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# Puerto Rico Medicaid Management Information System

DEL\_PRMMIS\_Final\_User\_Documentation\_PEP\_Enrollment\_Group\_Ref\_Guide

## Provider Enrollment Portal (PEP) Enrollment Steps – Group

Phase Two Final User Documentation

Training Material – Reference Guide

Version 5.0

## Change History

Version #	Date	Modified By	Description
5.0	11/10/2023	Gainwell Technologies	R23-R26 Updates
4.0	05/12/2023	Gainwell Technologies	R19-R22 Updates
3.1	10/22/2021	Gainwell Technologies	Logo updated per CR 21-672
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# 1 Acronyms

The following table contains the list of abbreviations used within the text of this document. Acronyms found in images are not necessarily addressed unless the acronym is needed to complete the task.

**Note: This acronym list will not include all potential HIPAA-related transaction information.**

**Table 1 – Acronyms**

Acronyms	Definition
ATN	Application Tracking Number
DDE	Direct Data Entry
DEA	Drug Enforcement Administration
EDI	Electronic Data Interchange
EIN	Employee Identification Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
ID	Identifier
IRS	Internal Revenue Service
LMS	Learning Management System
MCD	Medicaid ID
NPI	National Provider Identifier
PDF	Portable Document Format
PEP	Provider Enrollment Portal
PHI	Protected Health Information
PII	Personally Identifiable Information
PRMMIS	Puerto Rico Medicaid Management Information System
PRMP	Puerto Rico Medicaid Program
RTP	Return to Provider
URL	Uniform Resource Locator

## 2 Overview

The **Provider Enrollment Portal (PEP) Enrollment Steps – Group Reference Guide** includes enrollment application instructions and notifications applicable to providers wishing to enroll in the Puerto Rico Medicaid Program (PRMP) using the Provider Enrollment Portal (PEP). In order to complete an application for enrollment as a Group in the PRMP, you must complete all required enrollment steps and submit your application for review.

This document may be used in conjunction with training sessions or as a stand-alone reference resource.

Training participants are assumed to have general familiarity with navigating the internet, using computers, and understanding terminology such as icon, desktop, folders, tabs, browsers, search, toolbars, menus, mouse, hyperlinks, printing options, and save options. It is recommended for participants to bring note-taking materials such as writing utensils, a notepad, highlighters, or sticky notes.

This document, along with other PEP training documents, is available in the Puerto Rico Medicaid Program (PRMP) Learning Management System (LMS). You can find it by going to the following link:

<https://lms.prmis.pr.gov>

After reading the **Provider Enrollment Portal (PEP) Enrollment Steps – Group Reference Guide**, Providers should be able to complete these learning objectives in PEP:

- Complete all required enrollment application steps
- Submit an enrollment application
- Understand the different notifications received from the Provider Enrollment Portal and the required actions to take

**Note: This training guide contains fictitious information and does not contain protected health information (PHI) or personally identifiable information (PII) data.**

### 3 New Enrollment Application

A new enrollment application displays after having completed the Enrollment Registration page.

To see the detailed steps for completing the Enrollment Registration page, refer to **Section 2.1** of the **Provider Enrollment Portal (PEP) Navigation Reference Guide**.

The Group enrollment type consists of two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment). All payments made are reported to the IRS against the group's EIN.

The Enrollment Process for a Group consists of multiple steps that must be completed in order to accept and submit an enrollment application.

Each step is discussed in the following sections, including the panels and fields that must be completed.

### 3.1 General Information

#### Quick Reference – General Information

Table 2 – General Information

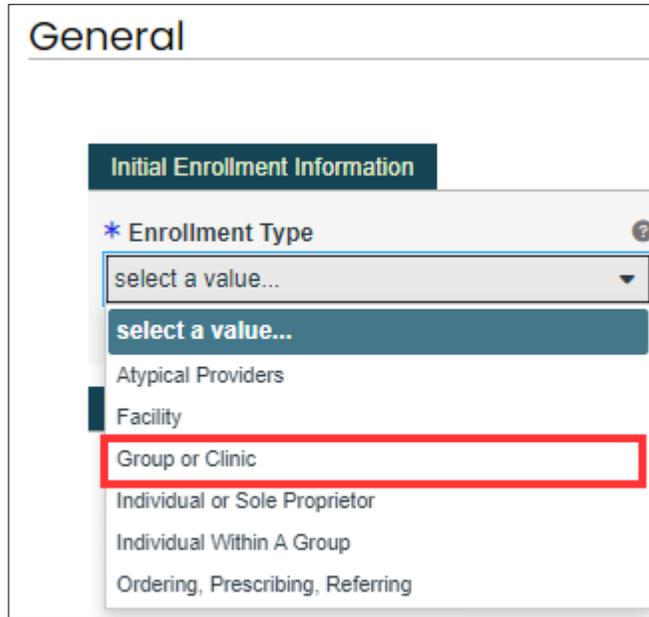
Step	Task	Action	Result
Start from the General Information page, the first step on a new enrollment application page.			
1	Select Enrollment Type.	Click the drop-down list under Enrollment Type and click Group or Clinic.	<ul style="list-style-type: none"> <li>a. Pop-up window displays, indicating that once the application is saved, the Enrollment Type cannot be changed.</li> <li>b. The required enrollment steps and a progress bar display at the top of the page.</li> </ul>
2	Select Provider Type.	Click the drop-down list under Provider Type and click the relevant Provider Type.	Pop-up window displays, indicating that once the application is saved, the Provider Type cannot be changed.
3	Add Effective Date.	Enter the date you wish the enrollment in PRMP to be effective.	Effective date is added
4	Add General Information.	Complete the rest of the General Information page, including: <ul style="list-style-type: none"> <li>a. Provider Information and related questions</li> <li>b. Contact Information</li> </ul> Click Save and Continue.	General Information is saved.  Progress bar advances to the next available page.

#### Detailed Steps

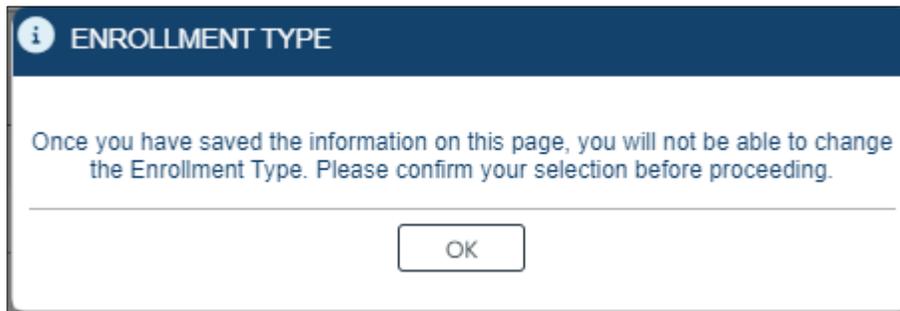
1. Once registration has been completed, the new enrollment application begins with the General Information page.

The screenshot shows the 'General Information' page in the Provider Enrollment Portal. At the top, there is a header for the Puerto Rico Medicaid Program. Below that, a tracking number '8057465962' is displayed. The main content area is titled 'General' and contains two tabs: 'Initial Enrollment Information' (active) and 'Provider Information'. Under the 'Initial Enrollment Information' tab, there are three dropdown menus: 'Enrollment Type' (with a note '\* Enrollment Type'), 'Provider Type' (with a note '\* Provider Type'), and 'Effective Date' (with a note '\* Effective Date' and a calendar icon). The 'Effective Date' field shows '11/03/2023'.

In the **Initial Enrollment Information** section, click the drop-down list under **Enrollment Type** and select the “**Group or Clinic**” option.



- a. Once an Enrollment Type is selected, a pop-up window displays, indicating that once the data on this page is saved, the Enrollment Type cannot be changed.



- b. The steps required to complete the enrollment for a Group will display at the top of the page, along with a progress bar to show your current progress.

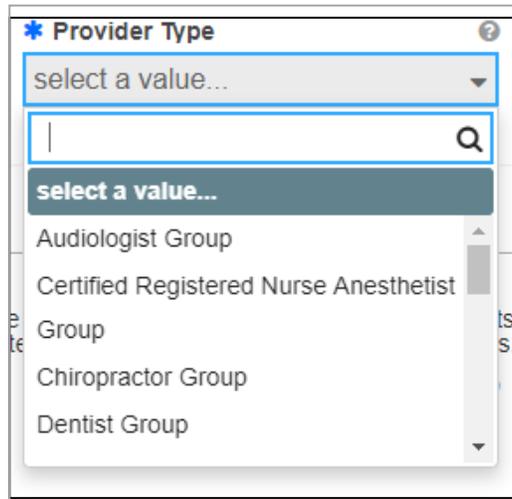




**DIFFERENT ENROLLMENT STEPS DISPLAYED:** *The steps displayed at the top of the screen may continue to change during the enrollment process as more information is entered in the application that dictate the remaining steps that are required.*

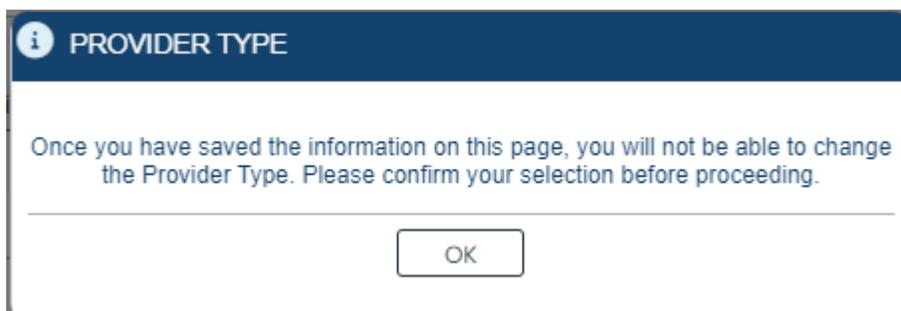
*Steps are determined to be required, optional, or non-applicable based on the Provider Type, Specialties, and other related information.*

2. Click the drop-down list under Provider Type and select the appropriate Provider Type for the Group that is enrolling. The Provider Types shown in the drop-down list are for the Group Enrollment Type.



**PROVIDER TYPE:** *The Provider Type drop-down list is dynamic based on the Enrollment Type selected. If you do not see your Provider Type in this list, verify that you have selected the correct Enrollment Type.*

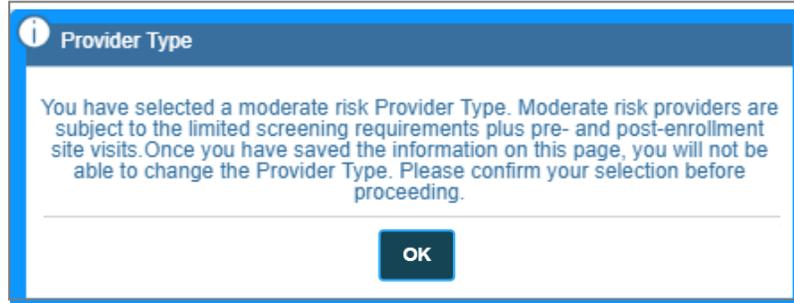
Once the Provider Type is selected, a pop-up window displays, indicating that once the data on this page is saved, the Provider Type cannot be changed.





**PROVIDER RISK:** Depending on the Provider Type chosen, the provider's risk level (limited, moderate, or high) and the additional steps that the provider must take in addition to the enrollment will be displayed in the generated pop-up window.

Example of Provider Type pop-up window with provider risk level disclosed:



3. In the **Effective Date** field, select the date (or leave the default) you wish the enrollment in PRMP to be effective once approved.



**NOTE:** Retroactive enrollment dates will only be considered for approval up to 90 days in the past.

4. Complete the sections of the General information page.
  - a. **Provider Information and related questions** – Identifies information about the provider applying for PRMP enrollment.

For a Group, this section displays business-related fields.



**NOTE:** Characters with accents are not accepted within PEP fields. If you are using your browser's auto-fill settings, verify that the information in the application's fields is correct before saving.

Answer the questions that display at the bottom of the **Provider Information** section. Answer the **“Are you currently enrolled as a Provider?”** and **“Were you previously enrolled as a provider?”** based on the appropriate scenario.

i. **New Enrollment:**

- If you have never been approved for enrollment in PRMP through PEP.

**Answer No to the currently enrolled and previously enrolled questions.**

Are you currently enrolled as a Provider?  Yes  No

Were you previously enrolled as a Provider?  Yes  No

ii. **Additional Enrollment:**

- If you have been approved for enrollment in PRMP through PEP,  
AND
- If you are currently active in the PRMP,

**These steps are most common if you are:**

- Adding a new Primary Service Location that was not previously included in your PEP enrollment application. This is most common if you open a new location after your initial enrollment.

OR

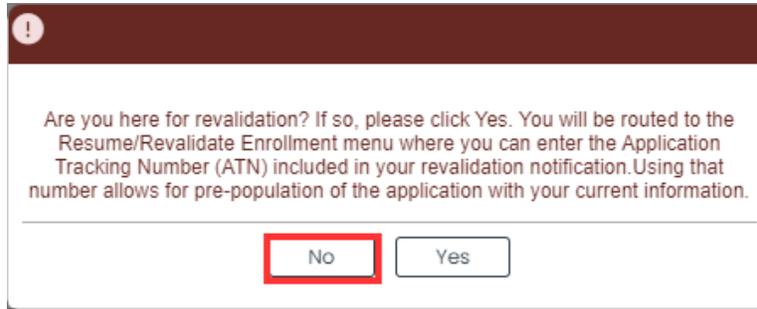
- Applying with a different Enrollment Type.

Please note that if you are applying with more than one Enrollment Type, you must **wait for your first enrollment application to be approved** before submitting your second application. You will need the provider identification number generated when your first enrollment application is approved in order to complete these steps.

Select **Yes** for the currently enrolled question.

Are you currently enrolled as a Provider?  Yes  No

Click **No** in the displayed revalidation pop-up window.



You will be prompted to enter your Current Provider Identifier. This is the Medicaid Identifier (MCD) that was listed in your Welcome Letter and is associated with your previously approved PEP enrollment application. If you have multiple service locations, enter the MCD for any active service location. The one ending in "00" is the primary service location and is preferred.

A form with two sections. The first section is titled "Are you currently enrolled as a Provider?" and has two radio buttons: "Yes" (selected) and "No". The second section is titled "Current Provider Identifier" and has a text input field.

Select **No** for the previously enrolled question.

A form titled "Were you previously enrolled as a Provider?" with two radio buttons: "Yes" and "No" (selected).

iii. **Revalidation (Currently Active):**

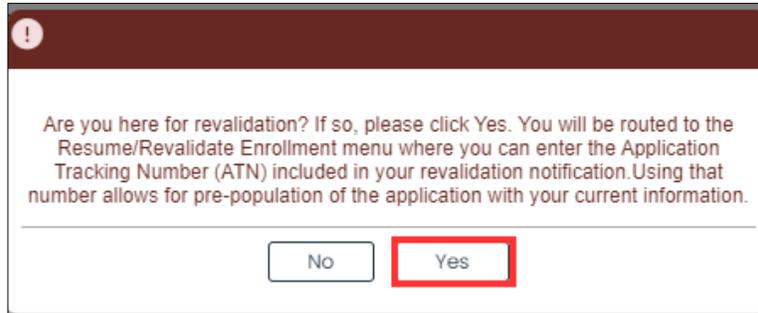
- If you were previously approved for enrollment in PRMP through PEP,  
AND
- If you are currently active in the PRMP,  
AND
- You received a letter requesting you to revalidate your enrollment.

The letter will include your ATN from your previously approved enrollment application; the ATN will be used to auto-populate data in your revalidation enrollment application.

Select **Yes** for the currently enrolled question.

A form titled "Are you currently enrolled as a Provider?" with two radio buttons: "Yes" (selected) and "No".

Click **Yes** in the displayed revalidation pop-up window.



Are you here for revalidation? If so, please click Yes. You will be routed to the Resume/Revalidate Enrollment menu where you can enter the Application Tracking Number (ATN) included in your revalidation notification. Using that number allows for pre-population of the application with your current information.



**NOTE:** If Yes is clicked in the revalidation pop-up window, you will be taken to the Resume/Revalidate Enrollment menu option. This option is discussed in **Section 2.4 of the Provider Enrollment Portal (PEP) Navigation Reference Guide**.

iv. **Reenrollment (Currently Inactive):**

- If you were previously approved for enrollment in PRMP through PEP,  
AND
- If you were terminated and are now inactive in the PRMP.

You must apply for reenrollment. Select No for the currently enrolled question and Yes for the previously enrolled question.

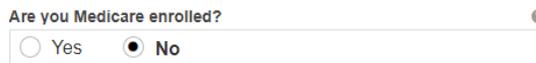


Are you currently enrolled as a Provider?  Yes  No

Were you previously enrolled as a Provider?  Yes  No

When you select **Yes**, you will be prompted to enter your Previous Provider Identifier. This is the Medicaid Identifier (MCD) that was listed in your Welcome Letter and is associated with your previously approved PEP enrollment application. If you have multiple service locations, enter the MCD for any active service location. The one ending in “00” is the primary service location and is preferred.

Answer the remaining question that asks if you are Medicare enrolled.



Are you Medicare enrolled?  Yes  No

- b. **Contact Information** – Enter contact information for the person responsible for addressing any application-related questions.

Provider Enrollment Portal (PEP) Enrollment Steps – Group

Contact Information

Title  \* Last Name  Second 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 Ext...  Fax Number

\* Email Address  \* Confirm Email

\* Preferred Communication



**VALID ADDRESS:** The PEP system will validate the address entered. If there is an updated variation, select that address from the pop-up window that displays.

Search Address

Number	Street	City	County	State	Country	ZIP Code
735	AVE PONCE DE LEON	SAN JUAN	SAN JUAN	PR	UNITED STATES	00917-5022

Address is found to be invalid, the following pop-up screen displays:

! ADDRESS CONFIRMATION

Address is invalid. Do you want to continue?

---

Please note that addresses will only be validated by USPS if they are entered in the following order: In the first line add the building or house number followed by the street name and/or number, and in the second line add the housing, neighborhood or county name.

*Example of a valid address: 735 Ave Ponce de León Suite 710*

*Torre Hospital Auxilio Mutuo  
San Juan PR 00917-5030*

*Example of an invalid address: Torre Hospital Auxilio Mutuo*

*735 Ave Ponce de León Suite 710  
San Juan PR 00917-5030*

Click **Save and Continue** at the bottom-right to save the General information page.

The screenshot shows a 'Contact Information' form with the following fields and values:

- Title: [Empty]
- Last Name: [Empty]
- Second Last Name: [Empty]
- First Name: [Empty]
- Middle Name: [Empty]
- Suffix: [Empty]
- Address Line 1: [Empty]
- Address Line 2: [Empty]
- City: SAN JUAN
- State: Puerto Rico
- Country: United States
- ZIP Code/Postal Code: 00917-5030
- Phone Type: Work
- Telephone Number: [Empty]
- Telephone Number Extension: [Empty]
- Fax Number: [Empty]
- Email Address: [Empty]
- Confirm Email: [Empty]
- Preferred Communication: select a value...

Buttons: Cancel (bottom-left), Save and Continue (bottom-right, highlighted with a red border).



**NOTE:** *If you exit your enrollment application before submitting it, the information you had previously saved will be retained and you may resume your enrollment where you left off.*

*If you wish to exit your enrollment application without saving the information you have added to the page, click the Cancel button on the bottom left corner of the page.*

A screenshot of a web form. At the top, there is a label "\* Preferred Communication" in blue text, followed by a question mark icon. Below this is a dropdown menu with the text "select a value..." and a downward-pointing arrow. Below the dropdown menu is a rectangular button with the text "Cancel" inside. The "Cancel" button is highlighted with a red rectangular border.

## 3.2 Specialties

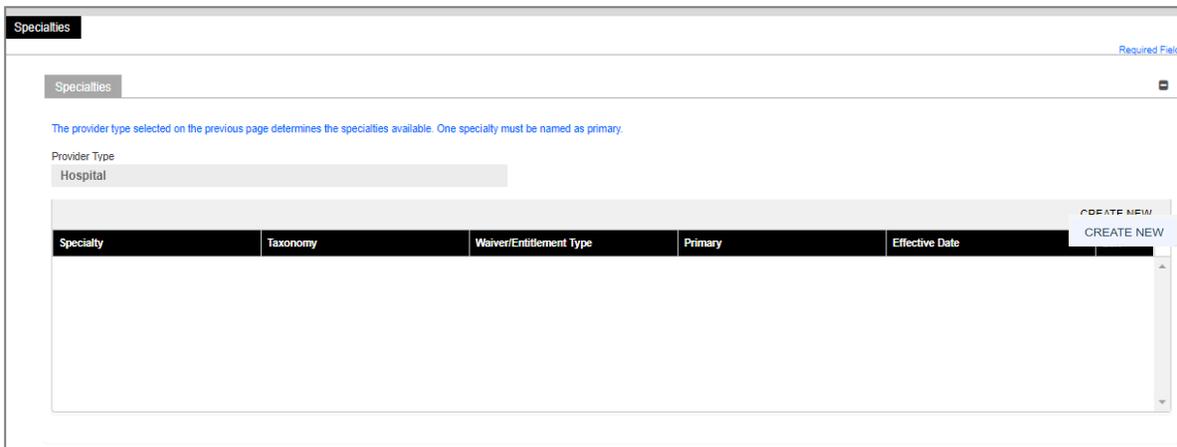
### Quick Reference – Specialties

Table 3 – Specialties

Step	Task	Action	Result
Start from Specialties page. This page displays after clicking Save and Continue from the previous page.			
1	Add one or more Specialties.	a. To add a new specialty, click Create New. Once saved, the specialty information will be displayed. b. To edit a specialty, click the Edit button next to the desired specialty and save the changes.	Specialties are added.
2	Add Additional Taxonomies (if applicable).	a. To add a taxonomy, click Create New at the top-right of the panel. Once filled out and saved, the taxonomy displays in the panel. b. To edit an added taxonomy, click the Edit button next to the desired taxonomy and save the changes.  Click Save and Continue.	Additional Taxonomies are added.  Progress bar advances to the next available page.

### Detailed Steps

1. The Specialties page is displayed. The Provider Type selected on the General Information page is displayed at the top of the **Specialties** section.



1. To add a specialty, click **Create New** at the top right of the **Specialties** section and complete the required fields in the pop-up window displayed.

The screenshot shows a table header with columns: Specialty, Taxonomy, Primary, Effective Date, and Edit. A red box highlights the 'Create New' button in the top right corner. Below the table is a 'New Specialty' pop-up window. The window contains a 'Make Primary' checkbox, and three required fields: 'Specialty' (dropdown), 'Taxonomy' (dropdown), and 'Effective Date' (calendar icon). 'Cancel' and 'Save' buttons are at the bottom right.

Once saved, the specialty displays in the window.

Specialty	Taxonomy	Waiver/Entitlement Type	Primary	Effective Date	Edit
901-General Hospital	282N00000X-General Acute Care Hospital		x	11/15/2018	



**PRIMARY SPECIALTY REQUIRED:** You must have one Primary Specialty in order to Save and Continue to the next step. To make a Specialty “Primary,” check the Make Primary checkbox in that specific specialty.

**New Specialty**

**Make Primary** ?

- a. To edit an added specialty, click the **Edit** button next to the desired specialty and save the changes.

Specialty	Taxonomy	Waiver/Entitlement Type	Primary	Effective Date	Actions
901-General Hospital	202H00000X-General Acute Care Hospital		x	11/15/2018	<a href="#">CREATE NEW</a> <a href="#">EDIT</a>

- 2. Related taxonomies can be added and edited in the **Additional Taxonomies** section of the Specialties page.

**Additional Taxonomies** -

Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty.

[Create New](#)

Taxonomy	Edit

- a. To add a new taxonomy, click **Create New** at the top-right of the Additional Taxonomies panel.

**Additional Taxonomies** -

Additional taxonomy codes may be added below. The taxonomy codes will not be associated with a specialty.

[Create New](#)

Taxonomy	Edit

**New Taxonomy** x

Required Fields ( \* )

\* Taxonomy ?

select a value...

[Cancel](#)
[Save](#)

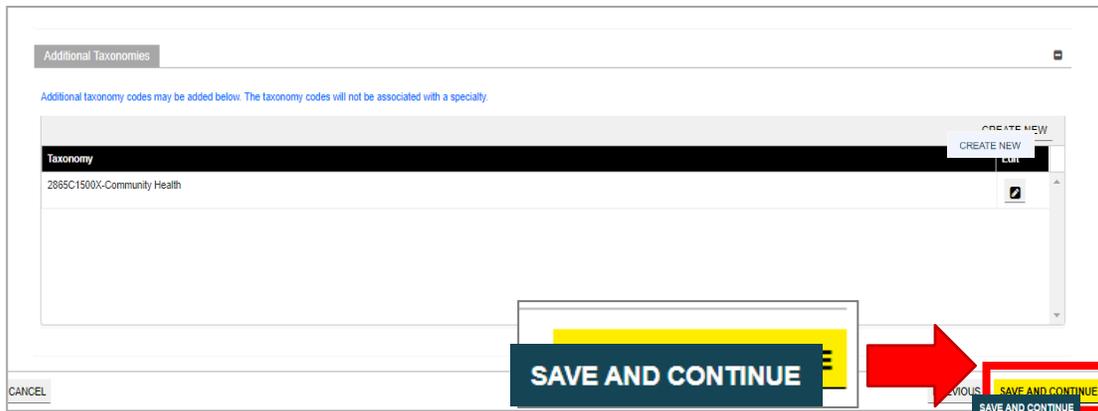
Once a taxonomy is selected from the **Taxonomy** drop-down list and saved, the taxonomy displays in the panel.



- b. To edit an added taxonomy, click the Edit button next to the desired taxonomy and save the changes.



Click **Save and Continue** at the bottom-right to save the Specialties page.



### 3.3 Service Location

#### Quick Reference – Service Location

Table 4 – Service Location

Step	Task	Action	Result
Start from the Service Location page. This page displays after clicking Save and Continue from the previous page.			
1	Add Service Location.	<ul style="list-style-type: none"> <li>a. To add a new Service Location, click Create New and complete the required address fields in the displayed pop-up window.</li> <li>b. Click Save to add this information.</li> <li>c. To edit an added Service Location, click the Edit button next to the desired taxonomy and save the changes.</li> </ul> <p>Click Save and Continue.</p>	<p>Service Location page is saved.</p> <p>Progress bar advances to the next available page.</p>

#### Detailed Steps

1. Service Location page is displayed.

The screenshot shows a web interface titled "Service Location". At the top right, there is a link for "Required Fields (\* )". Below the title is a dark blue header bar with "Service Location" and a minus sign icon. Underneath is a light grey bar containing a "Create New" button. The main content area features a table with the following columns: "Location ...", "Address L...", "Address L...", "City", "State", "Primary", and "Edit". The table body is currently empty. At the bottom of the page, there are three buttons: "Cancel", "Previous", and "Save and Continue".

- a. To add a Service Location, click **Create New** and complete the required address fields in the displayed pop-up window:

The screenshot shows a 'Service Location' pop-up window. At the top right, there is a link for 'Required Fields (\* )'. Below this is a header bar with 'Service Location' and a minus sign icon. A 'Create New' button is highlighted with a red box. Below the header is a table with columns: 'Location ...', 'Address L...', 'Address L...', 'City', 'State', 'Primary', and 'Edit'. The table is currently empty. At the bottom of the window are three buttons: 'Cancel', 'Previous', and 'Save and Continue'.

This screenshot shows the 'Service Location' pop-up window with a 'CREATE NEW' button highlighted by a red box. A red arrow points from this button to a modal window that also contains a 'CREATE NEW' button. The table in the background has columns: 'Location Name', 'Address Line 1', 'Address Line 2', 'City', 'State', 'Primary', and 'Edit'. At the bottom of the window are three buttons: 'CANCEL', 'PREVIOUS', and 'SAVE AND CONTINUE'.

**Service Location Name and Contact Information – Complete the required fields.**

**New Service Location** Required Fields ( \* )

Make Primary ?

Please complete all the required fields under the Service Location address. This will allow you to copy the address to the other address types. Note that copied addresses cannot be edited.

\* Location Name ?

Contact Information

\* Last Name ?    Second Last Name ?    \* First Name ?    Middle Name ?    Suffix ?

\* Address Line 1 ?    Address Line 2 ?    \* City ?

\* State ?    \* ZIP Code/ ... ?    Location Code ?    County ?    \* Country ?

Email ?    Confirm Email ?



**PRIMARY SERVICE LOCATION:** A primary service location is required in order to Save and Continue to the next enrollment step.

Check the “Make Primary” box when adding a new Service Location to mark it as your primary location.

**New Service Location** Required Fields ( \* )

Make Primary ?

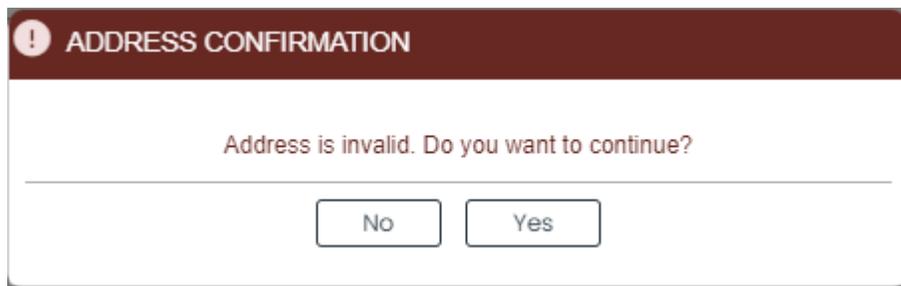
Please complete all the required fields under the Service Location address. This will allow you to copy the address to the other address types. Note that copied addresses cannot be edited.



**VALID ADDRESS:** The PEP system will validate the address entered. If there is an updated variation, select that address from the pop-up window that displays.

Search Address						
Number	Street	City	County	State	Country	ZIP Code
735	AVE PONCE DE LEON	SAN JUAN	SAN JUAN	PR	UNITED STATES	00917-5030

Address is found to be invalid, the following pop-up screen displays:



*Please note that addresses will only be validated by USPS if they are entered in the following order: In the first line add the building or house number followed by the street name and/or number, and in the second line add the housing, neighborhood or county name.*

*Example of a valid address: 735 Ave Ponce de León Suite 710*

*Torre Hospital Auxilio Mutuo*

*San Juan PR 00917-5030*

*Example of an invalid address: Torre Hospital Auxilio Mutuo*

*735 Ave Ponce de León Suite 710*

*San Juan PR 00917-5030*

**Phone Number** – Add a phone number related to your service location.

Phone Number			
At least one Phone Number must be provided.			
			<a href="#">Create New</a>
Phone Type	Telephone Number	Extension	Edit

To add a service location phone number, click **Create New** and complete the required fields in the displayed pop-up screen.

Phone Number			
At least one Phone Number must be provided.			
			<a href="#">Create New</a>
Phone Type	Telephone Number	Extension	Edit

**New Phone Number** ✕

Required Fields ( \* )

\* Phone Type ? \* Telephone Number ? Telephone Number Exten... ?

Once the information is saved, the phone number displays in the relevant panel.

Phone Number			
At least one Phone Number must be provided.			
			<a href="#">Create New</a>
Phone Type	Telephone Number	Extension	Edit
Work	787-882-5581		

To edit an added service location phone number, click the **Edit** button next to the phone number and save the changes.

Phone Number			
At least one Phone Number must be provided.			
			<a href="#">Create New</a>
Phone Type	Telephone Number	Extension	Edit
Work	787-882-5581		

Please enter your service location hours of operation

\*  Hours of Operation ?

\* Is the service location ADA compliant? ?

Yes  No

\* Is the service location accessible by public tra... ?

Yes  No

\* What are your after-hour arrangements? ?

Phone Type ? Emergency Phone ... ? Extension ?

select a ▼

**Service Location Hours** – Disclose the Service Location’s hours of operation. Check the box next to **Hours of Operation**.

In the new Hours of Operation panel that displays, add hours of operation by clicking **Create New** and complete the required fields in the displayed pop-up window.

Please enter your service location hours of operation

\*  Hours of Operation ?

**Hours of Operation** [-]

**Create New**

Day	From Hour	To Hour	Edit
-----	-----------	---------	------

**New Hours Of Operation** [x]

Required Fields ( \* )

\* Day ? \* From Hour ? \* To Hour ?

select a value... select a value... select a value...

Cancel **Save**

Once the information is saved, the hours of operation display in the relevant panel.

**Hours of Operation** [-]

Create New

Day	From Hour	To Hour	Edit
EveryDay	24 Hours		

To edit the hours of operation, click the **Edit** button next to the desired hours and save the changes.

**Hours of Operation** [-]

Create New

Day	From Hour	To Hour	Edit
EveryDay	24 Hours		

Answer the questions regarding your service location hours by selecting or typing in the relevant answer.

**\* Is the service location ADA compliant?** ?

Yes  No

**\* Is the service location accessible by public transportatio...** ?

Yes  No

**\* What are your after-hour arrangements?** ?

Phone Type ? Emergency Phone Number ? Extension ?

**Service Address Information** – Complete the fields underneath the Service Address Information.

### Service Address Information

Accepting New Patients with Special Needs ?

Age Restrictions ?

**\* Accepting New Patients** ?

**\* Preferred Patient Gender** ?

- b. Once all sections of the pop-up window are completed, click **Save** at the bottom of the window.

### Service Address Information

Accepting New Patients with Special Needs ?

Age Restrictions ?

**\* Accepting New Patients** ?

select a value...

**\* Preferred Patient Gender** ?

select a value...

Cancel
Save

Once the information is saved, the service location displays in the relevant panel.

### Service Location Required Fields ( \* )

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	735 AVE PONCE DE LEON		SAN JUAN	Puerto Rico	x	

Cancel
Previous
Save and Continue



**MULTIPLE SERVICE LOCATIONS:** Based on the application Provider Type, you may be able to add more than one service location on this application.

If the Create New button is disabled after entering one Service Location, this means only one is allowed.

Follow the previous steps to add multiple service locations to your application if applicable.

The multiple service locations that are added must have the same Name, Provider Type, Tax ID, NPI, and Primary Specialty, and the same information in fields related to these sections. The Addresses of these locations must be different.

- c. To edit an added Service Location, click the **Edit** button next to the desired location and save the changes.

Service Location Required Fields ( \* )

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	735 AVE PONCE DE LEON		SAN JUAN	Puerto Rico	x	

Click the **Save and Continue** button at the bottom right to save the Service Location page.

Service Location Required Fields ( \* )

Location Name	Address Line 1	Address Line 2	City	State	Primary	Edit
Hospital	735 AVE PONCE DE LEON		SAN JUAN	Puerto Rico	x	

### 3.4 Addresses

#### Quick Reference – Addresses

Table 5 – Addresses

Step	Task	Action	Result
Start from the Addresses page. This page displays after clicking Save and Continue from the previous page.			
1	Add Addresses to enrollment application.	Complete the required fields in all address types presented.	Addresses are added to the enrollment application.
2	Add a Phone Number to each Address type.	<ul style="list-style-type: none"> <li>a. Click Create New to add at least one phone number.</li> <li>b. To edit an existing phone number, click the Edit button next to the desired number and save the changes.</li> <li>c. Click Save and Continue.</li> </ul>	<p>A phone number is added to each Address type. Address information is saved.</p> <p>Progress bar advances to the next available page.</p>

#### Detailed Steps

1. The Addresses page is displayed. Complete the fields that display below the Service Address Information:

*Example: Pay To Address*

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

\* Location Name

---

**CONTACT INFORMATION**

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

\* Address Line 1    Address Line 2    \* City    \* State

\* ZIP Code/ Postal C...    \* Country

Same as Service Location

Email    Confirm Email

*Example: Mail To Address*

Mail To

You may enter the Mail To address only after completing all the required fields for the Service Location address.

Same as

Location Name

---

**CONTACT INFORMATION**

Last Name    Second Last Name    First Name    Middle Name    Suffix

Address Line 1    Address Line 2    City    \* State

ZIP Code/ Postal Code    \* Country



**ADDRESS SAME AS SERVICE LOCATION:** *If the addresses to be entered in this section are the same address as the Primary Service Location, click the “Same as Service Location” checkbox at the top of each Address type section. This will automatically fill the Address with the same information entered as the primary Service Location on the Service Location page.*

**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 ?

For some Address types, you could see a drop-down list at the beginning named “Same As”. The drop-down list will include all address types you have entered up to this point (example: Service Location, Pay To, etc.). This will automatically complete the Address fields with the same information previously entered for the chosen address type.

**Same as** ?

select a value... ▼

select a value...

Service Location

Pay To

2. Add phone numbers to the Address step of your enrollment.

**Phone Number**

At least one Phone Number must be provided.

Create New

Phone Type	Telephone Number	Extension	Edit

- a. To add a phone number, click **Create New** at the top-right of the **Phone Number** section and complete the required fields in the displayed pop-up window.

**Phone Number**

At least one Phone Number must be provided.

Create New

Phone Type	Telephone Number	Extension	Edit

Once the information is saved, the phone number displays in the relevant panel.

Create New			
Phone Type	Telephone Number	Extension	Edit
Home	787-882-5581		

- b. To edit an added address phone number, click the **Edit** button next to the phone number and save the changes.

Create New			
Phone Type	Telephone Number	Extension	Edit
Home	787-882-5581		



*Like the Addresses, phone numbers added to a Service Location can be carried over by clicking the Same as Service Location checkbox near the Phone Number panel.*

 Same as Service Location 

- c. Click **Save and Continue** at the bottom-right to save the Addresses page.

## Provider Enrollment Portal (PEP) Enrollment Steps – Group

**Phone Number**

At least one Phone Number must be provided.

Create New

Phone Type	Telephone Number	Extension	Edit
Work	787-882-5581		

Cancel Previous **Save and Continue**

### 3.5 Capacities

The Capacity page is presented if the Provider Type and Specialty disclosed in previous steps requires capacity information to be entered. If this page is not available on your application, you can continue to [Section 3.6 Organization](#) to see the instructions for your next required step.

### 3.6 Quick Reference – Capacities

Table 6 – Capacities

Step	Task	Action	Result
Start from the Capacity page. This page displays after clicking Save and Continue from the previous page.			
1	Add Capacity information.	<ul style="list-style-type: none"> <li>a. To add capacity information, click Create New and complete the required fields in the displayed pop-up window. Once the information is saved, the capacity information is displayed.</li> <li>b. To edit added capacity information, click the Edit button next to the desired capacity entry and save the changes.</li> <li>c. Click Save and Continue.</li> </ul>	<p>Capacity information is added and saved.</p> <p>Progress bar advances to the next available page.</p>

#### Detailed Steps

1. The Capacity page displays. A capacity is the maximum Medicaid Member count for each of a provider’s Specialties within the County and State.

The screenshot shows the 'Capacity' page in the PEP. At the top, there's a search bar with '962 - Optometrist' entered. Below the search bar is a 'CREATE NEW' button. A table displays capacity information with the following columns: State, County, Waiver/Entitlement Type, Maximum Medicaid Member Count, and Edit. The table contains one row: Puerto Rico, Isabela Municipio, (blank), (blank), and an edit icon. At the bottom of the page, there are three buttons: CANCEL, PREVIOUS, and SAVE AND CONTINUE.

To add a new capacity, click **Create New** and complete the required fields in the displayed pop-up window.

The screenshot shows a 'Capacity' panel with a table. The table has columns for State, County, Waiver/Entitlement Type, and Maximum Medicaid Member Count. One row is visible with State 'Puerto Rico' and County 'Isabela Municipio'. A red box highlights a 'CREATE NEW' button in the top right corner of the table area, with a red arrow pointing down to a larger 'CREATE NEW' button at the bottom right of the panel. Other buttons include 'CANCEL', 'PREVIOUS', and 'SAVE AND CONTINUE'.

The screenshot shows a 'New Capacity' pop-up window. It contains three required fields: State (dropdown), County (dropdown), and Maximum Medicaid Member Count (text input). The State and County dropdowns show 'select a value...'. Buttons for 'CANCEL' and 'SAVE' are at the bottom right.

Once the information is saved, the capacity displays in the relevant panel.



**CAPACITY ALREADY DISPLAYED:** Some enrollments show a partially completed capacity entry already added in the Capacity panel, based on the service location address and specialty. You will still need to edit the existing capacity entry to supply the Maximum Medicaid Member Count.

See the next step for instructions on editing a capacity.

- a. To edit an added capacity information, click the **Edit** button next to the desired capacity entry and save the changes.

Provider Enrollment Portal (PEP) Enrollment Steps – Group

Capacity

Capacity By Specialty

962 - Optometrist

State	County	Waiver/Entitlement Type	Maximum Medicaid Member Count	Edit
Puerto Rico	Isabela Municipio			

CANCEL PREVIOUS SAVE AND CONTINUE

Edit Capacity

Required Fields ( \* )

\* State Puerto Rico

\* County select a value...

\* Maximum Medicaid Member Count

REMOVE CANCEL SAVE

- b. Click **Save and Continue** at the bottom-right to save the Capacity page.

Capacity

Capacity By Specialty

962 - Optometrist

State	County	Waiver/Entitlement Type	Maximum Medicaid Member Count	Edit
Puerto Rico	Isabela Municipio			

CANCEL PREVIOUS SAVE AND CONTINUE

### 3.7 Organization

#### Quick Reference – Organization

Table 7 – Organization

Step	Task	Action	Result
Start from the Organization page. This page displays after clicking Save and Continue from the previous page.			
1	Add Organizational Details.	a. Complete the required and relevant fields in the Organizational Details section. b. Click Save and Continue.	Organizational Details are saved. Progress bar advances to the next available page.

#### Detailed Steps

1. The Organization page is displayed.
  - a. Complete the required and relevant fields in the **Organizational Details** section.

Organization Required Fields (\*)

**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 ?  
 select a value... ▼

\* Tax Classification ?  
 select a value... ▼

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://www.estado.pr.gov/>

Registered with Secretary Of State ?

Incorporated ?

Chain Affiliated ?

Operated by Management Company ?

Domestic Owned Corporation ?

Foreign Owned Corporation ?

Business Start Date ?  
 📅

Incorporation Date ?  
 📅

Cancel
Previous
Save and Continue



**ORGANIZATIONAL DETAILS:** *The organizational details added in this page must match the information you disclose when filing your taxes.*

*If you have any questions regarding what information you enter in this step, consult your tax specialist.*

- b. Click **Save and Continue** at the bottom-right to save the Organization page.

Organization Required Fields (\*)

**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 ?  
select a value... ▼

\* Tax Classification ?  
select a value... ▼

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://www.estado.pr.gov/>

Registered with Secretary Of State ?  ?

Incorporated ?  ?

Chain Affiliated ?

Operated by Management Company ?

Domestic Owned Corporation ?

Foreign Owned Corporation ?

### 3.8 Associations

**NOTE:** The Associations page displays based on the Provider Type and Specialty disclosed in previous steps. If you intend to add Individual associations to your Group enrollment application, you will need their Puerto Rico Medicaid Program (PRMP) Provider Location ID or their National Provider Identifier (NPI) in order to complete this step. If needed, see the instructions in **Section 2.4** of the **Provider Enrollment Portal (PEP) Navigation Reference Guide** for resuming your enrollment application after it has started.

If the Associations page does not display in your enrollment application, it is not required for your Provider Type. You can continue to [Section 3.8 Credentials](#) to see the instructions for your next required step.

#### Quick Reference – Associations

Table 8 – Associations

Step	Task	Action	Result
Start from the Associations page. This page displays after clicking Save and Continue from the previous page.			
1	Add Individual Associations.	<ol style="list-style-type: none"> <li>a. Click Create New at the top-right of the Individual Association section.</li> <li>b. Type in the desired association’s Provider Location ID or NPI in the pop-up screen and click Search.</li> <li>c. Click the desired Association from the Search Results.</li> <li>d. Once the information is saved, the association information will be displayed.</li> </ol> Click Save and Continue.	Associations are saved.  Progress bar advances to the next available page.

#### Detailed Steps

The Associations page is displayed. **Group** enrollment types display an **Individual** Associations panel. This allows Groups to associate with already-enrolled Individual Within a Group providers.

2. To add a new Association, click **Create New** at the top right corner of the **Individual Association** section.

- a. Type in the desired association's Medicaid ID (MCD) in the Provider Location ID field or their NPI in the pop-up screen and click **Search**.



**ADDING ASSOCIATIONS:** Associations are limited to providers that are **already enrolled** in the Medicaid program. If a provider is not found with the entered search criteria, an error message displays indicating that an invalid Provider number was entered.

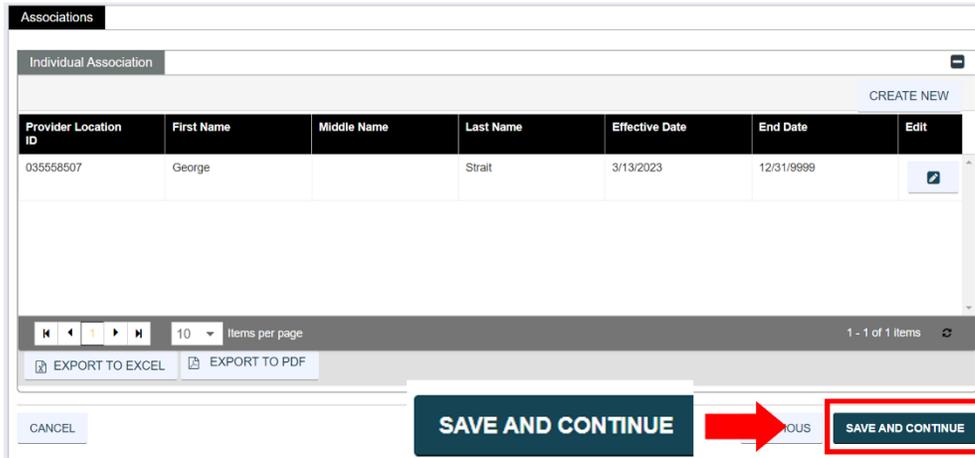
*If the provider that you want to associate with is not enrolled, please contact that provider directly.*

- b. Select the desired association from the Search Results. This will populate the New Group Association pop-up window with data from the selected association. Save the information once finished.

Once saved, the association information is displayed in the panel, and the options to **Export to Excel** or **Export to PDF** are activated.

Provider Location ID	First Name	Middle Name	Last Name	Effective Date	End Date	Edit
035558507	George		Strait	3/13/2023	12/31/9999	

- c. Click the **Save and Continue** button at the bottom right to save the Associations page.



### 3.9 Credentials

**NOTE:** The information collected on this page may differ depending on the Provider Type and Specialty chosen in previous enrollment steps.

#### Quick Reference – Credentials

Table 9 – Credentials

Step	Task	Action	Result
Start from the Credentials page. This page displays after clicking Save and Continue from the previous page.			
1	Add Credentials information.	Complete the required information for any of the following sections that are presented: <ul style="list-style-type: none"> <li>a. License</li> <li>b. Medicare Participation</li> <li>c. Medicaid Program</li> <li>d. DEA</li> <li>e. Puerto Rico Controlled Substance Certificate</li> </ul> Click Save and Continue.	Credentials are successfully added and saved.  Progress bar advances to the next available page.

#### Detailed Steps

1. The Credentials page is displayed. The credential information that may be collected for Group enrollments are shown below:
  - a. **License** – Add a license, in good standing, in the same state as the service location.

License					
					<a href="#">Create New</a>
License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit



**LICENSE:** Only add license information in this panel pertaining to medical licenses belonging to the provider being enrolled.

To add a new license, click **Create New** at the top-right of the **License** section and complete the required fields in the displayed pop-up window.

License					
License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit
					Create New

**New License** ✕

Required Fields ( \* )

\* License Number ? \* Issuing State ? \* Issuing Board ? \* Effective D... ? \* End Date ?

select a ▼
select a value... ▼
 📅
 📅



**ISSUING BOARD:** The Issuing Board information will come directly from the license that was issued by the appropriate Board, State, or Entity.

Once saved, the license will display in the relevant panel.

To edit an added license, click the **Edit** button next to the desired license and save the changes.

License					
License Number	Issuing State	Issuing Board	Effective Date	End Date	Edit
					Create New
8685747645	Puerto Rico	OTHER - OTHER	11/08/2023	11/08/2033	



**ADDING MULTIPLE LICENSES:** You can add more than one license to the License panel if needed.

Repeat the previous steps to add more licenses.

- b. **Medicaid Program** – Answer if you are enrolled in any other state Medicaid Program by selecting **Yes** or **No**.

**Medicaid Program**

\* Are you enrolled in other state Medicaid programs? If so, please indicate which states. ?

Yes
  No

If **Yes** is selected, a new panel opens for you to indicate which state(s) Medicaid Program you are currently enrolled in.

Click **Create New** at the top-right of the **Medicaid Program** section and complete the required fields in the displayed pop-up window.

Once the information is saved, the credentials will display in the relevant window.

To edit an added Medicaid Program entry, click the **Edit** button next to the desired entry and save the changes.

Medicaid Program

\* Are you enrolled in other state Medicaid programs? If so, please indicate which states. ?

Yes  No

Create New

Program	State	Effective Date	End Date	Edit
TEST	Puerto Rico	11/08/2023	11/08/2028	



**ADDING MULTIPLE RECORDS:** You can add more than one record to the Medicaid Program panel if needed.

Repeat the previous steps to add more records.

- c. **DEA** – Add Drug Enforcement Administration (DEA) number information.

To add a new DEA number, click **Create New** at the top-right of the **DEA** section and complete the required fields in the displayed pop-up window.

DEA

Create New

DEA Number	Effective Date	End Date	Edit
------------	----------------	----------	------

Create New

New DEA

Required Fields ( \* )

\* DEA Number ? \* Effective Date ? \* End Date ?

CANCEL SAVE

Once saved, the DEA license will display in the relevant panel.

To edit an added DEA number entry, click the **Edit** button next to the desired DEA number and save the changes.

DEA			
CREATE NEW			
DEA Number	Effective Date	End Date	Edit
AD0865937	3/14/2019	3/14/2025	

- d. **Puerto Rico Controlled Substance Certificate** – Indicate if you prescribe and/or dispense controlled substances in Puerto Rico by selecting **Yes** or **No**.

**Puerto Rico Controlled Substance Certificate (previously ASSMCA)**

Do you prescribe controlled substances in Puerto Rico? ?

Yes  No

Do you dispense controlled substances in Puerto Rico? ?

Yes  No

If **Yes** is selected for either question, a new section opens for you to add your Registration Number.

**Puerto Rico Controlled Substance Certificate (previously ASSMCA)**

Do you prescribe controlled substances in Puerto Rico?

Yes  No

CREATE NEW

Registration Number	Effective Date	End Date	Edit

Do you dispense controlled substances in Puerto Rico?

Yes  No

CREATE NEW

Registration Number	Effective Date	End Date	Edit

Click **Create New** at the top-right of the new section and complete the required fields in the displayed pop-up window.

Once the information is saved, the Registration Number information is displayed.

To edit an added Registration Number entry, click the **Edit** button next to the desired entry and save the changes.

Registration Number	Effective Date	End Date	Edit
AB123467	3/14/2019	3/14/2025	



**ADDING MULTIPLE RECORDS:** You can add more than one record to the Medicaid Program panel if needed.

Repeat the previous steps to add more records.

Once all credentials have been added, click **Save and Continue** at the bottom-right to save the Credentials page.

Provider Enrollment Portal (PEP) Enrollment Steps – Group

Puerto Rico Controlled Substance Certificate (previously ASSMCA)

Do you prescribe controlled substances in Puerto Rico?  
 Yes  No

CREATE NEW

Registration Number	Effective Date	End Date	Edit
AB123467	3/14/2019	3/14/2025	

Do you dispense controlled substances in Puerto Rico?  
 Yes  No

CREATE NEW

Registration Number	Effective Date	End Date	Edit
BB962151	3/14/2019	3/14/2025	

CANCEL **SAVE AND CONTINUE** **SAVE AND CONTINUE**

### 3.10 Provider Type

The information displayed on this page will be a different combination of panels, depending on the Provider Type and specialty chosen in previous enrollment steps.

#### Quick Reference – Provider Type

Table 10 – Provider Type

Step	Task	Action	Result
Start from Provider Type page displayed. This page displays after clicking Save and Continue from the previous page.			
1	Add Provider Type information.	Complete the required information for the panels displayed: a. Surety Bond  Click Save and Continue.	Provider Type information is added and saved.  Progress bar advances to the next available page.

#### Detailed Steps

1. The Provider Type page displays. Below are the Provider Type credentials that can be displayed for Group enrollments.
  - a. **Surety Bond** – Displays only for Home Health Agencies. Home Health Agencies are required to disclose their Medicaid surety bonds.

Complete the fields displayed in this section.

The screenshot shows a web form titled "Provider Type" with a sub-section "Surety Bond Information". Below the title, there is a note: "Enter surety bond information below. Medicaid surety bonds are required for Home Health Agencies. Medicare surety bond information is optional." The form contains three rows of input fields:

- Medicaid Surety Bond Number**: A text input field followed by "Effective Date" and "End Date" fields, each with a calendar icon.
- Medicare Surety Bond Number**: A text input field followed by "Effective Date" and "End Date" fields, each with a calendar icon.
- Accrediting Organization**: A dropdown menu with "select a value..." and "Effective Date" and "End Date" fields, each with a calendar icon.

At the bottom of the form, there are three buttons: "CANCEL", "PREVIOUS", and "SAVE AND CONTINUE".

Once all sections are completed in the page, click **Save and Continue** at the bottom-right to save the Provider Type page.

# Provider Enrollment Portal (PEP) Enrollment Steps – Group

**Provider Type**

**Surety Bond Information**

Enter surety bond information below. Medicaid surety bonds are required for Home Health Agencies. Medicare surety bond information is optional.

Medicaid Surety Bond Number	Effective Date	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare Surety Bond Number	Effective Date	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Accrediting Organization	Effective Date	End Date
<input type="text" value="select a value..."/>	<input type="text"/>	<input type="text"/>



### 3.11 Other

**NOTE:** The information collected on this page may differ depending on the Provider Type and Specialty chosen in previous enrollment steps.

#### Quick Reference – Other

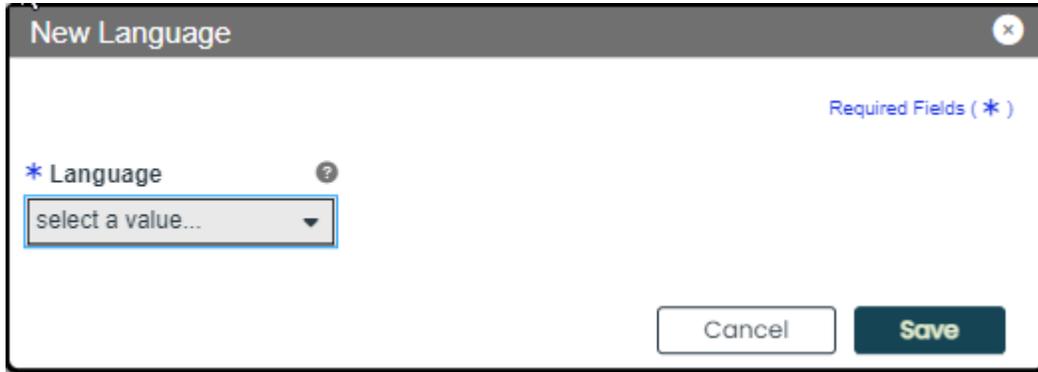
Table 11 – Other

Step	Task	Action	Result
Start from the Other page. This page displays after clicking Save and Continue from the previous page.			
1	Add Other information.	Complete the required information for any of the following sections that are presented: <ul style="list-style-type: none"> <li>a. Languages</li> <li>b. Certifications</li> <li>c. Additional Information</li> <li>d. Malpractice Carrier Information</li> <li>e. Malpractice Suit Information</li> </ul> Click Save and Continue.	Other information is added and saved.  Progress bar advances to the next available page.

#### Detailed Steps

1. The Other page is displayed. The other information that may be collected for Group enrollments are shown below.
  - a. **Languages** – To add a new language, click **Create New** at the top-right of the **Languages** section and select the applicable language from the **Languages** drop-down list in the pop-up window.





The image shows a 'New Language' pop-up window. At the top right, there is a close button (X) and a label 'Required Fields ( \* )'. The main content area contains a required field labeled '\* Language' with a question mark icon. Below the label is a dropdown menu with the text 'select a value...'. At the bottom right, there are two buttons: 'Cancel' and 'Save'.

Once the information is saved, the language information is displayed.



The image shows a table titled 'Languages'. Above the table, there is a message: 'At least one record is required. Provider cannot save and continue until a record is added.' The table has a 'Create New' button at the top right. The table has two columns: 'Language' and 'Edit'. The first row contains the text 'English' and an edit icon.

Language	Edit
English	

b. **Certifications** – To add a new certification, click **Create New** at the top-right of the **Certification** section and complete the required fields in the displayed pop-up window.



The image shows a table titled 'Certifications'. Above the table, there is a 'Create New' button highlighted with a red box. The table has several columns: 'Specialty', 'Certificate Type', 'Other Certificat...', 'Certification N...', 'Exempt from A...', 'Effective Date', 'End Date', and 'Edit'.

Specialty	Certificate Type	Other Certificat...	Certification N...	Exempt from A...	Effective Date	End Date	Edit
-----------	------------------	---------------------	--------------------	------------------	----------------	----------	------

### New Certification ✕

Required Fields ( \* )

**\* Specialty** ?

select a value...

Exempt from Accreditation ?

Certificate Type ?    Other Certification ?    Certification Number ?

select a value...

Effective Date ?    End Date ?

📅

📅

Cancel

Save

Once the information is saved, the certification information is displayed.

Certifications ☰

Specialty	Certificate Type	Other Certificat...	Certification N...	Exempt from A...	Effective Date	End Date	Edit
941-Non	Other	Medical Transport	5551234		11/08/2023	11/08/2033	<span style="border: 1px solid gray; padding: 2px 5px; font-size: x-small;">📄</span>

Create New

- c. **Additional Information** – Enter the **URL** for your provider website. This step is optional.

Additional Information ☰

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

**Provider Website URL** ?

- d.

- e. **Malpractice Carrier Information** – To add a new malpractice carrier information, click **Create New** at the top-right of the **Malpractice Information** section and complete the required fields in the displayed pop-up window.

Malpractice Information

At least one record is required. Provider cannot save and continue until a record is added.

Please complete the malpractice information below

**Create New**

Type of Carrier	Name of Carrier	Coverage Amo...	Coverage Amo...	Policy Number	Effective Date	End Date	Edit
-----------------	-----------------	-----------------	-----------------	---------------	----------------	----------	------

Once the information is saved, the carrier information displays in the relevant window.

Malpractice Information

At least one record is required. Provider cannot save and continue until a record is added.

Please complete the malpractice information below

**Create New**

Type of Carrier	Name of Carrier	Coverage Amo...	Coverage Amo...	Policy Number	Effective Date	End Date	Edit
Comprehensive General Liability	Triple M	2000000	500000	3675643205	11/08/2023	11/08/2025	

**Malpractice Suit Information** – Select **Yes** or **No** to answer the question regarding current and previous Malpractice suits.

If you click **No**, no additional information is needed.

Are you currently or have you within the last 5 years been involved in a malpractice suit or claim in which your care and treatment of a patient was an issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit?

Yes  No

If you select **Yes**, it is then necessary to provide information regarding current and previous malpractice suits. To add the suit information, click **Create New** at the top-right of the **Malpractice Suit** section.

Are you currently or have you within the last 5 years been involved in a malpractice suit or claim in which your care and treatment of a patient was an issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit?

Note: Enter all information in this panel, however, if you have a large volume of cases or claims, you may enter the most recent case in this section and then must include a detail document with a list of all other cases or claims within the 5-year period in the additional information tab / attachment section.

Yes  No

**Create New**

Patient Name	Policy Number	Your status in the ...	Claimant / Plaintiff ...	Status Claim	Edit
--------------	---------------	------------------------	--------------------------	--------------	------

Complete the required fields in the displayed pop-up window.

**New Malpractice Information** Required Fields ( \* )

\* Patient/Plaintiff Name ?  
 Patient Name  Plaintiff Name

\* Patient Name ?  
\_\_\_\_\_

\* Your Involvement in the Case ? \* Date of occurrence ? \* Your status in the Case ? \* Claim Date ?  
select a value... \_\_\_\_\_ select a value... \_\_\_\_\_

\* Liability carrier involved ? \* Carrier's phone number ? \* Policy Number ? \* Additional defendants ?  
\_\_\_\_\_

\* Describe the allegations against you ? \* Describe the alleged injury to the patient ?  
\_\_\_\_\_  
\_\_\_\_\_

\* Claimant / Plaintiff filed suit in court ?  
 Yes  No

Please enter either State or Federal Court Case Number but not both.

\* State Court Case Number ? \* State ? \* County ?  
\_\_\_\_\_ select a value... select a value...

\* Federal Court Case Number ? \* District ?  
\_\_\_\_\_

\* Status Claim ?  
select a value...

Once the information is saved, the malpractice suit information is displayed

## Provider Enrollment Portal (PEP) Enrollment Steps – Group

Once all sections of the page have been completed, click **Save and Continue** at the bottom-right to save the Other page.

Patient Name	Policy Number	Your status in the Case	Claimant / Plaintiff filed suit...	Status Claim	Edit
Tropical Punch	387648326	Co-Defendant	Yes	Pending	

Buttons: Cancel, Previous, **Save and Continue**

### 3.12 Disclosures

#### Quick Reference – Disclosures

Table 12 – Disclosures

Step	Task	Action	Result
Start from the Disclosures page. This page displays after clicking Save and Continue from the previous page.			
1	Complete Disclosure forms.	<p>a. Complete the disclosure forms displayed by clicking Create New next to each form.</p> <p>b. To edit or delete a form, click the desired form’s name and then the Edit button in the displayed pop-up window.</p> <p>Click Save and Continue once all forms are completed.</p>	<p>Disclosures are completed.</p> <p>Progress bar advances to the next available page.</p>

#### Detailed Steps

1. The Disclosure page lists the required forms that need to be completed.

**Disclosures**

**Disclosure Details**

**PRIVACY 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 Puerto Rico Medicaid Program (PRMP). 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, Puerto Rico Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state or local agencies as appropriate.

Providing this information is mandatory to be eligible to enroll as a provider with the PRMP, 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 Medicaid funds.

**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)

Note that your list of disclosures may differ from the following examples as the disclosure requirements are based on your responses throughout the enrollment application. Disclosures that do not apply to your application will not display.

DISCLOSURE FORMS		
<p>All entities and persons enrolling or revalidating with PRMP are required to report their disclosing entities. (Please note this does not include those providers enrolling as ordering, referring, or prescribing (OPR) providers.) Possible disclosing entities can be: A person with direct or indirect ownership equal to 5% or more, an entity that owns an interest of 5% or more in a mortgage, deed/trust, note or other obligation or a managing employee, and/or a subcontractor.</p> <p>Answer all questions. If you do not believe that a question is applicable, select a response of "No". If you answer "Yes" to any question, please provide the additional information that may be requested.</p>		
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"/>

- a. To start completing a disclosure form, click **Create New** next to the desired form name.

Some disclosures allow more than one form to be completed. The **Create New** button will be enabled if the form can be completed again.

For example, if there is more than one owner with controlling interest, a separate disclosure will need to be completed for each owner. Click **Create New** to complete an additional disclosure for each owner with controlling interest.

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"/>

The disclosure form details display in a pop-up window. Complete all fields within the form.

Example: Provider Self Disclosure

**New Provider Self Disclosure**

Required Fields (\*)

Providers are required to answer all questions on this form. For questions that may not be applicable, select a response of "No".

Title Last Name ... First Last N... Second Las... First Name Middle Name

Suffix Birth Date 11/07/1993 SSN 123-45-6789

**Licensure**

\* Has any action ever been taken against your license or certification, by any state or certification board in the past 10 years?  Yes  No

\* Have there been any changes to your license, registration or certification in the past 10 years?  Yes  No



**ADDITIONAL FIELDS IN FORM:** If "Yes" is clicked for any question on the form, an additional field or panel will display to add more information.

Once the form is completed, click **Save**.

**Convictions Of Criminal Offense**

\* Has the provider been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs?  Yes  No

**SAVE**

Delete Cancel **Save**

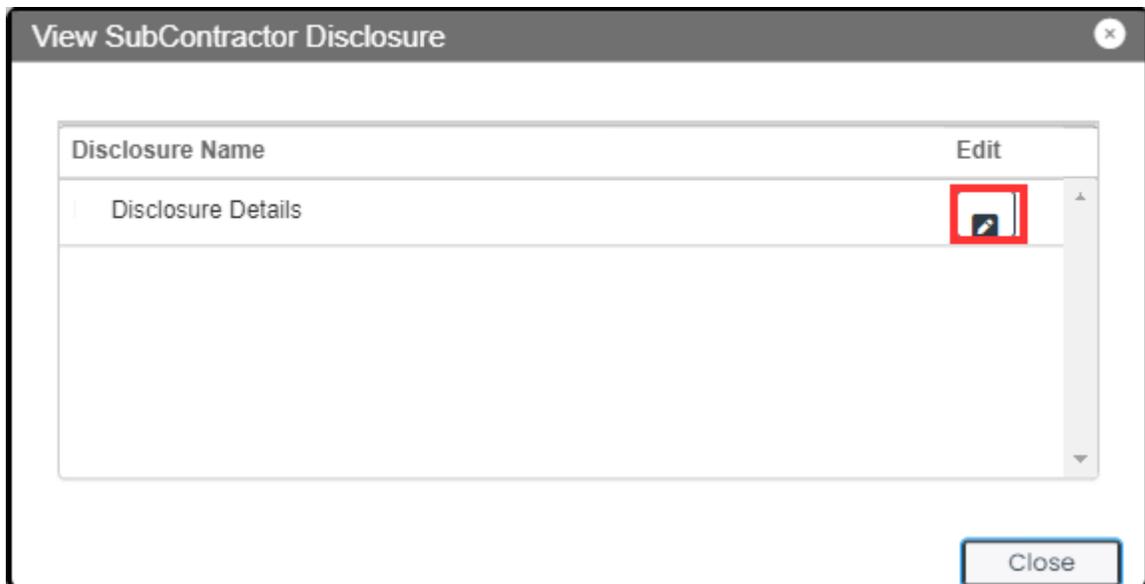
When the form is saved, the form’s status will change to “Completed.”

- b. To edit or delete an added disclosure form, click on the name of the desired form.

Disclosure Form	Status	Create New
Provider Self Disclosure	Completed	<input type="button" value="Create New"/>
<b>Sub-Contractor Disclosure</b>	Completed	<input type="button" value="Create New"/>
Ownership and Control Interest	New	<input type="button" value="Create New"/>

A pop-up window displays the forms you have submitted for that disclosure type. If you completed more than one form for that disclosure type, you will see multiple forms.

Click the **Edit** button next to the desired form from the list.





If you want to delete the form, scroll to the bottom of the form and click **Delete** in the bottom-left corner.

\* If the SubContractor is a corporation, select 'yes' and provide the owner information below by clicking 'create new'. If the SubContractor is an individual, select 'no'.

Yes  No

**Delete** Cancel Save

A pop-up window displays for you to confirm if you would like to delete the form. Click **Yes**.

Delete Confirmation

Are you sure you want to delete this record?

NO YES

The form is now deleted from your application.

Please note that if you deleted the only form for that disclosure type, the status will change from “Completed” to “New.”

- c. Once all forms are completed, click **Save and Continue** at the bottom-right of the page to save the Disclosure forms added on the Disclosures page.

Disclosure Form	Status	Create New
Provider Self Disclosure	Completed	Create New
Sub-Contractor Disclosure	Completed	Create New
Ownership and Control Interest	Completed	Create New
Managing Employees	Completed	Create New
Business Transaction	Completed	Create New

Cancel Previous **Save and Continue**



**SAVING AND CONTINUING:** All required forms must display a “Completed” status to save the Disclosures step and continue to the next enrollment step.

*If required forms remain incomplete, you will not be allowed to continue to the next step.*

### 3.13 Background Check

**NOTE:** The Background Check page displays for high-risk providers with an individual owner.

If the Background Check page does not display in your enrollment, it is not required for your Group Provider Type. If this is the case, go to [Section 3.13 Attachments](#) to view the instructions for your next required step.

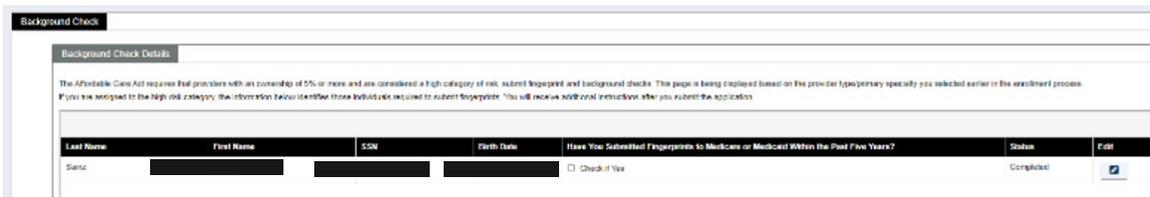
#### Quick Reference – Background Check

Table 13 – Background Check

Step	Task	Action	Result
Start from the Background Check page. This page displays after clicking Save and Continue from the previous page.			
1	Review Background Check information.	a. Verify that all names displayed in the Background Check Details panel are correct.  b. Check the box in the final column of the panel if the person has submitted fingerprints to Medicaid within the past five years.  Click Save and Continue.	Background check is reviewed.  Progress bar advances to the next available page.

#### Detailed Steps

1. The Background Check page is displayed. Individuals with 5% or greater ownership who may be required to submit fingerprints are displayed in the Background Check Details panel. This information was populated from the Disclosures step.



- a. Verify that all names displayed in the Background Check Details panel are correct.



**MISSING OWNERS OR INCORRECT INFORMATION:** If information displayed is incorrect or any owners are missing, go back to the Disclosures step in your enrollment (discussed in [Section 3.11](#)), update and save the information.

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	Status	Edit
Sainz				<input type="checkbox"/> Check if Yes	Completed	

Check the **Submitted prints to Medicare or Medicaid within the past five years** box in the final right column of the panel if the person has submitted fingerprints to Medicaid within the past five years.

Last Name	First Name	SSN	Birth Date	Submitted prints to Medicare or Medicaid within the past five years
Graham				<input type="checkbox"/>
Long				<input type="checkbox"/>

**NOTE:** If no fingerprints have been submitted in the past 5 years, you do not have to click the check box and no additional steps are required.

**Medicare/Medicaid Fingerprints Submission**

Required Fields ( \* )

\* 1. Have you submitted prints to Medicare within the last five years?  
 Yes  No

\* 2. Have you submitted prints to another state Medicaid agency within the last five years?  
 Yes  No

CANCEL SAVE

Select “Yes” for both questions and complete the required data. Use Calendar feature to complete the dates. Click **Save**.

**Medicare/Medicaid Fingerprints Submission**

Required Fields ( \* )

\* 1. Have you submitted prints to Medicare within the last five years?  
 Yes  No

\* Submitted Date

\* 2. Have you submitted prints to another state Medicaid agency within the last five years?  
 Yes  No

\* State

\* Submitted Date

CANCEL SAVE

To edit Fingerprints Submission, click the **Edit** button next to the desired.

## Provider Enrollment Portal (PEP) Enrollment Steps – Group

Last Name	First Name	SSN	Birth Date	Have You Submitted Fingerprints to Medicare or Medicaid Within the Past Five Years?	State	Full
Serna	Carina	333-22-1212	4/20/1982	<input type="checkbox"/> Check if true	Completed	

Enter Fingerprints Submission details and click Save to save the changes

Medicare/Medicaid Fingerprints Submission

Required Fields ( \* )

1. Have you submitted prints to Medicare within the last five years?  
 Yes  No

Submitted Date  
01/04/2021

2. Have you submitted prints to another state Medicaid agency within the last five years?  
 Yes  No

State  
Louisiana

Submitted Date  
06/16/2020

CANCEL SAVE

b. Click **Save and Continue** at the bottom-right to save the Background Check page.

Background Check Details

The Affordable Care Act requires that providers in the high risk category submit to fingerprinting and criminal background checks. This page is being displayed based on the provider type/primary specialty you selected earlier in the enrollment process.

If you are assigned to the high-risk category, the information below identifies those individuals required to submit fingerprints. You will receive additional instructions after you submit the application.

Last Name	First Name	SSN	Birth Date	Submitted prints to Medicare or Medicaid within the past five years
Graham				<input type="checkbox"/>
Long				<input type="checkbox"/>

CANCEL

SAVE AND CONTINUE

SAVE AND CONTINUE

### 3.14 Attachments

#### Quick Reference – Attachments

Table 14 – Attachments

Step	Task	Action	Result
Start from the Attachments page. This page displays after clicking Save and Continue from the previous page.			
1	Add Attachments.	a. Add the attachments requested a  section by clicking <b>Create New</b> and filling out the required fields in the displayed pop-up screen. Once the documents are uploaded, the attachment information is displayed and the requirement is marked as met.  Click Save and Continue.	Attachments are added and saved.  progress bar at  the next available page.

## Detailed Steps

1. The Attachments page is displayed.

Additional Information indicates any required additional documentation based on your Provider Type and information provided during previous enrollment steps.

### Attachments Required Fields ( \* )

Provider Type  
**Non-Emergency Medical Transportation**

Specialty  
**Non-Emergency Medical Transportation**

**Additional Information** -

Your provider type and specialty may require additional information.

If you are required to attach the Provider Consent Form, please click [Here](#) to download form.

If you have a large volume of malpractice cases or claims, please provide a detail document with a list of the other cases or claims within the 5-year period using the **malpractice suit or claim list** attachment type.

If this is a Change of Ownership (CHOW), please attach the purchase/sale contract and a letter that explains this is a CHOW and includes the old owner's NPI, Medicaid ID, and effective date of the new ownership. Use the **Change of Ownership (CHOW)** Attachment Type.

If you're enrolling as business with an Employer Identification Number (EIN) selecting an enrollment type of any of the following; Facility, Group or Atypical provider, the consent form is not required. Please upload a statement that you are enrolling as a group or facility and that an individual provider's consent is not required.

**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
Provider Enrollment Consent Form	NO
General Liability Insurance	NO
Transportation Department Certification – Public Services Commission Certification for each unit (ambulance)	NO

Required attachments for your Provider type and specialty are displayed in the **Required Attachments** section. The Requirement Met column displays “No” if an attachment has not been added.

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
Provider Enrollment Consent Form	NO
General Liability Insurance	NO
Transportation Department Certification – Public Services Commission Certification for each unit (ambulance)	NO

a. Click **Create New** on the Attachment Details panel to add a new attachment.

Attachment Details			
			Create New
Transmission Method	Attachment Type	File Name	Edit
There are no records found.			

Complete all the required fields in the pop-up window and upload the document.

**New Attachment**
✕

Required Fields ( \* )

**\* Transmission Method** ?

select a value... ▼

**\* Attachment Type** ?

select a value... ▼

**Upload File** ?

Select Files...

Cancel

Save



**ACCEPTED FILE TYPES:** File types currently accepted as attachments include .xlsx, .xls, .docx, .doc, .png, .txt, .jpg, .pdf, .gif, and .zip.

Once saved, the attachment displays in the panel.

Attachment Details			
Create New			
Transmission Method	Attachment Type	File Name	Edit
Electronic Only	Federal W-9 Form	Sample File.pdf	
Electronic Only	Physician's board certification: Evidence of current board certification by ABMS, AOA, ABOMS, ABPS, ABOPPM, RCPSG, CFPC or RCPCS	Sample File.pdf	

In the Required Attachments panel, the Requirement Met column of an attachment changes from “No” to “Yes” once the attachment has been added.

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
Provider Enrollment Consent Form	Yes
General Liability Insurance	Yes
Transportation Department Certification – Public Services Commission Certification for each unit (ambulance)	Yes

b. Click **Save and Continue** at the bottom-right to save the Attachments page.

Attachment Details			
Create New			
Transmission Method	Attachment Type	File Name	Edit
Electronic Only	Federal W-9 Form	Sample File.pdf	
Electronic Only	Physician's board certification: Evidence of current board certification by ABMS, AOA, ABOMS, ABPS, ABOPPM, RCPSG, CFPC or RCPCS	Sample File.pdf	



**SAVING AND CONTINUING:** All required attachments must be added before saving the Attachments page and continuing to the next enrollment step.

### 3.15 Fees

If you are required to pay a fee to apply for PRMP enrollment, the Fees page will be available in the application process.

If the Fees page does not display, it is not required for your Provider Type. If this is the case, go to [Section 3.15 Agreement/Submit](#) to view the instructions for your next required step.

### Quick Reference – Fees

Table 15 – Fees

Step	Task	Action	Result
Start from the Fees page. This page displays after clicking Save and Continue from the previous page.			
1	Disclose and pay Additional Fees.	a. Complete the fields displayed in the Fees section. b. Final Amount Due displays. c. Click Save and Continue.	Answers to the Fee questions and final amount are saved.  Progress bar advances to the next available page.

### Detailed Steps

1. The Fees page is displayed.

**Application Fee** Required Fields ( \* )

**Important Revalidation Fees:** If you have paid Fees during revalidation for another service location in Puerto Rico, please answer 'Yes' to Question 2 below to request application fee waiver for this service location. (Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prosthesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.)

The Affordable Care Act requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidations, and change of ownership, as required, and is assessed in full for each application submitted to the Puerto Rico Medicaid Program (PRMP).

\*Fee Update effective January 1, 2023\*

Pursuant to 42 CFR § 455.420 and 455.460, state Medicaid programs must collect an application fee for new provider applications, re-validations, and re-enrollments/reactivations due to being terminated for any reason. The application fee is intended to cover the cost of the Medicaid Program's provider screening. 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

The application fee for 2023 is \$688.00. A bank manager's check (cashier's check) or money order is required to pay the fee. You must include the following information with the payment:

- Provider's name as indicated on the application
- Provider's National Provider Identifier (NPI)\*
- Provider's Application Tracking Number (ATN)

Checks should be made payable to: Secretario de Hacienda

Mail the bank manager's check (cashier's check) or money order to:

Puerto Rico Medicaid Program  
 Provider Enrollment Unit  
 PO Box 70184  
 San Juan, PR 00936-8184

\*Non-Emergency Medical Transportation (NEMT) providers who do not have an NPI must include their Tax ID.

Note: In order to waive the application fee, proof of enrollment or revalidation in Medicare or another state Medicaid plan is required. Proof of payment is a receipt or formal notification from Medicare or the other state Medicaid plan specifically indicating payment of the application fee. Proof of payment can be uploaded as an attachment to your application.

If an application is received and deemed to require an application fee and one is not paid, 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.

- a. Read the information disclosed in the **Application Fee** section and answer the Application Fee questions underneath.

**APPLICATION FEE QUESTIONS**

If the service location is enrolled in Medicare a fee payment is not required.

1. Is the service location enrolled in Medicare? ?

Yes  No

---

If the service location has paid an application fee to another Medicaid program then a fee payment is not required.  
 Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prothesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.

2. Has the application Fee for the Service location been paid to another state's Medicaid program or paid during revalidation for another service location in Puerto Rico? ?

Yes  No

---

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

---

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

If you answer “Yes” to the first Application Fee question, an enrollment date is required.

**APPLICATION FEE QUESTIONS**

If the service location is enrolled in Medicare a fee payment is not required.

1. Is the service location enrolled in Medicare?

Yes  No

**\* Date Enrolled** ?

11/09/2023 

If you answer “Yes” to the second Application Fee question, the state and date of payment are required.

If the service location has paid an application fee to another Medicaid program then a fee payment is not required.  
 Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prothesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.

2. Has the application Fee for the Service location been paid to another state's Medicaid program or paid during revalidation for another service location in Puerto Rico? ?

Yes  No

**\* State** ?      **\* Payment Date** ?

Florida       11/09/2023 

- b. The final amount of fees is displayed at the bottom of the screen when all questions are completed.

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

**APPLICATION FEE QUESTIONS**

If the service location is enrolled in Medicare a fee payment is not required.

1. Is the service location enrolled in Medicare? ?

Yes  No

---

If the service location has paid an application fee to another Medicaid program then a fee payment is not required.

Fees paid to other service locations during revalidation only apply for Infusion Center / Agency, Vision Center / Optics, Prosthesis and Orthotics Supplier, and Implant Supplier provider types under the same NPI.

2. Has the application Fee for the Service location been paid to another state's Medicaid program or paid during revalidation for another service location in Pue... ?

Yes  No

---

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

---

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

---

Enrollment Application Fee	\$XXX.XX
Total Amount Due	\$XXX.XX



**AMOUNT DUE:** If "No Fee" displays next to "Amount Due" after answering all questions, you do not have to pay an application fee.

If an amount of fees displays, the instructions for paying the fee are disclosed in the top section of the Fees page. This includes the payment method accepted, the address to send the payment to, and the information required when making the payment.

PAY APPLICATION FEE
✕

**Welcome to the the Online Bill Pay Process**

Please complete each section of the online bill pay process to make a one-time payment for your Colorado Medicaid bill.

The following forms of payment are accepted:

Account Information
⊞

**Account Information** ⓘ

Personal     Business

**Last Name** ⓘ    **First Name** ⓘ

**Address** ⓘ

**City** ⓘ    **State** ⓘ    **ZIP Code** ⓘ

select a value...

**Telephone Number** ⓘ

Payment Information
⊞

**\* Payment Method** ⓘ

select a value...

**\* Card Number** ⓘ    **\* Verification Code** ⓘ

**\* M.** ⓘ    **\* Y.** ⓘ    **\* Billing Address ZIP ...** ⓘ

**Payment Amount** ⓘ

**\* Email Address** ⓘ    **\* Email Address Confirmation** ⓘ

Authorize Payment
⊞

Please verify your payment above and make any necessary changes. When verification is complete,click the "Authorize Payment" button below to submit your payment.

Your payment will not be processed until you click the "Authorize Payment" button below. Only click once to avoid duplicate payments. Once your payment has processed,you will receive a confirmation number that you can print for your records. Click the "Cancel" button below to stop this payment process and exit. Do not use your browser Back button.

Cancel
Authorize Payment

c. Click the **Save and Continue** button at the bottom right to save the Fees page.

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

---

Enrollment Application Fee \$XXX.XX

---

Total Amount Due \$XXX.XX

### 3.16 Agreement/Submit

#### Quick Reference – Agreement/Submit

Table 16 – Agreement/Submit

Step	Task	Action	Result
Start from Agreement/Submit page. This page displays after clicking Save and Continue from the previous page.			
1	Accept Terms and Conditions.	Click Proceed to accept the terms and conditions.	Provider Agreement PDF displays.
2	Accept Provider Agreement.	Read the Provider Agreement and click the I Accept checkbox.	Confirmation pop-up window displays.
3	Confirm Provider Agreement.	Click Yes in the pop-up window to confirm agreement.	Signature section displays.
4	Complete Signature section.	a. Click the I Accept checkbox and fill in the rest of the fields. b. Click Request Verification Code.	Verification code is sent via email.
5	Add verification code.	Enter verification code sent via email and click Submit.	Enrollment submission confirmation screen displays.
6	Confirm submission of enrollment.	Click Yes to confirm submission.	Enrollment submission notification is received via pop-up screen and via email.

#### Detailed Steps

1. The Agreement/Submit page is displayed. This is the final step to complete and submit a new Provider Enrollment Application. Information previously entered during the other enrollment steps displays under the Terms of Agreement.

**Agreement/Submit** Required Fields ( \* )

Access the tabs above to review all data that has been entered into the application. Changes can be made, except for enrollment type and provider type, by navigating back to the appropriate screen using the tabs in the table of contents. If the enrollment type and/or provider type selected is incorrect, do not submit the application. You must complete a new application for the appropriate enrollment and/or provider type.

The terms of the enrollment are stated below. You must accept these terms in order to submit the enrollment application for review and approval. Once the terms are accepted, and the application has been confirmed and submitted, a PDF version of the application is available for saving. If terms are not accepted, the application will be saved to return later (within 30 calendar days) to complete and submit the application. If not submitted within 30 calendar days, the application will be deleted, and the application process would need to be started from the beginning.

Once your application is approved, your information will be shared with the Medicaid Managed Care Organizations (MCOs)/Medicare Advantage Organizations (MAOs). Be aware that the MCO/MAO can contact you, or you may contact the MCO/MAO to pursue contracts with them. This enrollment does not automatically establish a contract with an MCO/MAO.

**Terms of Agreement**

Legal Name on your Tax ID/SSN	Contact Name	Contact Email	Tax ID Type
			SSN
Tax ID Number	Service Location		
123-45-6789	735 AVE PONCE DE LEON SAN JUAN PR, 009175030		

The above provider agrees to participate in the Puerto Rico Medicaid Program.

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the Puerto Rico Medicaid Program.

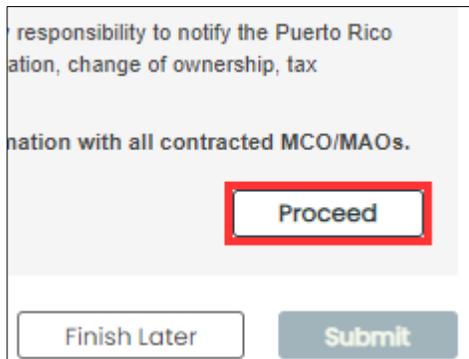
I understand that should I be approved as a provider of services under the Puerto Rico Medicaid Program that it is my responsibility to notify the Puerto Rico Medicaid Program of any change to the information on this application including but not limited to address, group affiliation, change of ownership, tax identification number, or NPI.

I understand and agree that by submitting my application, Puerto Rico Medicaid Program will share my information with all contracted MCO/MAOs.

**Proceed**

Cancel Previous Finish Later Submit

To accept the Terms of Agreement, click **Proceed** at the bottom of the screen.



2. A new section with a PDF form displays underneath.

Form

Please read the Provider Agreement document below.

LoadAgreementPdf 1 / 8

GOVERNMENT OF PUERTO RICO  
Department of Health  
Medicaid Program

Medicaid Provider Enrollment Agreement  
to the Puerto Rico Government Health Plan (GHP)

I certify my signature, under penalty of perjury that I am the individual applying, or I am duty 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.

I Accept



**PROVIDER AGREEMENT:** The Provider Agreement is available in both English and Spanish. The first half of the document is in English and the second half is in Spanish.

Print or save a copy of the Provider Agreement now to keep for your records. Once you have completed this step, you will not be able to return to the Provider Agreement.

Read the Provider Agreement contained in the PDF document displayed and click the **I Accept** box.

Form

Please read the Provider Agreement document below.

LoadAgreementPdf 1 / 8

GOVERNMENT OF PUERTO RICO  
Department of Health  
Medicaid Program

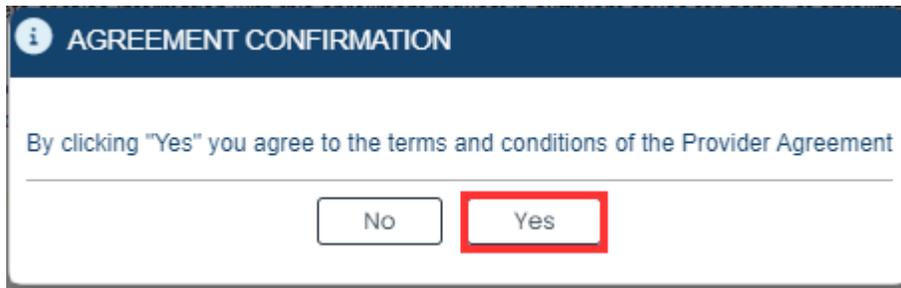
Medicaid Provider Enrollment Agreement  
to the Puerto Rico Government Health Plan (GHP)

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

I Accept

I Accept

3. A pop-up window displays to confirm your agreement. Click **Yes**.



The **I Accept** checkbox is now checked.



4. The **Signature** section displays.

**Signature**

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

\* I Accept

Title ? \* Last Name ? Second Last N... ? \* First Name ? Middle Name ? Suffix ?

Comments ?

Click on "Request Verification Code" button. An email will be sent to the registered email address. 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.

Verification Code  Submission Date 11/9/2023

- a. Click the **I Accept** checkbox in this section and complete the rest of the fields.

**Signature**

The Provider Agreement is fully electronic. By selecting the "I Accept" box below, same extent as my written signature.

\* I Accept

b. Click **Request Verification Code**.

Click on "Request Verification Code" button. An email will be sent to the registered email address. 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.

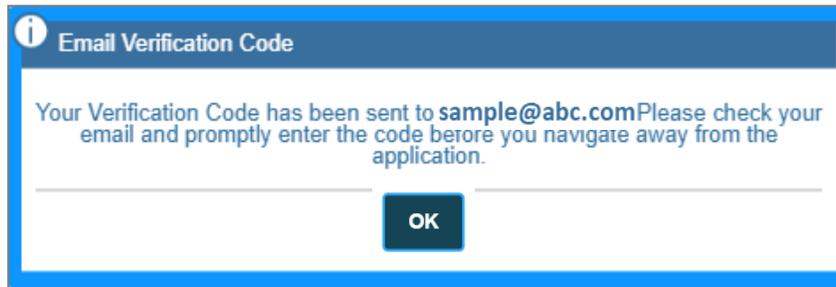
---

Request Verification Code

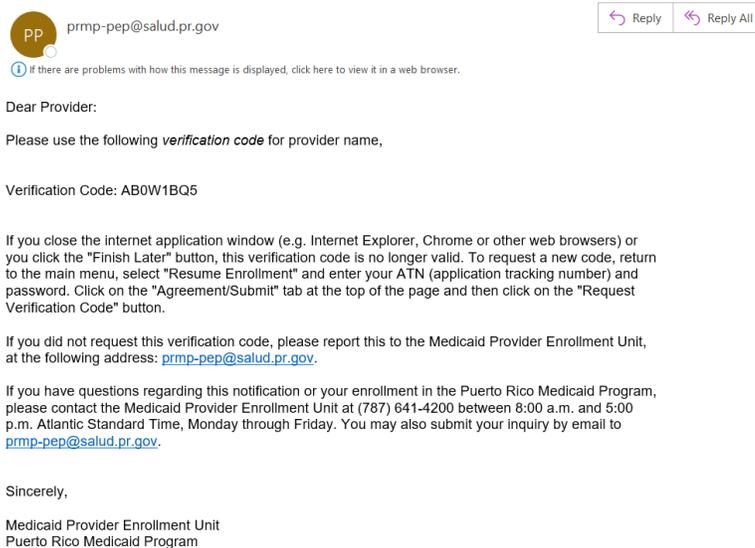
Verification Code

Submission Date 11/9/2023

The verification code will be sent to the email address confirmed in the required fields.



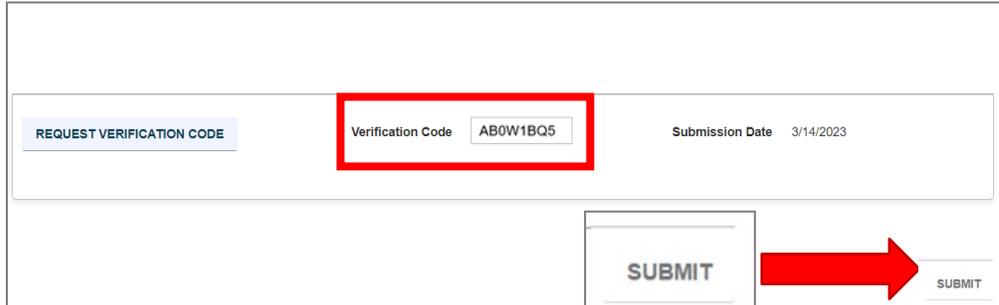
*Example of email received with verification code:*



**VALID VERIFICATION CODE:** *If you close the internet window containing your enrollment application before entering the verification code sent to you, that verification code is no longer valid.*

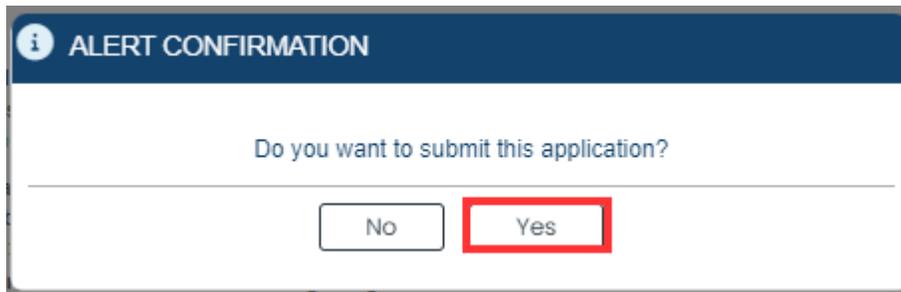
*If this happens, resume your enrollment using your ATN and enrollment password (see **Section 2.4** in the **Provider Enrollment Portal (PEP) Navigation Reference Guide** for detailed steps), and request a new verification code.*

5. Enter the verification code in the **Verification Code** field and click **Submit**.



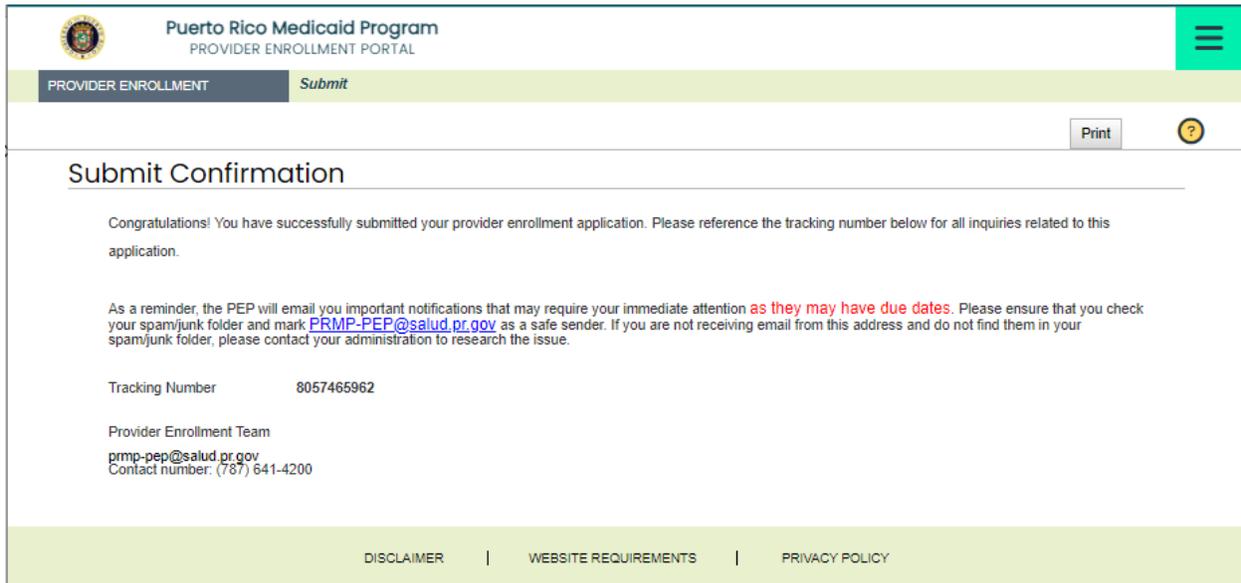
The screenshot shows a web form with a 'REQUEST VERIFICATION CODE' button on the left. In the center, there is a 'Verification Code' field containing the text 'AB0W1BQ5', which is highlighted with a red rectangular box. To the right of this field is a 'Submission Date' field showing '3/14/2023'. Below these fields, there is a 'SUBMIT' button, also highlighted with a red rectangular box. A large red arrow points from this button to another 'SUBMIT' button located further to the right.

6. Confirm the submission by clicking **Yes** in the pop-up screen.



The screenshot shows a dark blue header with a white information icon and the text 'ALERT CONFIRMATION'. Below the header, the text 'Do you want to submit this application?' is centered. At the bottom of the pop-up, there are two buttons: 'No' and 'Yes'. The 'Yes' button is highlighted with a red rectangular box.

A message confirming your enrollment application submission is displayed on screen.



The screenshot shows the 'Submit Confirmation' page in the Puerto Rico Medicaid Program Provider Enrollment Portal. The page has a green header with the program name and logo. Below the header, there is a 'Submit' button and a 'Print' button. The main content area contains the following text:

Congratulations! You have successfully submitted your provider enrollment application. Please reference the tracking number below for all inquiries related to this application.

As a reminder, the PEP will email you important notifications that may require your immediate attention **as they may have due dates**. Please ensure that you check your spam/junk folder and mark [PRMP-PEP@salud.pr.gov](mailto:PRMP-PEP@salud.pr.gov) as a safe sender. If you are not receiving email from this address and do not find them in your spam/junk folder, please contact your administration to research the issue.

Tracking Number            8057465962

Provider Enrollment Team  
[prmp-pep@salud.pr.gov](mailto:prmp-pep@salud.pr.gov)  
Contact number: (787) 641-4200

At the bottom of the page, there are links for 'DISCLAIMER', 'WEBSITE REQUIREMENTS', and 'PRIVACY POLICY'.

A notification will be sent via email confirming the application was successfully submitted for review.

**New Enrollment Complete Notification**

 prmp-pep@salud.pr.gov Reply Reply All

ⓘ if there are problems with how this message is displayed, click here to view it in a web browser.

Dear Provider:

Your provider enrollment application with the Puerto Rico Medicaid Program (PRMP) has been received. The Medicaid Provider Enrollment Unit will be evaluating your enrollment application. You will receive an approval notification via email, and if necessary, additional instructions to complete the process. Below is your tracking number that has been associated with your enrollment application.

Application Tracking Number: 1426435421  
Password: \*\*\*\*\*

You may check the status of your application by going to 'Enrollment Status' in PEP and entering your ATN and password.

If you have additional questions regarding your enrollment in the Puerto Rico Medicaid Program, please contact the Medicaid Provider Enrollment Unit at (787) 641-4200 between 8:00 a.m. and 5:00 p.m. Atlantic Standard Time, Monday through Friday. You may also submit your inquiry by email to [prmp-pep@salud.pr.gov](mailto:prmp-pep@salud.pr.gov).

Sincerely,

Medicaid Provider Enrollment Unit  
Puerto Rico Medicaid Program

## 4 Notifications

Below are the different types of notifications you can get as a provider after submitting your enrollment. Please make sure to verify your junk mail folder for any notifications from PEP.

### 1. Fingerprints Required

You may receive a Secure Communications email informing you that your enrollment requires additional screening. This includes submitting fingerprints and criminal background checks for all owners of 5% or more of the provider being enrolled.

If this screening is not completed within 30 days of receiving the email, the enrollment will be denied.

### 2. Return to Provider

You may receive a Secure Communications email informing you that your application requires corrections. The email will include the specific issues in the application that require your attention. You must access your application in the PEP (using the ATN/password used for the application registration), make the necessary updates and resubmit the application.

### 3. Enrollment Approval

You will receive a Welcome letter upon approval of your enrollment. For newly-enrolling providers, your Welcome letter will include the provider number and other important program participation information. You will get an email notification that you have a Welcome letter to view and download as a PDF at the Secure Communications site.

### 4. Enrollment Denial

You will receive written confirmation via a Secure Communications email if your new enrollment application has been denied. The notification includes the reason(s) why the enrollment was denied and information about appeal rights.