Welcome to Pennsylvania Certified Perinatal Doula Enrollment Training

Topics

Primary topics:

- Affordable Care Act Overview
- What is a Perinatal Doula?
- Perinatal Doula Enrollment Requirements
- Accessing the Enrollment Application
- Enrollment Application Completion
- Resume Application
- Check Application Status
- Resources

ACA - Overview

- In accordance with federal Medicaid requirements at 42 CFR §§ 438.602(b) and 438.608(b), relating to state responsibilities and program integrity requirements under the contract, with regard to the screening, enrollment and revalidation of providers, a provider must be enrolled in the MA Program as a condition of being enrolled in a managed care network.
- Pennsylvania Certified Perinatal Doulas who wish to participate as MCO network providers to render services to MA beneficiaries under the MA managed care delivery system must be enrolled in the MA Program.
- The ACA and implementing regulations require states to revalidate the enrollment of providers every five years.

Please Note: This training does not address MCO credentialing or contracting questions or concerns.

What is a Perinatal Doula?

- Perinatal Doulas are trained professionals who provide non-medical support and guidance to pregnant individuals in various aspects including reproductive health and family services.
- Perinatal Doula services include emotional, physical, and informational support and guidance, advocacy, evidence-based education, and connections to any needed resources.

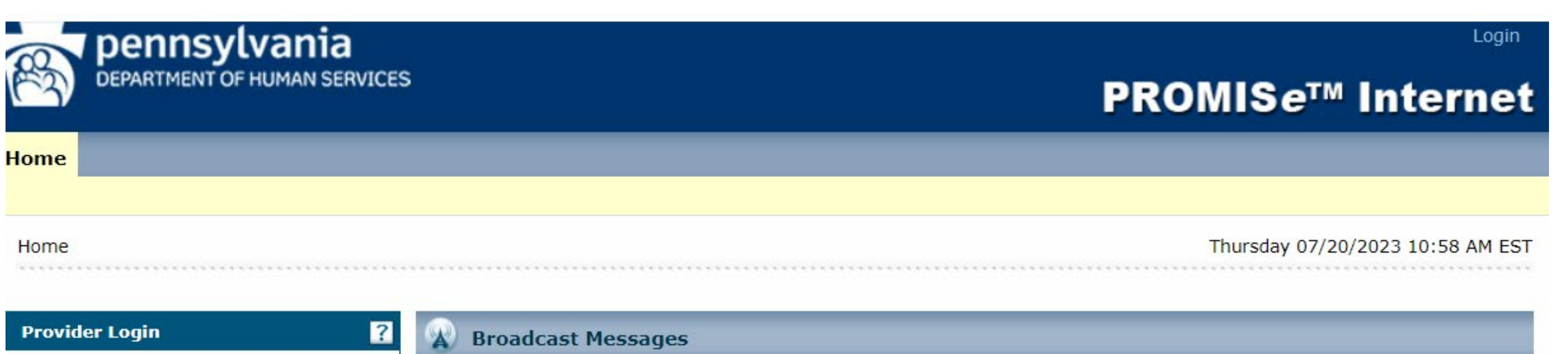
Perinatal Doula Enrollment Requirements

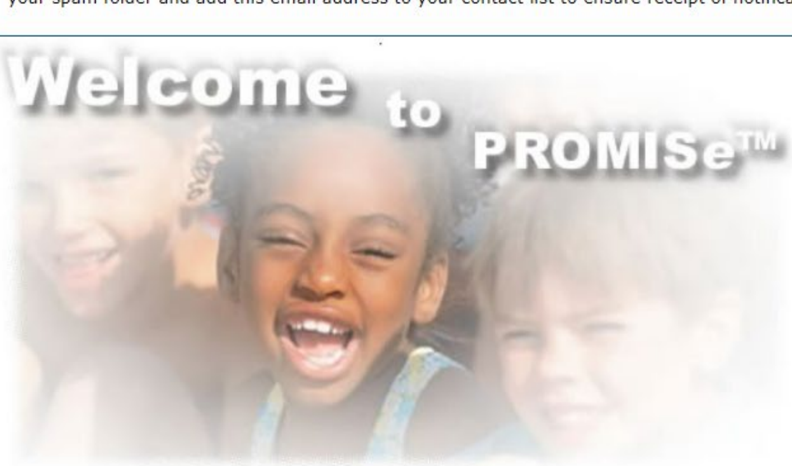
- Effective February 1, 2024, Perinatal Doulas may enroll in the Medical Assistance (MA) Program to allow for participation in the managed care networks within the MA managed care delivery system.
- Must have current certification from the Pennsylvania Certification Board as a Certified Perinatal Doula.
  - Provider Type 13 – Non-Traditional Provider
  - Specialty Code 130 Certified Doula

Accessing Enrollment Application

- Perinatal Doulas wishing to enroll will need to complete a new enrollment application
  - Step 1:
    - Go to the Landing page of the PROMISe™ Portal.
      - website: promise.dpw.state.pa.us
  - Step 2:
    - Select “New Application” from the Provider Enrollment Section of the Landing Page.
  - Step 3:
    - Complete the application using the Doulas’ information and submit.

Accessing Enrollment Application





The Commonwealth of Pennsylvania Department of Human Services offers state of the art technology with PROMISe™, the claims

Application Tracking Number (ATN)

- Each online provider enrollment application is assigned a unique Application Tracking Number (ATN).
- An email containing the 10-digit ATN will be sent to the email address entered in the Contact Information.
- Additionally, the ATN will display at the top of the application.
- The ATN is required to resume or check the status of the application.

Email Notifications

The electronic enrollment system will send email notices to providers at key points during the application submission and determination process. The emails will be generated from a ‘do not reply’ email address. The following are the types of emails generated:

- Online Application Initiated
- Online Application Submitted
- Online Application Returned to Provider for Revisions
- Online Application Initiated – Expiring
- Online Application Returned to Provider – Expiring

Perinatal Doula Enrollment Application Completion

Request Information Page

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ATN: 1000008163 **Provider Number:** Pending **Type:** New Enrollment **Start Date:** 11/13/2023 **Completion By:** 01/12/2024

Request Information

You are initiating a provider enrollment application for the Pennsylvania Department of Human Services (DHS) Medical Assistance (MA) program and/or the Pennsylvania Children's Health Insurance Program (CHIP). If you are enrolled as a MA provider and provide CHIP services at this service location, a separate CHIP enrollment application is not required.

If you exit the application before it has been submitted, you can resume your provider enrollment application at a later time by providing the system generated Application Tracking Number (ATN), the Federal Tax Identification Number (FEIN or SSN) and password you established.

In addition, once submitted, you can check the status of your application at any time by selecting the "Application Status" link from the PROMISe portal landing page on the left side under "Provider Enrollment", entering the ATN, SSN/FEIN, and password fields and clicking "submit". The Application Summary section will display on the page showing the current status of the application.

* Indicates a required field.

Indicates an attachment is required.

Initial Enrollment Information

Verify your program type, provider type and enrollment type selections prior to saving this page. Once this information is saved, it cannot be changed. If this information is incorrect, you will need to begin a brand new application.

* **Program Type**	Pennsylvania Medical Assistance (PA MA)
* **Provider Type**	13 - Non-Traditional Provider
* **Enrollment Type**	Individual with SSN

Tax Identifier

Based on the Enrollment Type selected above, you are required to specify either a Social Security Number (SSN) or Federal Tax Identification Number (FEIN). A Federal Tax Identification Number (FEIN) is used to identify a business entity. A Social Security Number (SSN) is used to identify an individual.

* **Social Security Number (SSN)**
* **Confirm Social Security Number (SSN)**

Name of Enrollee

Based on the Enrollment Type selected above, you are required to specify either an Entity Name or an Individual's Name.

* **Last Name**	Doula		
* **First Name**	Provider	**Middle Initial**	

Medicare Enrollment Information

* **Are you a Medicare participating Provider?** ☐ Yes ☑ No

Contact Information

Contact information will be used for correspondence regarding this application. This is not required to be the provider's contact information, but rather should be the contact information of the person who is completing the application and can assist with questions regarding this application. In addition, email notifications will be sent to the contact email address provided, at key points during the application process:

- Online application initiated
- Online application submitted
- Online application returned to provider for revisions
- Online application expiring

* **Last Name**	Elias		
* **First Name**	Lana		
Title			
* **Phone Number**	717-634-1567	**Phone Extension**	
Toll Free Number	###-###-####	**Toll Free Extension**	
Fax Number	###-###-####		
* **Email**	lana.elias@gainwelltechnologies.com		
* **Confirm Email**	lana.elias@gainwelltechnologies.com		

Finish Later Save & Continue

Service Location Address Page

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ATN: 1000008163 **Provider Number:** Pending **Type:** New Enrollment **Start Date:** 11/13/2023 **Completion By:** 01/12/2024

Service Location Address

Complete the fields on this page and select the Save and Continue button to continue with this application

* Indicates a required field.

Indicates an attachment is required.

Service Location Physical Address

This address must be a physical address where a practitioner maintains an office, holds office hours/sets appointments and renders services. A post office box is not a valid Service Location Physical Address.

Verify your selection of the service location physical address state prior to saving this page. Once this information is saved, it cannot be changed. If this information is incorrect, you will need to begin a brand new application.

*Street	10 Apple Lane	Room/Suite	
*City	Hometown	*State	PA - Pennsylvania
*Zip+4	18001-1234	*County	Schuylkill
*Email	lana.elias@gainwelltechnologies.com	*Confirm Email	lana.elias@gainwelltechnologies.com
*Phone Number	717-634-1567	Phone Extension	
Fax Number	###-###-####		

After this information is saved, you will have the option to enter different address information for Mail-To, Pay-To, and Home Office Addresses on a separate page.

General & Historical Questions

The following questions pertain to the service location you are enrolling.

*Does the office have exterior steps leading to the main entrance doorway?	Yes	No ☑
*Does the office have interior steps leading to the main entrance doorway?	Yes	No ☑
*Is this address an active Rural Health Clinic or FQHC?	Yes	No ☑

Has screening been performed at this location for this provider within the last 12 months by:

*Medicare?	Yes	No ☑
*Children's Health Insurance Program (CHIP)?	Yes	No ☑
*Another state's Medicaid?	Yes	No ☑

Finish Later | Save & Continue

Other Addresses Page

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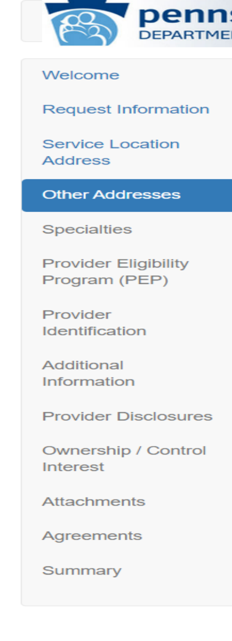

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Other Addresses

On this page you have the option to assign a Mail-To, Pay-To or Home Office address that is different from the Service Location Physical Address.

Below is the physical address of your service location. This address is currently being set as the default address for all other address types. If you would like to specify a different address, please check the box next to the corresponding address type. Leaving a box unchecked will default that address to your service locations address.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.

Service Location Physical Address

Street	10 Apple Lane	**Room/Suite**	
City	Hometown	**State**	PA - Pennsylvania
Zip+4	18001-1234		

Other Address Information

Select the address type that you would like to be different than the Service Location Physical Address:

- ☐ Mail-To
- ☐ Pay-To
- ☐ Home Office

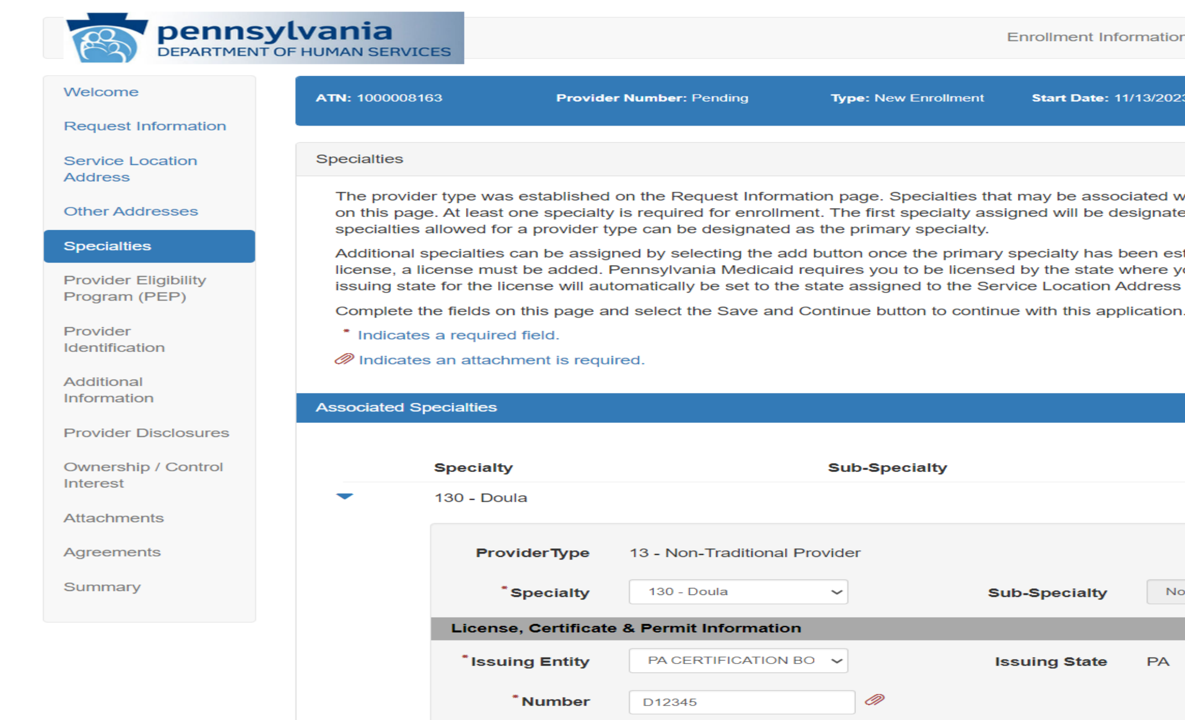
If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information: https://www.dhs.pa.gov/providers/Providers/Pages/Electronic-Funds-Transfer.aspx

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

***Would you like to receive E-Mail notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used.** ☑ Yes ☐ No

Finish Later | Save & Continue

Specialties Page



Program Eligibility Program (PEP) Page

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Provider Eligibility Program (PEP)

Provider Eligibility Programs (PEPs) that may be associated with the provider type and specialties selected earlier in the application process can be added on this page. At least one PEP is required for enrollment.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.

Requested Effective Date

By default, the requested effective date for this application will be set to the submission date of the application when the application is submitted.

***Is a requested effective date prior to the application submission date required for this enrollment?** ☐ Yes ☑ No

Associated PEPs

You may select more than one Provider Eligibility Program (PEP) by clicking on the appropriate PEPs.

***Provider Eligibility Program (PEP)**

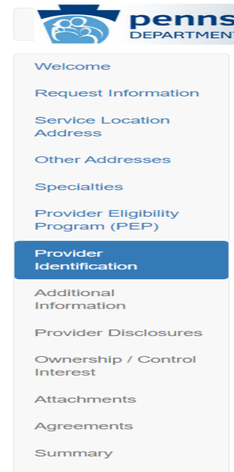
☑ Enrollment Not Paid

Click below to download a listing of the Provider Eligibility Programs (PEP) and their descriptions.

Download

Finish Later Save & Continue

Provider Identification Page



Additional Information Page

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Additional Information

Additional information for the provider is collected on this page.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.
Indicates an attachment is required.

Enrollment Languages

***In addition to English, do you or your staff communicate with patients in another language?** ☐ Yes ☑ No

Finish Later | Save & Continue

Provider Disclosure Page

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Provider Disclosures

Respond to the following provider disclosure questions and select the Save and Continue button to continue with this application.

* Indicates a required field.
Indicates an attachment is required.

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.
Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Have you ever:

- * Had clinical privileges or hospital privileges denied, suspended, restricted, revoked, or not renewed; either voluntarily or involuntarily for an agreed to definite or indefinite period of time? — Yes / No
- * Had any judgments entered against you or settlements been agreed to in any professional liability cases? — Yes / No
- * Are there any professional liability lawsuits pending against you at the present time? — Yes / No
- * Do you have physical or mental health condition(s) which in any way impairs your ability to practice your profession, with or without accommodations? — Yes / No
- * Do you have any physical or mental health condition(s) which in any way poses a risk of harm to your patients? — Yes / No
- * Are you currently using, or have you used in the past five years, drugs or any other chemical substance that has or may impair your ability to practice your profession? — Yes / No

Have you or anyone in your employ ever:

- * Been terminated, excluded, precluded, suspended, debarred from or had your participation in any federal or state health care program or hospital privileges limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time? — Yes / No
- * Been the subject of a disciplinary proceeding by any licensing or certifying agency, had your license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? — Yes / No
- * Had a controlled drug license withdrawn? — Yes / No
- * Been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? — Yes / No
- * Been convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? — Yes / No
- * Been convicted of interference with or obstruction of any investigation? — Yes / No
- * In connection with the delivery of a health care item or service, or with respect to any act or omission in a heath care program, been convicted of any criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? — Yes / No
- * Been in default on repayments of scholarship obligations or loans in connection with your education as a health professional? — Yes / No
- * Been subject to a civil penalty or assessment for any act or omission related to Medicare, Medicaid, or a state health care program? — Yes / No

Finish Later | Save & Continue

Ownership/Control Interest Page

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Ownership/Control Interest

Note: Ownership and control information is required in accordance with Federal Regulations 42 CFR Part 455, Subpart B published July 17,1979, and expanded through additional subparts on February 02,2011 through the Provider Enrollment and Screening provisions of the Affordable Care Act

* Indicates a required field.

Indicates an attachment is required.

Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

a. An individual, agency, or organization to which a provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Managing Employee or Agent Disclosure

* **Does the enrolling individual practitioner have any Managing Employees or Agents?** ☐ Yes ☑ No

Direct Or Indirect Ownership

* **Are there any subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more?** ☐ Yes ☑ No

Criminal Offense

* **Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?** ☐ Yes ☑ No

Significant Business Transactions

* **Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?** ☐ Yes ☑ No

Finish Later | Save & Continue

Attachments Page

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Attachments

For each of the required attachments below you must upload the corresponding documents.

Use the Browse... to navigate to the document you wish to upload. Once you have chosen your document, please save the document to your application by clicking on Upload. Portable Document Format (PDF) is the only accepted document type for upload. Each file that you upload is limited to a maximum of **4MB** in size. Click on the appropriate link for more information on creating a PDF document when using Microsoft Windows or Apple macOS.

Some attachments require the use of a form that is available to download. If a form is required, the download icon will be displayed next to the Required Attachment's name. You can click this button to download the form as a PDF.

When available, additional information regarding the attachment/file can be displayed by clicking on the information icon.

Provider

Required Attachments (1 Total)	File
Copy of PA Certification Board	PCB123456L

Finish Later Save & Continue

Agreements Page

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

Provider Agreement for Outpatient Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and **Provider Doula** (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

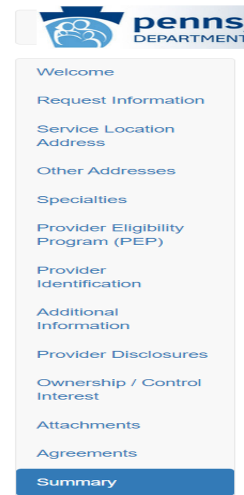
1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.
2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.
3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania Medical Assistance Program.
4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.
5. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
6. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:
   A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12—month period ending on the date of the request; and
   B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5—year period ending on the date of the request.
7. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
8. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.
9. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).
10. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.
11. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

* Please sign by typing your full name here: Provider Doula | Today's Date: 11/13/2023

Finish Later | Save & Continue

Summary Page



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ATN: 1000008163 **Provider Number:** Pending **Type:** New Enrollment **Start Date:** 11/13/2023 **Completion By:** 01/12/2024

Summary

Provider Information

Program Type Pennsylvania Medical Assistance (PA MA)
Provider Type 13 - Non-Traditional Provider
Enrollment Type Individual with SSN
Last Name Doula **First Name** Provider **Middle Initial**

Social Security Number (SSN) 987654321

Are you a Medicare participating Provider? No

Contact Information

Last Name Elias **First Name** Lana **Title**
Phone Number (717) 634-1567 **Extension**
Toll Free Number **Extension**
Fax Number
Email lana.elias@gainwelltechnologies.com

Service Location

Street 10 Apple Lane **Room/Suite**
City Hometown **State** PA - Pennsylvania
Zip+4 18001-1234 **County** Schuylkill
Email lana.elias@gainwelltechnologies.com
Phone Number (717) 634-1567 **Extension**
Fax Number

General & Historical Questions

Does the office have exterior steps leading to the main entrance doorway? No
Does the office have interior steps leading to the main entrance doorway? No
Is this address an active Rural Health Clinic or FQHC? No
Has screening been performed at this location for this provider within the last 12 months by:
Medicare? No
Children's Health Insurance Program (CHIP)? No
Another state's Medicaid? No

Enrollment Application Individual

Provider and Contact Information

ATN: 1100000000 **Provider Number:** Pending **Type:** New Enrollment **Start Date:** 11/16/2023 **Completion By:** 12/16/2023

Provider Information

Program Type Pennsylvania Medical Assistance (PA MA)
Provider Type 13 Certified Perinatal Doula
Enrollment Type SSN
Last Name Smith **First Name** John **Middle Initial**

Social Security Number (SSN)

Are you a Medicare participating Provider? Yes

Contact Information

Last Name Smith **First Name** John **Title** credentialing
Phone Number (215) 111-1111 **Extension**
Toll Free Number **Extension**
Fax Number
Email JJohn@newapp

Service Location Information

Service Location

Street	111 Holiday Ave	**Room/Suite**	
City	Philadelphia	**State**	PA - Pennsylvania
Zip+4	11111-2434	**County**	Philadelphia
Email	ekiss@gainwelltechnologies.com		
Phone Number	(215) 7894897	**Extension**	
Fax Number			

General & Historical Questions

Does the office have exterior steps leading to the main entrance doorway? No

Does the office have interior steps leading to the main entrance doorway? No

Is this address an active Rural Health Clinic or FQHC? No

Has screening been performed at this location for this provider within the last 12 months by:

- Medicare? No
- Children's Health Insurance Program (CHIP)? No
- Another state's Medicaid? No

Other Addresses

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information: Electronic Funds Direct Transfer (https://www.dhs.pa.gov/providers/Providers/Pages/Electronic-Funds-Transfer.aspx)

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

Would you like to receive E-Mail notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used. Yes

☑ **Mail-To Address :**

Street	111 B Street	**Room/Suite**	
City	Philadelphia	**State**	PA - Pennsylvania
Zip+4	11111-4106	**County**	Philadelphia
Email			
Phone Number	(215) 707-2433	**Extension**	
Fax Number			

☐ Check here if this address should be applied to all active service locations associated with this legal entity.

Specialties

Primary Specialty	Sub-Specialty	Primary
130 - Certified Doula		Yes

ProviderType 13 - Non-Traditional Provider

Specialty 130 - Certified Doula **Sub-Specialty**

License, Certificate & Permit Information

Issuing Entity	PA CERTIFICATION BOARD	**Issuing State**	PA
Number	PCB123456L		
Issuing Date	01/01/2018	**Expiration Date**	12/31/2035

Provider Eligibility Program (PEP)

Requested Effective Date

Is a requested effective date prior to the application submission date required for this enrollment? No

Associated PEPs

Provider Eligibility Program (PEP)

☑ Enrollment Not Paid

Provider Identification

Provider IRS/Legal Name and Address

Last Name		First Name		Middle Name	
Street		Room/Suite			
City		State	PA - Pennsylvania		
Zip+4					

Contact IRS/Legal Name and Address

Last Name		First Name		Title	
Phone Number		Extension			
Toll Free Number		Extension			
Fax Number					
Email	ekiss@gainwelltechnologies.com				

We DO NOT accept a W9 as verification of the Tax ID

Provider Identification

Individual Provider

Birth Date 04/02/1987 **Gender** M
Title/Degree

NPI

NPI 1609853225
Taxonomy

☐ 374J00000X - Nursing Service Related Providers: Doula

Additional Information

Enrollment Languages

In addition to English, do you or your staff communicate with patients in another language? No

Fee Assignments

Would you like to be fee assigned (linked) to a group? No

Provider Disclosures

Have you ever:

Had clinical privileges or hospital privileges denied, suspended, restricted, revoked, or not renewed; either voluntarily or involuntarily for an agreed to definite or indefinite period of time? No

Had any judgments entered against you or settlements been agreed to in any professional liability cases? No

Are there any professional liability lawsuits pending against you at the present time? No

Do you have physical or mental health condition(s) which in any way impairs your ability to practice your profession, with or without accommodations? No

Do you have any physical or mental health condition(s) which in any way poses a risk of harm to your patients? No

Are you currently using, or have you used in the past five years, drugs or any other chemical substance that has or may impair your ability to practice your profession? No

Have you or anyone in your employ ever:

Been terminated, excluded, precluded, suspended, debarred from or had your participation in any federal or state health care program or hospital privileges limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time? No

Been the subject of a disciplinary proceeding by any licensing or certifying agency, had your license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? No

Had a controlled drug license withdrawn? No

Been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? No

Been convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? No

Been convicted of interference with or obstruction of any investigation? No

In connection with the delivery of a health care item or service, or with respect to any act or omission in a heath care program, been convicted of any criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? No

Been in default on repayments of scholarship obligations or loans in connection with your education as a health professional? No

Been subject to a civil penalty or assessment for any act or omission related to Medicare, Medicaid, or a state health care program? No

Ownership / Managing Individuals

Managing Employee or Agent Disclosure

Does the enrolling individual practitioner have any Managing Employees or Agents? No

Direct Or Indirect Ownership

Are there any subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more? No

Criminal Offense

Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? No

Significant Business Transactions

Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? No

Provider

Required Attachment	Uploaded File Name
Copy of PA CERTIFICATION BOARD	PCB123456L

Provider Agreement for Outpatient Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and John Smith (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.

2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.

3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania Medical Assistance Program.

4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.

5. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.

6. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:

   A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12–month period ending on the date of the request; and

   B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5–year period ending on the date of the request.

7. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.

8. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.

Provider Agreement (cont.)

9. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).

10. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.

11. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

Please sign by typing your full name here: **John Smith** **Today's Date: 11/16/2023**

Submission Details

I have reviewed the information in this enrollment application and affirm that the information submitted in or with this application is true, accurate and complete.

I understand that I am responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if I become aware that any of the information is not true, accurate or complete.

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities.

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of my enrollment in the Pennsylvania Medical Assistance (PA MA).

Please sign by typing your full name here: **John Smith** Date of Submission: **11/16/2023**

⚠ **Prepared on 11/16/2023 by the PA Department of Human Services Provider Enrollment On-line Application.**

Enrollment Application Group

Provider Information

Program Type	Pennsylvania Medical Assistance (PA MA)
Provider Type	13 - Non-Traditional Provider
Enrollment Type	Group
Entity Name	Doula Group

FEIN 254131333

Are you a Medicare participating Provider? Yes

Contact Information

Last Name	doula	**First Name**	darla	**Title**
Phone Number	(254) 131-3334	**Extension**		
Toll Free Number		**Extension**		
Fax Number				
Email	ekiss@gainwelltechnologies.com			

Service Location

Street	320 woodruff way	**Room/Suite**	
City	harrisburg	**State**	PA - Pennsylvania
Zip+4	17112-1234	**County**	Dauphin
Email	ekiss@gainwelltechnologies.com		
Phone Number	(254) 131-3133	**Extension**	
Fax Number			

General & Historical Questions

Do you bill for a mobile medical unit from this location? No

Do you bill for a mobile dental unit from this location? No

Does the office have exterior steps leading to the main entrance doorway? No

Does the office have interior steps leading to the main entrance doorway? No

Is this address an active Rural Health Clinic or FQHC? No

Other Addresses

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information: Electronic Funds Direct Transfer (https://www.dhs.pa.gov/providers/Providers/Pages/Electronic-Funds-Transfer.aspx)

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

Would you like to receive E-Mail notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used. Yes

- ☐ **Mail-To Address :** *Same As Service Location*
- ☐ **Pay-To Address :** *Same As Service Location*
- ☐ **Home-Office Address :** *Same As Service Location*

Specialties

Primary Specialty	Sub-Specialty	Primary
130 - Certified Doula		Yes

ProviderType	13 - Non-Traditional Provider		
Specialty	130 - Certified Doula	**Sub-Specialty**	

Provider Eligibility Program (PEP)

Requested Effective Date

Is a requested effective date prior to the application submission date required for this enrollment? No

Associated PEPs

Provider Eligibility Program (PEP)

☑ Enrollment Not Paid

Provider Identification

Provider IRS/Legal Name and Address

Entity Name	Doula Group		
Street	320 woodruff way	**Room/Suite**	
City	harrisburg	**State**	PA - Pennsylvania
Zip+4	17112-1234		

Contact IRS/Legal Name and Address

Last Name	doula	**First Name**	darla	**Title**
Phone Number	(254) 131-3334	**Extension**		
Toll Free Number		**Extension**		
Fax Number				
Email	ekiss@gainwelltechnologies.com			

We DO NOT accept a W9 as verification of the Tax ID

Organizational Structure

Type Business Corporation, For Profit

Does the provider operate under a Fictitious business / doing business as (d/b/a) name? No

NPI

NPI 1821872698

Taxonomy

☑ 374J00000X - Nursing Service Related Providers: Doula

Enrollment Languages

In addition to English, do you or your staff communicate with patients in another language? No

Tax Exempt Status

Do you currently have tax exempt status? No

Fee Assignments

Would you like to associate members to your group? Yes

* Provider Number	
300604780-0001	Ekiss, Doula

Provider Disclosures

Have you, any agent, or managing employee ever:

Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?
No

Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? No

Had a controlled drug license withdrawn? No

Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation? No

In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? No

Ownership / Managing Individuals

Managing Employee or Agent Disclosure

Does the enrolling disclosing entity have any Managing Employees or Agents? Yes

Name		
doula	debbie	Managing Employee

Last Name	doula	**First Name**	debbie	**Middle Initial**	
Birth Date	1983-01-09				

Social Security Number (SSN) 552178787

Street	320 woodruff way	**Room/Suite**	
City	harrisburg	**State**	PA - Pennsylvania
Zip+4	17112-1234		

Is this individual a managing employee or agent? Managing Employee

Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? No

Individuals with an Ownership or Control Interest in The Disclosing Entity

Do any individuals have at least 5% direct or indirect ownership and/or control interest (i.e. serve as officers/board members) in the disclosing entity? Yes

Entity Name	
doula	donnald

Last Name doula **First Name** donnald **Middle Initial**

Birth Date 1987-08-15

Social Security Number (SSN) 870011548

Street 320 woodruff way **Room/Suite**

City harrisburg **State** PA - Pennsylvania

Zip+4 17112-1234

Ownership / Managing Individuals

If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity. If the individual listed above has no ownership interest but has a controlling interest (i.e. holds a position as board member, director, or officer), please enter 0% ownership.

Direct Percent	100
Indirect Percent	0
Name of Entity Owned	

What position is held by the individual listed above?

Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity?
No

Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity? No

Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"? No

Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? No

Ownership / Managing Individuals

Corporate Entities with Ownership or Control Interest in Disclosing Entity

Do any corporate entities have at least 5% direct or indirect ownership interest in the disclosing entity? No

Individuals with an Ownership or Control Interest in Subcontractors

Are there any individuals with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more? No

Corporate Entities with an Ownership or Control Interest in Subcontractors

Are there any corporate entities with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more? No

Subcontractors of Disclosing Entity

Does the disclosing entity have a direct or indirect ownership interest of 5% or more in any subcontractors? No

Ownership or Control Interest in Other Entities

Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"? No

Significant Business Transactions

Has the disclosing entity had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? No

Corporate Entities with Ownership or Control Interest in Disclosing Entity

Do any corporate entities have at least 5% direct or indirect ownership interest in the disclosing entity?

This question is followed by questions regarding Subcontractor ownership. These questions are asking about the disclosed Corporate owner and if they own other entitles.

After this section is completed, you will need to upload verification documentation to be able to submit the application. Please note as you answer questions in the portal any item that has a paperclip will require a document to be uploaded here.

All entity and individual provider applications will require signature of a provider Agreement. This agreement must be signed by the individual or on an entity application the signature must be from an individual in the organization that can make
Business decisions on behalf of the entity.

Provider

Required Attachment	Uploaded File Name
Copy of Federal IRS Tax Document	Enroll Attach.pdf
Copy of Department of State Corporation Bureau or Business Partnership Agreement	Enroll Attach.pdf
Completed Group Members Form	Enroll Attach.pdf

Submission Details

The provider represents and warrants that the person signing this application is a duly authorized representative of the provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the provider that is seeking to enroll in the Pennsylvania Medical Assistance (PA MA).

I have reviewed the information in this enrollment application and affirm on behalf of the provider seeking to enroll in the Pennsylvania Medical Assistance (PA MA) that the information submitted in or with this application is true, accurate and complete.

I understand that the provider is responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if the provider becomes aware that any of the information is not true, accurate or complete

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities.

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of the provider from the Pennsylvania Medical Assistance (PA MA).

Please sign by typing your full name here: **donald doula** Date of Submission: **12/21/2023**
Title **ceo**

⚠ **Prepared on 12/21/2023 by the PA Department of Human Services Provider Enrollment On-line Application.**

After the agreement and the application is signed, you will have to review all of the sections of the application prior to submitting it to the department.

Please note: All application pass through automated checks that can take Up to 15 days prior to appearing in the departments work queues.

The Department cannot see an ATN prior to the ATN being completed and submitted.

How to Resume or Check Enrollment Application Status

Resume Application

- Resume application
  - Allows a provider to resume an application that has been started but not yet submitted.
  - Or resume an application that was returned to the provider for corrections.
  - Items needs to Resume Application
    - Application Tracking Number (ATN)
    - FEIN or SSN of provider on the application
    - Password created when saving the application

Resume Application

- To resume an application
  - Step 1:
    - Go to the Landing page of the PROMISe™ Portal
      - website: promise.dpw.state.pa.us
  - Step 2:
    - Select "Resume Application" from the Provider Enrollment Section of the Landing Page
  - Step 3:
    - This link opens a window requesting the Application Tracking Number (ATN), Tax Id or SSN and Password
    - Once supplied and verified, the provider can resume an application that has not been submitted or resume and application that has been returned for corrections

Resume Application

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Login

PROMISe™ Internet

Home

Home Wednesday 11/29/2023 10:26 AM EST

Provider Login

***User ID**

Log In

Forgot User ID?

Register Now

Where do I enter my password?

Provider Enrollment

New Application

Reactivation

Resume Application ←

Application Status

Quick Links

Broadcast Messages

Attention Provider Groups and Individuals: Effective 10/27/2023: The Department has added functionality to the Provider Enrollment system to allow one application to revalidate multiple Individual and Group locations. Providers can utilize this functionality if they are enrolled as one of the following Provider types 09, 14, 15, 17, 18, 19, 20, 23, 27, 31, 32, 33 and meet specific match criteria. For more details, please review Quick Tip #270 PROMISeQuickTip270 (pa.gov).

NOTE: Providers will begin to receive communications from donotreply@gainwelltechnologies.com. Please be sure to check your spam folder and add this email address to your contact list to ensure receipt of notifications.

Welcome to PROMISe™

Resume Application

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information ▾ Co

Resume Application

Enter your application tracking number (ATN), Federal Tax Identification Number (FEIN or SSN) and password in order to resume your existing provider enrollment application.

If you have any questions about completing an electronic enrollment application, please call the appropriate phone number shown on the Important Phone Numbers and Addresses page of this site.

* Indicates a required field.

* **Application Tracking Number (ATN)** ############

* **SSN or FEIN** ###########

* **Password** Enter application password

Forgot Password?

I'm not a robot — reCAPTCHA Privacy - Terms

Submit

Application Status

- Application Status
  - Allows a provider to check on the status of an existing application either submitted or incomplete.
  - Items needs to check Application Status
    - Application Tracking Number (ATN)
    - FEIN or SSN of provider on the application
    - Password created when saving the application

Application Status

- To check the status of a submitted application
  - Step 1:
    - Go to the Landing page of the PROMISe™ Portal
      - website: promise.dpw.state.pa.us
  - Step 2:
    - Select "Application Status" from the Provider Enrollment Section of the Landing Page
  - Step 3:
    - This link opens a window requesting the Application Tracking Number (ATN), tax Id or SSN and Password.
    - Once supplied and verified, the provider can view the status of a current application whether submitted or not. The provider can also view the application PDF of a submitted application from this page.

Application Status

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Login

PROMISe™ Internet

Home

Home　　Wednesday 11/29/2023 10:26 AM EST

Provider Login

*User ID

Log In

Forgot User ID?

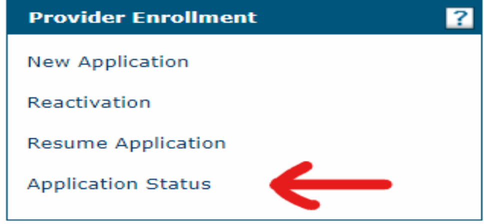
Register Now

Where do I enter my password?

Broadcast Messages

Attention Provider Groups and Individuals: Effective 10/27/2023: The Department has added functionality to the Provider Enrollment system to allow one application to revalidate multiple Individual and Group locations. Providers can utilize this functionality if they are enrolled as one of the following Provider types 09, 14, 15, 17, 18, 19, 20, 23, 27, 31, 32, 33 and meet specific match criteria. For more details, please review Quick Tip #270 PROMISeQuickTip270 (pa.gov).

NOTE: Providers will begin to receive communications from donotreply@gainwelltechnologies.com. Please be sure to check your spam folder and add this email address to your contact list to ensure receipt of notifications.



Quick Links

Application Status

pennsylvania DEPARTMENT OF HUMAN SERVICES

Enrollment Information ▾ Contact Information ▾ Help

Application Status

Enter your application tracking number (ATN), Federal Tax Identification Number (FEIN or SSN) and password in order to review your application status.

If you have any questions about completing an electronic enrollment application, please call the appropriate phone number shown on the Important Phone Numbers and Addresses page of this site.

* Indicates a required field.

*Application Tracking Number (ATN): 1000006626

*SSN or FEIN:

*Password: ·············

Forgot Password?

I'm not a robot (reCAPTCHA, Privacy - Terms)

Search

Application Status Summary

This is the most current information regarding your Pennsylvania Medical Assistance (PA MA) provider enrollment application.

Application Tracking Number (ATN):	1000006626
Start Date:	10/13/2022
Date Submitted:	10/18/2022
Status:	Application Approved
Status Date:	10/18/2022
Application Submission PDF:	Download

Approved Application Summary

Below are the details regarding your approved Pennsylvania Medical Assistance (PA MA) provider enrollment application.

Provider ID:	300594890-0001
Effective Date:	10/14/2022
Revalidation Date:	10/24/2027

Resources

Resources

Electronic Provider Enrollment Application

- https://promise.dpw.state.pa.us

Provider Enrollment Information

- Enrollment Information (pa.gov)
- Includes information regarding requirements for each Provider Type

Provider Enrollment and Screening Requirements of the Affordable Care Act

- ACAforproviders (pa.gov)
- Includes the most current information from the Department relating to the ACA federally mandated regulations

Medicaid Information

- Medicaid | Medicaid
- Provides information about the ACA federally mandated regulations and how they relate to the Medicaid program

Resources (continued)

Department of Human Services Website

- http://www.dhs.pa.gov/

Provider Quick Tip

#265 - How to Check the Status of Your Electronic Provider Enrollment Application/Actions to Take if Your Application Was Returned for Additional Information

- Quick Tips (pa.gov)

Medical Assistance Bulletins

MAB xx-xx-xx – Doula Enrollment in the Medical Assistance (MA) Program
MAB 99-16-10 – Revalidation of Medical Assistance (MA) Providers

- Bulletin Search (pa.gov)

DHS Provider Services Center – 800/537-8862 option 2; option 4 for Enrollment

Questions