

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

The screenshot shows the homepage of the Kansas Medical Assistance Program (KMAP) website. The header includes the Kansas Department of Health and Senior Services logo and the text "Kansas Medical Assistance Program (KMAP)". A navigation bar contains links for "Member", "Provider", "Publications", "EDI", "Provider Directory", "Links", and "FAQ". A yellow banner at the top right reads "KMMMS incidents impacting Providers, click 'Open' or 'Closed' to re". The main content area features a grid of six tiles: "Member", "Provider", "Drug Manufacturer", "Publications", "Provider Enrollment", and "COVID information for Providers". There are also links for "Disclaimer" and "About".

Provider Enrollment tile

The screenshot displays the "Provider Enrollment" page of the Gainwell Technologies Medicaid system. The page title is "Gainwell Technologies Medicaid" with the subtitle "Medicaid Management Solutions". The navigation bar shows "Provider Enrollment" and "New Enrollment". A "Welcome" message is followed by instructions: "Welcome to the Online Provider Enrollment System", "To start a NEW application please click the 'Start' button in the bottom right corner to begin the enrollment process. The application will automatically save each time you click 'Continue'. To RESUME an application click [Here](#)", and "To start a REVALIDATION click [Here](#)". A "List of status descriptions" includes: "Pended/Stand-by - Application has been started but not yet been submitted or a revalidation has been generated and requires the provider to complete the revalidation.", "Awaiting Attachments - Application has been submitted but is waiting for required attachments/documents.", "Submitted - Application is complete and has been submitted for review.", "Pending - Application has been queued for the enrollment team for review.", "KIP (Referred to Provider) - Application requires corrections. Applicant will receive a separate notification identifying the specific issues requiring attention.", "Approved - Application has been approved. Applicant will receive written confirmation that the application has been approved. For newly-enrolling Providers, the Welcome Packet includes the Provider number and other program participation information.", "Expired - Application was not submitted within the allowable timeframe. A new application is required in this situation.", "Submitted to Managed Care - Application has been forwarded to MCCOs for contracting. (This status is used for KMAP-approved applications that have also requested to participate with additional managed care organizations.)"

Please note that only one service location and one provider type can be enrolled per application. All attachments must be complete, legible and current. You will be notified if your application cannot be processed because it is incomplete or the information is incorrect. Listing Group members (individuals in a Group) only need to be enrolled once for each state in which they practice. Individual in a Group providers may affiliate to multiple organizations.

All Providers may need the following minimum information to complete your enrollment request:

- Address Information
- Tax Identification Number/Social Security Number
- TIN
- Application Fee

Additional information may also be required depending on provider type such as:

- National Provider Identifier
- Taxonomy code(s)
- License Number(s) and Effective Dates
- CCLU Number and License Dates - If billing laboratory codes

For general enrollment Frequently Asked Questions, click [Here](#).
For any questions related to your application, call 800-833-6933.

A "START" button is located in the bottom right corner.

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

START

Enrollment Pre-Checklist

Please select the below parameters to generate a checklist enlisting the credentials and documents required to complete an enrollment application. All the credentials that are furnished in the application must be current. Future dated or expired credentials will cause your application to be returned.

* Enrollment Type	* Provider Type
Facility	Hospital
* Specialty	* Tax ID Type
008-Mental Diseases (Hospital)	<input checked="" type="radio"/> EIN <input type="radio"/> SSN
select a value...	* I will accept patients in the following programs:
008-Mental Diseases (Hospital)	FFS and MCO
009-General Hospital with a Psychiatric Unit	
010-Acute Care	
011-Psychiatric Hospital	
012-Rehabilitation Hospital	
017-Tuberculosis Hospital	

CLEAR **GENERATE PRE-CHECKLIST**

[DISCLAIMER](#) | [WEBSITE REQUIREMENTS](#) | [PRIVACY POLICY](#)

GENERATE PRE-CHECKLIST

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

Pre-Enrollment Checklist

Criteria	
Enrollment Type	Provider Type
Facility	Hospital
Speciality Type	Tax ID Type
008-Mental Diseases (Hospital)	<input checked="" type="radio"/> EIN <input type="radio"/> SSN
Are you Medicare enrolled?	I will accept patients in the following programs:
<input checked="" type="radio"/> Yes <input type="radio"/> No	FFS and MCO

Results
<p>Please find below the credentials and documents required to complete the enrollment application. The requirements may still vary based on any other criteria that you may enter during the enrollment application. All the credentials mentioned here that are furnished in the application must be current. Future dated or expired credentials will cause your application to be returned.</p> <ul style="list-style-type: none"> • Malpractice Information details are required. • Bed Information details are required. • Medicare Participation details are required. • Capacity details are required. • Application Fee details are required. <p>Required Attachments:</p> <ul style="list-style-type: none"> • Section 12 Attestation/Consent and Release Form details are required. • Federal W-9 Form details are required. • Hospital License details are required. • Approval Letter from the Kansas Department for Aging and Disability Services, details are required. • Copy of Declaration Sheet and/ or Certificate of Insurance (Professional Malpractice and Comprehensive General Liability Insurance Policies) 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.

Registration Required Fields: (4)

Register below to be assigned a unique enrollment tracking number. Be sure to write down your password. An email confirmation will be sent with the tracking number. If you don't submit your enrollment right away, you can use this tracking number and password to resume your enrollment application later.

Click Register button and you get the confirmation below

Provider Enrollment General Information Print

Tracking Number: 7923540668 ?

Initial Enrollment Information

Provider Information

The Provider Name must be the current name on tax, corporation, or other legal documents. The legal name of the business must be used for businesses and Internal Revenue Service records for individuals.

Are you currently enrolled as a Provider?
 Yes No

Were you previously enrolled as a Provider?
 Yes No

Are you Medicare enrolled?
 Yes No

If this application is for enrollment into the Fee-for-Service (FFS) program only. It will not be allowed with the other state Managed Care Organizations. You will need to apply directly to each MCO program once your FFS application is approved. Your answer to the question below is strictly for informational purposes. Please select the appropriate option.

Registration Complete

Your tracking number is **7923540668**.

An email will be generated and sent to your email address **[redacted]** at **gainwelltechnologies.com** with further instructions.

You can now continue with your enrollment application.

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

New Enrollment Registration Notification



Kansas-Provider-Enrollment@gainwelltechnologies.com

To



3:16 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.

Congratulations! You have successfully registered your provider enrollment application with the Kansas Medical Assistance Program. Below is the tracking number and password associated with your enrollment application.

Application Tracking Number:

Password: F*****3

↓
Provider Reference: SIA Test App

To resume a previously saved enrollment application, click the link below, enter your application tracking number and the password. Please note, an application pending submission will be inactive 30 days after the last date it was updated.

<https://portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentResume/>

If you have any questions or concerns, please contact Provider Enrollment at 1-800-933-6593.

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

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

next page. SAVE AND CONTINUE.

Make sure you Select YES for Medicare Enrolled

Select FFC/ MCO or BOTH

Select EACH of the MCO separately .

FFS and MCO

Please select the programs to which you are applying. You must choose at least one.

- AETNA Better Health of KS Inc
- Sunflower Health Plan
- United Healthcare Community Plan

You will have all the selected plans showing up

Please select the programs to which you are applying. You must choose at least one.

AETNA BETTER HEALTH OF KS INC | Are you registered with CAQH? | H PLAN | UNITED HEALTHCARE COMMUNITY PLAN

Are you registered with CAQH?

Yes No

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

Contact Information

Title Last Name First Name Middle Name Suffix

Address Line 1 Address Line 2

City State Country ZIP Code/ Postal Code

Phone Type Telephone Number Telephone Number Extension Fax Number

Email Address Confirm Email

Preferred Communication

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

Required Fields (4)

Make Primary

Specialty Taxonomy

008-Mental Diseases (Hospital) 283Q00000X - Hospitals/Psychiatric Hospital

Effective Date

11/13/2023

CANCEL SAVE

3. Select Location

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

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
---------------	----------------	----------------	------	-------	---------	------

4. Addresses

Maybe all the same or different.

PROGRESS: 1 General Information, 2 Specialty, 3 Service Location, 4 **Address**, 5 Capacity, 6 Organization, 7 Credentials, 8 Provider Type, 9 Other, 10 Dashboard, 11 Attachments

CANCEL PREVIOUS SAVE AND CONTINUE

Addresses Required Fields (4)

Pay to

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

Same as Service Location

Same as Service Location

Same as Service Location

Same as Service Location

CONTACT INFORMATION

* Last Name * First Name Middle Name Suffix Billing Agent Name

* Address Line 1 Address Line 2 * City * State

* ZIP Code/Postal Code * Country

Same as Service Location

Email Confirm Email

Phone Number

At least one Phone Number must be provided

Phone Type	Telephone Number	Extension	Edit
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5. Capacity:

SIA Test App

PROGRESS

1 General Information 2 Specialty 3 Service Location 4 Address 5 Capacity 6 Organization 7 Credentials 8 Provider Type 9 Other 10 Disclosure 11 Affidavits

12 Fee 13 MCO Consent 14 Agreement / Signoff

CANCEL PREVIOUS SAVE AND CONTINUE

Capacity

Capacity By Specialty

008 - Mental Diseases (Hospital)

CREATE NEW

State	County	Minimum/Enrollment Type	Maximum Medicaid Member Count	Edit
Kansas	Shawnee			

CANCEL PREVIOUS SAVE AND CONTINUE

6. Organization Details

Only the first 2 fields are required

Organization

Organizational Details

If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.
If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.

Organization Type

Tax Classification

Entities doing business in the State, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. For more information on the registration process, please go to the Secretary of State website at <https://sos.ks.gov/>

Registered with Secretary Of State Business Start Date

Incorporated Incorporation Date

Chain Affiliated

Operated by Management Company

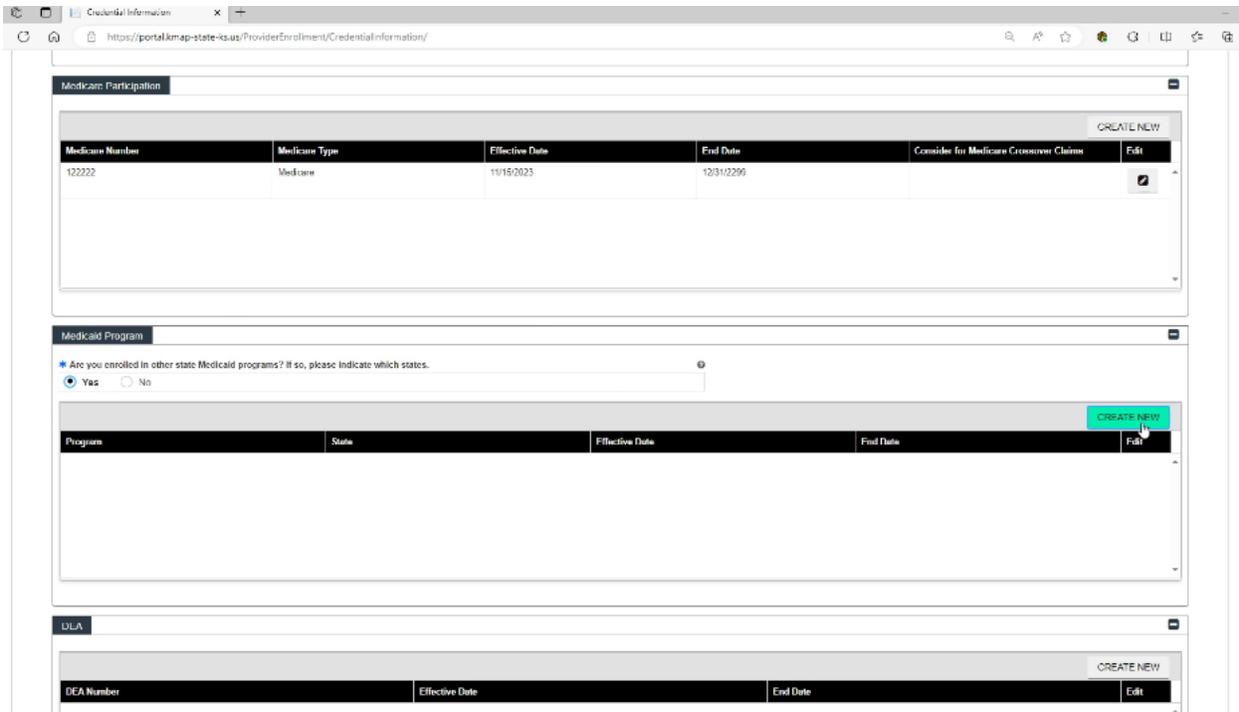
Domestic Owned Corporation

Foreign Owned Corporation

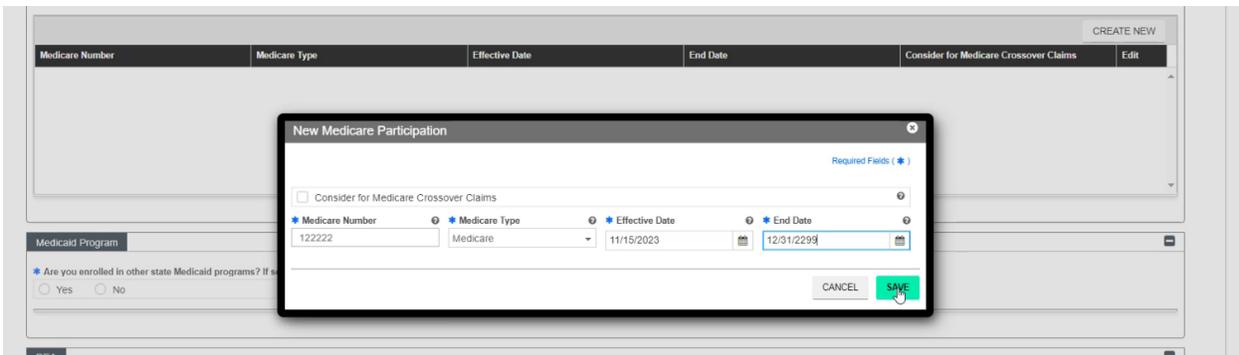
CANCEL PREVIOUS SAVE AND CONTINUE

7. Credentials

Medicaid Program



Medicare Participation is required.



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

Additional Information

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

Provider Website URL:

Malpractice Information

Please complete the malpractice information below.

New Malpractice Carrier Information

Required Fields (4)

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

Yes No

Another required question below:

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

Yes No

10. New provider self-disclosure.

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

PRIVACY ACT NOTICE STATEMENT

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

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

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

OWNERSHIP/CONTROLLING INTEREST

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

DISCLOSURE FORMS

Answer 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 provide the additional information that may be requested.

Disclosure Form	Status	Create New
Provider Self Disclosure	New	<input type="button" value="CREATE NEW"/>
Sub-Contractor Disclosure	New	<input type="button" value="CREATE NEW"/>
Ownership and Control Interest	New	<input type="button" value="CREATE NEW"/>
Managing Employees	New	<input type="button" value="CREATE NEW"/>
Business Transaction	New	<input type="button" value="CREATE NEW"/>

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

Attachment Details

CREATE NEW

12. Fees

Per CMS final rule 6026-F, state Medicaid programs must collect an application fee for new provider applications and reactivations due to being terminated for any reason. The following providers are exempt from the application fee:

- Individual providers or non-physician practitioners
- Providers who are enrolled with Medicare
- Providers who paid the application fee to either Medicare or another state Medicaid plan after March 25, 2011

The application 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 the applicant as incomplete after January 1, 2023 the new fee will be required.

If an application 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 returned to the provider requesting proper payment.

Please Answer all questions. If you answer "NO" to all the questions below, then you must pay an application fee.

Application Fee Questions

Service Location - If the service location is enrolled in Medicare a fee payment is not required. Is this service location enrolled in Medicare?

1. Is the service location enrolled in Medicare? ?

Yes No

Date Enrolled ?

12 13 14 15 16 17 18
19 20 21 22 23 24 25
26 27 28 29 30 1 2
3 4 5 6 7 8 9

location has paid an application fee to another Medicaid program then a fee payment is not required.
 another state's Medicaid program for the service location? ?

Wednesday, November 15, 2023

Waiver Received - If you have received a waiver from the programs mentioned below a fee payment is not required.

3. Have you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship? ?

Yes No

Financial Hardship - If you are requesting a waiver for financial hardship, please submit a letter explaining the financial hardship along with your enrollment application, including proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as a loan denial.

4. Are you requesting a waiver of the application fee because of financial hardship? ?

Yes No

Amount Due

13. MCO Consent

MCO Consent

Add Consent

Aetna Better Health of KS Inc

I Agree

Title: [] Last Name: Doe First Name: John Middle Name: [] Date: 11/15/2023

Sunflower Health Plan

I Agree

Title: [] Last Name: Doe First Name: John Middle Name: [] Date: 11/15/2023

United Healthcare Community Plan

I Agree

Title: [] Last Name: Doe First Name: John Middle Name: [] Date: 11/15/2023

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

Submit

https://portal.kmap-state-ks.us/ProviderEnrollment/Submit/

I certify my signature, under my penalty of perjury that I am individual applying, or I am duly authorized by the individual applying to bind such person to the provider agreement and that I have read and understood the provider agreement & provider manuals & bulletins.

Signature

The Provider Agreement is now fully electronic. By selecting the "I Accept" box below you acknowledge that you understand your electronic signature binding to the same extent as your written signature.

I Accept

Title: [] Last Name: Doe First Name: John Middle Name: []

Comments

Verification Email ID: gregory.ear.green-4@gainwelltechnologies.com

Click on "Request Verification Code" button. An email will be sent to the verification email address listed above. Check your email and enter the code immediately before you leave the application or Submit page. The verification code will expire when the page is closed.

DO NOT NAVIGATE AWAY FROM PAGE

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

REQUEST VERIFICATION CODE

Verification Code: []

Submission Date: 11/15/2023

CANCEL PREVIOUS FINISH LATER SUBMIT

New Enrollment Verification Code

Kansas-Provider-Enrollment@gainwelltechnologies.com

Expires: 11/14/2025

Please use the following Verification code for provider, Test Location

Verification Code: 0

If your application has closed or you chose "Finish Later", this verification code will no longer be valid. To request a new code:

1. Return to the main menu
2. Select "Resume Enrollment"
3. Enter the ATN & Password
4. Click on "Agreements" at the top of the page and click "Request Verification Code"

If you are not the intended recipient, please contact the sender and destroy all copies and the original message.

If you have any questions, please contact KMAP Provider Enrollment at 1-800-933-6593.

Sincerely,
Kansas Medical Assistance Program

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

gainwell | gainwell technologies | medicare
Medicaid Management Solutions

Home | MENU | Provider Enrollment | Submit | Contact Us

Print

Submit Confirmation

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

Cover Sheet

Sincerely,
State Medical Assistance Program
apps@product@gainwelltechnologies.com
Contact us: 1-800-259-2999

DISCLAIMER | WEBSITE REQUIREMENTS | PRIVACY POLICY

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Kansas Medical Assistance Program
P.O. Box 3571 | Topeka, KS 66601-3571 | Provider Line: 1-800-933-6593 | Consumer Line: 1-800-766-9012
From the office of the Fiscal Agent



Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. BOX 3571
Topeka, KS 66601-3571

Tracking #: 7923540668

Date: 11/15/2023

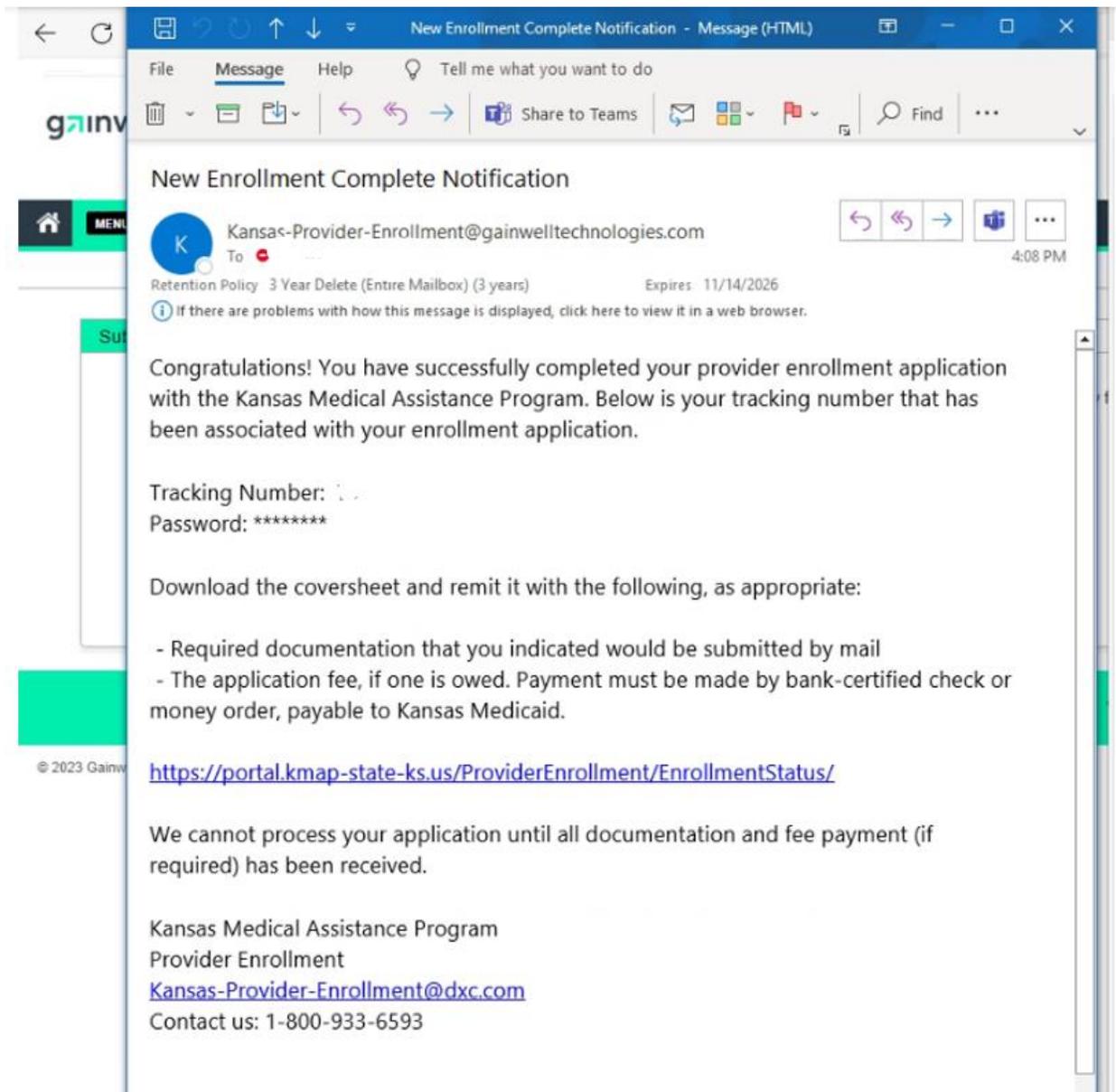
Contact :
John Doe
6500 SE FORBES AVE
TOPEKA, Kansas
United States 66619-1446

Enrollment form for the following provider:
John Doe
Test Location
6500 SE FORBES AVE
TOPEKA, Kansas
UNITED STATES-666191446

Listed below are the additional attachments necessary to successfully complete your enrollment as a KMAP provider. The information listed below must be sent along with your printed application cover sheet. Please include this letter as your cover sheet.

- * Section 12 Attestation/Consent and Release Form
- * Federal W-9 Form
- * Hospital License
- * Approval Letter from the Kansas Department for Aging and Disability Services.

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)