For new individual practitioners serving Maryland Medicaid participants during the COVID-19 state of emergency ONLY.

Please note this option only works for providers whose NPIs are unknown to Maryland Medicaid; previously enrolled providers need to re-enroll via ePREP.

1. Visit encrypt.emdhealthchoice.org/emedicaid/. Select “go!” next to Step 1.

Maryland
MEDICAL PROGRAMS
Web Services
... brought to you by the Maryland Department of Health

Welcome to our site!

If you are not a Maryland Medicaid provider or their representative, please visit our home page.

Healthcare Professionals:
This site provides secure online services for Maryland Medicaid Providers where you can verify recipient eligibility, obtain payment information and Remittance Advice (RA).

Step 1: If you are enrolling to serve Maryland Medicaid participants during the COVID-19 state of emergency ONLY, please select 'go!' next to Step 1. go!

Step 2: If you already have a Medicaid Provider Number, Register to use this site. Check eMedicaid User's guide for help. go!

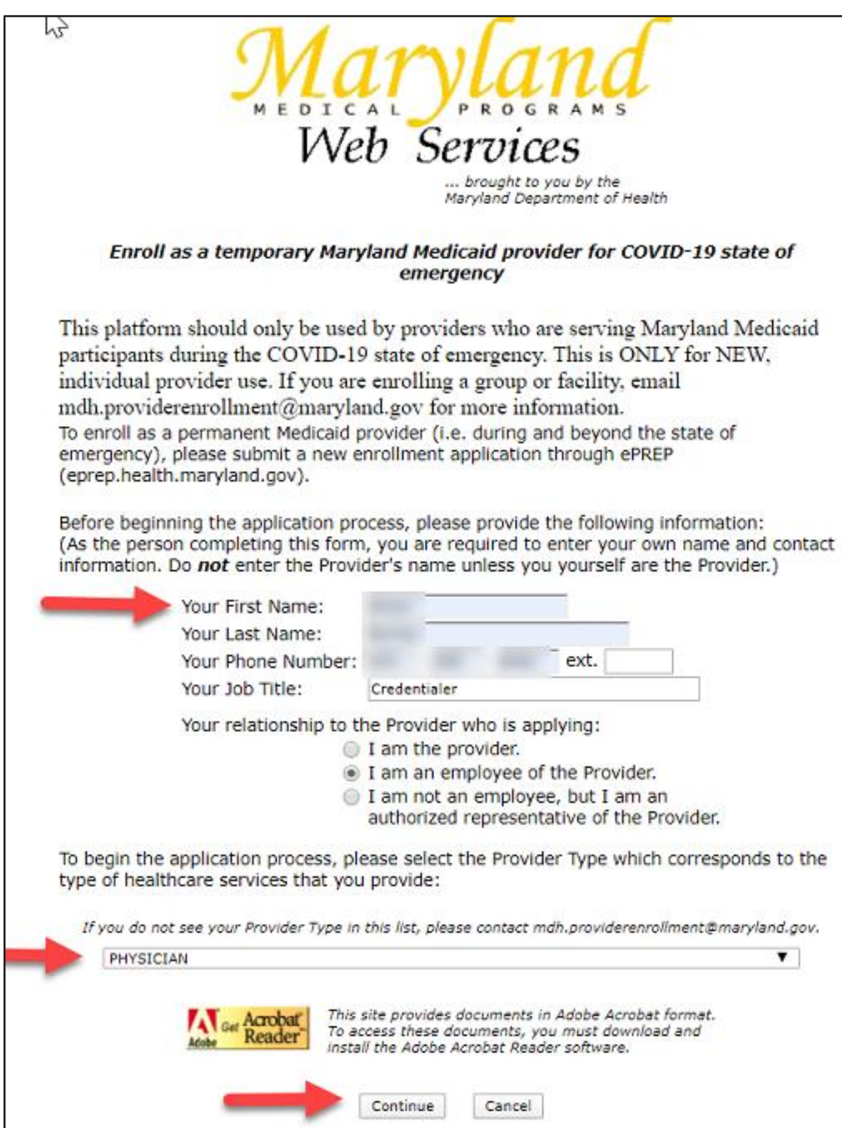
Step 3: Sign in!

eMedicaid User's guide
EVS Help

Sign In
User ID:
Password:
Sign In
Forgot Your Password?

Figure 1

2. Enter your name and contact information. If you are completing this application on behalf of the provider, please enter your own information. Next, select the provider type corresponding to the services the provider offers.



Maryland MEDICAL PROGRAMS Web Services

... brought to you by the Maryland Department of Health

Enroll as a temporary Maryland Medicaid provider for COVID-19 state of emergency

This platform should only be used by providers who are serving Maryland Medicaid participants during the COVID-19 state of emergency. This is ONLY for NEW, individual provider use. If you are enrolling a group or facility, email mdh.providerenrollment@maryland.gov for more information.
To enroll as a permanent Medicaid provider (i.e. during and beyond the state of emergency), please submit a new enrollment application through ePREP (eprep.health.maryland.gov).

Before beginning the application process, please provide the following information:
(As the person completing this form, you are required to enter your own name and contact information. Do ***not*** enter the Provider's name unless you yourself are the Provider.)

Your First Name:
Your Last Name:
Your Phone Number: ext.
Your Job Title: Credentialer

Your relationship to the Provider who is applying:
- I am the provider.
- I am an employee of the Provider.
- I am not an employee, but I am an authorized representative of the Provider.

To begin the application process, please select the Provider Type which corresponds to the type of healthcare services that you provide:

If you do not see your Provider Type in this list, please contact mdh.providerenrollment@maryland.gov.

PHYSICIAN

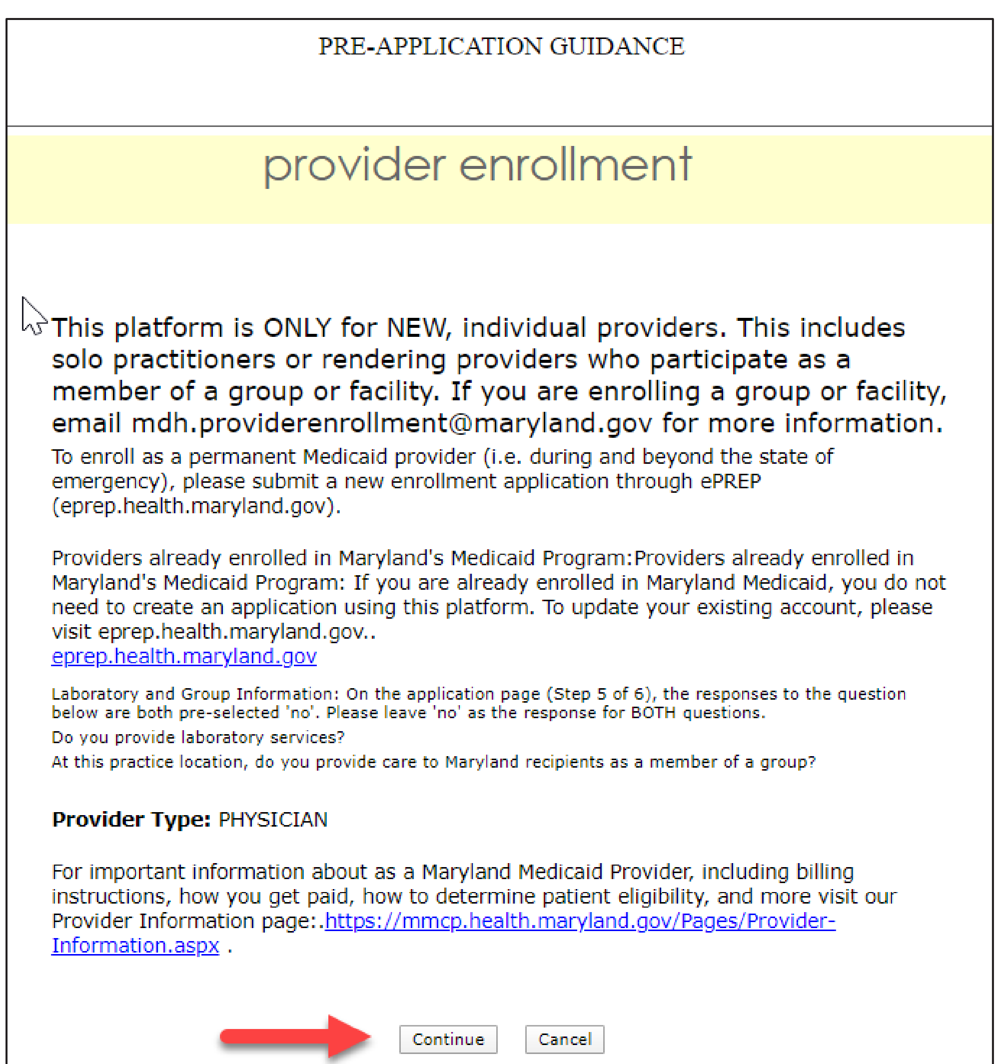
Get Acrobat Reader

This site provides documents in Adobe Acrobat format. To access these documents, you must download and install the Adobe Acrobat Reader software.

Continue Cancel

Figure 2

3. Review pre-application guidance carefully to determine whether this enrollment option is appropriate for you. If yes, click "continue". If no, contact mdh.providerenrollment@maryland.gov for further guidance.


PRE-APPLICATION GUIDANCE

provider enrollment

This platform is ONLY for NEW, individual providers. This includes solo practitioners or rendering providers who participate as a member of a group or facility. If you are enrolling a group or facility, email mdh.providerenrollment@maryland.gov for more information.

To enroll as a permanent Medicaid provider (i.e. during and beyond the state of emergency), please submit a new enrollment application through ePREP (eprep.health.maryland.gov).

Providers already enrolled in Maryland's Medicaid Program:Providers already enrolled in Maryland's Medicaid Program: If you are already enrolled in Maryland Medicaid, you do not need to create an application using this platform. To update your existing account, please visit eprep.health.maryland.gov..
eprep.health.maryland.gov

Laboratory and Group Information: On the application page (Step 5 of 6), the responses to the question below are both pre-selected 'no'. Please leave 'no' as the response for BOTH questions.
Do you provide laboratory services?
At this practice location, do you provide care to Maryland recipients as a member of a group?

Provider Type: PHYSICIAN

For important information about as a Maryland Medicaid Provider, including billing instructions, how you get paid, how to determine patient eligibility, and more visit our Provider Information page:.https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx .

Continue Cancel

Figure 3

4. **Step 1 of 6**: Review the electronic signature agreement. Select the checkbox indicating your agreement to the terms. Select "continue".

Figure 4

5. **Step 2 of 6**: Please review and attest to the Maryland Medicaid provider agreement. Select the checkbox to indicate your agreement with the terms.

Figure 5

6. **Step 3 of 6**: Enter the requested enrollment begin date. Maryland Medicaid will honor retroactive enrollment begin dates for temporary providers back to the beginning of the COVID-19 state of emergency, or March 5, 2020.

   Please note: Professional title, FEIN, and website address are optional fields. All other fields are required for pre-enrollment screening.

Step 3 of 6 ***Provider Information***

Requested Enrollment Begin Date: 03 / 12 / 2020 (mm/dd/yyyy)

Note: Maryland Medicaid will honor requested enrollment begin dates for temporary providers back to the beginning of

First Name:
Last Name:
Professional Title: MD
Social Security Number: - -
Date Of Birth: - - (mm/dd/yyyy)
Federal Employer Identification Number (FEIN):
Please be sure to provide the best email address to reach the individual responsible for this application to ensure Maryland Medicaid can follow up for reimbursement purposes.

eMail Address:
Website Address: providerwebsite.com

Would you prefer electronic correspondence, in lieu of paper, when available? ◉ yes ○ no

☑ I understand that if I or my group is salaried by a hospital or other institution for Medical Care Program for those services for which I or my group is salaried.

Continue Cancel

Figure 6

7. **Step 4 of 6**: Verify the information reported on the previous page and provide your electronic signature. If you need to correct any information, select "make changes" to return to the previous page. Select the checkbox under "electronic signature" to indicate your agreement to the terms.

- **You must agree to the Electronic Si**

Provider Type: PHYSICIAN
Submission Date: 04/15/2020

Requested Enrollment Begin Date: 03/12/2020

Provider Information:

First Name:
Last Name:
Professional Title: MD
Social Security Number:
Date Of Birth:
Federal Employer Identification Number:

eMail Address:
Website Address: providerwebsite.com

Would you prefer electronic correspondence, in lieu of paper, when available? Yes

☑ I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

☑ I agree to the terms of the Electronic Signature Agreement.

☑ I agree to the terms of the Provider Agreement.

Figure 7 a

Submitted By:
Credentialier
Relation to applying provider: I am an employee of the Provider.

Make Changes

Electronic Signature

☑ I agree to the terms set forth below:

- I have read and understand all warnings, restrictions, information, policies, and general rules that are relevant to this electronic transaction. I am responsible for any misinformation or mistakes that are made.
- I understand that my electronic signature is as legally binding as my handwritten signature.
- I agree that the Departmental electronic signature, if any, is an original signature as legally binding as a handwritten signature.
- I affirm that the information I have provided in this electronic transaction is true and complete to the best of my knowledge and belief.

Continue Cancel

Figure 7 b

8. **Step 5 of 6** requests provider practice information. Red arrows indicate required fields:
   - Practice and ownership type dropdowns are required, but MDH will not be collecting or editing based on this information.
   - If you have a DEA number, please provide it. Otherwise, it is not required. Medicare numbers are not required.
   - Laboratory license and permit information: Red arrows indicate responses that are pre-selected 'no'. Please leave 'no' as the response for all questions in this section.
   - Group information: Maryland Medicaid does not edit on affiliations between rendering and group providers; please leave responses pre-selected 'no'.
   - The 'Medicaid numbers in other states' is optional.

Please note: For practice type, select "Individual/ Rendering Practice". For ownership type, select whichever is most appropriate for your practice.

provider enrollment

Step 5 of 6 ***Practice Location Information***
The information on this page will be collected once for each Practice Location that you choose to enroll. Upon completing the application process for each continue and enroll additional Practice Locations.

Please select the Practice Type for this location: Individual/Rendering Practice
Please select the Ownership Type for this location: Privately Owned, Non-Profit

Practice Address

Address Line 1: 201 W. Preston Street
Address Line 2:
City: Baltimore State: Maryland Zip: 21201
If this Practice is located in Maryland, please select the County where this Practice is located: Baltimore City
Phone Number: (410) 767 - 3000
Fax Number: ( ) -

Pay-To Address (Optional)

Figure 8 a

Medical License information for services rendered at this Practice Location

State Board License Number:
License Effective Date: 01 / 15 / 1991 (mm/dd/yyyy) Expiration Date: 9 / 30 / 2022
National Provider Identification Number (NPI): DEA Number:

Medicare Numbers for services rendered at this Practice Location:
(Leave blank, if enrolling as a member of a group and do not wish to be reimbursed directly by the state.)

Laboratory License and Permit information for services rendered at this Practice Location
Providers enrolling for COVID-19 state of emergency purposes should select "no "

Do you provide laboratory services? yes no
Do you provide laboratory services for other than your own patients? yes no
Do you recieve specimens that originate in the State of Maryland? yes no
CLIA Number:

Figure 8 b

Group Information
Providers enrolling for COVID-19 state of emergency purposes should select "no"
If you render services as a member of a Group practice at this Practice Location, please complete the following:

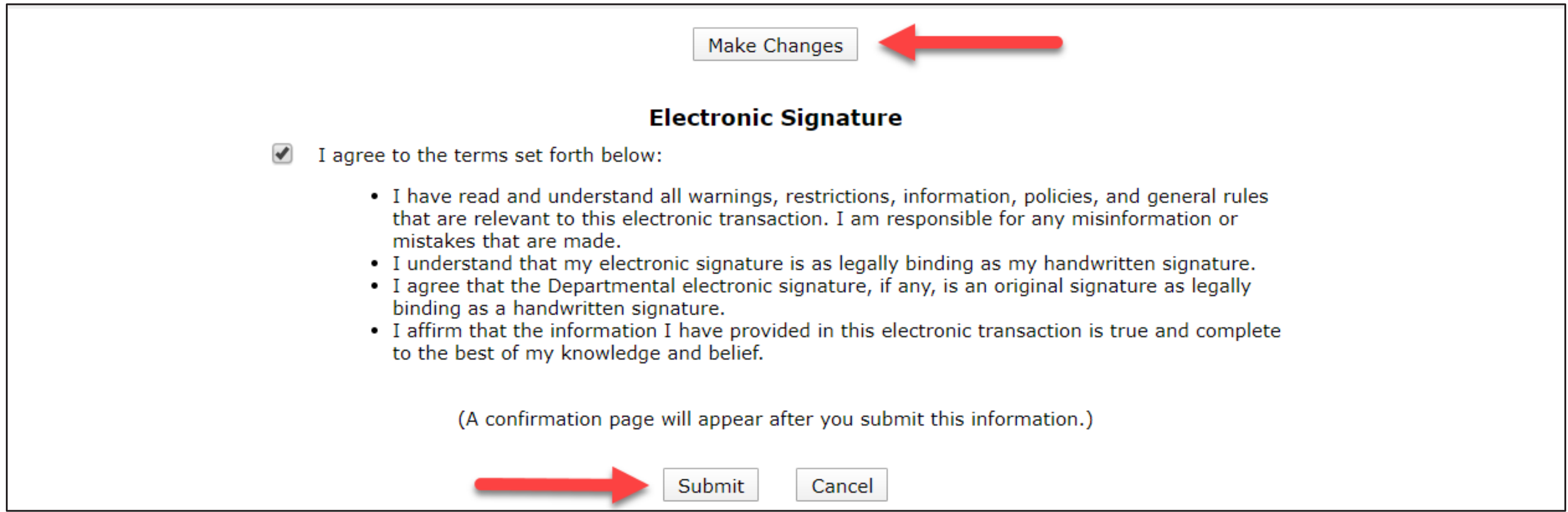
At this Practice Location, do you provide care to Maryland recipients as a member of a Group practice? yes n
At this Practice Location, do you also provide care to Maryland recipients through your private practice and wish to be reimbursed directly by the State? yes n
Please list the Maryland Provider Number of each Group for which you render services at this Practice Location. Please specify the Effective Date of your membership with each Group:

Group Number: Group Membership Effective Date:

Figure 8 c

9. **Step 6 of 6:** Verify the information you've entered in the application is correct. If you wish to make changes, select "make changes" to return to the application. If the information is correct, click "continue".

Figure 9



10. Transaction confirmation: Please record your confirmation number for your records. If approved, MDH will send an enrollment approval letter with the provider's temporary provider ID number to the email listed on the application. Please retain this number for your records as well.

    If you have any questions about temporary enrollment or the status of your application, please email mdh.providerenrollment@maryland.gov.

For information electronic claims submission through eMedicaid, please review the overview and tutorial on the eMedicaid homepage. If you have any questions about the electronic claims submission process, please email mdh.hipaaeditest@maryland.gov.

provider enrollment

Help

Transaction Confirmation
Please print this page for your records.

CONFIRMATION NUMBER: 200900000002

Your application is pending.

Provider Type:
Submission Date:

Requested Enrollment Begin Date: 03/05/2020

Provider Information: First Name:
Last Name:
Professional Title:
Social Security Number:
Date Of Birth:
Federal Employer Identification Number:

eMail Address:
Website Address:

Would you prefer electronic correspondence, in lieu of paper, when available? Yes

☑ I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

☑ I agree to the terms of the Electronic Signature Agreement.
☑ I agree to the terms of the Provider Agreement.

Figure 10