



Provider Enrollment Application Instructions for Individual SHARS Providers



Special Education Solutions

P.O. Box 400, Austin, Texas 78767-0400 • 888.247.4829
shars@tasb.org • tasb.org/specialeducation

Provider Enrollment Application Instructions for Individual SHARS Providers

In August 2021, Health and Human Services Commission (HHSC) announced several changes to the School Health and Related Services (SHARS) program. Amongst the changes were new policies that require school districts to obtain prescriptions for Physical Therapy (PT) and Occupational Therapy (OT), as well as referrals for all Speech Therapy (ST) and Audiology services, that list the name and National Provider Identifier (NPI) of the Medicaid enrolled physician or other eligible prescribing/referring provider to receive SHARS reimbursement for these services. These policies became effective on November 1, 2021, but districts were given a one-year grace period to complete the enrollment process and come under compliance. The purpose of these instructions is to guide individual SHARS providers through the Medicaid enrollment process. All Medicaid enrollment applications must be submitted via Texas Medicaid & Healthcare Partnership's (TMHP's) Provider Enrollment Management System (PEMS). *Please note that although these instructions guide individual providers through the application process, they are not official TMHP instructions and have not been authorized by TMHP.*

Step 1. Create a PEMS account

- a.) To access TMHP's new account page, click [here](#). Select Enroll as a Texas Medicaid Provider/Vendor and click Go.
- b.) Select Create a Provider Enrollment Account and click Next.
- c.) On the Create New Account page, complete all required fields (identified with a *).

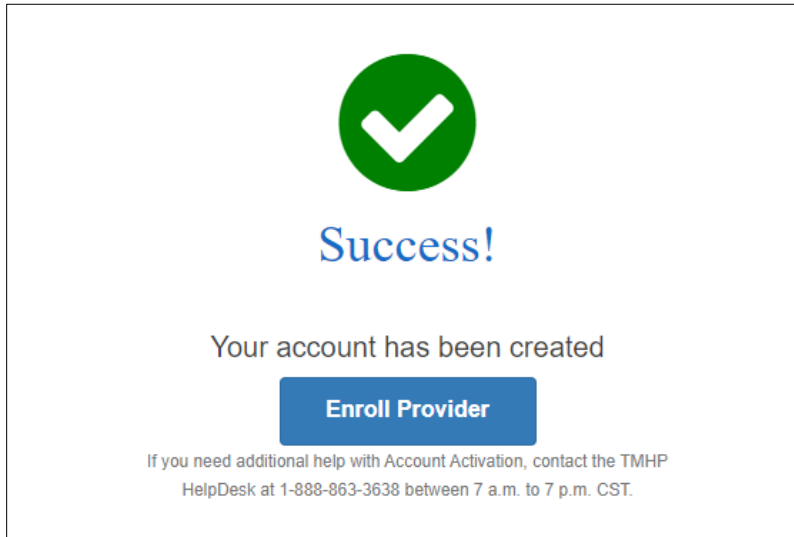
Create New Account

| | | |
|--|--|--|
| * User Name <small>Must be a different than your EDI Submitter ID</small> | <input type="text" value="User123"/> | 6-20 characters(no spaces or special characters) |
| * First Name | <input type="text" value="John"/> | (no special characters) |
| * Last Name | <input type="text" value="Smith"/> | (no special characters) |
| * Business Telephone | <input type="text" value="555-555-5555"/> | xxx-xxx-xxxx |
| * Email | <input type="text" value="johnsmith@gmail.com"/> | To ensure delivery to your inbox please add donotreply@tmhp.com to your address book today |
| * Confirm Email | <input type="text"/> | Retype email address. Do not copy and paste |
| * Password | <input type="text"/> | 8-20 characters(no spaces) |
| * Confirm Password | <input type="text"/> | Retype password. Do not copy and paste |

Review the General Terms and Conditions, click on the box next to "I agree to these terms", and press Submit. *Note: you may be asked to complete an "I'm not a robot" CAPTCHA before submitting.*

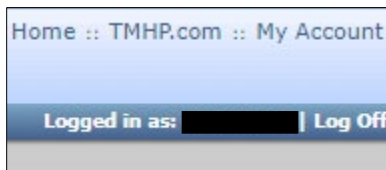


d.) If successful, click Enroll Provider.



Step 2. Log onto [PEMS](#)

- a) Using the username and password you created in Step 1, log into PEMS. *Note: Your username will be emailed to you by DONOTREPLY@TMHP.COM.*
- b) Once logged in, in the top right corner, click My Account.



- c) Next, in the Manage Provider Accounts box, select Provider Enrollment and Management System (PEMS).

Step 3. Access the Provider Enrollment application.

- a) In the top right corner, select Start New Enrollment.
- b) Review the welcome message, scroll down and select Continue.
- c) To begin, select the circle labeled Enroll as a Provider with an Existing National Provider Identifier. *Note: You will not be able to advance if you have not already obtained an NPI. If you do not already have an NPI and need assistance obtaining one, please refer to TASB's "NPI App Instructions" document.*

NPI & Enrollment Information

To Begin, Please Choose your Enrollment/Registration

Enroll as a Provider with an Existing National Provider Identifier
 Register as an Individual Transportation Participant
 Enroll as an Atypical Provider

Next, Please Enter your issued NPI NUMBER and validate NPPES information,

NATIONAL PROVIDER IDENTIFIER (NPI)

If you are trying to update the enrollment record then go to Provider Profile [Provider Management](#) section

- d) Enter your NPI and click Validate.
- e) Review the NPPES Information pulled from the validation. If correct, select No under ARE YOU SEEKING ENROLLMENT DUE TO A CHANGE OF OWNERSHIP (CHOW)?
- f) Review the Texas privacy statement, check the “I have read and agree to the Texas privacy statement and laws” box, and click Begin Enrollment/Registration.

Change of Ownership

ARE YOU SEEKING ENROLLMENT DUE TO A CHANGE OF OWNERSHIP (CHOW)?*

Yes No

Please review the 'Texas privacy statement' found below in a hyperlink and click the checkbox to conform you have read and agreed to the statement and laws.

Once these steps have been completed, please select the 'Begin Enrollment/Registration' Button to proceed with your enrollment.

I have read and agree to the [Texas privacy statement](#) and laws.

Step 4. Fill out the Provider Enrollment Application.

- a) Complete each section of the application fully. *Once a section is completed it will be marked with a checkmark. It is recommended that you progress from one section to the*



next as they are laid out in the navigation bar as certain sections become prepopulated from information entered in previous sections. Start the application by reviewing the information prepopulated on the NPI TAXONOMY INFORMATION. If all is correct, continue to the next section by clicking on SERVICES PROVIDED.

| NAME | GENDER | ELIGIBLE TEXAS TAXONOMIES |
|-----------------|------------|---------------------------|
| [REDACTED] | [REDACTED] | [REDACTED] |
| NPI NUMBER | NPI TYPE | |
| [REDACTED] | Individual | |
| SOLE PROPRIETOR | STATUS | |
| NO | Active | |

b) To complete the SERVICES PROVIDED section, click + Add Services Provided. This will activate the Locations Where Services are Provided page. Answer the questions prompted as follows:

- IS THIS A NEW LOCATION? Yes
- ARE YOU A MEMBER OF A GROUP AT THIS LOCATION? No
- DO YOU BILL FOR SERVICES AT THIS LOCATION USING YOUR TAX ID? Yes

For the location name, list the school district's name. For the address, list the district's central office address. Click Verify Address to continue. *(See screenshot on next page)* If the address entered does not match the official address format for the location you may receive an alert stating "Address could not be found or was invalid". If this happens, check the "Continue with address entered" box and click Verify Address to clear this requirement.



Locations Where Services are Provided

IS THIS A NEW LOCATION? *

Yes No

ARE YOU A MEMBER OF A GROUP AT THIS LOCATION? *

Yes No

DO YOU BILL FOR SERVICES AT THIS LOCATION USING YOUR TAX ID? *

Yes No

LOCATION NAME

School District Name

ADDRESS LINE 1 * ADDRESS LINE 2 CITY *

[Redacted] Enter Street Address 2 [Redacted]

STATE * ZIP CODE * ZIP CODE +4

TX - Texas [Red Arrow] [Redacted] Enter Zip Extension

Verify Address

Next, use the drop-down menus to complete the Program Participation section of the Services Provided form. For the Program, select “Acute Care – Comprehensive Care Program (CCP)”. The options available for selection from the Primary Taxonomy and Provider Type drop-down menus will vary depending on the Program selected as well as the taxonomies associated with your NPI. The screenshot below shows how a licensed Speech-Language Pathologist would complete this section. Click Save to continue. *If you provide multiple services, repeat the process as many times as necessary to record the other services you provide before advancing to the next section of the application.*

Program Participation

PROGRAM *

Acute Care - Comprehensive Care Program (CCP) ▾

PRIMARY TAXONOMY * PROVIDER TYPE *

235Z00000X ▾ Speech-Language Pathologist (SLP) ▾

Save [Red Arrow]



- c) Click on the Provider Information button to open that form. All required fields are identified with a red asterisk (*). Complete all required fields with your personal information. *It is recommended that you use your personal email address so that your enrollment can follow you throughout your career, regardless of who your employer is at any particular time.* Click Verify Email once all fields have been completed.

The screenshot shows a web form titled "Provider Information" with a sub-section "Basic Information". The form contains several input fields, many of which are marked with a red asterisk (*) to indicate they are required. The fields are arranged in a grid-like fashion:

- FIRST NAME ***: Text input field with a blacked-out value.
- MIDDLE NAME**: Text input field with the placeholder "Enter Middle Name".
- LAST NAME ***: Text input field with a blacked-out value.
- SUFFIX**: Dropdown menu with "Select One" selected.
- SOCIAL SECURITY NUMBER ***: Text input field with a blacked-out value.
- DATE OF BIRTH ***: Date picker field with a blacked-out date.
- GENDER ***: Dropdown menu with a blacked-out value.
- ID TYPE ***: Dropdown menu with "Drivers License" selected.
- ID NUMBER ***: Text input field with a blacked-out value.
- STATE ISSUER ***: Dropdown menu with "TX - Texas" selected.
- ISSUE DATE ***: Date picker field with a blacked-out date.
- EXPIRATION DATE ***: Date picker field with a blacked-out date.
- PRIMARY EMAIL ADDRESS ***: Text input field with a blacked-out email address.
- PRIMARY EMAIL STATUS**: Text input field (empty).
- SECONDARY EMAIL ADDRESS**: Text input field with the placeholder "Enter Secondary E-Mail".
- SECONDARY EMAIL STATUS**: Text input field (empty).

A red arrow points to a dark blue button labeled "Verify Email" located at the bottom right of the form.

This will automatically send an email to the address listed. It may take 10-15 minutes to receive the message. The email will be sent from PEMSEmailService@tmhp.com. Once received, open the message and click on the Confirm your email link. Then, return to the provider enrollment application, scroll to the bottom of the page and click Save.

- d) At this point, at a minimum you should see check marks for the NPI TAXONOMY INFORMATION, SERVICES PROVIDED, and PROVIDER INFORMATION sections of the application. *Other sections of the application may also show a check mark. This is because they are prefilled for you from the information entered in other sections of the application. You will need to review all sections to verify accuracy before submitting the application.* Select LICENSES/CERTIFICATIONS/ACCREDITATIONS button to open the next section.



| | |
|--|-------------------------------------|
| NPI TAXONOMY INFORMATION | <input checked="" type="checkbox"/> |
| SERVICES PROVIDED | <input checked="" type="checkbox"/> |
| PROVIDER INFORMATION | <input checked="" type="checkbox"/> |
| LICENSES/CERTIFICATIONS/ ACCREDITATIONS | <input type="checkbox"/> |

Click “+ Add Licenses/Certifications/Accreditations” to complete this form. Use the drop-down menus and enter the required information. If you do not have your licensure information on hand, reach out to your licensing board for guidance. See the example below. Once all information has been entered, click Save.

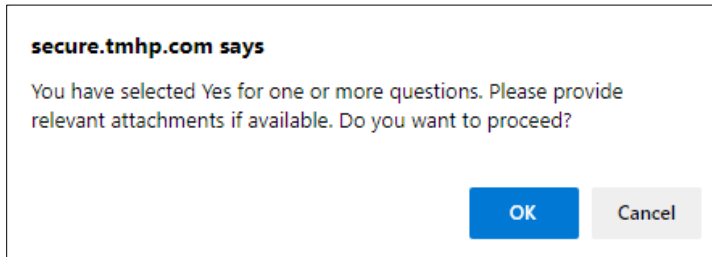
Add Licenses/Certifications/Accreditations Pending Change Request Number: [REDACTED]

| | | |
|---|--|---|
| LICENSE/CERTIFICATION/ACCREDITATION TYPE * | ISSUER* | NUMBER* |
| <input type="text" value="LICENSES"/> | <input type="text" value="Texas Department of Licensing"/> | <input type="text" value="123456789"/> |
| TYPE* | | |
| <input type="text" value="SPEECH LANGUAGE PATHOLOG"/> | | |
| EFFECTIVE DATE * | EXPIRATION DATE * | LAST UPDATE DATE |
| <input type="text" value="12/01/2020"/> | <input type="text" value="01/01/2024"/> | <input type="text" value="MM/DD/YYYY"/> |
| STATE ISSUER* | | |
| <input type="text" value="TX - Texas"/> | | |



If you have additional licenses that authorize you to provide Medicaid services, repeat this process. Otherwise, select DISCLOSURES from the left navigation bar to continue to the next section of the application.

- e) Answer each of the Yes/No questions on the Disclosures form. Click Save to continue. Most providers will receive the message below.



Except for the last question, if you answered Yes to any of the questions you will need to upload supporting documentation. Click OK to move forward. If you did answer Yes to any question, other than the citizenship question, use the drop-down menu to select the question associated with your upload, then use the Attachments tool to upload your supporting documentation.

- f) Next, from the navigation bar, select ACCOUNTING/BILLING INFORMATION. Then, click on "+Add Accounting/Billing Information". Complete all required fields. Use your personal home address to complete this section. For the "DO YOU HAVE A THIRD PARTY BILLER?" question, answer No. Click Verify Address.



0 TOTAL DEFICIENCIES

ACCOUNTING/BILLING

W-9

EFT

Pending Change Request Number: [REDACTED]

ACCOUNTING/BILLING INFORMATION

CONTACT - FIRST NAME *

CONTACT - MIDDLE NAME

CONTACT - LAST NAME *

ADDRESS LINE 1 *

ADDRESS LINE 2

CITY *

STATE *

ZIP CODE *

ZIP CODE +4

Address has been verified

Click to change address

CONTACT PHONE NUMBER *

EXT.

CONTACT FAX NUMBER

Third Party Biller

DO YOU HAVE A THIRD PARTY BILLER? *

Yes No

Once verified, click Save to continue.



Next, click the W-9 button to advance to the next page. *You will need a copy of your most recent tax return to complete this form.* Remember, you are to answer all questions using your personal information. See the example below. *Most providers will only need to answer Questions 1 and 3 of the top section. Questions 5 and 6 will be prefilled from information supplied in earlier sections of the application.*

Substitute Form W-9:
Taxpayer Identification Number and Certification

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.*

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only One of the following seven boxes.*

Individual/sole
 proprietor or single-member LLC C Corporation S Corporation

Partnership Trust/estate

Limited Liability Company. Enter the tax classification (C=Corporation, S=S corporation, P=Partnership)

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

6 City, state, and ZIP code

7 List account number(s) here (optional)



Next, complete Part I by filling out the Social Security Number field. Then, review the Certification statement in Part II. Look over the information you have entered on this page, if all is accurate, click on the “I attest this is what appears on my W-9.” box.

| | |
|---|---|
| Part I Taxpayer Identification Number (TIN) | |
| Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). | Social Security Number <input type="text"/> |
| Note: If the account is in more than one name, see the instructions for line 1. Also see What Name and Number To Give the Requester for guidelines on whose number to enter. | Or Employer Identification Number <input type="text"/> |
| Part II Certification | |
| <p>1. The number shown on this form is my correct taxpayer identification number; and</p> <p>2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and</p> <p>3. I am a U.S. citizen or other U.S. person; and</p> <p>4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.</p> <p>Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.</p> <p><input type="checkbox"/> Check here to cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.</p> <p><input checked="" type="checkbox"/> I attest this is what appears on my W-9.*</p> <p>The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.</p> | |

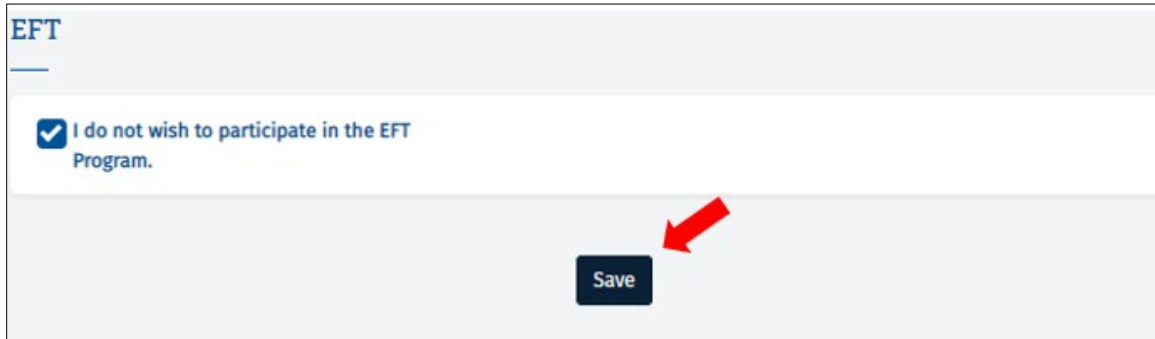
Scroll down to the Public/Private section. For the “Are you a private or public entity?” question, select Private.

| | |
|--|---|
| Public / Private | |
| Public/Private Entities (required for all providers): | |
| Definition: Public entities are those that are owned or operated by a city, state, county or other government agency or instrumentality, according to the Code of Federal Regulations, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds. | |
| Are you a private or public entity?* | <input checked="" type="radio"/> Private <input type="radio"/> Public |

Finally, in the Additional Entity Information and Attachments section, answer as indicated in your most recent tax return. *Most providers will be able to select No to move forward. Regardless of how you answer this question, you will at a minimum be required to use the drop-down menu to select a state for the State of Entity’s Formation.* Once you have completed all required fields, click Save to continue.

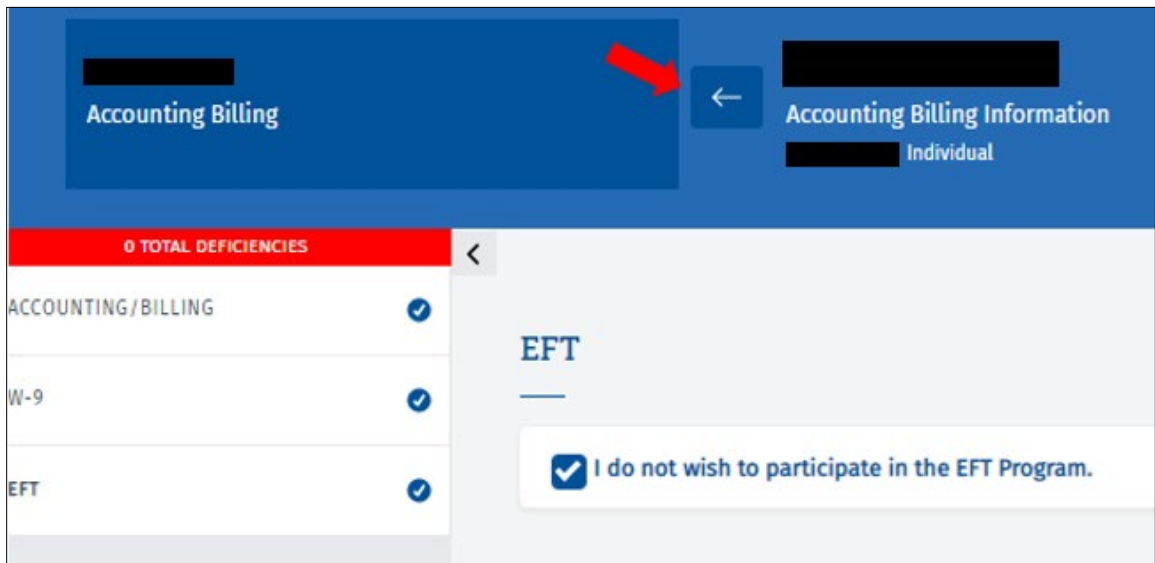


Next, click on the EFT button to open the next form. Individual SHARS providers do not bill TMHP for SHARS reimbursement directly. All reimbursement claims are submitted by the district. Therefore, it is not necessary to enter bank information for direct deposits. Simply click on the box next to “I do not wish to participate in the EFT program.”



The screenshot shows a form titled "EFT" with a checked checkbox labeled "I do not wish to participate in the EFT Program." Below the checkbox is a dark blue "Save" button. A red arrow points to the "Save" button.

Click Save to Continue. If you see a checkmark for all three Accounting Billing Information subsections, click on the back button to return to the main part of the application.



The screenshot shows the "Accounting Billing Information" screen for an individual. At the top, there is a blue header with "Accounting Billing" on the left and "Accounting Billing Information" on the right. Below the header is a red bar with "0 TOTAL DEFICIENCIES". A list of subsections is shown on the left: "ACCOUNTING/BILLING", "W-9", and "EFT", each with a blue checkmark. A back button with a white arrow is located to the right of the list. A red arrow points to the back button. The main content area shows the "EFT" form with the checked checkbox "I do not wish to participate in the EFT Program."

- g) Next, click on the OWNERSHIP/CONTROLLING INTEREST button. Read and answer all required Yes/No questions. *Most providers will answer No to all questions. Remember that as you review the questions and answers, your answers should be based on your personal information. You are not answering on behalf of your employer.* Once all Yes/No questions have been answered, scroll down to the bottom, click Save and then in the Owners/Creditors/Principals section, click “+Add Owner/Creditor/Principal”.

| NAME/COMPANY NAME | SSN/TAX ID | DATE OF BIRTH | RELATIONSHIP END DATE | DRIVER'S LICENSE OR OTHER NUMBER | PERCENT OWNED | FINGERPRINT REQUIRED |
|--------------------------------|------------|---------------|-----------------------|----------------------------------|---------------|----------------------|
| No data available in table | | | | | | |
| + Add Owner/Creditor/Principal | | | | | | |

As an individual provider, you are the principal you will be entering. The information you enter should be your personal information. Enter your SSN when prompted and press Verify Information.

SSN or Tax ID Lookup

Using the SSN or Tax ID Number, search for an existing owner, principal, or creditor.

Enter SSN or Tax ID Number

Before manually entering all the information required to add a new owner, creditor or principal, use the above search to see if the person or entity already exists in the system. This will ensure minimum errors and redundancies.

Verify Information
Cancel

Once verified, click Continue to advance to the next screen.



You will be taken to the Basic Information form. Answer the questions as indicated below:

Select person or entity: Person

Select principal or subcontractor: Principal

What is the percentage(%) of ownership? 100

As you complete these questions additional fields will be enabled. Answer them with your personal information. *Leave the Relationship questions at the bottom of the form blank.*

Select person or entity* Person Entity

Select principal or subcontractor* Principal Subcontractor

What is the percentage(%) of ownership?*

FIRST NAME MIDDLE NAME LAST NAME

GENDER DATE OF BIRTH SOCIAL SECURITY NUMBER

DRIVER'S LICENSE OR OTHER NUMBER STATE ISSUER DRIVER'S LICENSE OR OTHER NUMBER EXPIRATION DATE

MAIDEN NAME ALIAS NAME

OWNER/CREDITOR/PRINCIPAL RELATIONSHIP END DATE REASON RELATIONSHIP ENDED

Click Save and then open the Addresses form from the left navigation bar. When prompted, enter your personal address. Click Verify Address. Once verified, click the Same as Physical Address box to bypass the Accounting/Billing Address section.

Physical Address

ADDRESS LINE 1* ADDRESS LINE 2

CITY* STATE*

ZIP CODE* Zip Code + 4

Address has been verified

Verify Address Click to change address

Same as Physical Address



Click Save to record your entry. Then, open the HEALTHCARE LICENSES/CERTIFICATIONS/ACCREDITATIONS form. Answer Yes to the “Do you have a professional license” question. This will activate a new section. Click on “+ Add Healthcare Licenses/Certifications/Accreditations”. Use the drop-down menus to answer the LICENSE/CERTIFICATION/ACCREDITATION TYPE, ISSUER, TYPE, AND STATE ISSUER questions. Complete the remaining required fields manually. *See the example below.* Click Save to record your entries.

Add Healthcare Licenses/Certifications/Accreditations Detail Pending Change Request Number: [REDACTED]

LICENSE / CERTIFICATION / ACCREDITATION TYPE *
LICENSES

ISSUER *
Texas Department of Licensing a

NUMBER *
123456

TYPE *
SPEECH LANGUAGE PATHOLOGIST

EFFECTIVE DATE *
01/01/2020

EXPIRATION DATE *
01/31/2025

LAST UPDATE DATE
08/25/2022

STATE ISSUER *
TX - Texas

Save

Repeat the process if you have multiple licenses/certifications/accreditations to report. Note that you will not see a checkmark after you make your first entry for this form. This is because this section is left open for you to add more entries if necessary. Click on the EMPLOYMENT INFORMATION button to advance to the next form.

Answer the required questions, using the drop-down menus (when available). *The start date refers to the date you began employment with your current employer.* If you have worked for another Medicaid provider in the past, answer Yes to the “Do you have employment history with a separate provider” question. You will be prompted to enter additional information. If you do not have the provider’s information to complete this



section you can look up the provider using the [NPPES NPI Registry Look Up Tool](#). If you have not worked for another provider select No. When all entries have been made, click Save.

< **Employment Information** Pending Change Request Number: 20103033

YOUR TITLE IN THE PROVIDER ORGANIZATION FOR WHICH ENROLLMENT IS BEING SOUGHT * **YOUR DUTIES TO THE PROVIDER ORGANIZATION ***

Speech Language Pathologist Provide referrals, perform evaluation

YOUR ROLE IN THE PROVIDER ORGANIZATION * **ROLE EFFECTIVE START DATE *** **END DATE**

Employee ▼ 01/01/2020 MM/DD/YYYY Remove

+ Add Job Role

Do you have employment history with a separate provider? * Yes No

NPI * **PROVIDER NAME *** **ADDRESS (NUMBER, STREET, AND APT. OR SUITE NO.) ***

Enter NPI Number Enter Provider Name Enter Provider Address

CITY * **STATE *** **START DATE *** **END DATE**

Enter City Select One ▼ MM/DD/YYYY MM/DD/YYYY

Remove

+ Add Another

Save

Next, open the RELATIONSHIP INFORMATION form from the left navigation bar. Answer the Yes/No question. The question refers to if you currently have a contractual, working relationship with another Medicaid provider. If "Yes," list each of the medical entities with whom you have a contractual relationship and, if known, the NPI or Atypical



Provider Identifier (API) of each entity (if applicable). If you do not have the entity's NPI, you can look it up using the [NPPES NPI Registry Look Up Tool](#). When done answering, click Save.

At this point, you should see check marks for the first five sections of the Owner/Creditor/Principal Information form. Click on DISCLOSURES to open the last section.

A screenshot of a web form interface. At the top, a red banner displays "0 TOTAL DEFICIENCIES". Below this, a list of sections is shown, each with a checkmark icon to its right, indicating completion. The sections are: "BASIC INFORMATION", "ADDRESSES", "HEALTHCARE LICENSES/CERTIFICATIONS/ACCREDITATIONS", "EMPLOYMENT INFORMATION", "RELATIONSHIP INFORMATION", and "DISCLOSURES". A red arrow points to the "DISCLOSURES" section, which has an empty circle icon next to it, indicating it is not yet completed.

Answer each of the Yes/No questions on the DISCLOSURES form. The questions are similar to those answered in the previous Disclosures section. Click Save to continue after you have answered all questions. Most providers will receive the message below.

An alert box with a white background and a thin border. The text inside reads: "secure.tmhp.com says" followed by "You have selected Yes for one or more questions. Please provide relevant attachments if available. Do you want to proceed?". At the bottom right, there are two buttons: a blue "OK" button and a grey "Cancel" button.

Except for the last question, if you answered Yes to any of the questions you will need to upload supporting documentation. Click OK to move forward. If you did answer Yes to any question, other than the citizenship question, use the drop-down menu to select the question associated with your upload, then use the Attachments tool to upload your supporting documentation.



After all questions have been answered and any necessary supporting documentation has been uploaded, you should see six blue check marks in your navigation panel. Click on the back button to return to the main application.

The screenshot shows a web application interface. At the top, there is a blue header with a navigation panel. On the left, a box labeled 'Ownership & Interest' is visible. On the right, a back button (left arrow) is highlighted with a red arrow, and text reads 'Provider/Creditor/Principal Information' and 'Individual'. Below the header, a red bar indicates '0 TOTAL DEFICIENCIES'. The left navigation panel lists several sections, each with a blue checkmark: BASIC INFORMATION, ADDRESSES, HEALTHCARE LICENSES/CERTIFICATIONS/ACCREDITATIONS, EMPLOYMENT INFORMATION, RELATIONSHIP INFORMATION, and DISCLOSURES. The main content area is titled 'Disclosures' and contains text: 'Sanction' is defined as recoupment, payment hold, imposition of Have you ever been sanctioned (as defined above) in any state or Is your professional healthcare license or certification currently re.

Once returned to the Ownership/Controlling Interest form, scroll down to the Designation of Authorized Individuals section. Click "+ Add Authorized Signatory". Upon completion of the entire provider enrollment application, each provider must electronically sign an HHSC Medicaid Agreement. The principal you select in this section will be the person that is emailed the form for signature. Use the drop-down menu to make your selection on the Add Authorized Signatory window. As you are the only principal you entered earlier in the application, your name will be the only option to select. Enter the email address you provided for yourself earlier in the application and click Save changes.



Add Authorized Signatory

Updates to the Title can be made on the Employment page for the selected Authorized Signatory

PRINCIPAL * POSITION/TITLE EMAIL ADDRESS *

John Doe Speech Language Path john.doe@email.com

Save changes Close

When returned to the Ownership/Controlling Interest page, click Save.

- h) Click on the PROGRAMS button to open the next section of the application. Some of the Yes/No questions will have been answered for you using information from earlier sections of the application. You will need to answer the remaining questions. Unless you provide services outside of the school setting, you will select “No” for the remaining questions. *For most providers, Acute Care – Comprehensive Care Program (CCP) will be the only program answered with “Yes” on this page.* When all questions have been answered, click Save.

- i) Next, click on the PRACTICE LOCATION INFORMATION button in the left navigation bar to open that section of the application. *Note, you may see a checkmark on this button and thus may be tempted to skip this section. Parts of this form have been prefilled for you with information entered earlier in the application but there are most likely parts that need to be completed, so do not skip this or any other section that has been check marked before you have reviewed them.* You should see one location listed. Click on the ellipsis at the end of the location row and click on Open.



Five additional sections will be activated. You must complete all to move forward. The Basic Information form will be mostly prefilled for you. Review the information, if correct, click Verify Address. Then, enter your phone number and click Save.

Next, open the PROGRAMS AND SERVICES PARTICIPATION form. You will only need to complete the Programs and Services Participation section of this page. To complete the form, click on the ellipsis at the end of the Acute Care – Comprehensive Care Program row and press Open.

| PRIMARY TAXONOMY | PROGRAM | BENEFIT CODE | STATUS | EFFECTIVE DATES | REQUEST ACTION |
|------------------|---|--------------|-------------------|----------------------|----------------|
| 235Z00000X | Acute Care - Comprehensive Care Program (CCP) | CCP - CCP | PENDINGENROLLMENT | 08/25/2022 - Present | ADDED |

+ Add Program and Service Participation


Use the drop-down menus to complete the required questions in the Program Participation and Services Provided sections. Your options will be limited to information entered earlier in the application. *The screenshot on the next page shows how an SLP would complete these sections.*

Program Participation

SELECT A PROGRAM.*

Acute Care - Comprehensive Care Program (CCP) ▼

RETROACTIVE CLAIM DATE



Status Codes

| CODE | TYPE | DESCRIPTION | EFFECTIVE DATES |
|----------------------------|------|-------------|-----------------|
| No data available in table | | | |

Services Provided

PRIMARY TAXONOMY* 235Z00000X ▼

PROVIDER TYPE* Speech-Language Pathologist (SLP-CCP) ▼

PROVIDER SPECIALTY* Speech Therapy (CCP) ▼

PROVIDER SUBSPECIALTY* N/A ▼

BENEFIT CODE CCP - CCP ▼

SECONDARY TAXONOMY Select One ▼

Next, in the Licenses/Certifications/Accreditations section, click “+ Association License/Certification/Accreditation”. Use the drop-down menu in the pop-up window to select your previously entered credentials and then click Save.

Add Licenses / Certifications / Accreditations

LICENSE/CERTIFICATION/ACCREDITATION

Select License/Certification/Accreditation ▼

Select License/Certification/Accreditation

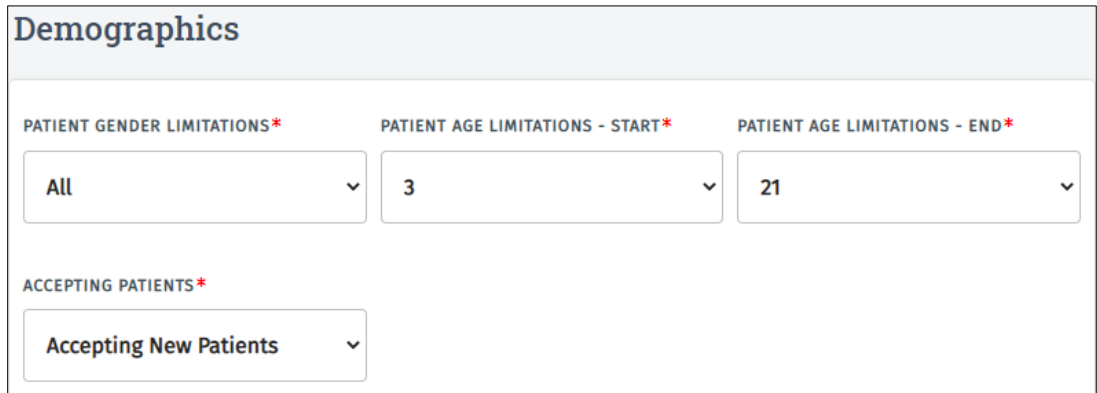
LICENSES - Texas Department of Licensing and Regulation - 123456

Cancel Save



Scroll down to the Demographics section. Use the drop-down menus to select the following options:

- PATIENT GENDER LIMITATIONS: All
- PATIENT AGE LIMITATIONS – START: 3
- PATIENT AGE LIMITATIONS – END: 21
- ACCEPTING PATIENTS: Accepting New Patients



The screenshot shows a form titled "Demographics" with four dropdown menus. The first menu, "PATIENT GENDER LIMITATIONS*", is set to "All". The second menu, "PATIENT AGE LIMITATIONS - START*", is set to "3". The third menu, "PATIENT AGE LIMITATIONS - END*", is set to "21". The fourth menu, "ACCEPTING PATIENTS*", is set to "Accepting New Patients".

These options are to be selected because you work with both male and female students as they come and go from the district. SHARS services are provided to students for them to receive a free and appropriate public education, which per regulations, begins as early as age 3. SHARS reimbursement for services to students, by rule, is limited to students 20 years of age and younger.

Next, scroll down to the Tax Payer Identification Number (TIN) section. Use the drop-down menu to select your social security number and address.

Scroll down to the Program Specific Questions. In the Training Provided area, select Not Applicable. Then, answer the required Yes/No questions. *Most providers will select no to all questions, except for the "Do you offer telehealth services" question.*

Finally, scroll down to the Healthy Texas Women (HTW) section. HTW is not a program that your school district participates in so select "No, I do not provide HTW or HTW Plus services at this location and do not wish for this location included in online provider lookup tools." Click Save and scroll back to the top of the page to select the Demographics form from the left-hand navigation panel.

Click the field below COUNTIES SERVED to select the county you provide services in. *You can select multiple counties if necessary.* Next, in the Office Hours section, enter your district's hours of operation. Enter the hours in the fields for Monday and then click Apply To All. This will apply the same hours to the other days listed. Select the Closed box for Saturday and Sunday and then click Save.



Office Hours

Monday*
 8:00 AM - 5:00 PM Closed

Tuesday*
 8:00 AM - 5:00 PM Closed

Wednesday*
 8:00 AM - 5:00 PM Closed

Thursday*
 8:00 AM - 5:00 PM Closed

Friday*
 8:00 AM - 5:00 PM Closed

Saturday*
 Select Open 1 - Select Close 1 Closed

Sunday*
 Select Open 1 - Select Close 1 Closed

Apply To All


Save

Scroll back to the top of the page. From the left-hand navigation panel, select Managing Employees. Click on “+ Add Managing Employee Association” to open the form. Use the drop-down menus to complete the SELECTED EMPLOYEE and MANAGING EMPLOYEE ROLE fields. Your options will be limited to information entered earlier in the application. If you have followed these instructions, you will be selecting yourself. As a result, the START DATE AT THIS LOCATION you should enter should be the date you started working for the district where you are currently employed. Click Save to record your answers.



Add/Edit Employee


| | | | |
|---------------------|-----------------------------|----------------------------------|---------------------------|
| SELECTED EMPLOYEE * | MANAGING EMPLOYEE ROLE * | START DATE AT THIS LOCATION * | END DATE AT THIS LOCATION |
| John Doe | Employee | 01/01/2022 | |



Once your entry has been processed, move on to the MAILING/CONTACT ADDRESSES section. Click on “+ Add Mailing/Contact Addresses”. Use the ADDRESS TYPE drop-down menu to select Contact Address. *Then, it is recommended that you enter your personal address. This is the address that will be used to send notices via mail. If you’d prefer to list the district’s address you used earlier in the application, you may do so but be certain to list the district’s name in the LOCATION NAME field.* Once you have made your entries, click Verify Address. Enter your PHONE NUMBER and then under the Contact Information, use the drop-down menu below CONTACT TYPE to select Provider. Enter your personal email address in the EMAIL ADDRESS field and then enter your first and last name in the final two fields. Click Save.

Contact Information

| | |
|----------------|---------------------|
| CONTACT TYPE * | EMAIL ADDRESS * |
| Provider | [REDACTED] |
| FIRST NAME * | COMPANY/LAST NAME * |
| [REDACTED] | [REDACTED] |



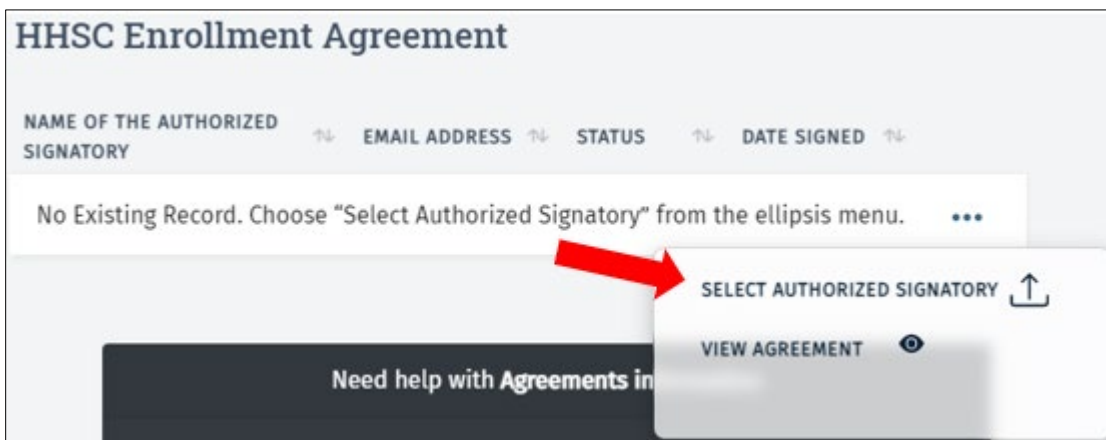
You should see check marks for all five of the sections of the Practice Location form. If you do, click on the arrow to return to “mail application”. If any section is not check marked, return to it to complete any unanswered questions.



If you provide services at multiple districts you can repeat these steps to add additional Practice Locations. If you do not provide services at other locations you can advance to the final steps of the application.

- j) From the left-hand navigation panel, open the AGREEMENTS form. *Per TMHP, your provider type is not required to pay an application fee and if all steps in these instructions have been followed, there should be no attachments needed to complete your application so both those forms can be skipped.*

All providers that enroll in Texas Medicaid, must electronically sign the HHSC Enrollment Agreement form. *The AGREEMENTS page is where you will select the principal that will sign the form on your behalf. As you are the only principal you entered earlier in the application, you will be limited to yourself as the only option to select. Click on the ellipsis and click SELECT AUTHORIZED SIGNATORY.*



The Add Authorized Signatory window should appear. Your name should auto-populate into the Name of Authorized Signatory field. Enter the email address that you would like the agreement sent to in the adjacent field and click Activate Agreement. Once you are

returned to the Agreements & Signatures page you will see the HHSC Enrollment Agreement status will say Sent.

Step 5. Electronically Sign HHSC Medicaid Agreement

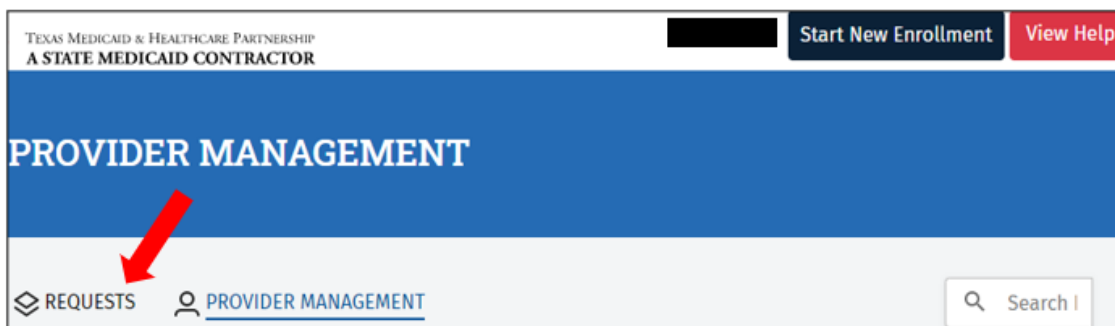
Usually, within 5 – 10 minutes, you will receive an email from PEMSEmailService@tmhp.com informing you there is a form that you will need to sign electronically to complete your provider enrollment application. Click on the link in the email message to open the form. You will be prompted to enter a code to verify your identity and access the form. The code will be the last four digits of your Social Security Number. Once you have opened the form, follow the prompts to sign the agreement electronically.

After you have signed all parts of the form you will receive a completed message. Once the signed form has been processed you will see the HHSC Enrollment Form status change from Sent to Signed. Please note that it may take 24-48 hours for the form to process.

Step 6. Submit application

Once the signed Medicaid Agreement form has been processed you will see the HHSC Enrollment Form status change from Sent to Signed, as well as a Submit button. Once the button has been enabled for you, click Submit to send the application for Provider Enrollment review.

In some cases, the Submit button is enabled almost instantly after the HHSC Provider Agreement is signed. If you must wait for it and need to log out, you can return to the application at a later time by following the instructions listed in Step 2. Once you have navigated to the Provider Enrollment Management System page, to access the form itself you will click on the REQUESTS button.



Click on the ellipsis and select Open to access the application. Then, click on the AGREEMENTS button. If the enrollment agreement has been processed, the Submit button will be enabled for you. If it has been more than 24 – 48 hours, you will need to call the TMHP Contact Center at 1-800-925-9126 to speak to the Provider Enrollment group for assistance.



Step 7. Follow Up on Application

After the application has been submitted, it will take 30-60 days to process. As the application is reviewed by TMHP, if any errors are identified, you will be contacted to make corrections.

It is recommended that you periodically follow up on the application. To do so, simply use the instructions in Step 2 to access PEMS and then click on the REQUESTS button. If you see the STATUS says PE Review, your application is still being processed. If the STATUS reads Closed – Enrolled, it has been accepted and no further action is needed. If you see any other status, click on the ellipsis and then Open the application. Once you have done so you should see a note box that informs you of any deficiencies that have been found that must be corrected to resubmit the application. For assistance clearing a deficiency, contact TASB Special Education Solutions at shars@tasb.org or call the TMHP Contact Center at 1-800-925-9126.

