jired. are required. Consent and Release Form details are required. s are required.
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Please find below the creat application. The requirem the enrollment application must be current. Future de Malpractice Information Bed Information details Medicare Participation Capacity details are required Application Fee details Required Attachments: Section 12 Attestation/ Federal W-9 Form details Hospital License details Approval Letter from the are required.	entials and documents required to complete the enrollment ints may still vary based on any other criteria that you may enter du All the credentials mentioned here that are furnished in the applica- ted or expired credentials will cause your application to be returned in details are required. are required. details are required. uired. are required. T Consent and Release Form details are required. is are required. are required. Consent and Release Form details are required. is are required. Consent and Release Form details are required. is are required. Consent and Release Form details are required.

Click the START in the right down corner to start the application.

Fill out all the required information marked by blue * and create an account.

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			Contact
ñ 🗖	Provider Enrollment 👻 New Enrollment		
			0
P	egistration		Resulted Fields (🛊)
R	spister below to be assigned a unique enrollment tracking number. Be sure to write down y u con't submit your enrollment right away, you can use this tracking number and password the Final	ur password. An email confirmation will be sent with the tracking number. If to resume your enrolment application later. Confirm Finnil	
La	Password 🔤 🖗	Confine Password Ø	
	Yovider Reference	Ð	
			PREVIOUS REGISTER
		DISCUMMER WEBSITE REQUIREMENTS PRIMOY POLICY	

Click Register button and you get the confirmation below

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nitial Enrollment Information			Menostation Counside	0
Encoliment Type	0	* Provider Type		
elect a value	+	select a value	Your tracking number is 7923540568.	
			gainwelltechnologies.com with futher instructions	
			You can now continue with your enrollment application	
				-
rovider information				0
Provider Information	poration, or other	legal documents. The leg	OK 69 for husinesses and internal Rayonus Sendoa recor	eds for individualis
Provider Information Provider Name must be the current name on tax, cor NP1 O	paration, or other	logal documents. The log	OK F5 trr basinesses and internet Revenue Sendor recor	eda for individualia
Provider Information he Frovider Name must be this current name on tax, cor NP1	poration, or other	legal documents. The leg	OK 55 for businesses and internal Revolue Sendia recor	ets ter individualis
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Nonder Information An Provider Information NP1 O NP1 O NP1 O NP1 O NP1 O NP O NP O	poration, or other	legal documents. The leg	0K 73 for businesses and internal Revenuel Sensice racer	eds for individualis
eroolder Information a Provider Yame must be the current name on tax, cor NP1	poration, or other	lagal documents. The lag	P3 tor businesses and internal Ravenus Sendor recor	ets ter individuals.
Voordere telecematical As Providere telecematical Net Poil Yes Yes Yes No No Yes Yes No No No No No No No No No N	rparation, or other	legal documents. The leg	P3 tor businesses and internal Revenue Sendse recor	es tor individuals.
Viewder Information Viewder Information NPI	nparadian, ar offher	legal documents. The leg	73 for husinesses and internal Revenue Sendor recor	ets for Individuals.

You will get an email like the one below and you can resume your application later form the link in the email

Kansas-Provider-Enrollment@gainwelltechnologies.com	5 (%) → 👹 … 3:16 PM
etention Policy 3 Year Delete (Entire Mailbox) (3 years) Expires 11/14/202	26
i) If there are problems with how this message is displayed, click here to view it in a w	eb browser.
ongratulations! You have successfully registered your provider enroll	ment application with the
ansas Medical Assistance Program. Below is the tracking number and nrollment application.	password associated with your
pplication Tracking Number:	
assword: F******3	
↓ rovider Reference: SIA Test App	
o resume a previously saved enrollment application, click the link bel	ow, enter your application
acking number and the password. <u>Please note, an application pendir</u> ays after the last date it was updated.	ig submission will be inactive 30
ttps://portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentResun	ne/

There are 12 steps that are shown on the progress bar at the top of the page

PROGRESS						_						
General Information	O Specialities	3 Service Location	Addresses	Coganization	Credentials	Provider Type	(B) Other	erueeteil 🕑	Atlachments	MCO Canaent		
Agecoment / Salamit												
CANCEL.										SAVE	AND CONTINUE	
General		18										_

1. Enrollment Type FACILITY (Once selected, it cannot be changed once you move to the next page), Provider Type is HOPSPITAL (Once selected, it cannot be changed once you move to the

next page. SAVE AND CONTINUE.

										_
Provider Enrollment	 General Inform 	ation								
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p 1: General Infor	mation - Trackin	g Number: 7	923540668	0						S
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General Information (2) Speciatives	(1) Service Location	Addresses	Organization	(6) Credentials	Patrider Type	() one	() Disclosures	10 Background Check	(1) Attachments	l l
MCO Consent (13) Agreement	Submit									
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Initial Enrolment Information										
		O Desuddes Trees		9	* Effective Date	0				
# Enrollment Type		Provider Type								

Make sure you Select YES for Medicare Enrolled

Facility	A ALIGNOUT THE		Effective Date	Ð	
	 Hospital 		* 11/15/2023	*	
Provider Information					
The Provider Name must be the current name on	tax, corporation, or other legal documents. The legal	name and Provider Federal Tax le	dentification Number (TIN) must match the in	formation on the W 9 for businesses and internal R	evenue Service records for individuals.
Legal Name Test Location	Iax Name		Doing Dusiness As Name	Ű	
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* NH 6/					
1110010010					
12 - 000 000	а а				
Are you currently enrolled as a Provider?		Ø			
🔿 Yes 🖲 No					
Were you previously enrolled as a Provider?		ø			
🔾 Yes 🖲 No					
Are you Medicare enrolled?		G			
● Yes ○ No					
If this application is for enrollment into the Fee-for	Service (FFS) program only. It will not be shared with	n the other state Managed Care O	rganizations. You will need to apply directly t	o each MCO program once your FES application is	approved. Your answer to the question below is strictly for
* I will accept patients in the following progra	ms:	6			
		-			
select a value		0			
select a value Are you maistered with CAOH?					
select a value Are you registered with CAQH?					
select a value Are you registered with CAQH? Ves No					

Select FFC/ MCO or BOTH

	If this application is for enrollment into the Fee-for-Service (FFS) program only. It will not be shared a informational purposes. Please select the appropriate option	with the other state Ma	anaged Care Organizations. You	will need to app
L	# I will accept patients in the following programs:	0		
	select a value	*		
	select a value			
	FFS only			
	MCO(s) only	D		
	FFS and MCO			

Select EACH of the MCO separately .

FFS and MCO		w	
Please select the programs to which you are applying. You must choose at least one.	0		
Aetoa Better Health of KS Inc			
Sunflower Health Plan			
United Healthcare Community Plan			

You will have all the selected plans showing up

TT3 dia moo	-
* Please select the programs to which you are applying. You must choose at least	аня. Ф
AETNA BETTER HEALTH OF KS Are you registered with CAQH? TH PLAN X	UNITED HEALTHCARE COMMUNITY PLAN X
Are you registered with CAQH?	0
⊖_yes ● No	
0	

Provide contact for the KMAP to contact at your organization. Email is not marked as required, but IT IS required.

Contact Information								
Title	0	* Last Name	0	* First Name		Middle Name	9	Suffix ©
		Doc		John				
* Address Line 1			0	Address Line 2			2	
6500 SE								Þ
* City	0	State	0	* Country O	•	* ZIP Code/ Postul Code	9	wg
		select a value	*	select a value +				
* Phone Type	0	Telephone Number	0	Telephone Number Extension 🛛 😡		Fax Number 6	9	
select a value	-							
Email Address			0	Confirm Emuil			9	
* Preferred Communication		0						
select a value		-						
Phone Type select a value Email Address Preferred Communication select a value	•	Telephone Number	0	Telepitone Namber Extension Confirm Email		Fux Numbes 6		

SAVE AND CONTINUE

2. Select New Specialty:

008 for Mental Health Disease for Hospital or 009 for Psych Unit

Taxonomy: Hospitals/Psychiatric Hospitals.

New Specialty				8
			Required I	Fields (🏶)
Make Primary		Θ		
Specialty		ø	Taxonomy	ø
008-Mental Diseases (Hospital)		*	283Q00000X - Hospitals/Psychiatric Hospital	-
Effective Date	ø			
11/15/2023	曲			
			CANCEL	SAVE
				- 8

3. Select Location

SELECT NEW for the Primary Location, fill out all the required fields like address, emil and phone number

I	Service Location						
						[CREATENEW
	Location Name	Address Line1	Address Line 2	City	State	Primary	Edit
L							

4. Addresses

Maybe all the same or different.

cerceal Information (2) Speciallies	3 Service Local	a Abbresses	() Capacity	(5) Organization	Credentals	(B) Provider Type	(1) Other		Disclosures	(11) Alaximent	ь
eea 🚺 MCO Corosent	🕑 Aquesment / S	alamat.									
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5505										1	Required Fields
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5. Capacity:

Step 5: Capacity - Tracking Numbe	r: 7923540668 🕜		STEP 5 OF 14
SIA Test App			
General Information Specialities Service Location	e 🕐 Addresses 🕑 Capacity	🕚 Congenization 🖉 Crossleritein	hronder Type 🕘 Other 👘 Dischwaren 👘 Allischrearte
1 Tone 1 1 WCO Corene 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ionet -		
CANCEL			PREVIOUS SAVE AND CONTINUE
Capacity			
			Required Fields (*)
Capacity By Speciality			
008 - Mental Diseases (Hospital)			
		10 1 17 CO	CREATE NEW
Kansas D	Shawnee	worken contennen sype	
CANCEL			PREVICUS SAVE AND CONTINUE

6. Organization Details

Only the fist 2 fields are required

				Required Field
Organizational Details				
If your business is chain affiliated, the ink	ormation about the company or organiz	ation must be included in the disclosure i	ormation.	
If your business is operated by a manage organization must be included in the disc	ment company or leased (in whole or i losure information.	in part) by another organization, information	about the management company or	
 Organization Type 	0			
Corporation	-			
Tax Classification	Ð			
OTHER	-			
Entities doing business in the State, exc	opt for informal associations such as s	ole proprietorships or general partnership	must be registered with the Secretary of State.	
For more information on the registration	process, please go to the Secretary of	State website at https://sos.ks.gov/ Business Start D		
Registered with Secretary Of State		0		
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Incorporated		e Incorporation Dat		
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7. Credentials

Medicaid Program

Medicare Participation					
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122222	Medicare	11/15/2023	12/31/2299		2
Medicaid Program					
Medicaid Program	Medicaid programs? If so, please indicate which state	ş.	ũ		
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Medicaid Program * Are you enrolled in other state • Yes No	Medicaid programs? If so, please indicate which state	s.	Ũ		CORFATE NEW
Medicaid Program * Are you enrolled in other state • Yes Nn Program	Medicald programs? If so, please indicate which state	5. Filed	Q Na Dute	FedTute	
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Medicaid Program * Are you enrolled in other state Viss No Program	Medicald programs? If so, please Indicate which state	5. Ffled	0 We Three	Fed flats	
Medicaid Program * Are you enrolled in other state Viss Na Program DLA	Medicald programs? If so, please indicate which state	5. Ffled	0 No Dife	Fedflute	

Medicare Participation is required.

dicare Number	Medicare Type	Effective Date	En	d Date	Consider for Medicare Crossover Claims	s Edit
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	New Medicare Part	icipation			8	
				Required	Fields (*)	
					0	~
	Consider for Medica	are Crossover Claims			0	
	* Medicare Number	Medicare Type	Effective Date	* End Date	0	
licald Program	122222	Medicare	▼ 11/15/2023	12/31/2299	#	•
e you enrolled in other state Medicaid programs	? If se					
Yes No				CANCEL	SAVE	
					0	

8. Provider Type

Bed Information is Required (psychiatric beds, # of beds, effective date and open end date)

9. Other

you will need Malpractice Detail - it is required

aldubornal Information Please enter the provi Provider Website UR	der website addreas below. It must begin L	with "http." or "https:"	followed try a valid a	address Ø							
dapractice Information	New Malpractice Carrier In	formation				_	_			Secure Falls (*)	-
ease complete the malpri	* Type of Carrier Professional Liability	Ø T	Name of Carrier Test	r	0	Policy Number 11152023		0		(and a second of the particular of the particul	CREATE N
Type of Carrier	* Coverage Amount Aggregate 5000	I	Ð	Coverage Amount Per Oc 4000	curance		🛛 🏶 Effective Da	n () * End Date	9 #	Edi
										CANCEL SAVE	
		_		_		_		_	-		
re you currently or have you t	within the last ten years been involved in	a malpractice sult or	claim in which your c	are and treatment of a patient s	vas at Iss	ue, including pending or dismi	ssed cases or claims settled	before or during trial of	or settled to avoid	d a lawsult? 😡	

Another required question below:

Are you currently or have you within the last ten years been involved in a majuractice sulfyer claim in which your care and treatment of a patient was at issue, including pending or demissed cases or claims settled before or during trial or settled to avoid a lancout?

10. New provider self-disclosure.

Create new for each. Subcontractor and Business transaction are not required, all the rest are required.

is statement explains the use and disclosure of information about providers and the authority and purposes for which taxpayer curity Numbers (SSNs) and dates of birth (DOB), may be requested and used.	identification numbers, including Social		
ny information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for tate Medical Assistance Program. This information will also be used to ensure that no payments will be made to providers who formation may also be provided to the U.S. DHHS Centers for Medicare and Medical Services, the Internal Revenue Service, edicaid Fraud Control Unit, or other federal, state or logical agencies as appropriate.	purposes of the administration of the re excluded from participation. Any state Office of the Attorney General, the		
roviding this information is mandatory to be eligible to enroll as a provider with the State Medical Assistance Program, pursuant o submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a prov unibers used by the provider to obtain reimbursement from the State Medical Assistance Program.	to 42 CFR § 455 and CFR § 438. Failure der and deactivation of all provider		
WNERSHIP/CONTROLLING INTEREST			
ederal law requires individuals and entities with ownership, control, management or a business relationship to submit a separati erson affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 106, 42 CF	disclosure form for each entity or R § 455.436, 42 CFR § 1002.3, and CFR		
438.602 (b)			
438.602 (b) ISCLOSURE FORMS nearer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please p quested.	rovide the additional information that may be		
438.602 (b) ISCLOSURE FORMS Inswer all questions. If you do not believe that a question is applicable, select a response of "No". If you respond "Yes" to any question, please p operated. Disclosure form	ovide the additional information that may be	Status	Create New
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11. Attachments

To attach – choose File transfer in the drop down.

Drop down should match the lines in the Attachment type

Proof of board certification or proof of residency is required for the requested specialty.		
Required Attachments		
Below are the list of required attachments. Please submit all of the required documentation to continue with the enrollment.		
Attachment Type	Requirement Met	
Section 12 Attestation/Consent and Release Form	NO	^
Federal W-9 Form	NO	
Hospital License	NO	
Approval Letter from the Kansas Department for Aging and Disability Services.	NO	
Copy of Declaration Sheet and/ or Certificate of Insurance (Professional Malpractice and Comprehensive General Liability Insurance Policies)	NO	
		Y
Attachment Details		
	CREATE NEW	

12. Fees

Yes No	
incial Hardship - If you are requesting a waiver for financial hardship, please submit a letter explaining the financial hardship along with your enrolment application, iding proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as a loan denial. e you requesting a waiver of the application fee because of financial hardship?	0
Yes U No	
ver Received - If you have received a waiver from the programs mentioned below a fee payment is not required. we you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship?	0
fedhesday, November 15, 2023	
27 28 29 30 1 2 4 5 6 7 8 9 another state's Medicald program for the service location?	Ø
13 14 15 16 17 18 20 21 22 23 24 25	
te Enrolled O	
Yes O No	
rice Location - If the service location is enrolled in Medicare a fee payment is not required in service location enrolled in Medicare?	Θ
ation Fee Questions	
ex to the provider requesting proper payment. Answer all questions. If you answer 'NO' to all the questions below, then you must pay an application fee.	
splication is received and deemed to require an application fee and one is not attached or payment is not in an acceptable format, the entire application will be add the provider requires in proper narmost	
pplication fee for 2023 is \$688. Payment must be made in the form of a check or money order made out to the state of Kansas-Medicaid. If a request is returned to pplicant as incomplete after January 1, 2023 the new fee will be required.	
Providers who paid the application fee to either Medicare or another state Medicaid plan after March 25, 2011	
* Individual providers or non-physician practitioners Providers who are provider with Medicare Providers who are provider with Medicare	

13. MCO Consent

						Required Fiel
Add Consent						۵
Aetna Better Healt	th of KS Inc					
* 🗹 I Agree						Θ
Title	A Last Name	First Name	Middle Name	Date	Θ	
	Doe	John		11/15/2023		
Sunflower Health I	Plan		I Agree			
Sunflower Health I	Plan		1 Agree			L 0
Sunflower Health I	Plan • Last Name Doe	* First Name John	I Agree Middle Name	Date	Ø	je o
Sunflower Health I * I Agree Title	Plan * Last Name Doe	Ø ♥ First Name	Agree Middle Name	O Date 11/15/2023	Ø	J. O
Sunflower Health I	Plan Last Name	O ≢ First Name John	Middle Name	• Date 11/15/2023	0) ⁽¹⁾
Sunflower Health I	Plan Last Name	O * First Name John	Agree Middle Name	Date 11/15/2023	Ø	<u>ه</u> و
Sunflower Health I	Plan Last Name Doe Community Plan	First Name John	Middle Name	Data 11/15/2023	0	€ ⁰
Sunflower Health I	Plan	First Name John	Middle Name Middle Name	Date 11/15/2023 Oate	0	

14. Agree and Submit

Click Proceed, Read the agreement, Click Agree, Click Yes for the pop-up Agreement confirmation, Click I Accept, enter your information (name and email are required)

Click REQUEST VERIFICATION CODE

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t certify my signature, under my per	nality of perjury that I am individual ar	oplying, or I am duty authorized by the individu	all applying to bind such person to the provider	File Message Help Q Tell me what you want to do
agreement and that I have read and	d understood the provider agreement	& provider manuals & bulletins.		ⓐ - - ∽ ∽ → 📾 Share to Teams 📮 - №
				New Enrollment Verification Code
Signature				Kansas-Provider-Enrollment@gainwelltechnologies.com
				Retention Pulicy: 3 Year Delete (Entire Mailbox) (3 years) Dupines: 11/14/2026
The Provider Agreement is now full	ly electronic By selecting the "I Accept	t" box below you acknowledge that you under	stand your electronic signature binding to the same	(i) If there are problems with how this message is displayed, dick here to view it in a web browser.
Accept				Please use the following Verification code for provider, Test Location
Tala	O A Last Name	D . B Cost Name	O Middle Name	Verification Code: 0
inte	Doe	John	Ø middle name	If your application has closed or you chose "Finish Later", this verification code will no longer
				To request a new code:
Comments		0		1. Patien to the main menu
		Email Verification 0	Code	2. Select "Resume Enrollment"
		Your Verific	ation Code has been sent to	3. Enter the ATN & Password
		. @gainwelitechnol the ventication	ogies.com. Please Check Your email and Promptly enter code before you navigate away from the application.	 Click on "Agreements" at the top of the page and click "Request Verification Lode"
				If you are not the intended recipient, please contact the sender and destroy all copies and the
* Verification Email ID			OK	message.
* Verification Email ID gregory ear green-siggainwelte	chinologies.com		OK	message. If you have any questions, please contact KMAP Provider Enrollment at 1-800-933-6593.
* Verification Email ID gregory ear green-li@gainwellte	chnologies.com		OK	message. If you have any questions, please contact KMAP Provider Enrollment at 1-800-933-6593.
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You will get an email with the Verification code, enter the code in the Verification Code and Click Submit. Click YES on the Alert Window.

You will receive a Confirmation page

g	Jinwell Technologies Medicaid Medicaid Management Solutions		
		C	Contact Us
ñ	Provider Enrollment V Submit		
		Print	(2)
	Submit Confirmation		7
G	Congratulations) You have successfully submitted your provider enrollment application. Please reference the tracking number below for all inquiries related to this application.		
	Tracking Number 7923540668 Soverscheet		
	Sincerely, State Midcal Assistance Program		
	Bysen Annone Control Telesconter Bysen Anno 2015		
	DISCUMMER WEBSITE REQUIREMENTS PRIVACY POLICY		
© 202	23 Gamwell Technologies. Al rights reserved.		

Kansas Medical Assistance Progra	m KanCare	
Topeka, KS 66601-3571 Consumer Line: 1-800-766-9012	From the office of the Fiscal Agent	
Kansas Medical Assistance Program		Date: 11/15/2023
Office of the Fiscal Agent	Tracking #: 7923540668	Dute: 11/10/2020
Topeka, KS 66601-3571		
Contact :		
John Doe		
6500 SE FORBES AVE		
TOPEKA, Kansas		
United States 66619-1446		
Enrollment form for the followin	g provider:	
John Doe		
Test Location		
6500 SE FORBES AVE		
TOPEKA, Kansas		
UNITED STATES-666191446		
Listed below are the additional attack	nments necessary to successfully complete y	our enrollment as a KMAP
provider. The information listed below Please include this letter as your cover	w must be sent along with your printed appl er sheet.	lication cover sheet.
* Section 12 Attestation/Consent a	ind Release Form	
* Federal W-9 Form		
* Hospital License		

New Enrollment Complete Notification - Message (HTML) FT C 6 File Message Q Tell me what you want to do Help Î E N-5 5 \boxtimes Po -~ Share to Teams O Find gainv New Enrollment Complete Notification (6) Kansas-Provider-Enrollment@gainwelltechnologies.com To C 4:08 PM Retention Policy 3 Year Delete (Entire Mailbox) (3 years) Expires 11/14/2026 If there are problems with how this message is displayed, click here to view it in a web browser. Su Congratulations! You have successfully completed your provider enrollment application with the Kansas Medical Assistance Program. Below is your tracking number that has been associated with your enrollment application. Tracking Number: Password: ******* Download the coversheet and remit it with the following, as appropriate: - Required documentation that you indicated would be submitted by mail - The application fee, if one is owed. Payment must be made by bank-certified check or money order, payable to Kansas Medicaid. © 2023 Gain https://portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentStatus/ We cannot process your application until all documentation and fee payment (if required) has been received. Kansas Medical Assistance Program Provider Enrollment Kansas-Provider-Enrollment@dxc.com Contact us: 1-800-933-6593

You will also receive a confirmation email

Application will be processed once received.

NOTE: After the application is submitted – you might be invited by Gainwell to make corrections and/or submit additional documentation. Please watch your email for those to ensure the application does not expire (**Submitted** application will expire in 90 days)