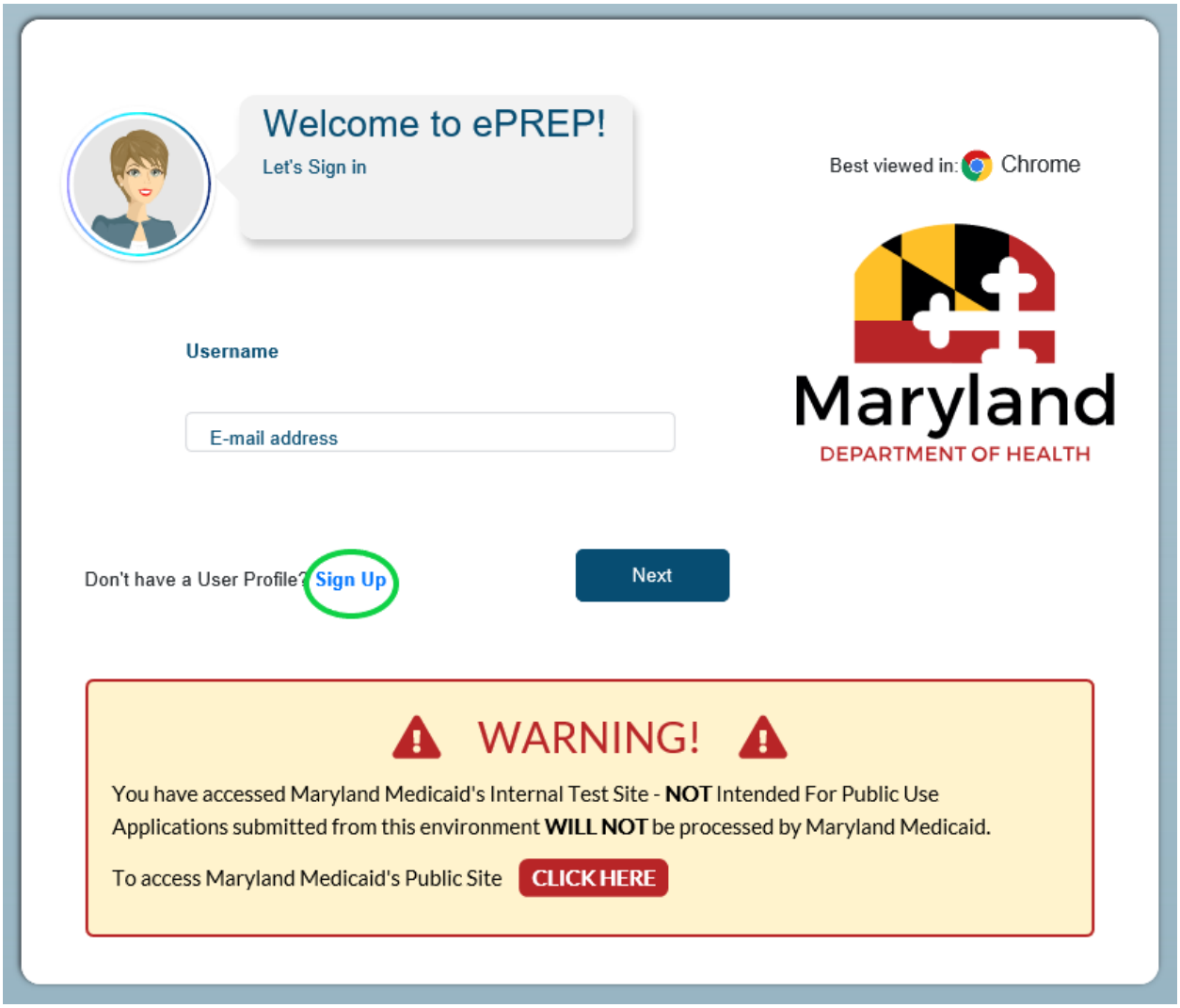
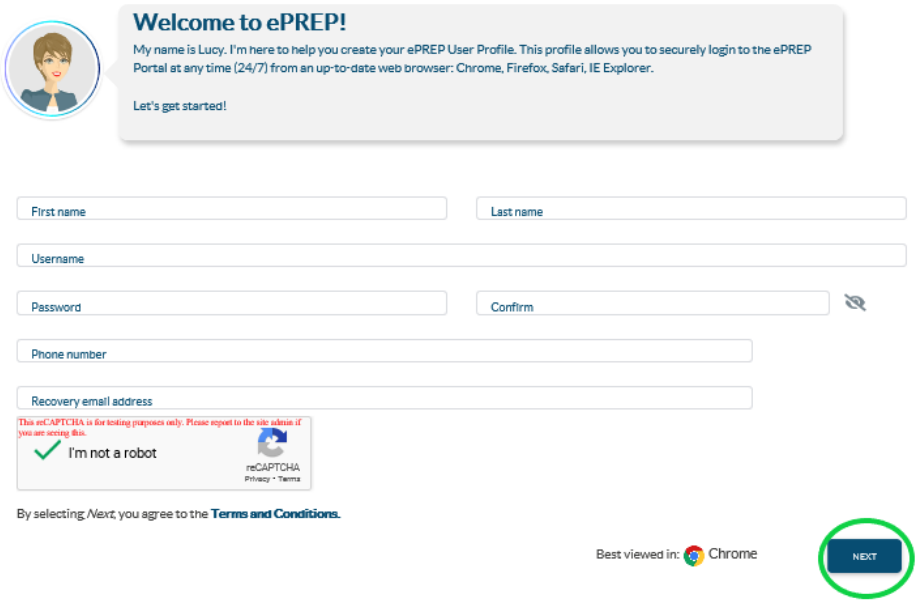
Welcome to the e PREP provider portal page!

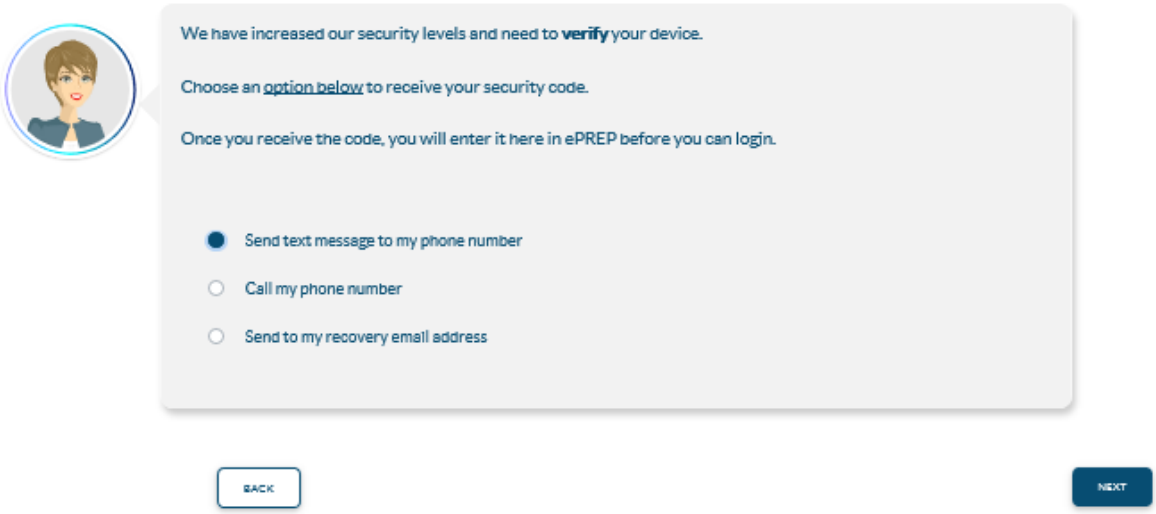
1. New providers / groups enrolling with Maryland Medicaid for the first time will need to create a user profile. In order to begin this process, please click the “Sign Up” hyperlink shown below:



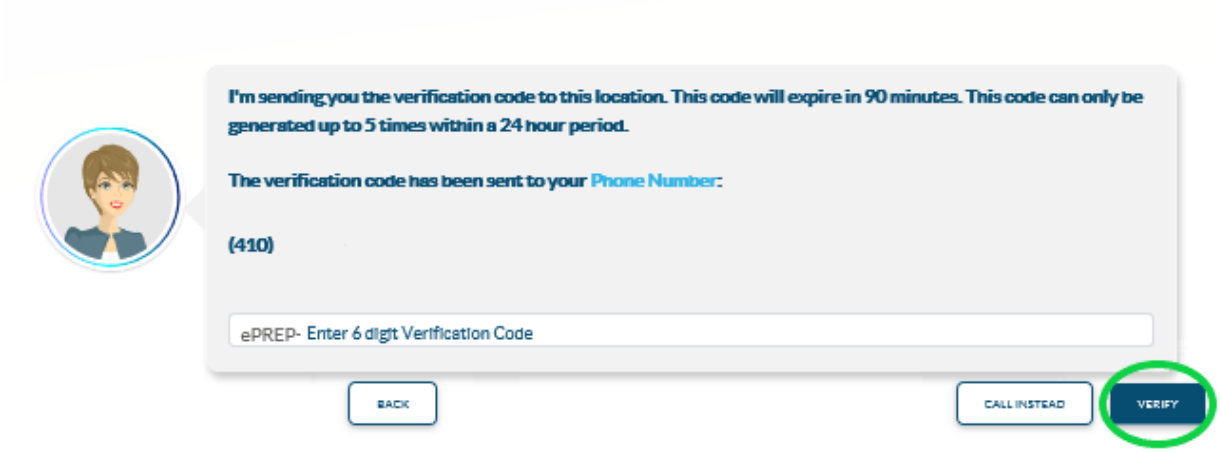
2. On this page, you will enter your personal information (first and last name), create a username, password and fill in all corresponding information followed by selecting the “Next” button when completed.

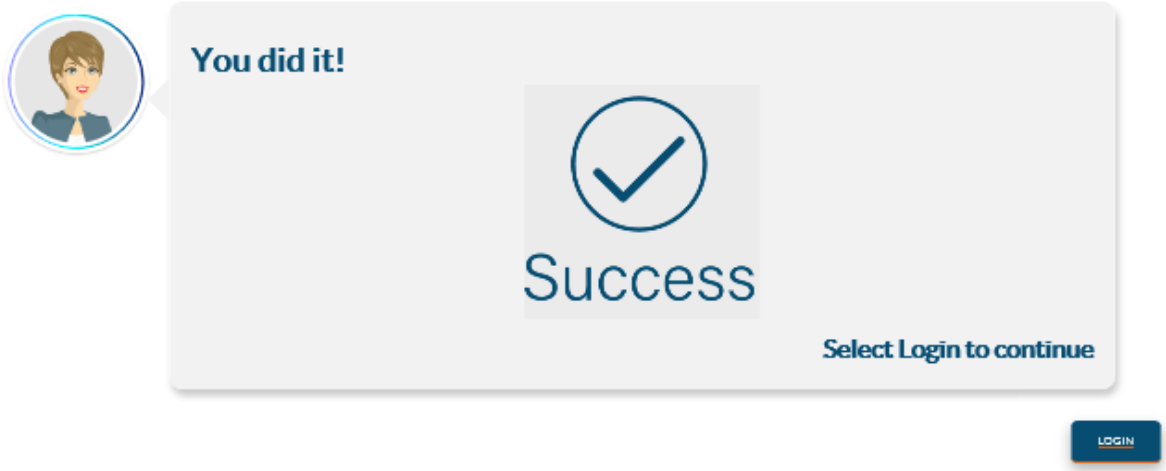


3. In an attempt to increase security measures within the portal, please determine how you would like to receive your authentication code - once you have made your selection, please click 'Next".

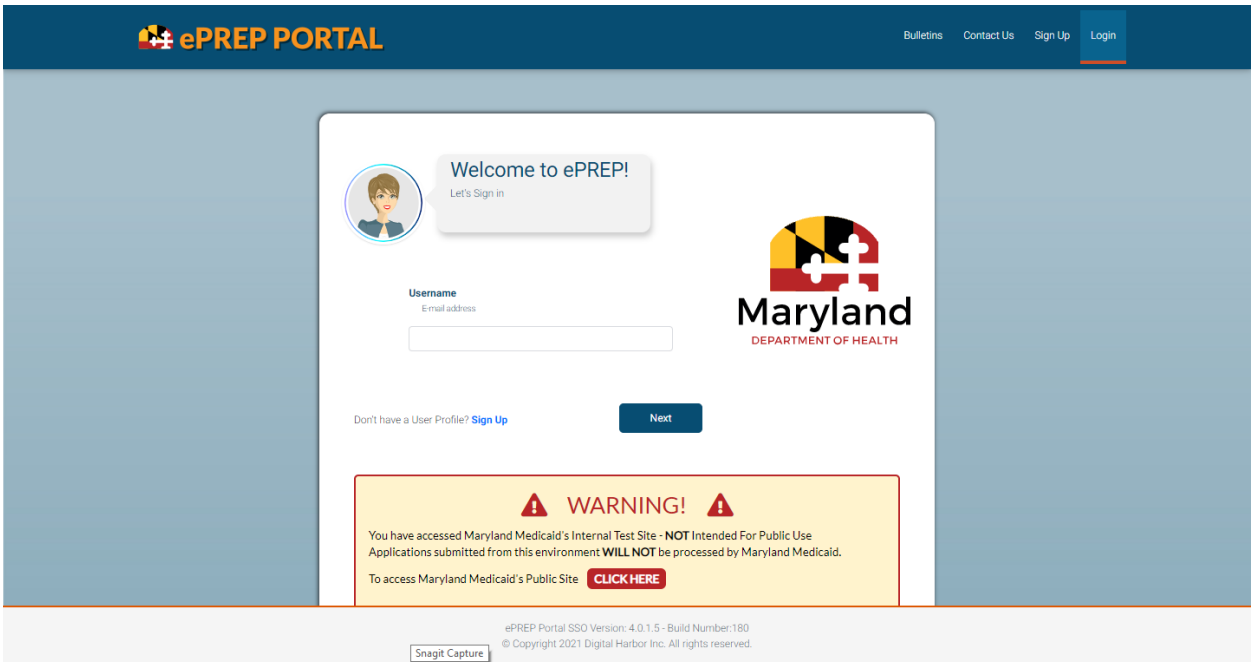


4. Please enter your 6 digit authentication code and click "Verify".

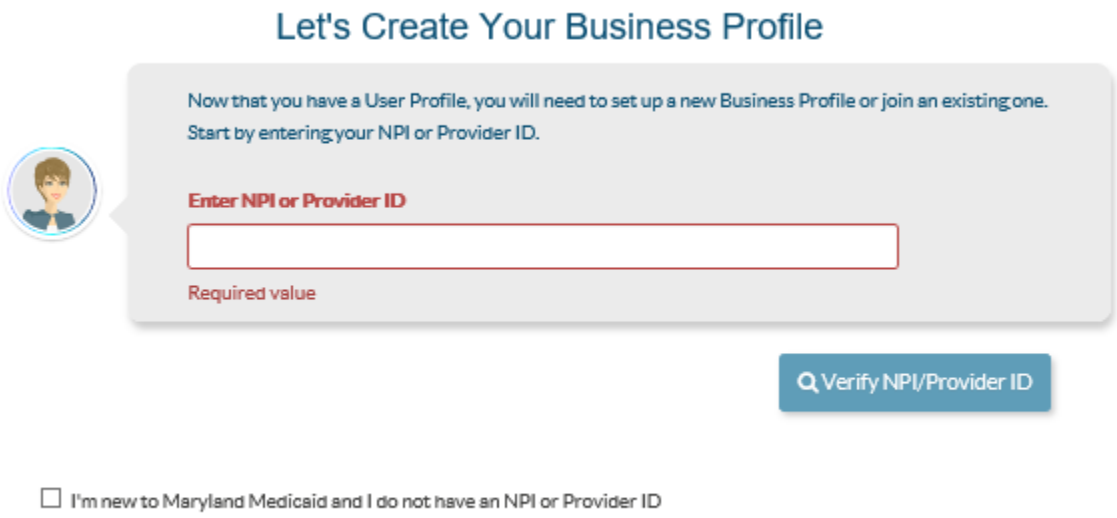




5. Once you have successfully entered and verified your security code, users will need to login for the first time with your username (email address) and password. Both of which were entered and created in the steps above.

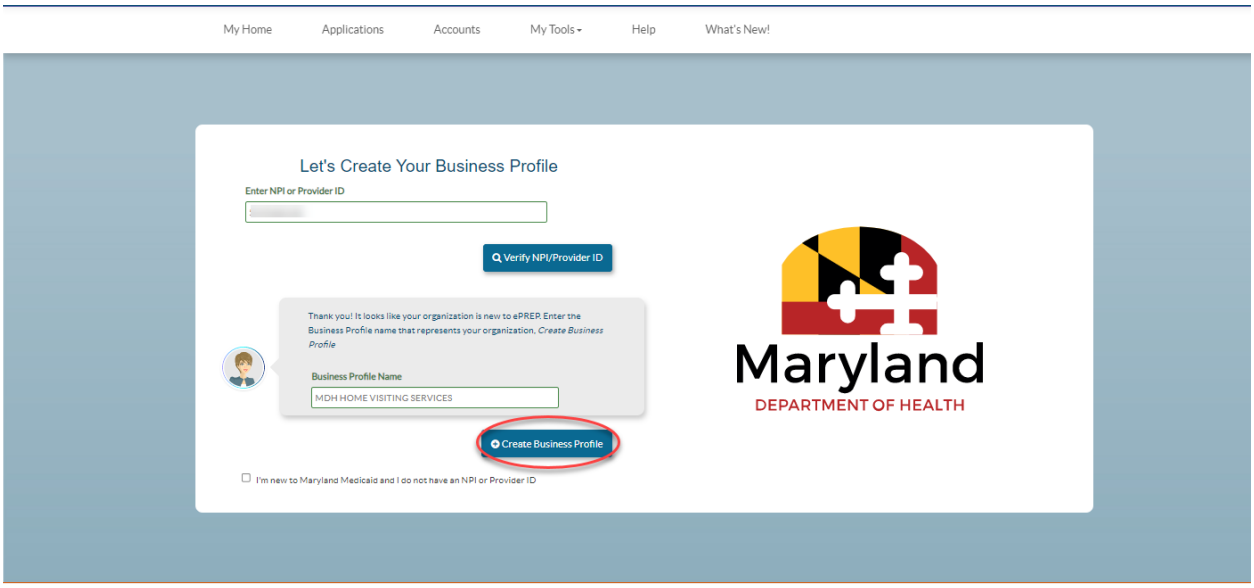


6. Once you have entered your credentials, you will be asked to create your business profile. In order to do this, you must first enter and verify your NPI number.

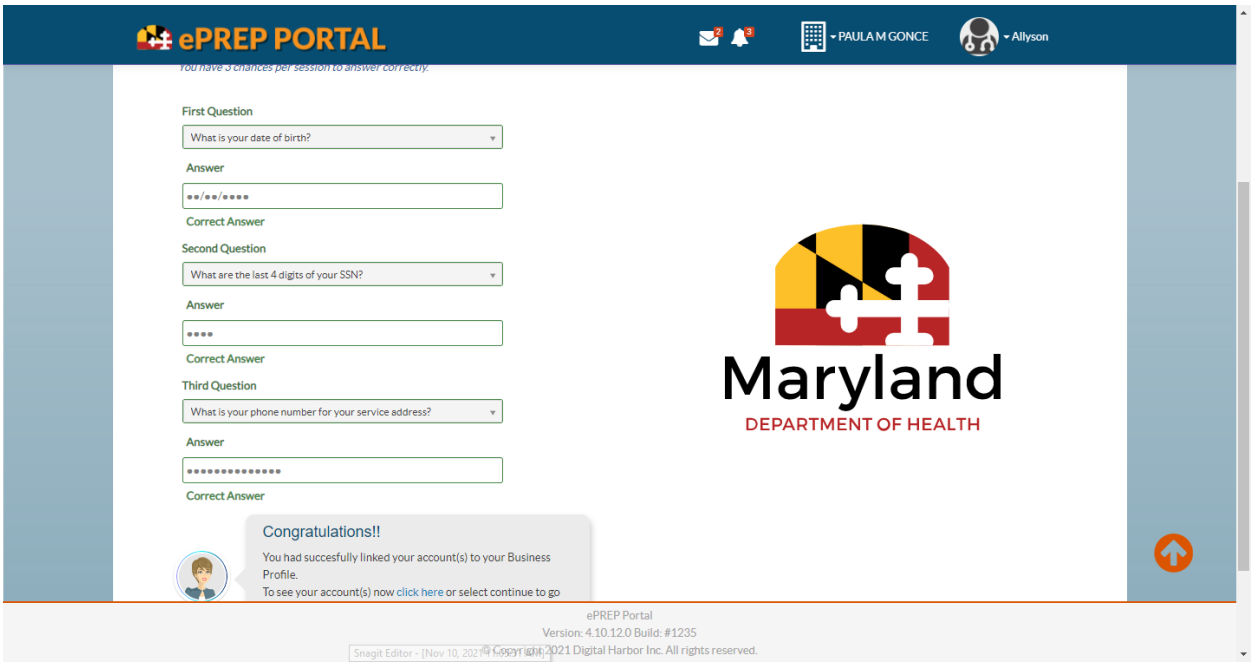


7. Once you have entered and verified your NPI, the provider ID box will turn green and you will be able to enter the provider / group name you are attempting to enroll.

This is the name that will be listed on your provider business profile.



8. Security questions portion: please select and correctly answer three corresponding security questions as they pertain to your business. Once you have completed this portion, you will be able to continue moving forward through the business profile creation process by selecting “Next”.



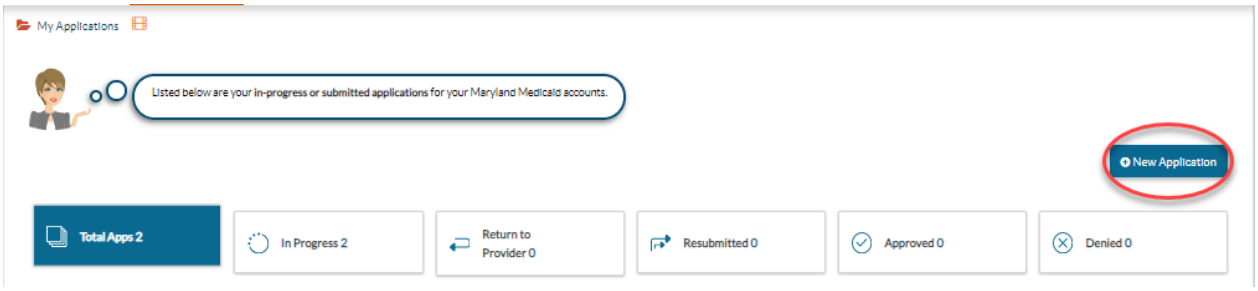
****It’s important to note that sometimes these security questions are bypassed and are able to be completed later in the enrollment process****

9. Once your business profile has been created, you will be taken to the e PREP home page

shown below:

10. From here, please click the “My Applications” tab / or building with the “My Applications” heading attached shown above.

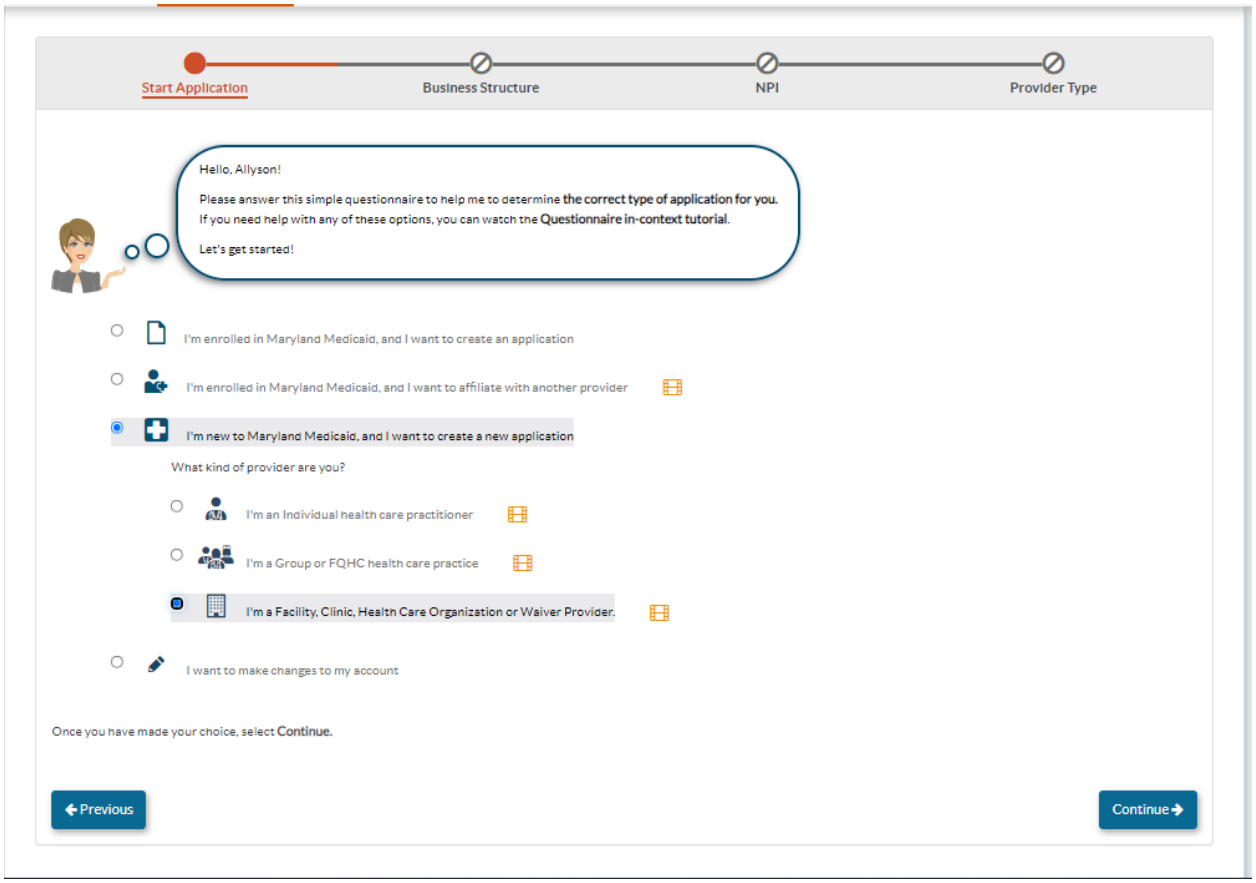
11. Once you have successfully entered the “My Applications” tab, you will need to create a new application in order to enroll your provider type with Maryland Medicaid. **Circled in the screenshot below.**



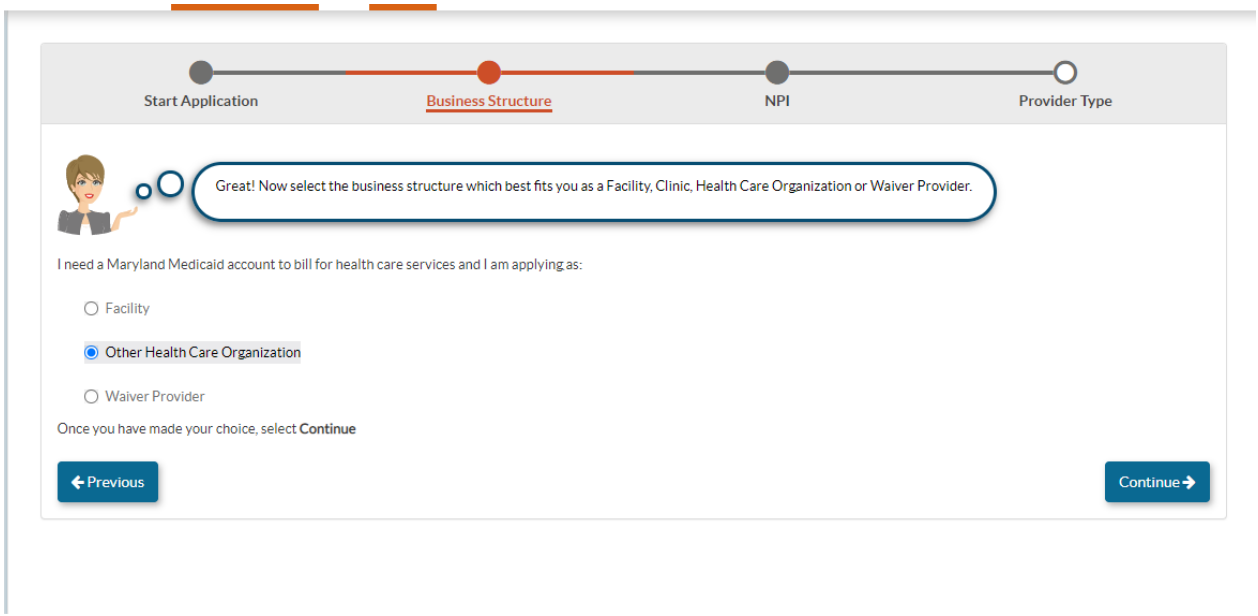
10. **Application Generation**: One you have clicked the 'New Application' tab, the following selection will need to take place in order to generate your enrollment application.

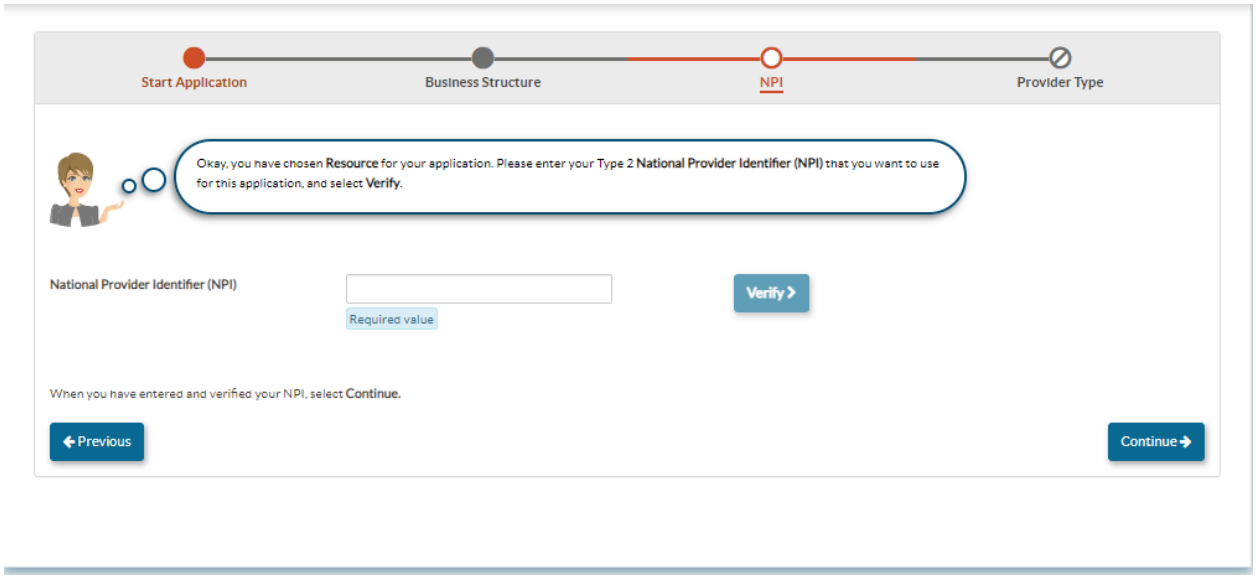
11. **Application Generation Selection**: please make the selections listed below:

- I'm new to Maryland Medicaid, and I want to create a new application
- I'm a Facility, Clinic, Health Care Organization or Waiver Provider.



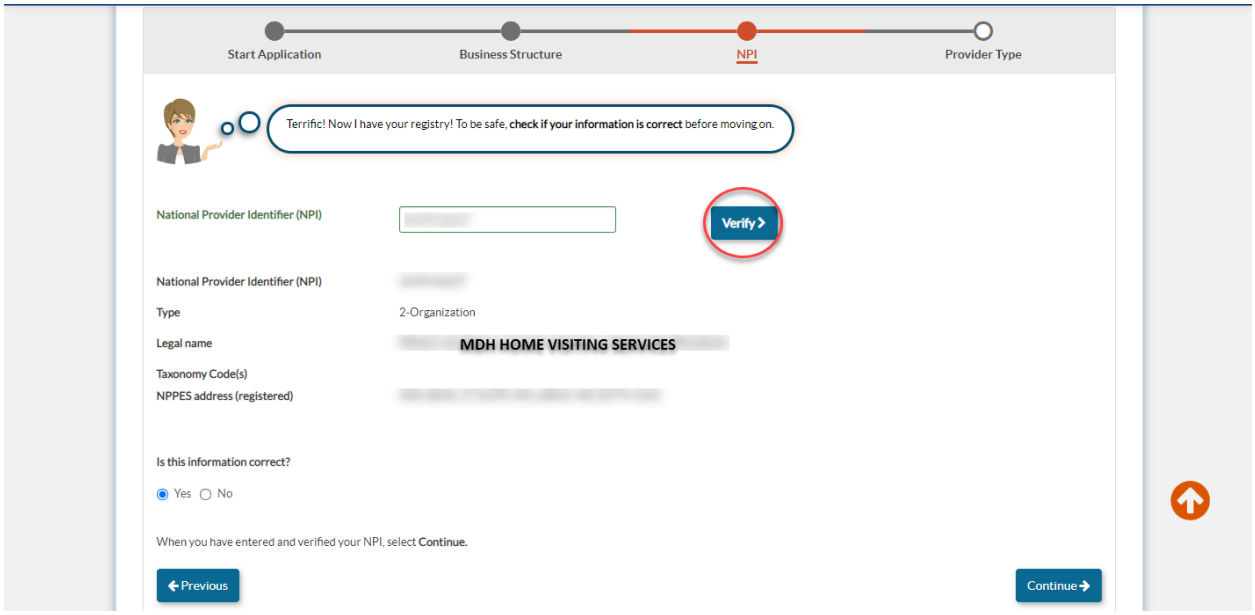
- Select the option: Other Healthcare Organization





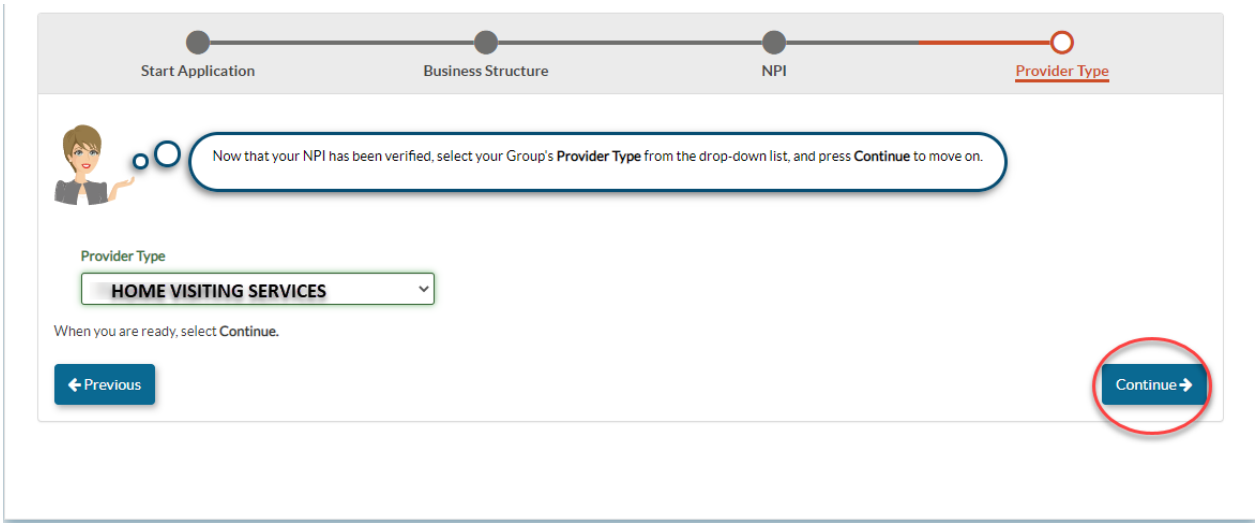
12. Once you have entered your NPI, please click the ‘verify’ option. Once the NPI has been verified, the NPI box will turn green and you will be able to successfully continue through the application generation process.

Please ensure that the Legal name, Provider type, entity type and Taxonomy are correct

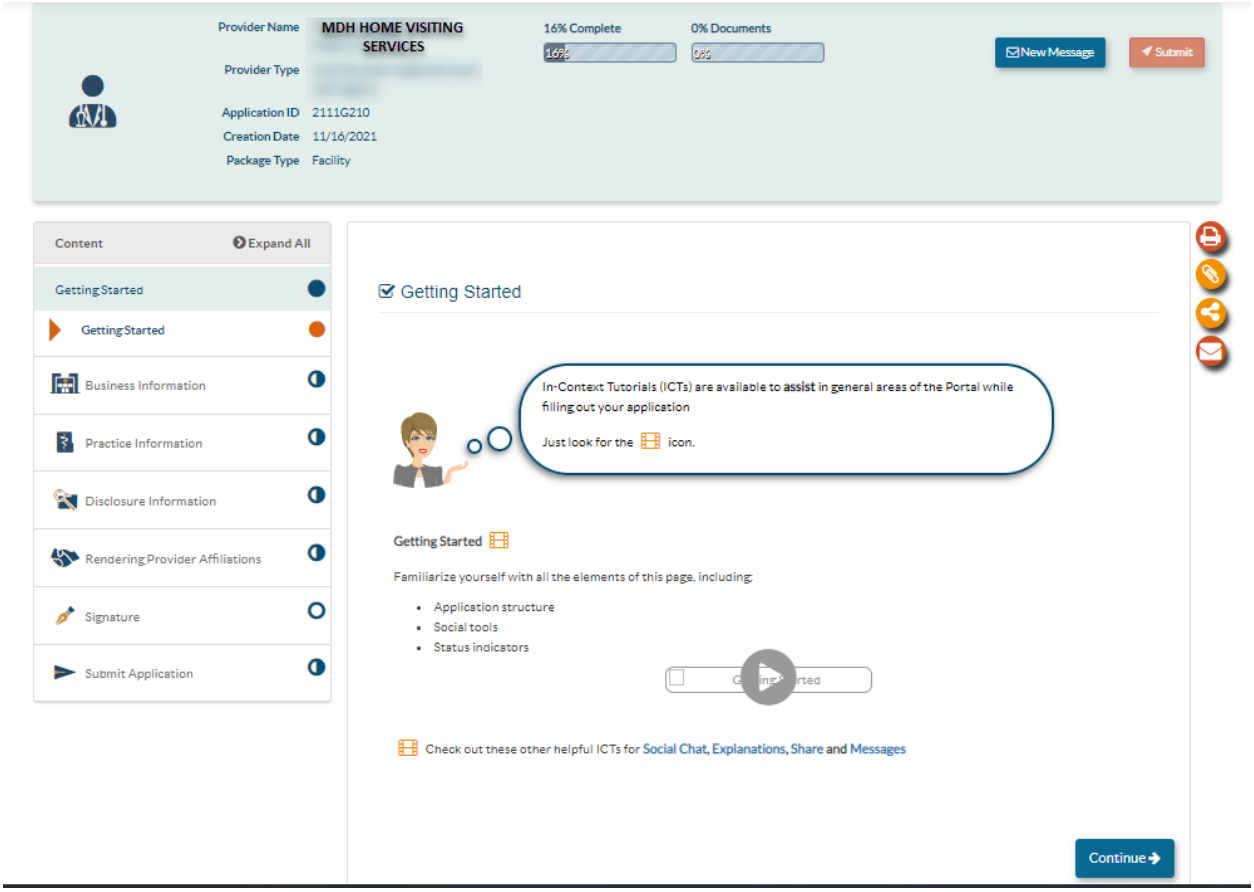


13. If all of the organizational information displays correctly, please select ‘Yes’ and continue.

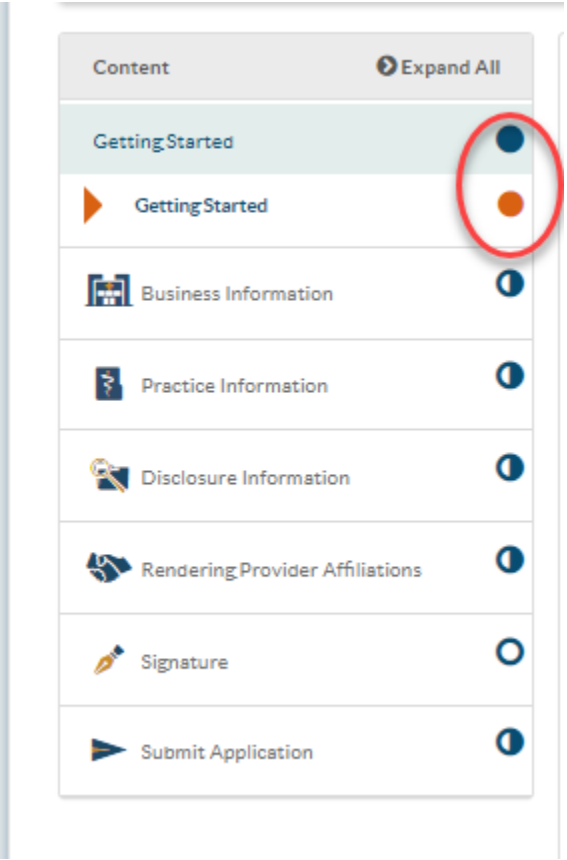
14. **Provider Type** - in the drop down box menu, please select the provider type **Home Visiting Services** and click continue.



15. **Successful Application Generation** - Once you have generated the application, you will be able to complete each required section from start to submission.



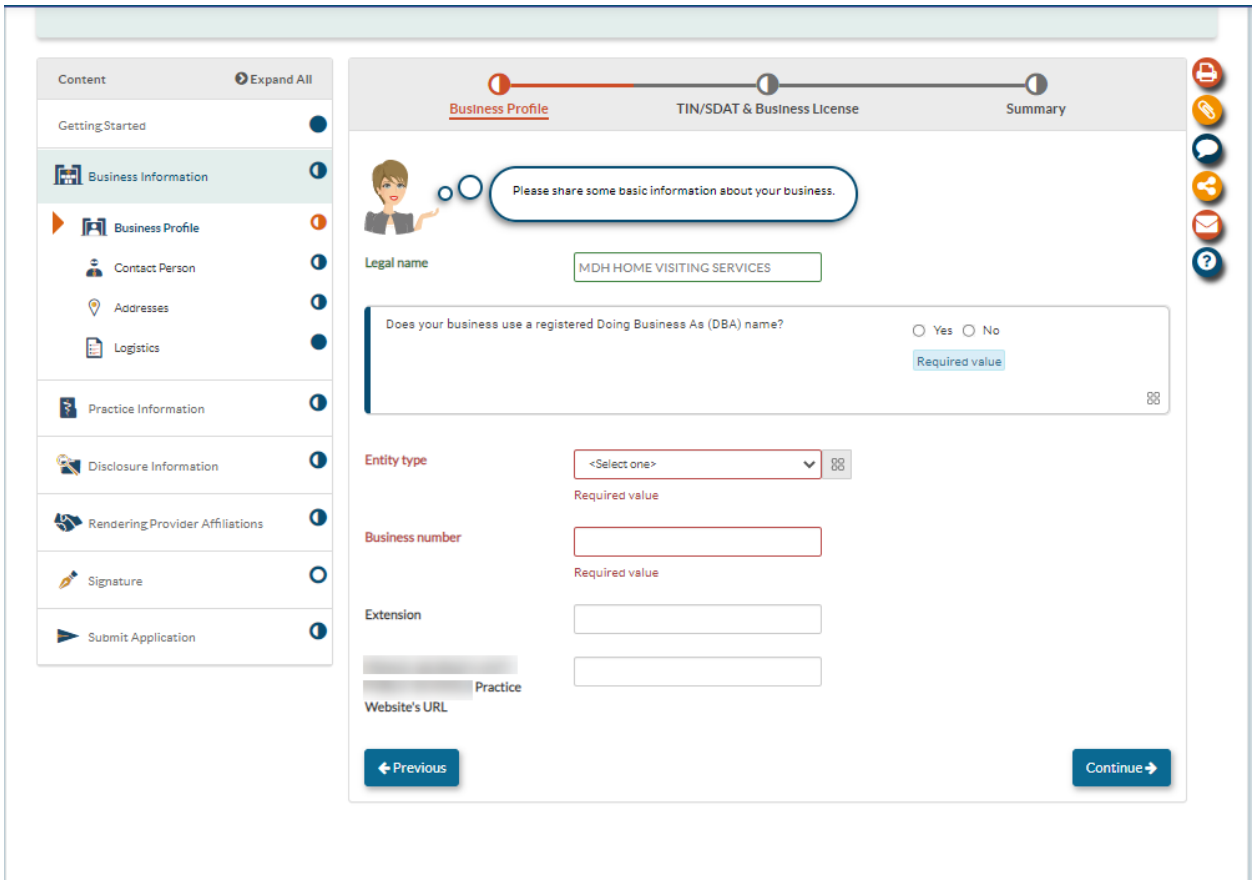
16. As you navigate the application, this side bar will indicate your progress. A fully shaded circle denotes a finished section, while a half shaded circle signifies an incomplete section. Example shown below:

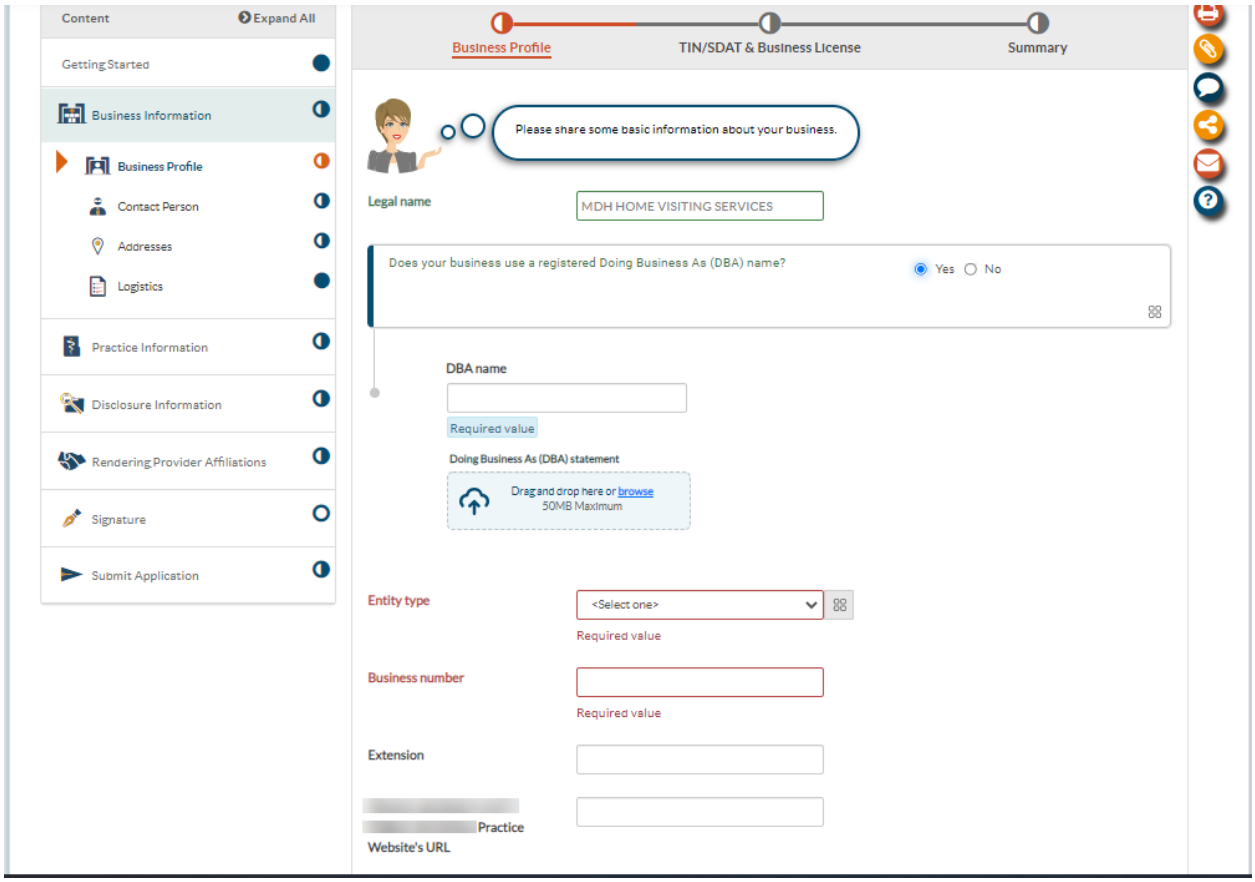


Business Information: Please enter all provider information into the corresponding data fields within this section.

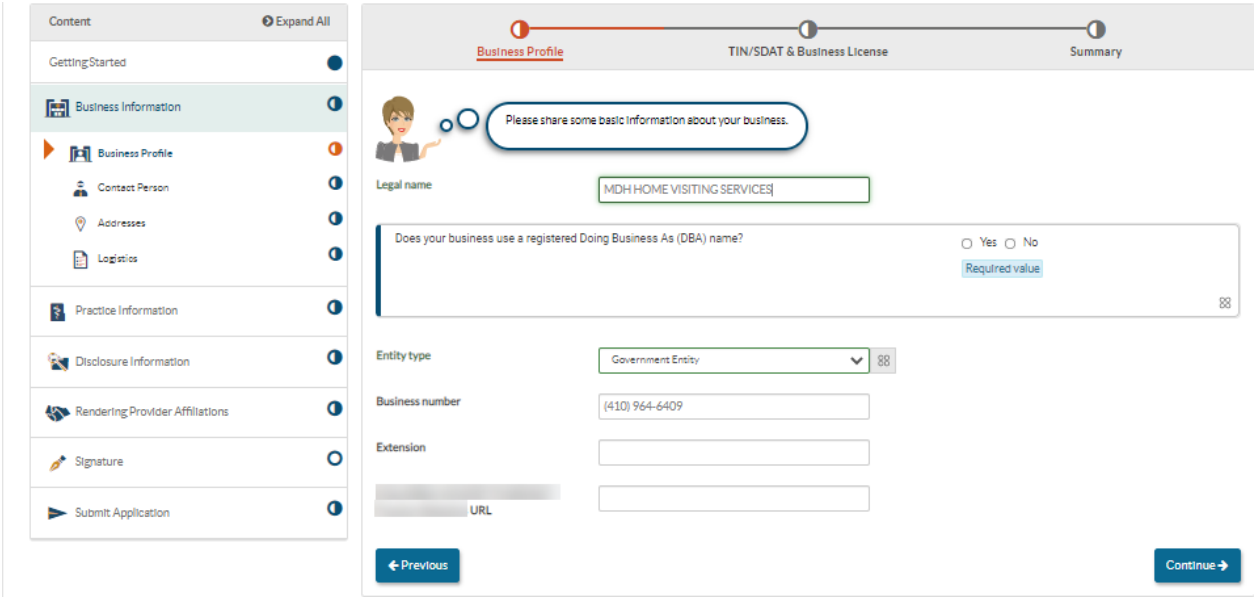
17. If your organization has a DBA name, please select 'Yes' and enter the DBA name in addition to adding the supporting documentation for this DBA.

- If your organization does not have a DBA, please select 'No'

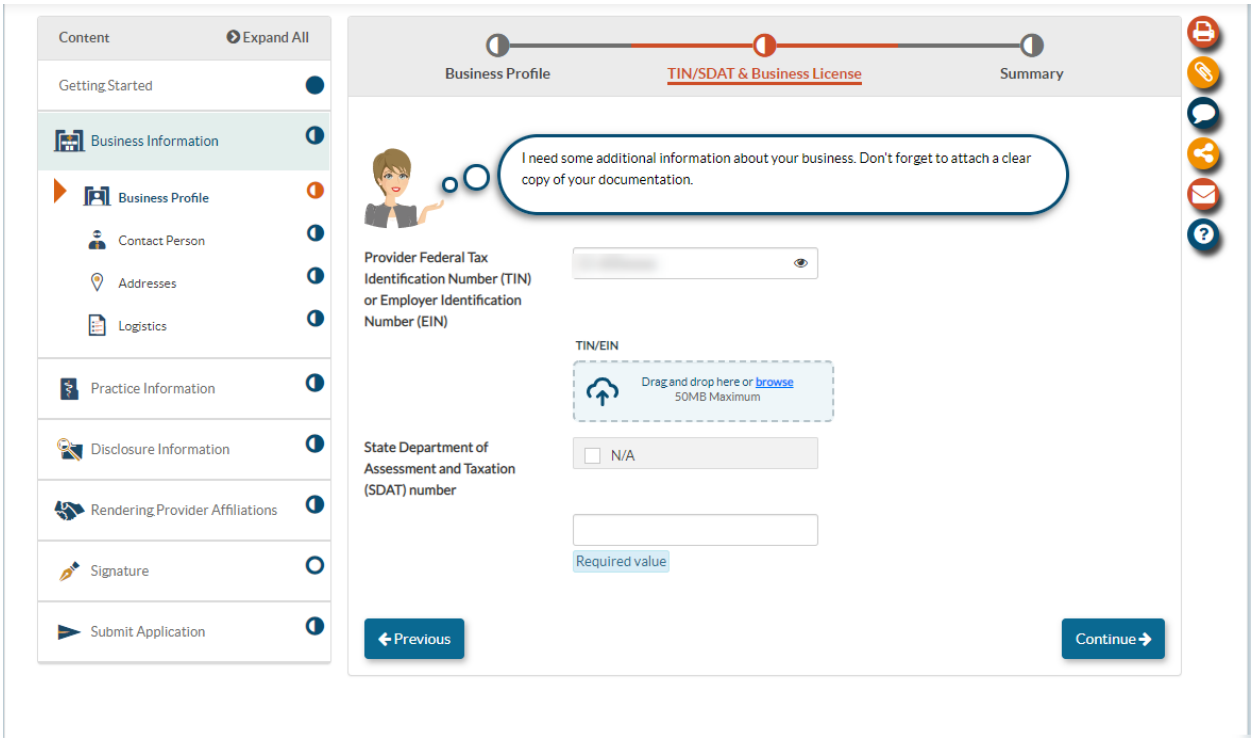

Content
Expand All
Getting Started
Business Information
Business Profile
Contact Person
Addresses
Logistics
Practice Information
Disclosure Information
Rendering Provider Affiliations
Signature
Submit Application
Business Profile
TIN/SDAT & Business License
Summary
Please share some basic information about your business.
Legal name
MDH HOME VISITING SERVICES
Does your business use a registered Doing Business As (DBA) name?
Yes
No
Required value
Entity type
<Select one>
Required value
Business number
Required value
Extension
Practice
Website's URL
Previous
Continue

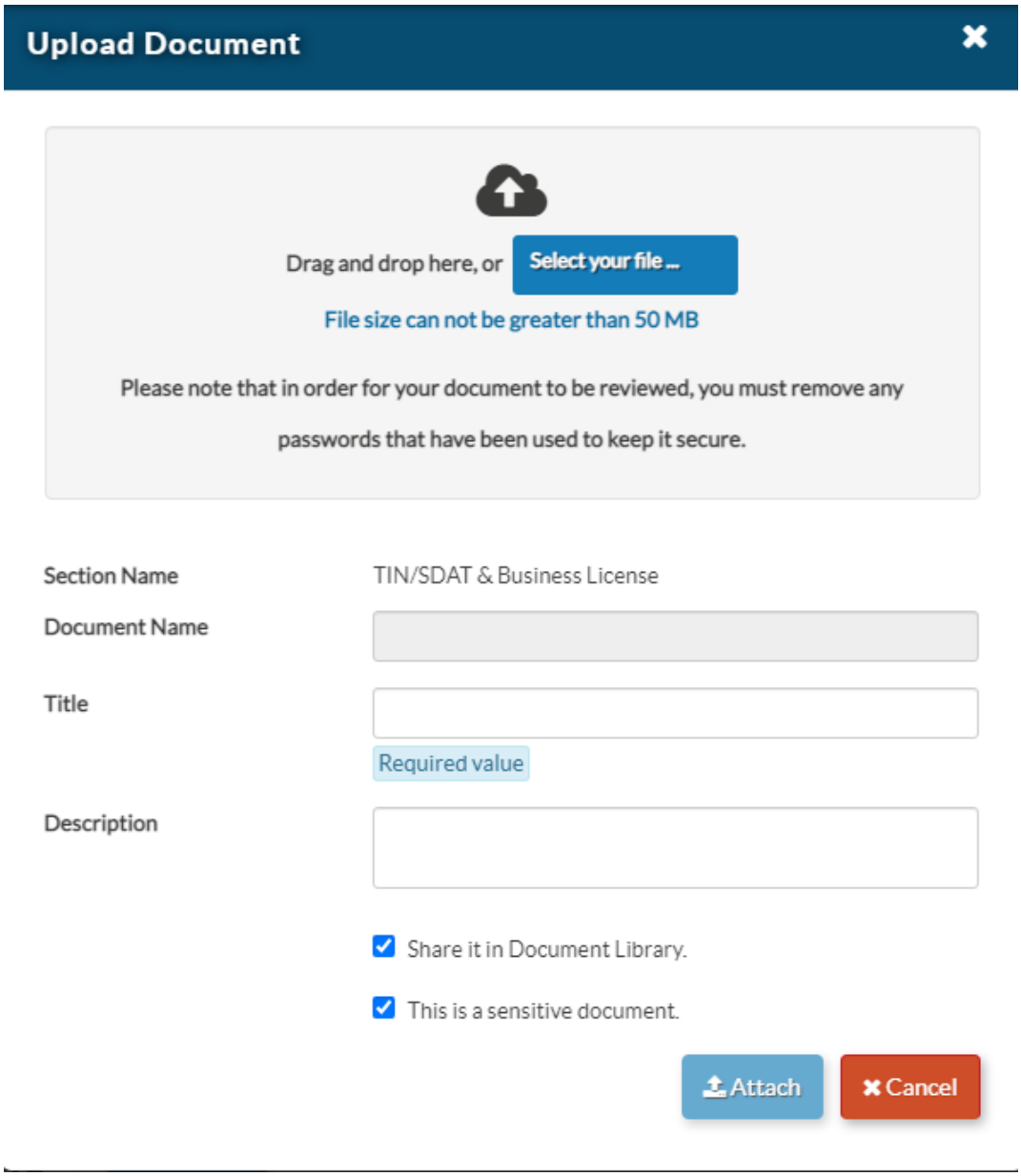


For Entity type, please choose '**Government Entity**.' This will exempt you from the SDAT requirement.

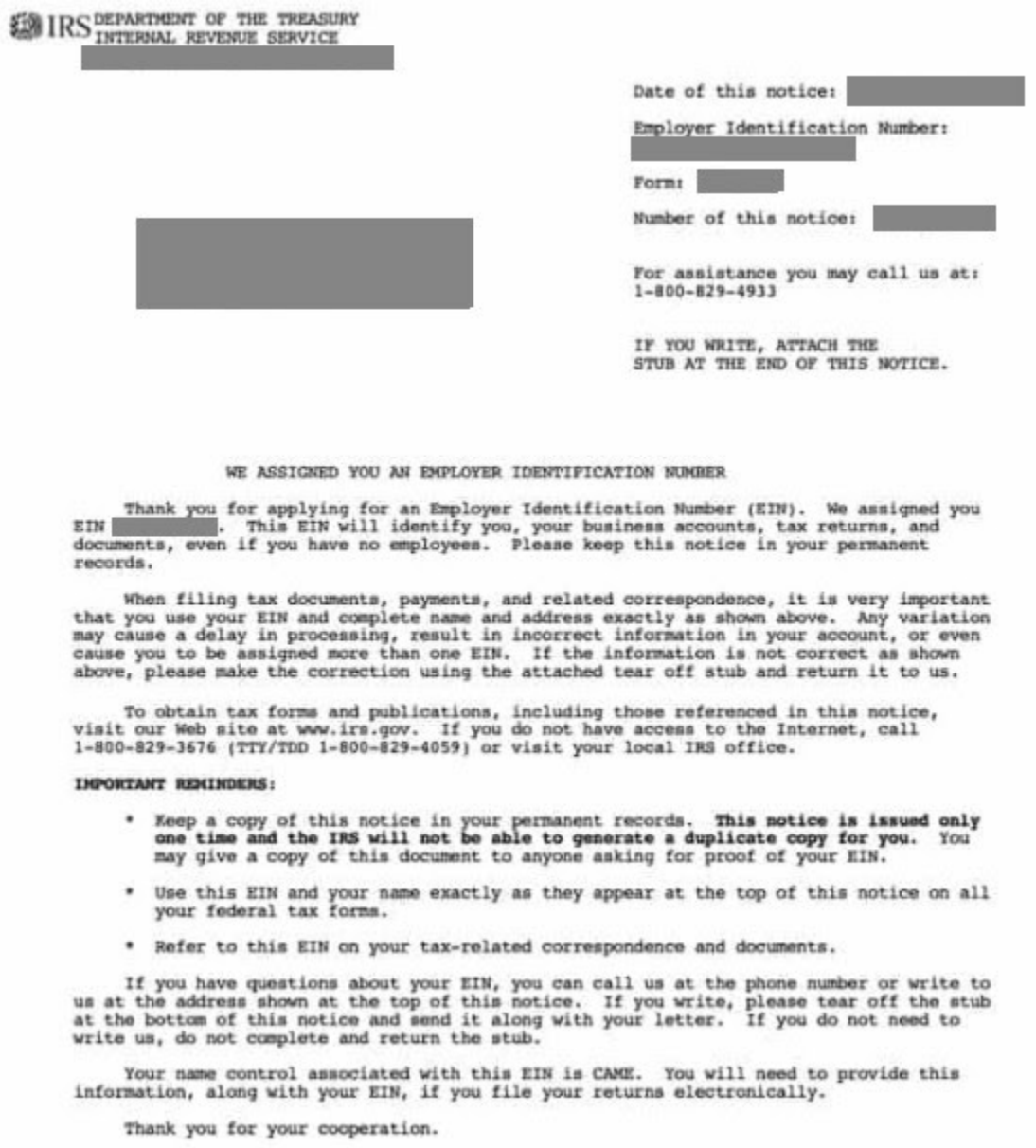


18. **TIN / SDAT Business License**: Please enter your TAX ID number into the corresponding data field. Once entered, please click on the 'Select your file' button to upload the TIN/EIN document and name your document in the 'Document Name' box.





Example of a TIN / EIN Letter:



IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
[redacted]

Date of this notice: [redacted]

Employer Identification Number:
[redacted]

Form: [redacted]

Number of this notice: [redacted]

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

[redacted]

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [redacted]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

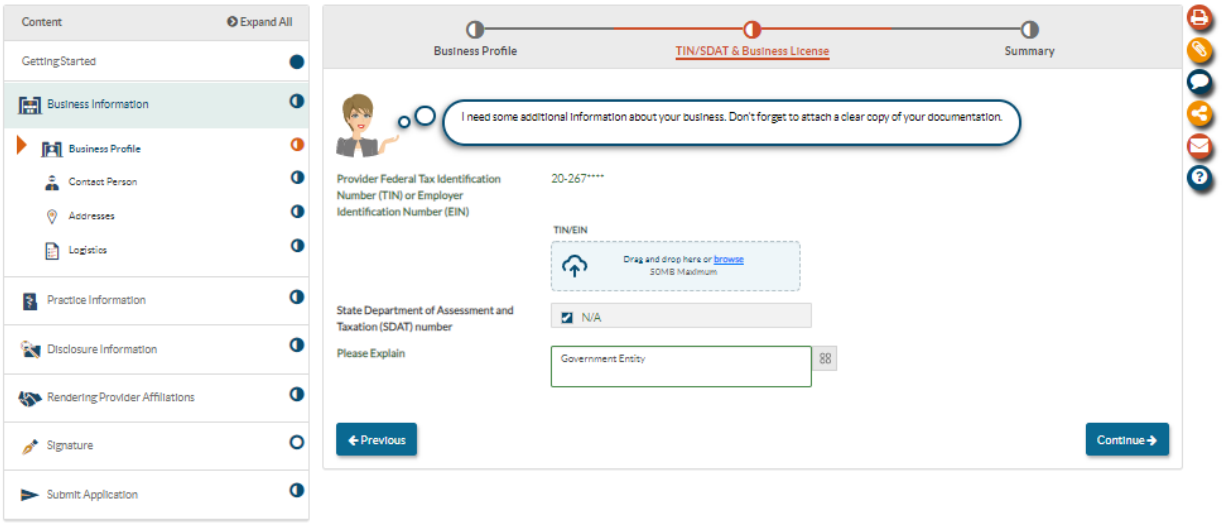
* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is CAME. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

19. **State department of Assessment and Taxation** (SDAT): Please check the `N/A' option and in the explanation box please enter 'Government Entity'.



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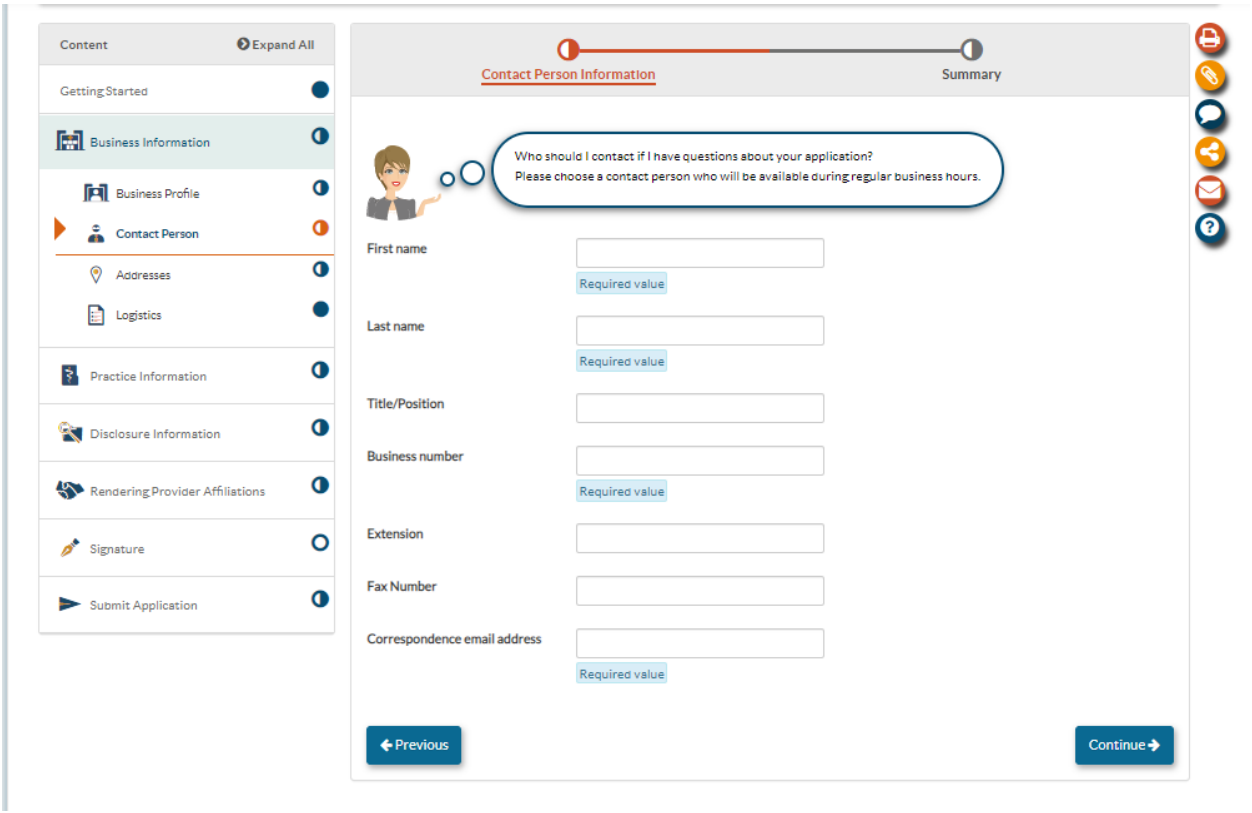
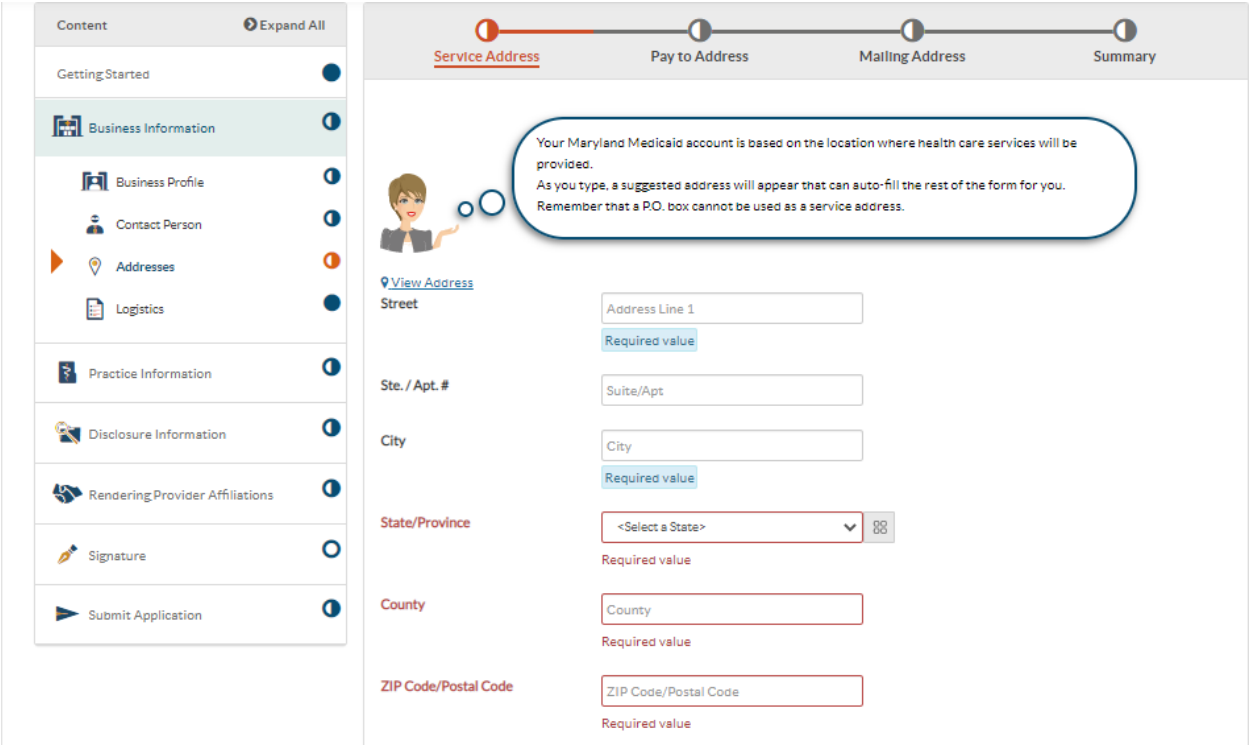
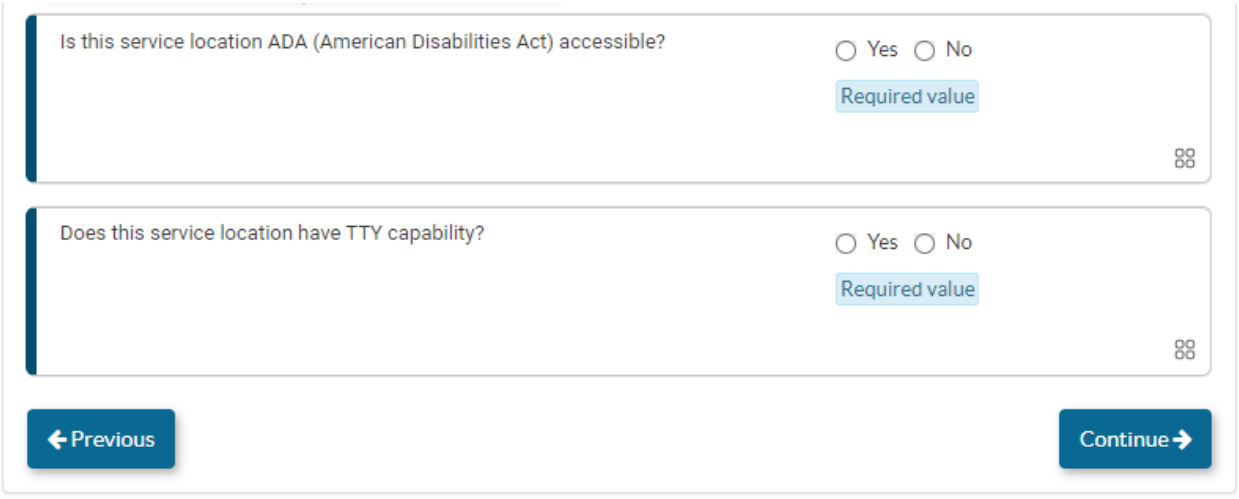
20. **Contact Person Information**: Please be sure to fill out the contact information correctly. The contact person should be the managing employee of the application. If there are any questions regarding the application, this person will be the direct contact person.



21. **Service Address**: Please fill out the service address portion of the application

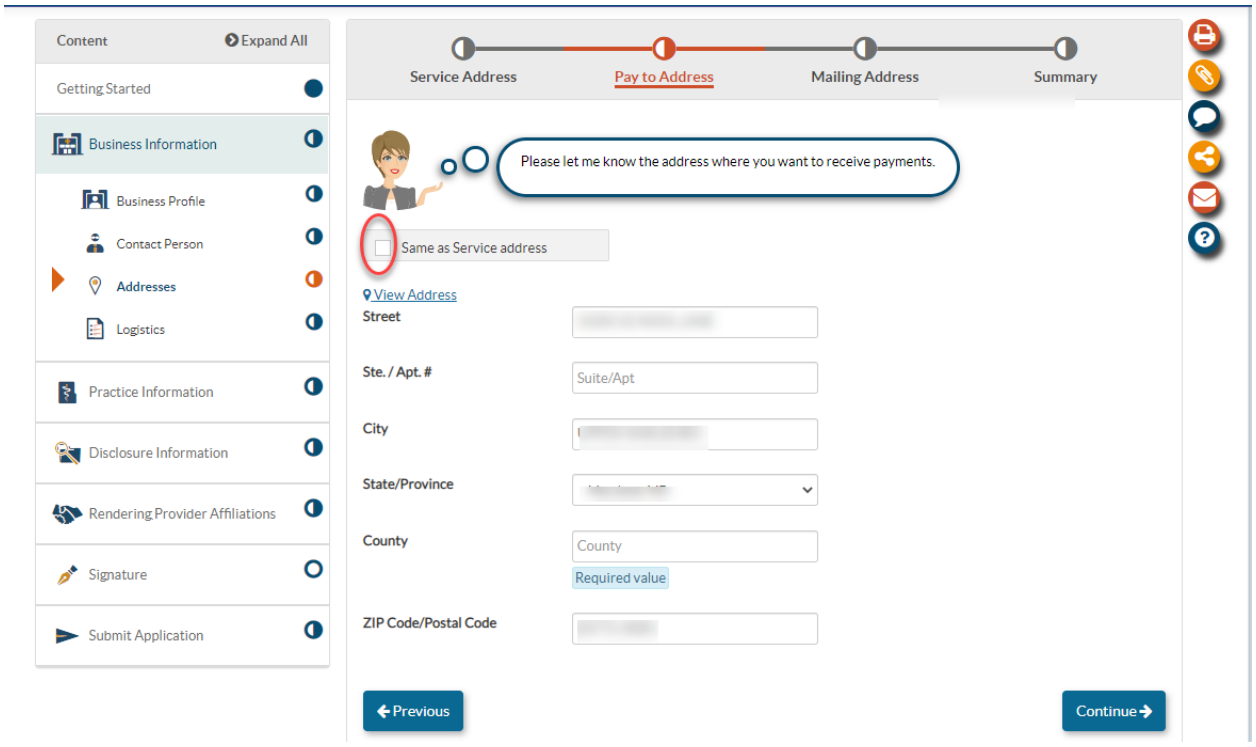


22. Please answer the following “Yes” or “No” questions as they pertain to the organization.



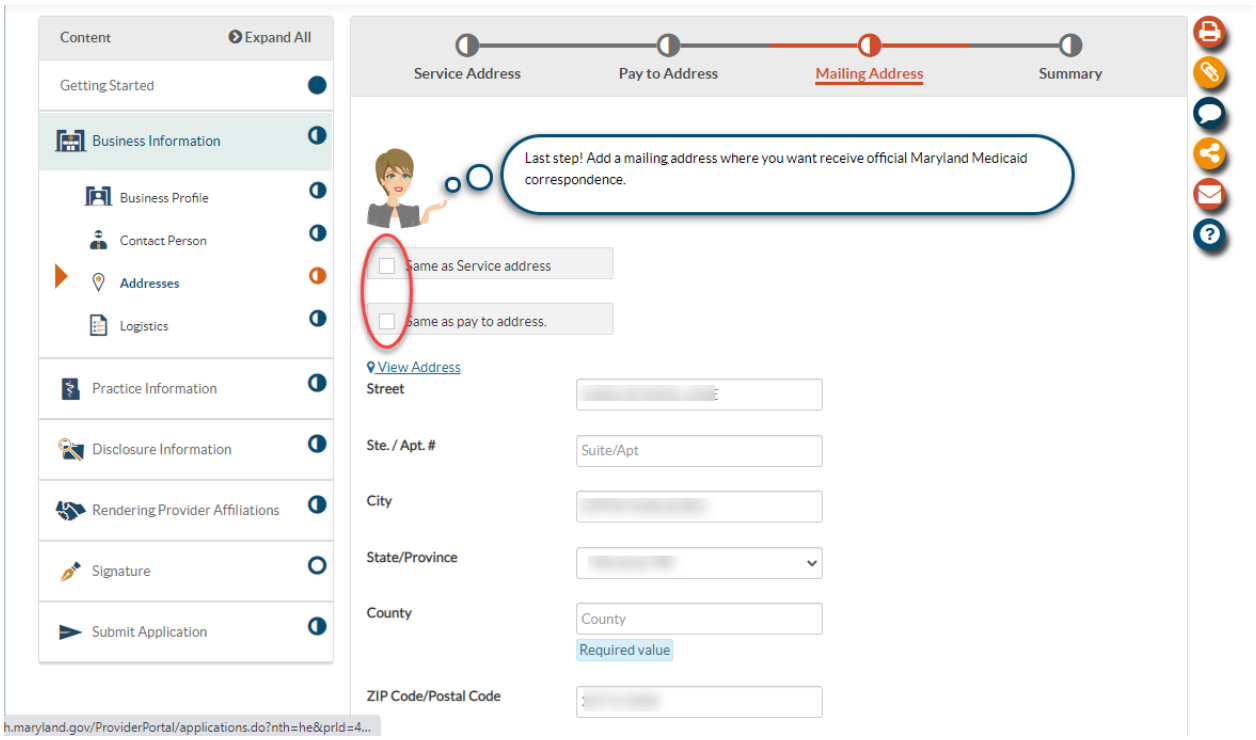
23. **Pay-to Address**: Please enter the pay to address of the group. If the pay-to address is the same as the group’s service address, please select the “same as service address” check box.

- If you are not registered for EFT, this is the address the payment will be sent to.



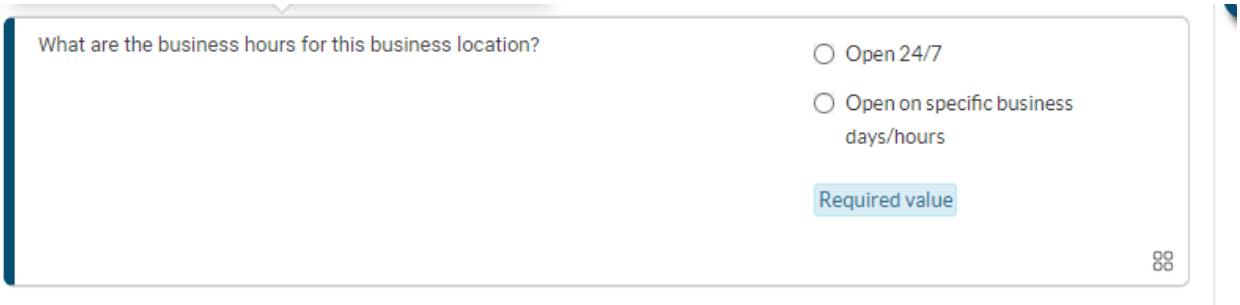
24. Please fill out the Mailing Address for the location. If there is a specific person that needs correspondence, please identify them. Please say: **ATTN:LAST NAME, FIRST NAME**

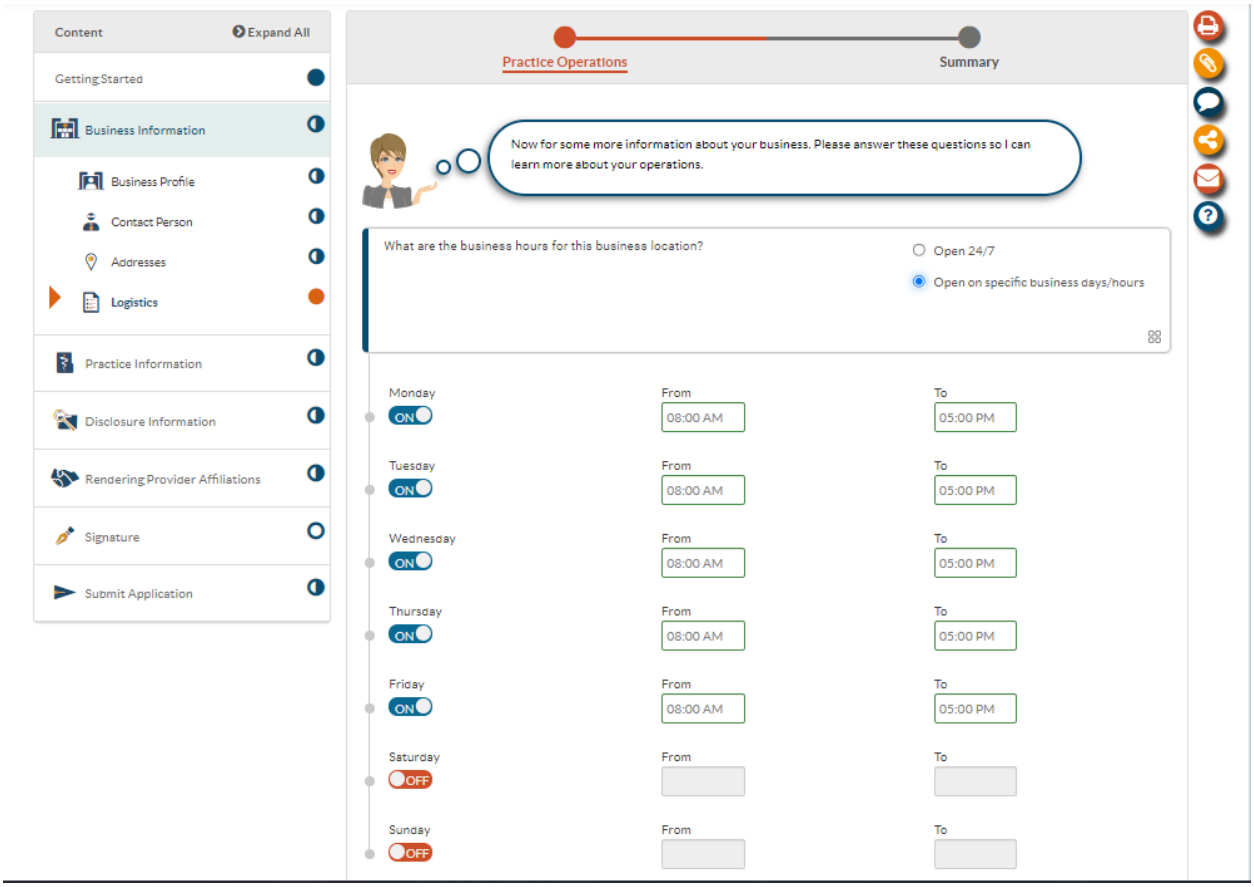
- If the mailing address is the same as either the service address or pay-to address (or both), please check the boxes circled below.



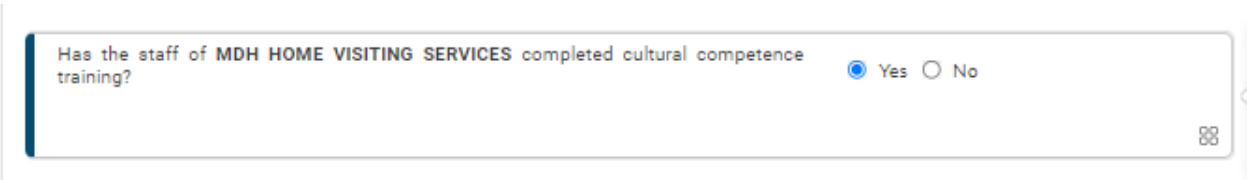
Logistics / Practice Operations - Please answer the following questions as they pertain to your business:

25. What are the business hours for this business location?
    - If you are open 24/7, please check the box.
    - If you are open for specific business hours, please list them here

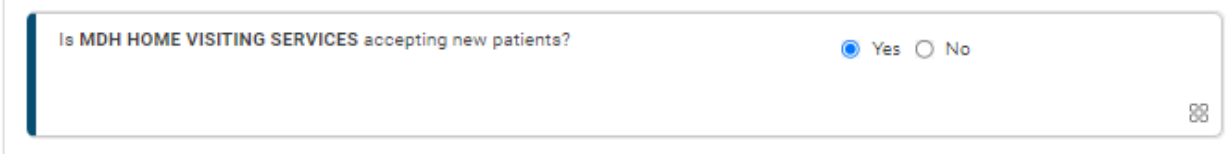




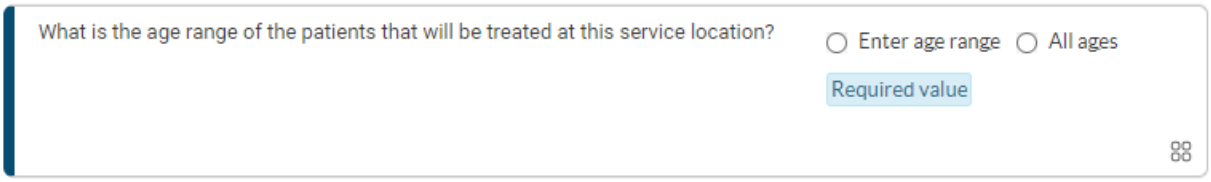
26. Has the staff of (Organization) completed cultural competency training? Please answer yes or no.



27. Is (Organization) accepting new patients? Please answer yes or no.

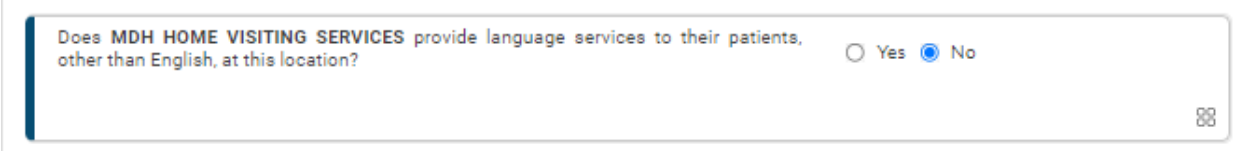


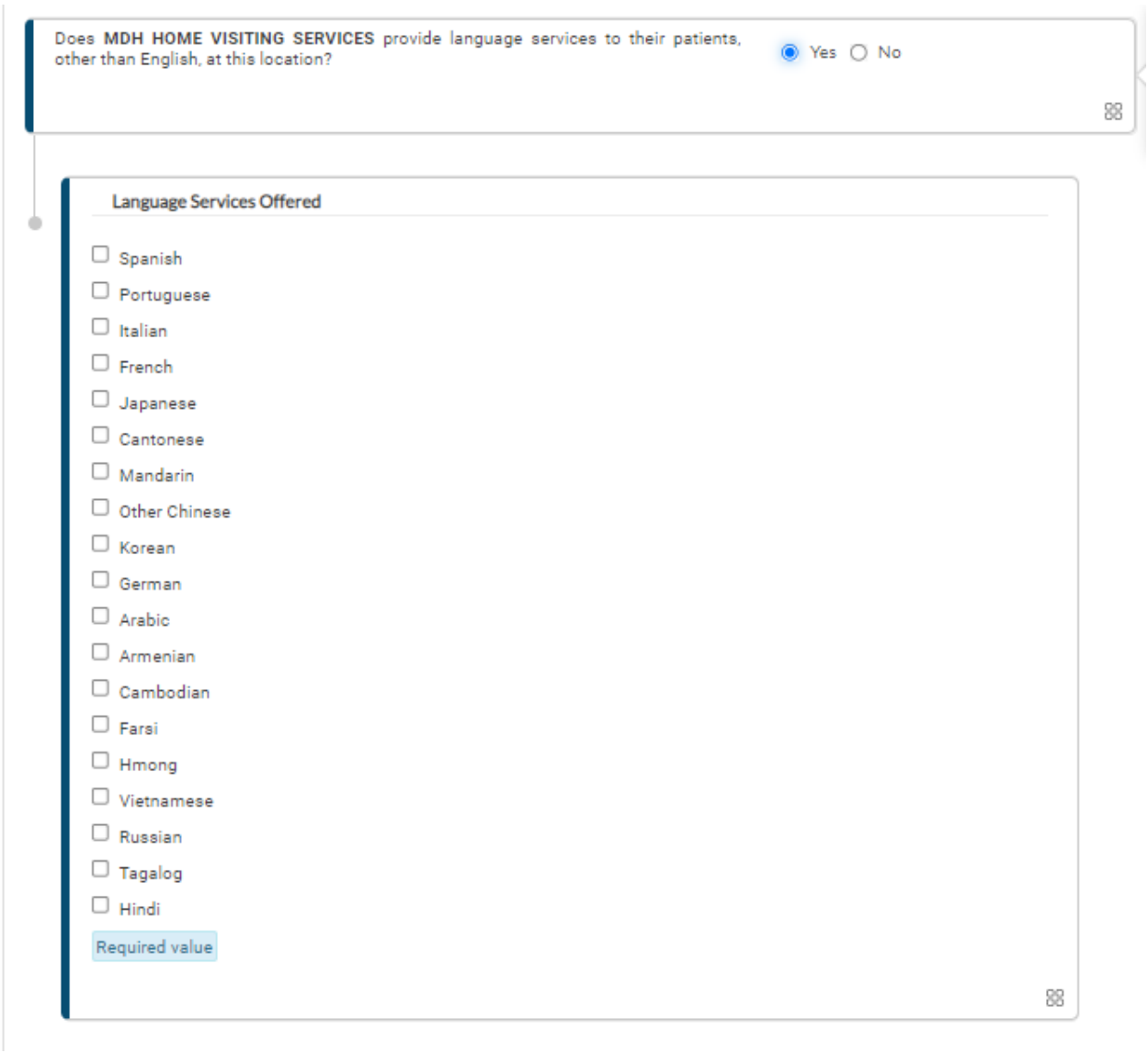
28. What is the age range of the patients that will be treated at this service location?



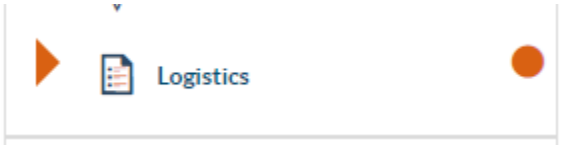
29. Does (Organization) see fee-for-services (FFS) Medicaid participants? Please answer **'yes'** to the following question.

30. Does (Organization) provide language services to their patients, other than English, at this location? Please answer yes or no.





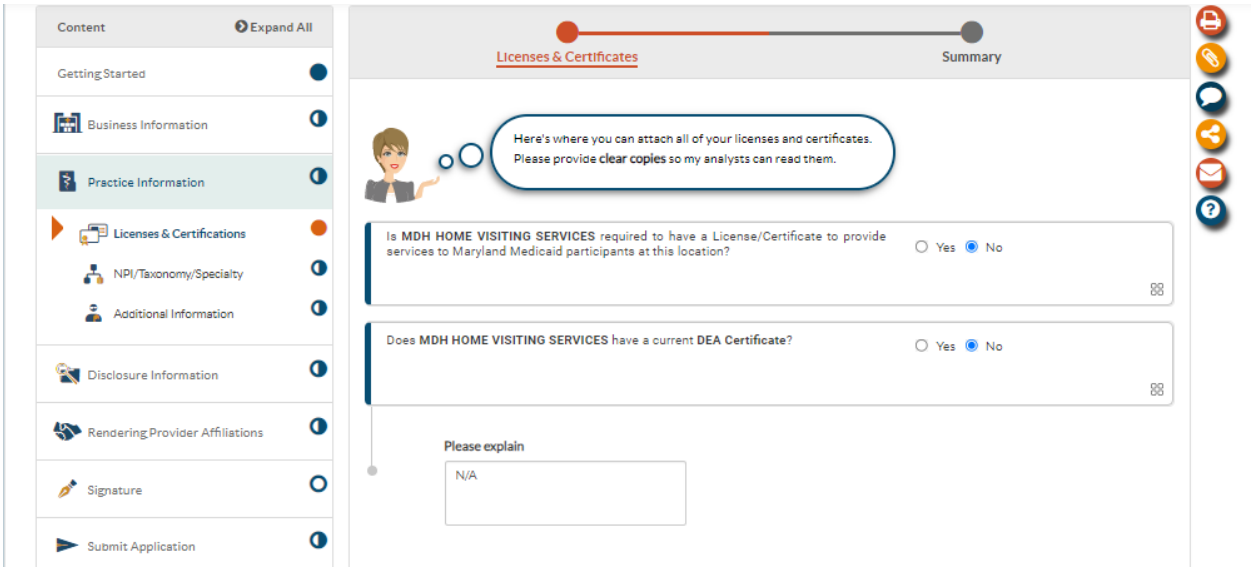
31. Once you have completed filling out all of the Business Information, the circle will be completely filled in.



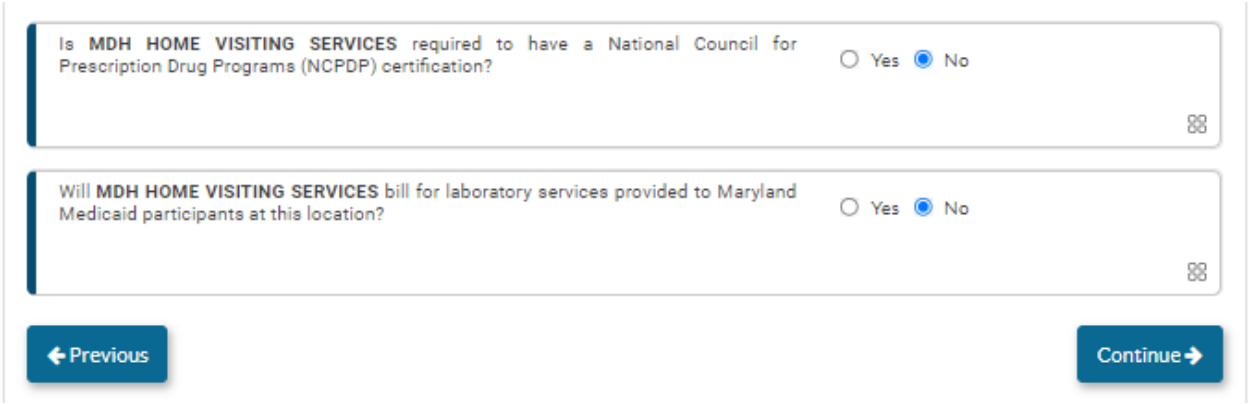
Practice Information: License and Certifications

32. Please select 'No' for any questions regarding license / Certifications / DEA / NCPDP / and

Laboratory certifications

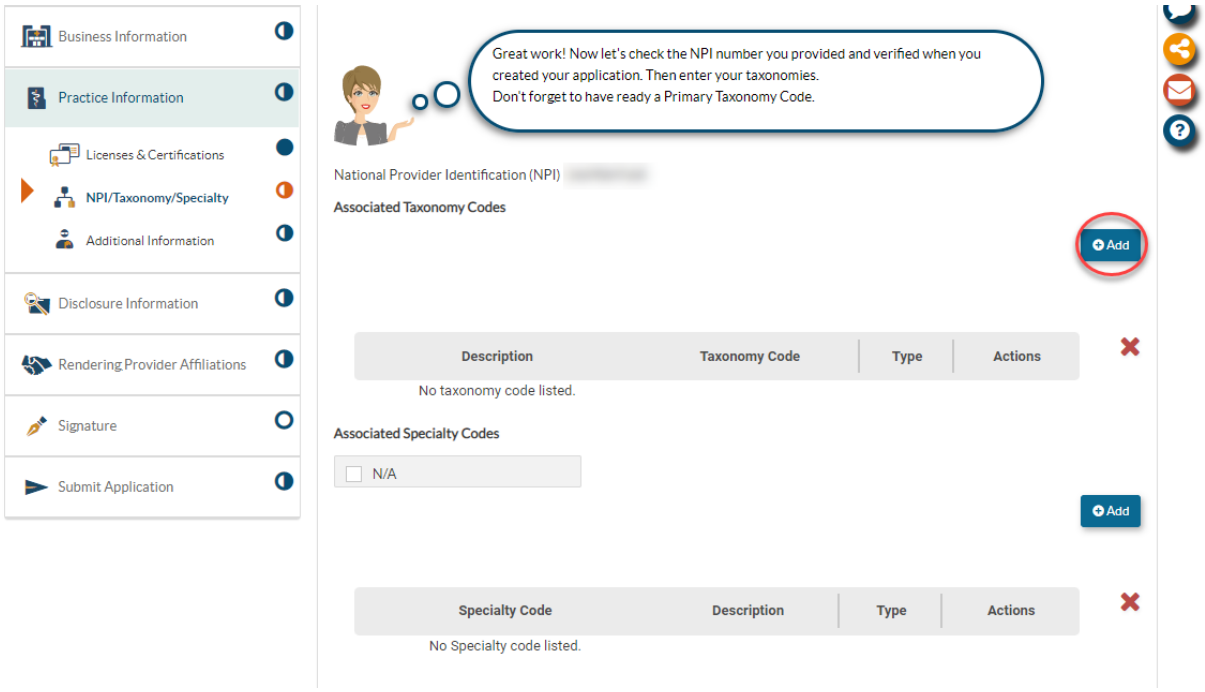


- **In the explanation box, please enter 'N/A'**

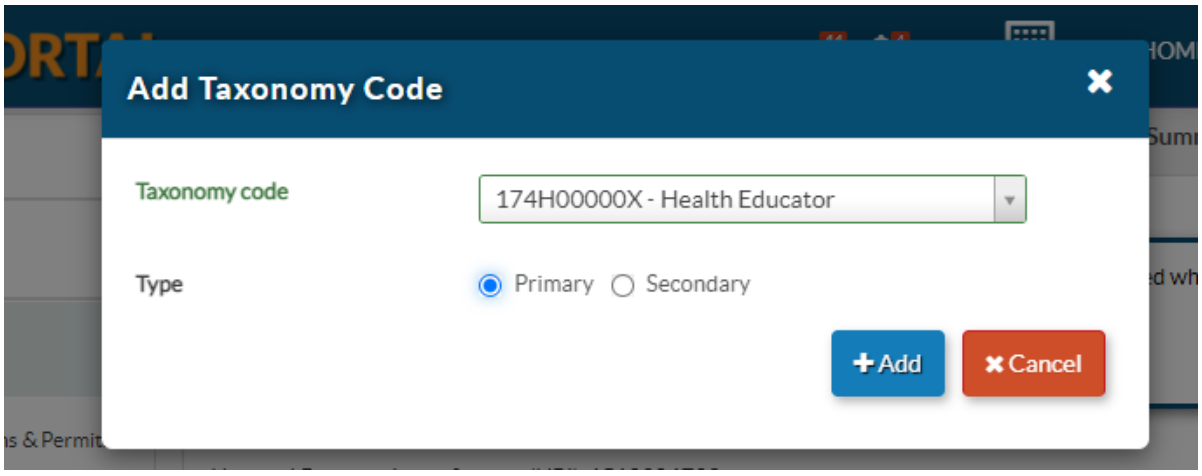


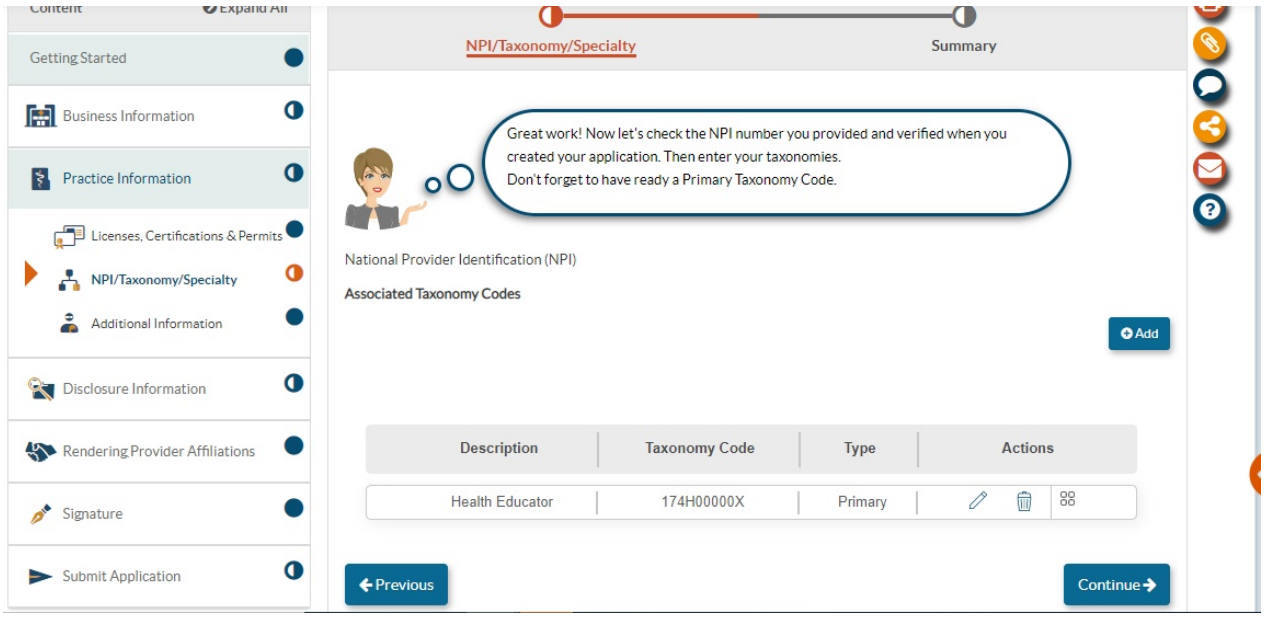
33. NPI/ Taxonomy/ Specialty page: Please double check that the NPI listed on this page is correct.

- Taxonomy code should match what is in NPPES
- Specialty codes are assigned by MDH staff, Leave specialty codes blank - please select 'N/A'

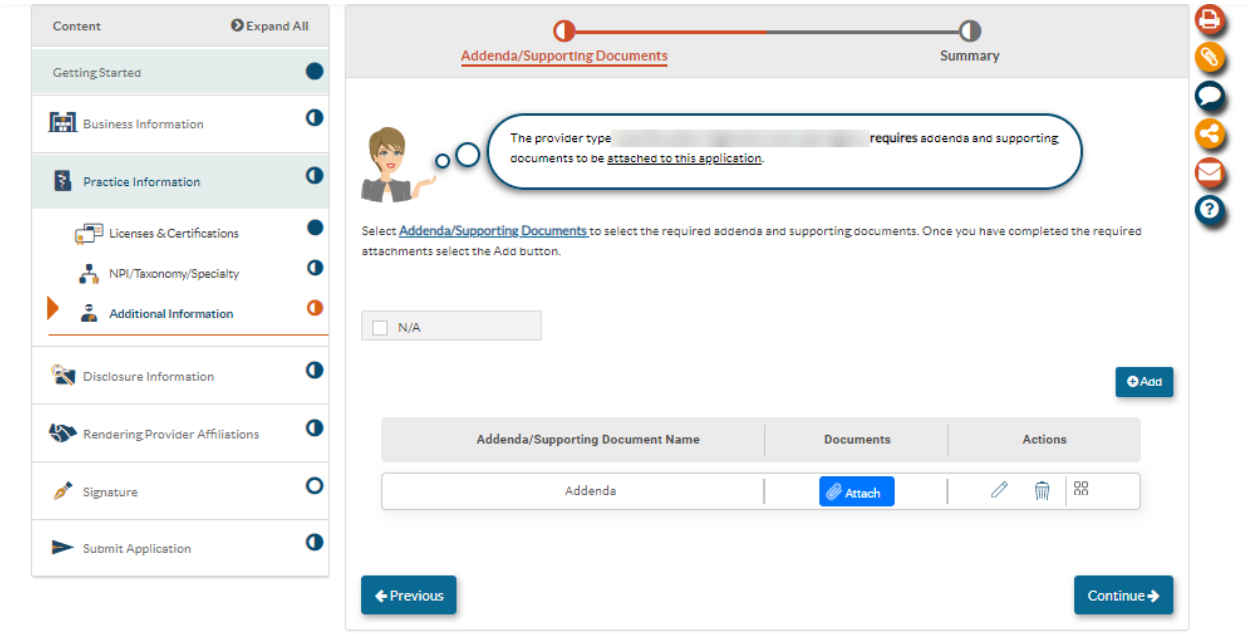


Please list the associated taxonomy code. This taxonomy code is listed in NPPES and was given to you when you first registered for the NPI.





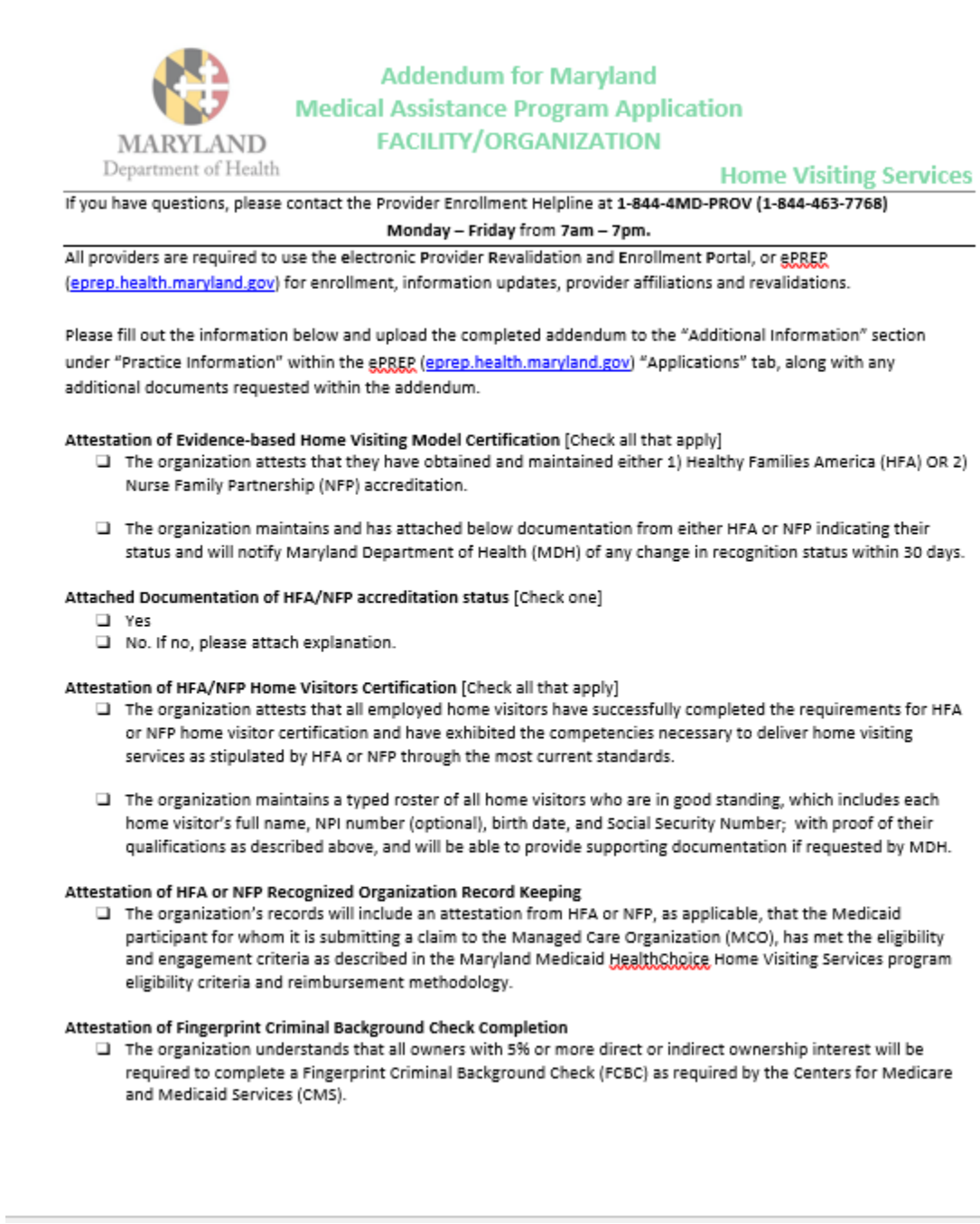
34. This is the Addenda/ Supporting Documents page. Please be sure to attach the 'Medical Assistance Program Application Facility / Organization: PT **Home Visiting Services**.



You can find the needed Addendum by going to the Maryland Medicaid website or by clicking on the following link and downloading the Addendum:

https://health.maryland.gov/mmcp/Pages/Provider-Enrollment.aspx

The following screenshot is an image of the needed Addendum.



MARYLAND
Department of Health

Addendum for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

Home Visiting Services

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**

Monday – Friday from **7am – 7pm.**

All providers are required to use the electronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Attestation of Evidence-based Home Visiting Model Certification [Check all that apply]

- ❑ The organization attests that they have obtained and maintained either 1) Healthy Families America (HFA) OR 2) Nurse Family Partnership (NFP) accreditation.
- ❑ The organization maintains and has attached below documentation from either HFA or NFP indicating their status and will notify Maryland Department of Health (MDH) of any change in recognition status within 30 days.

Attached Documentation of HFA/NFP accreditation status [Check one]

- ❑ Yes
- ❑ No. If no, please attach explanation.

Attestation of HFA/NFP Home Visitors Certification [Check all that apply]

- ❑ The organization attests that all employed home visitors have successfully completed the requirements for HFA or NFP home visitor certification and have exhibited the competencies necessary to deliver home visiting services as stipulated by HFA or NFP through the most current standards.
- ❑ The organization maintains a typed roster of all home visitors who are in good standing, which includes each home visitor's full name, NPI number (optional), birth date, and Social Security Number; with proof of their qualifications as described above, and will be able to provide supporting documentation if requested by MDH.

Attestation of HFA or NFP Recognized Organization Record Keeping

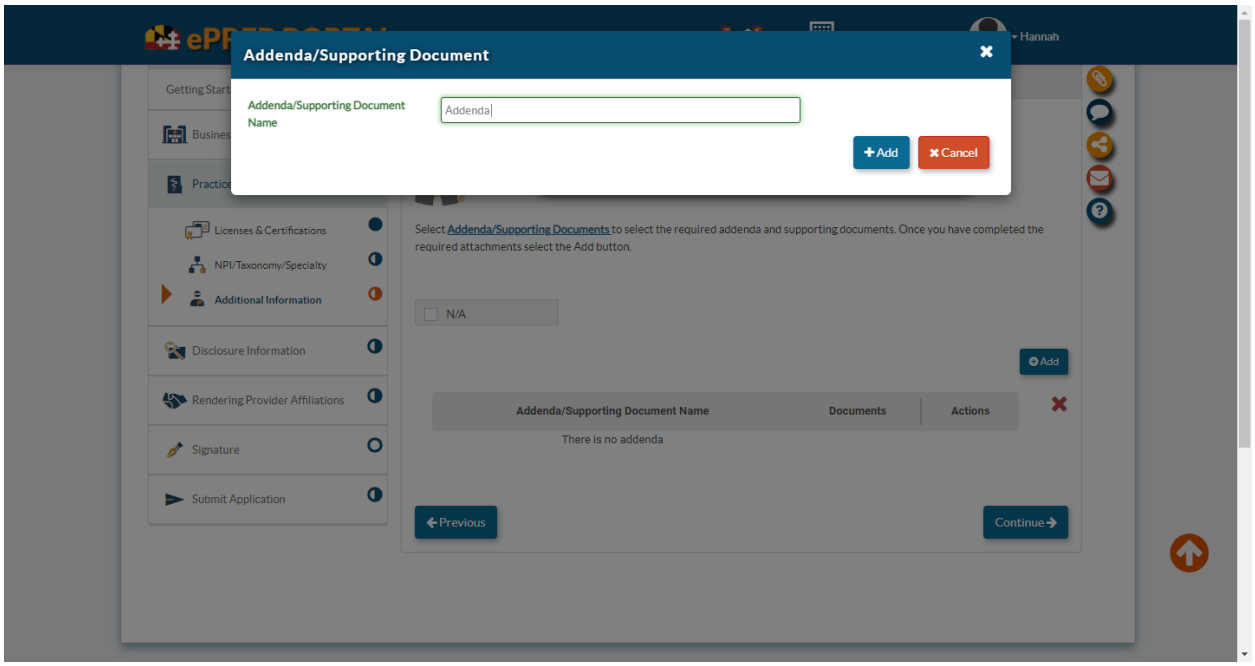
- ❑ The organization's records will include an attestation from HFA or NFP, as applicable, that the Medicaid participant for whom it is submitting a claim to the Managed Care Organization (MCO), has met the eligibility and engagement criteria as described in the Maryland Medicaid HealthChoice Home Visiting Services program eligibility criteria and reimbursement methodology.

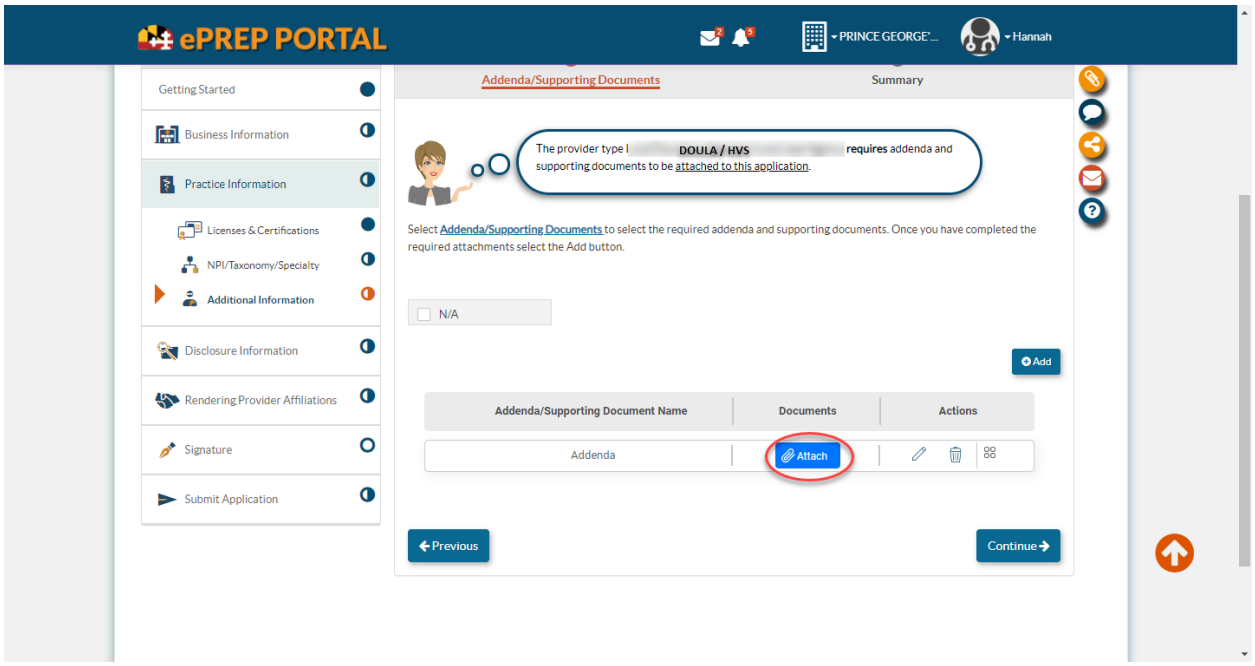
Attestation of Fingerprint Criminal Background Check Completion

- ❑ The organization understands that all owners with 5% or more direct or indirect ownership interest will be required to complete a Fingerprint Criminal Background Check (FCBC) as required by the Centers for Medicare and Medicaid Services (CMS).

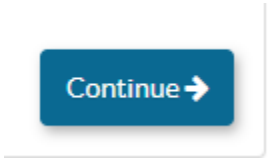
If you answered 'Yes' and additional documentation is needed, please upload it to the application.

35. Please click on the 'Add' button to name the Addendum

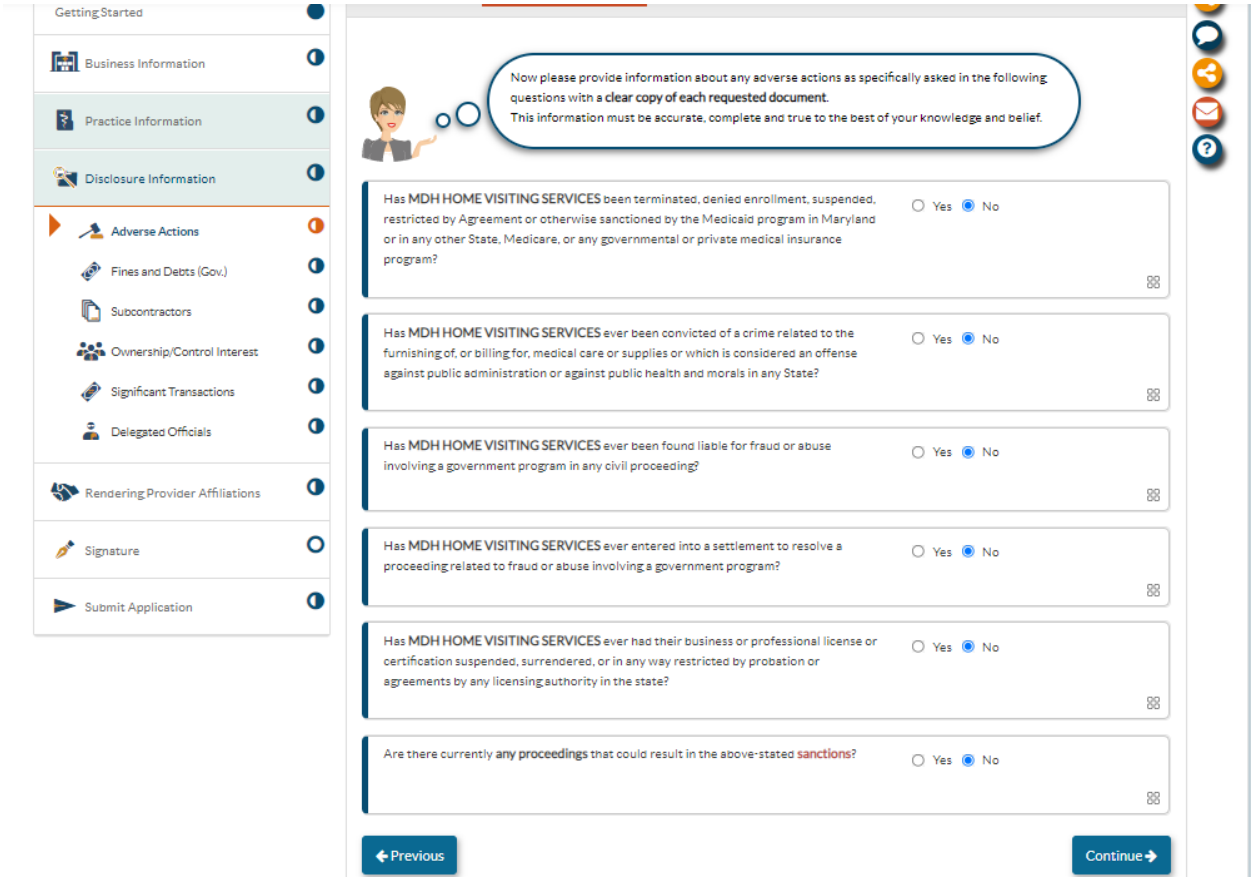




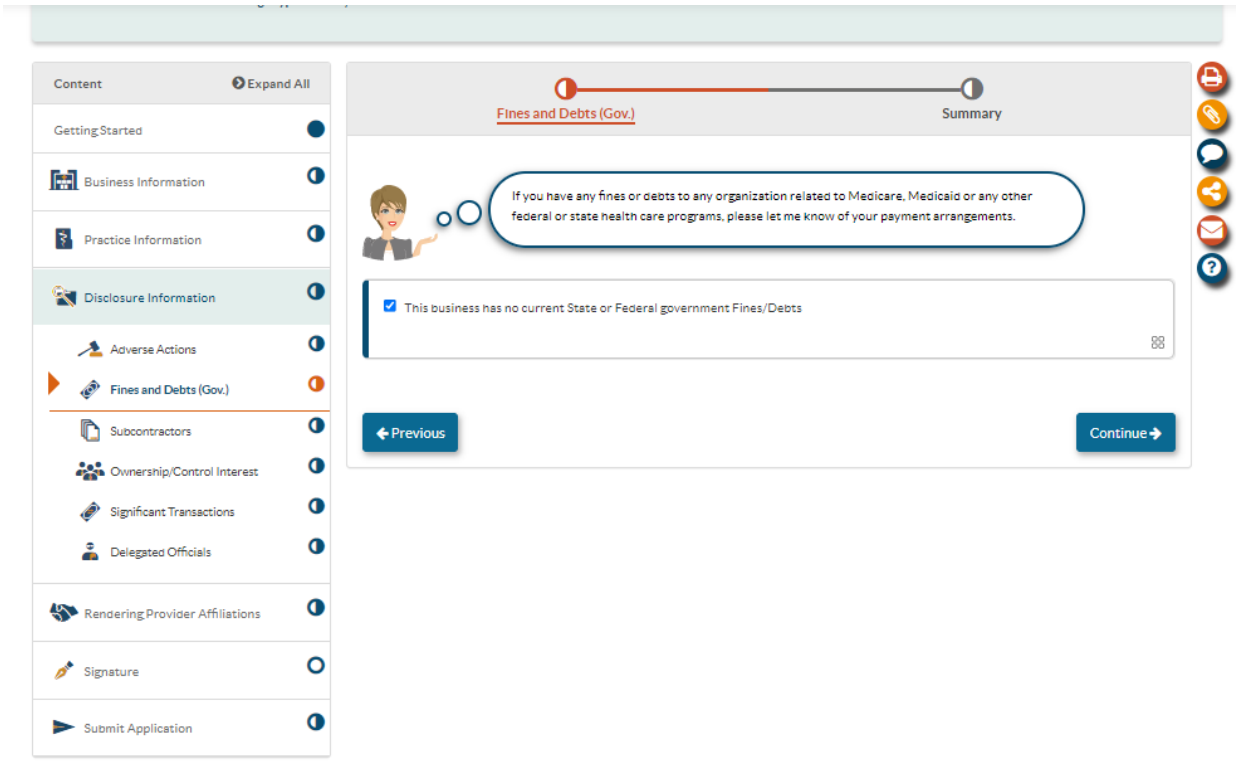
36. Once the Addendum is uploaded, please click continue.



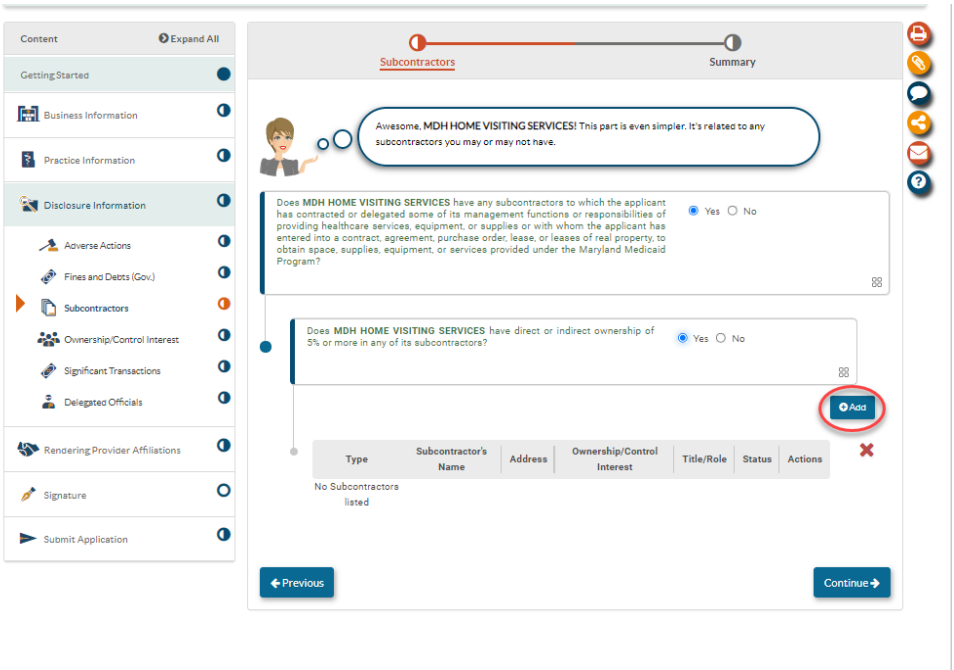
37. **Adverse Action:** Please fill out any adverse action information.

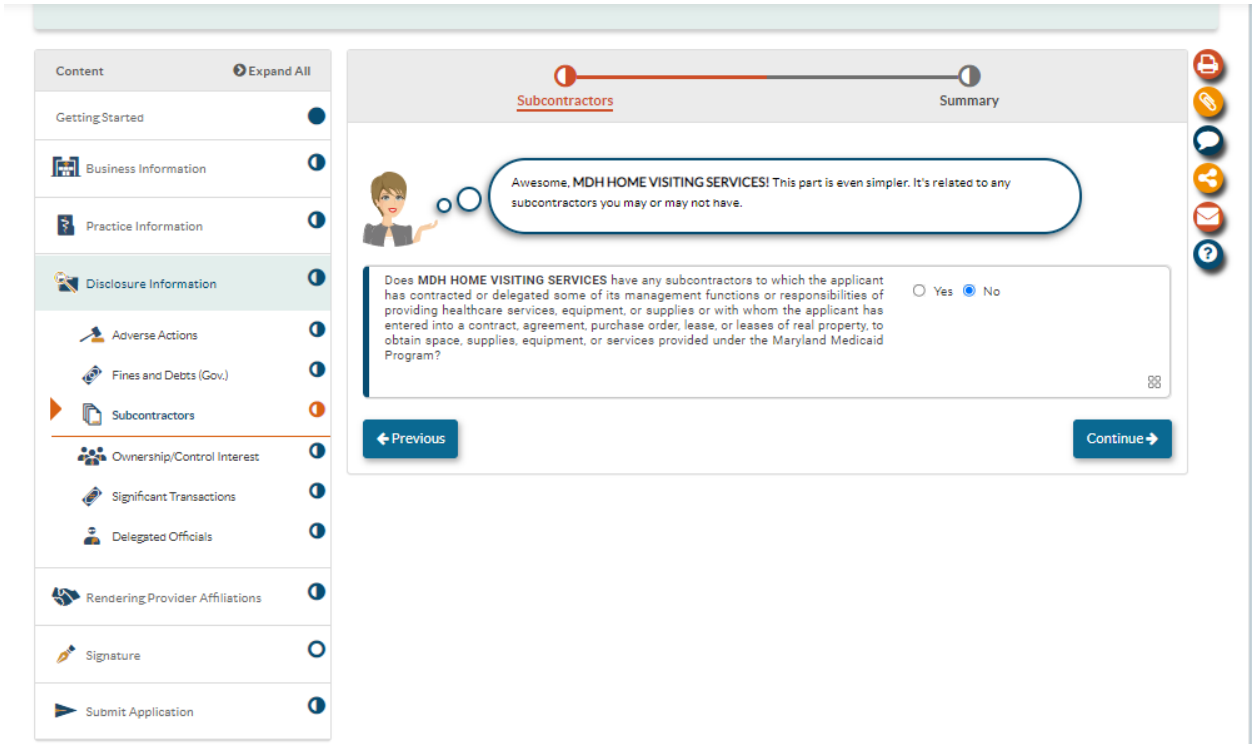


38. Once you have completed the adverse action page, please click continue. Please fill out any fines or debts that the organization has.

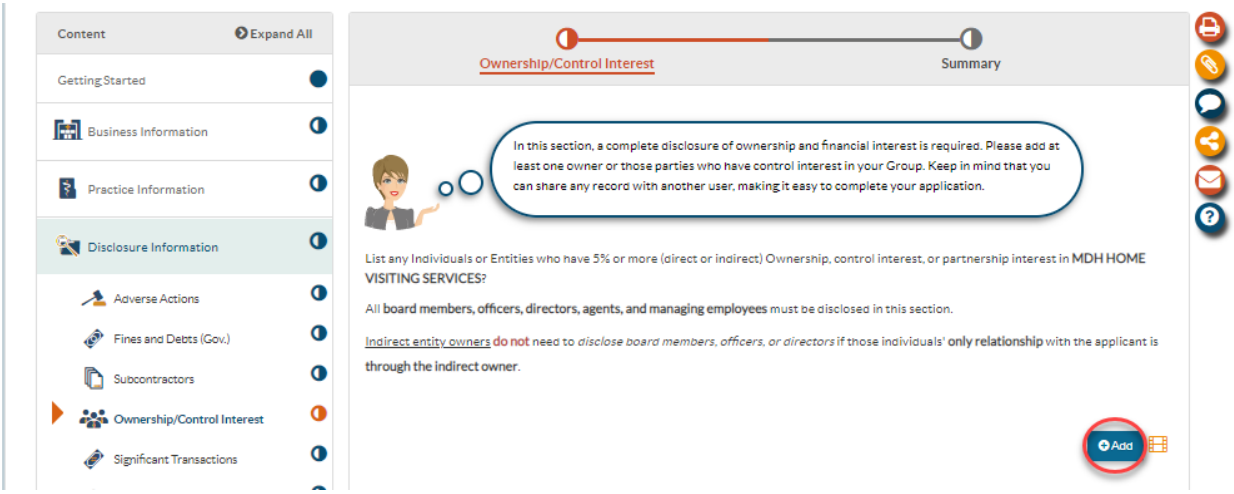


39. Subcontractors: please list any subcontractors the business currently has. If none, please select ‘no.’

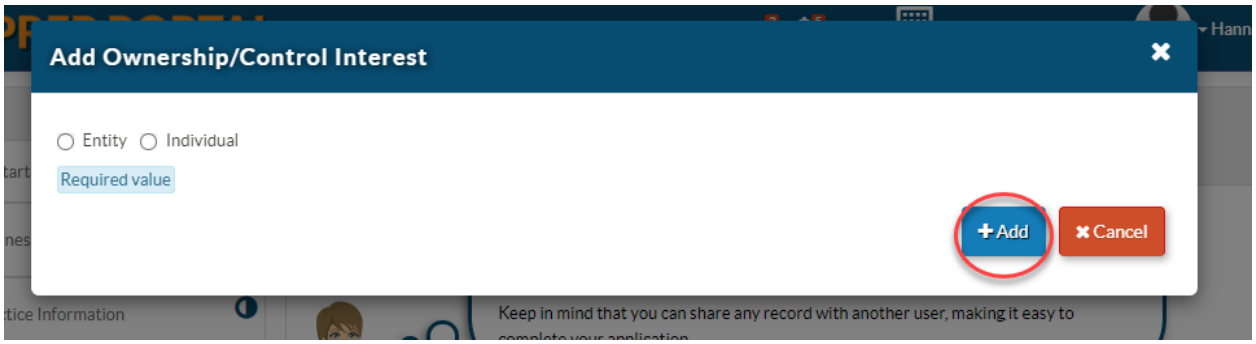




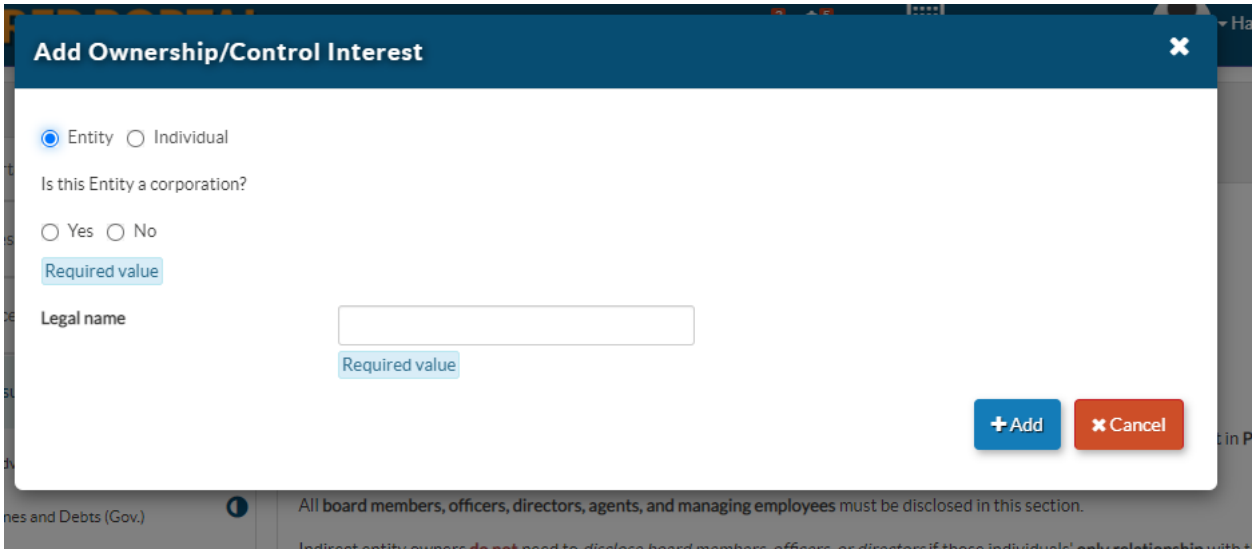
40. **Ownership/ Control Interest**: Please list all individuals / entities who currently own 5% or more of the organization.

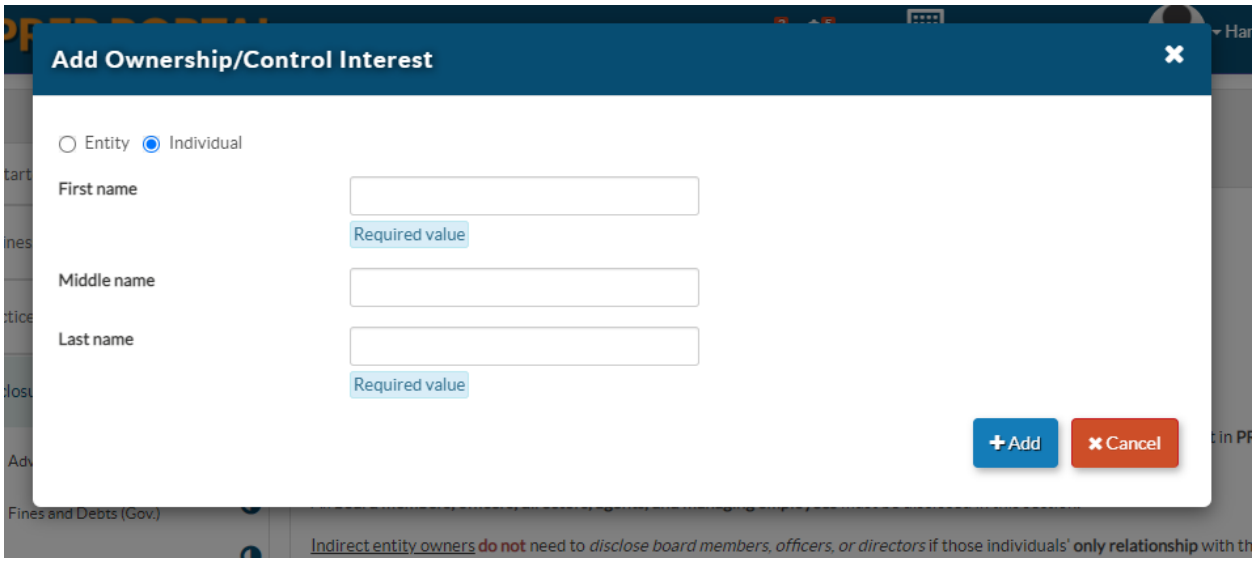


41. Please identify if the organization is owned by an entity or an individual; click ‘add.’

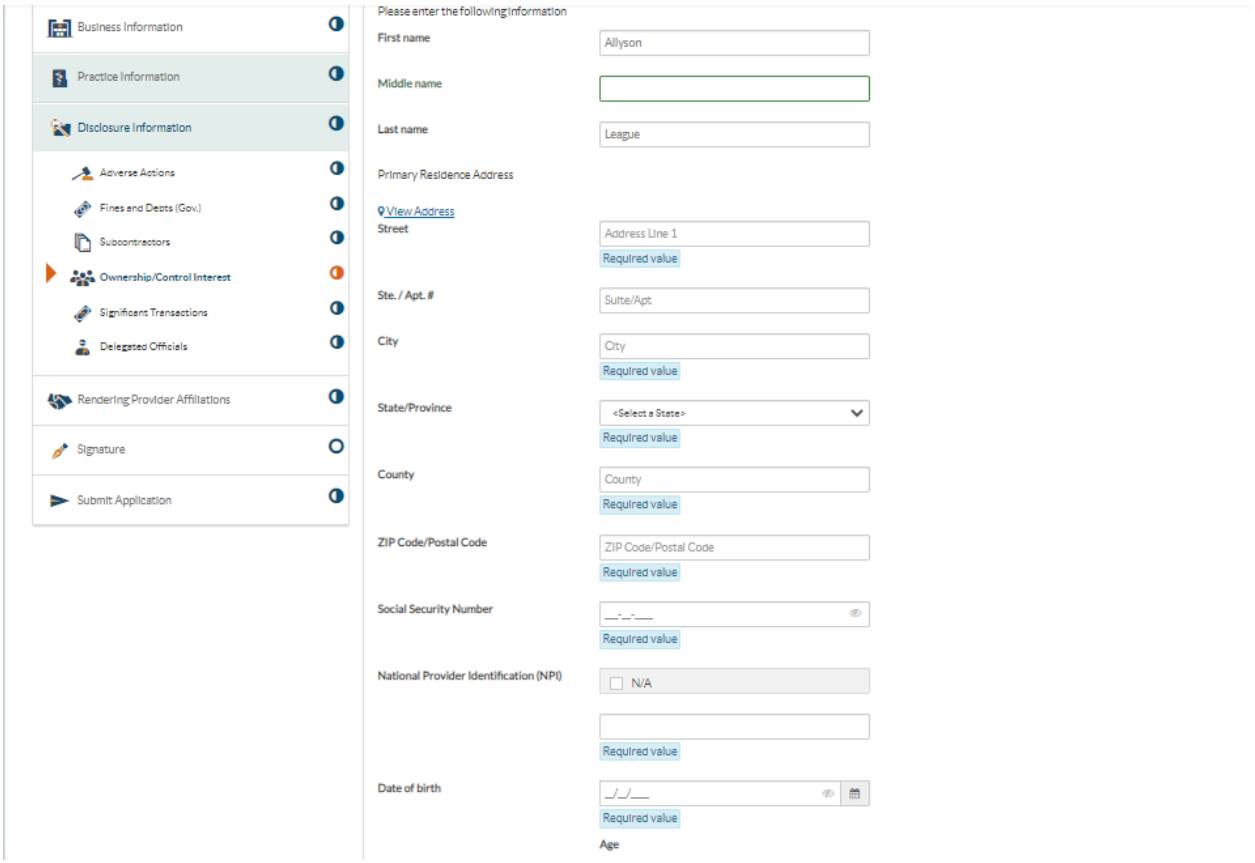


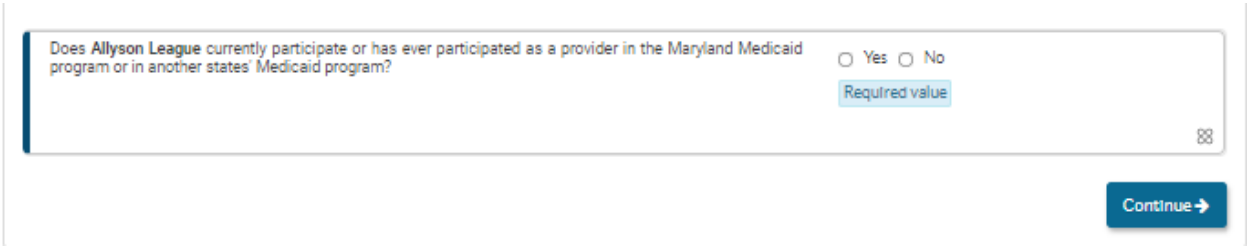
42. With either the entity or individual, please identify their name.



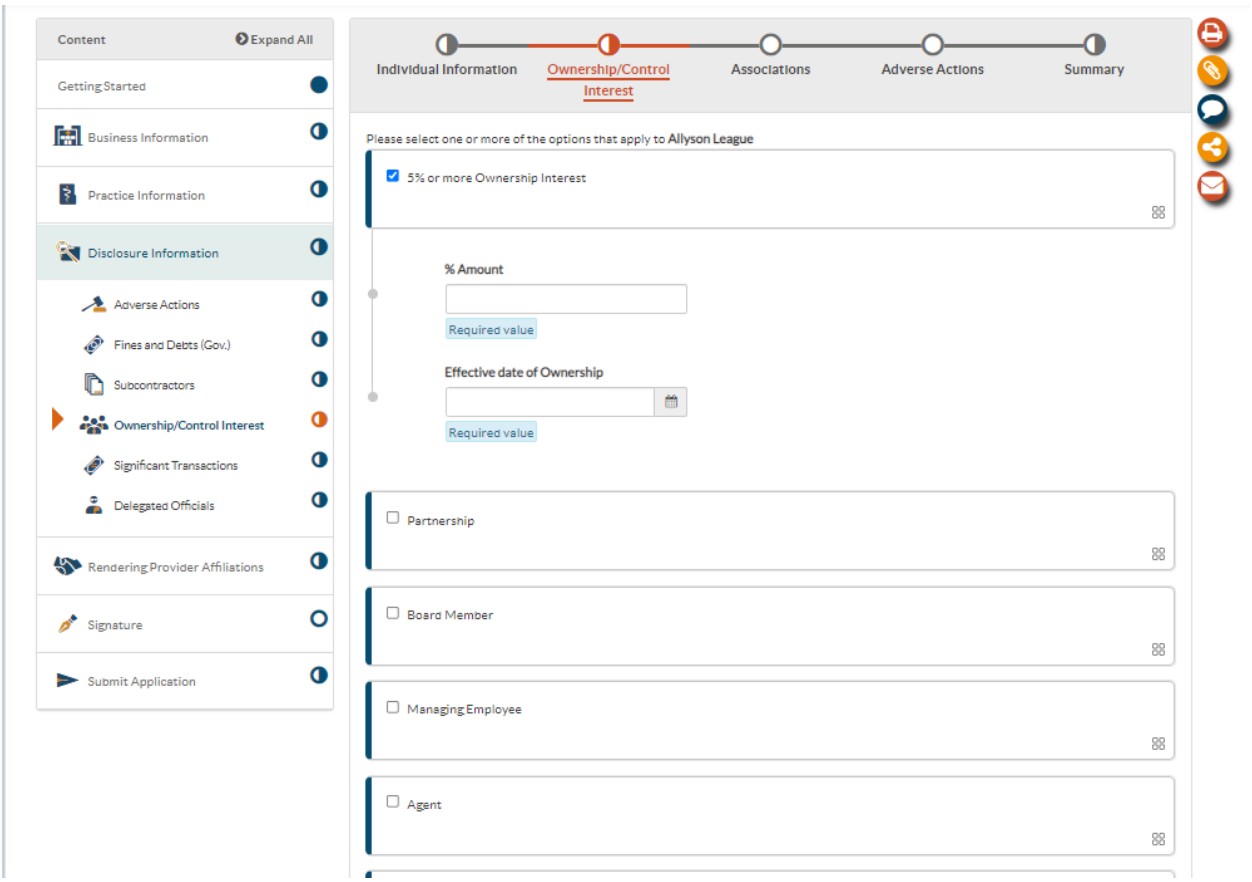


43. Please fill out the ownership individual/entity information.

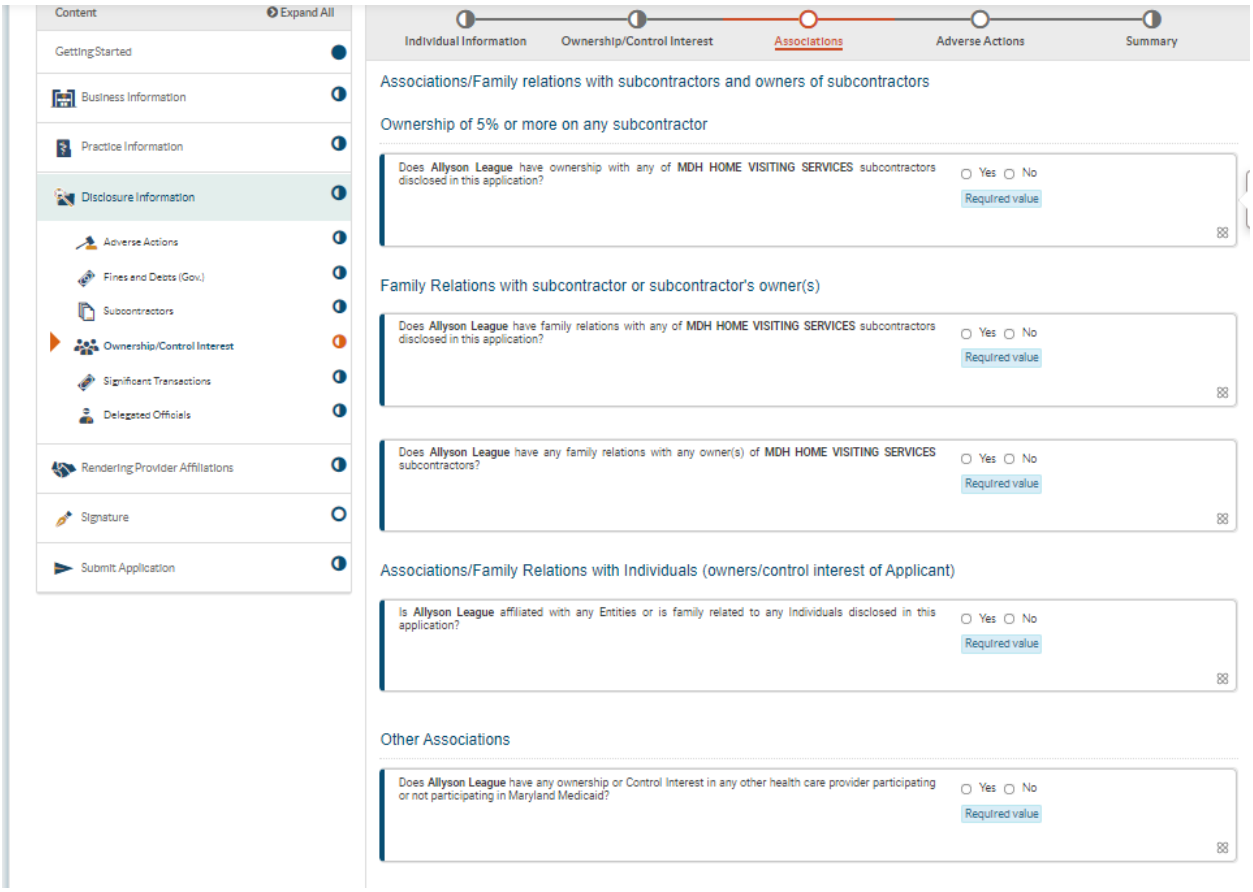




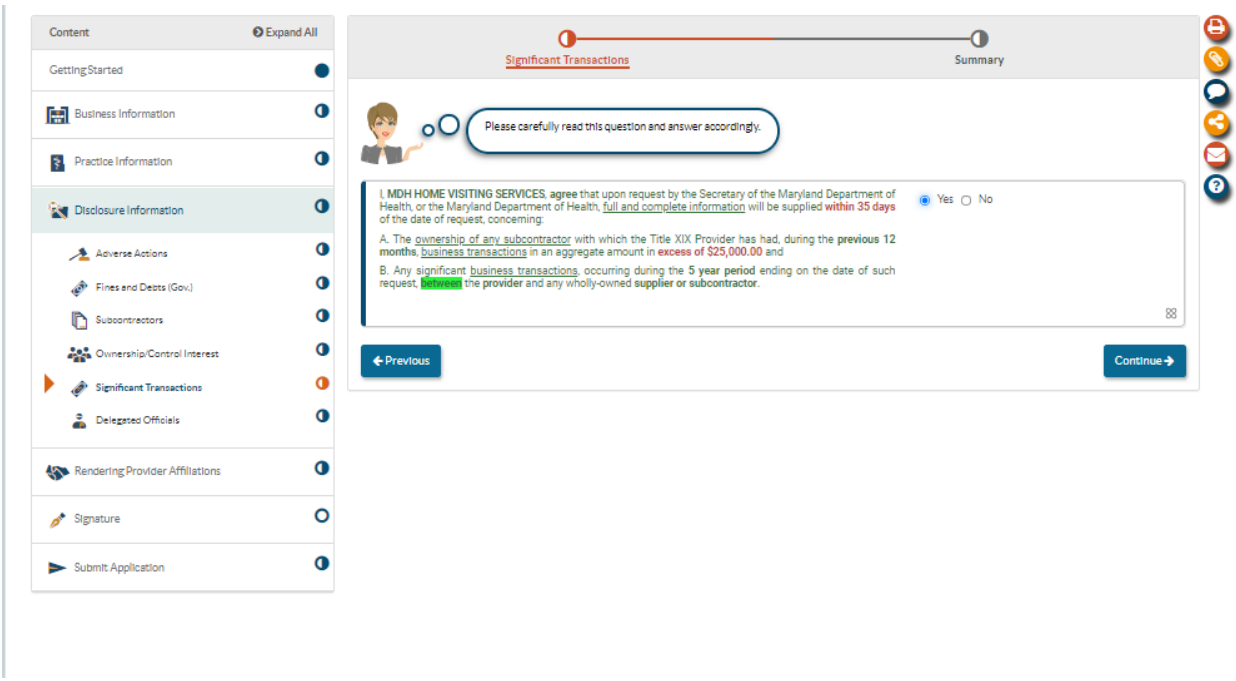
Please select the correct option as it pertains to each individual / entity and enter the corresponding ownership percentage:



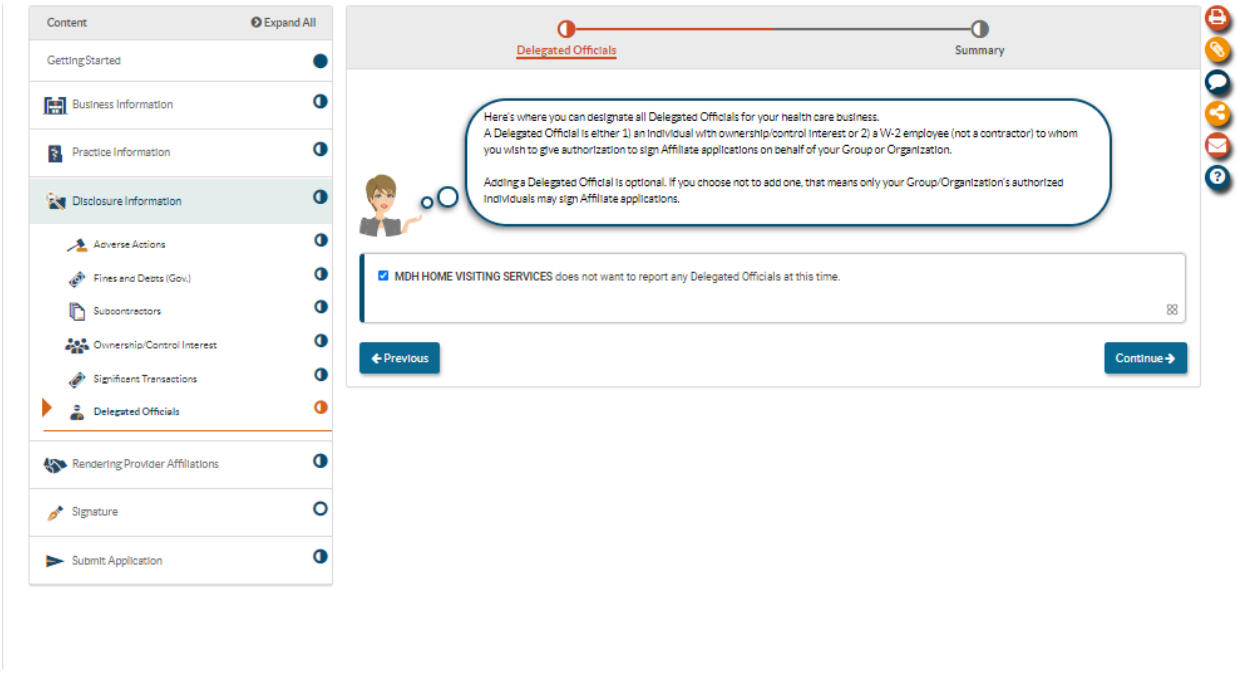
44. Please answer the yes or no questions about the ownership entity or individual.



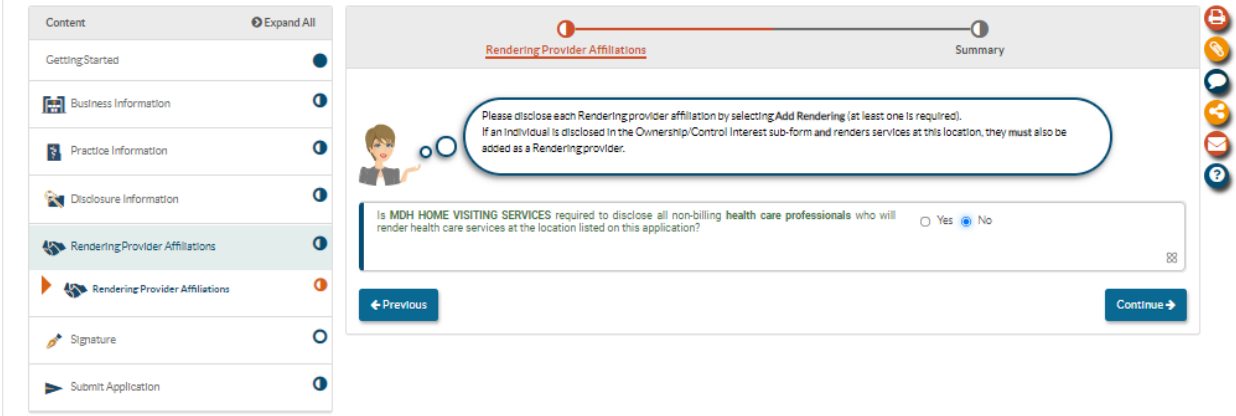
45. This is the ‘Significant Transactions’ page. Please mark ‘yes’ to the following question.



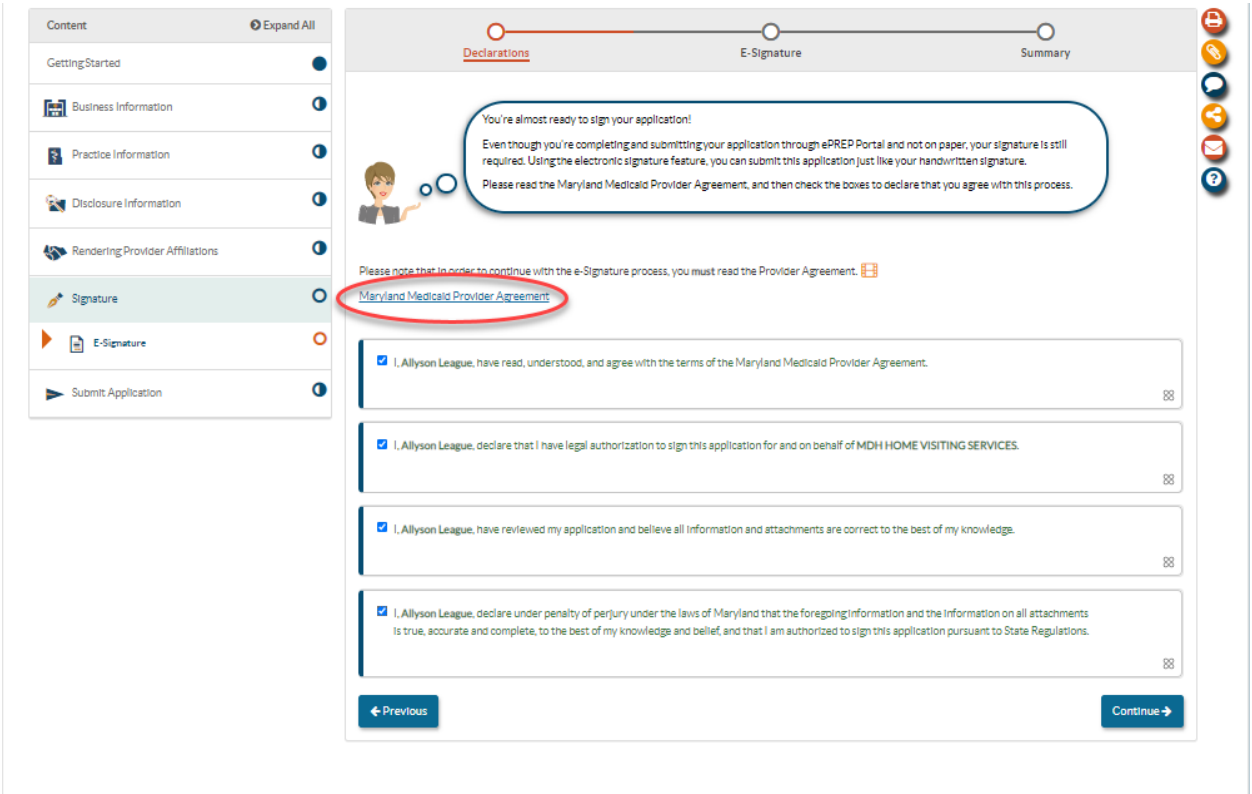
46. Please identify any delegated officials. If you do not wish to disclose any delegated officials, please check the box associated with the question.

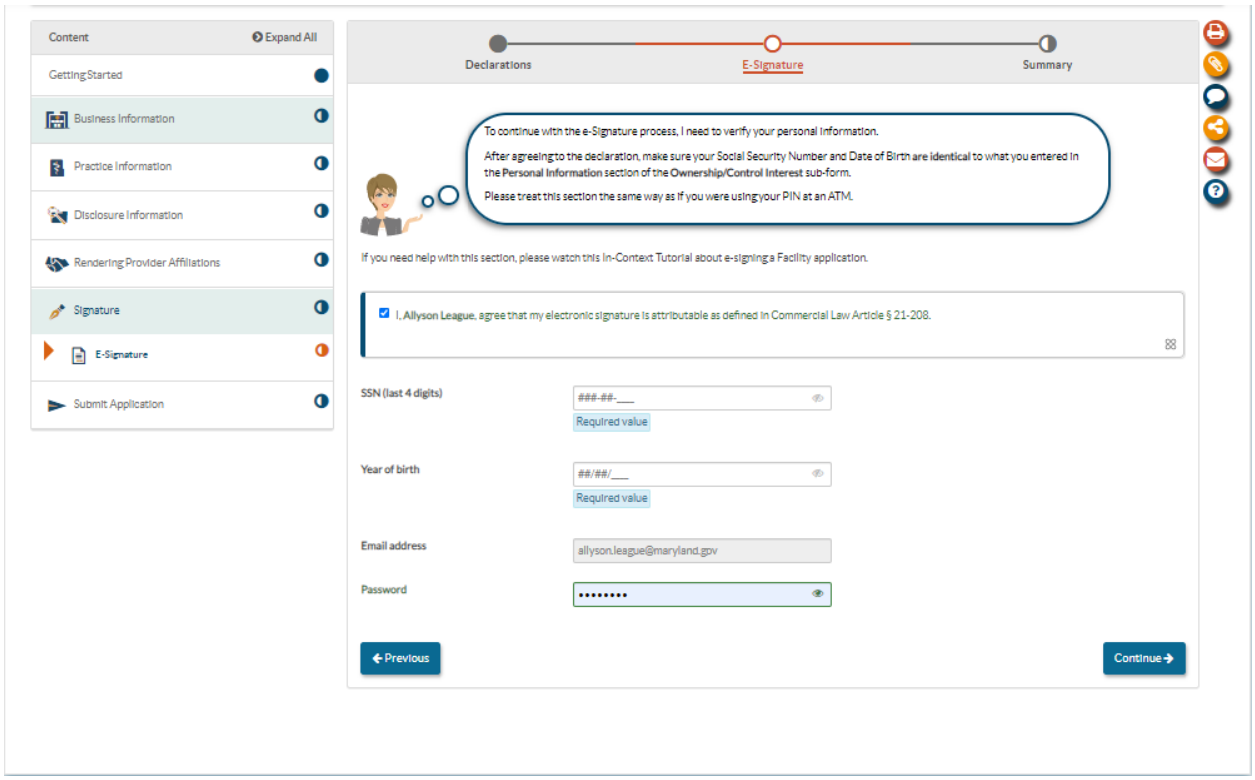


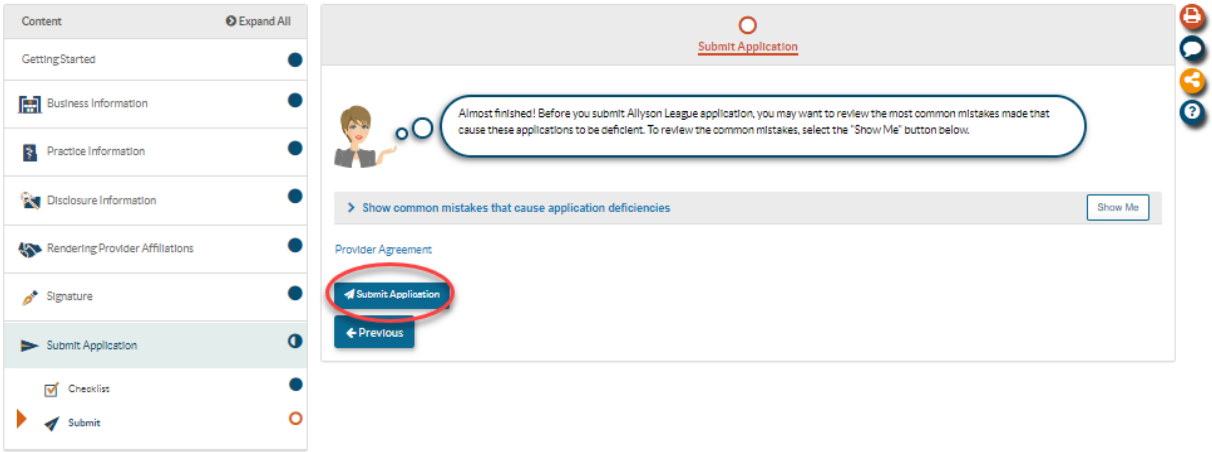
47. Home Visiting Services are not required to add rendering provider affiliations, please select 'No'.

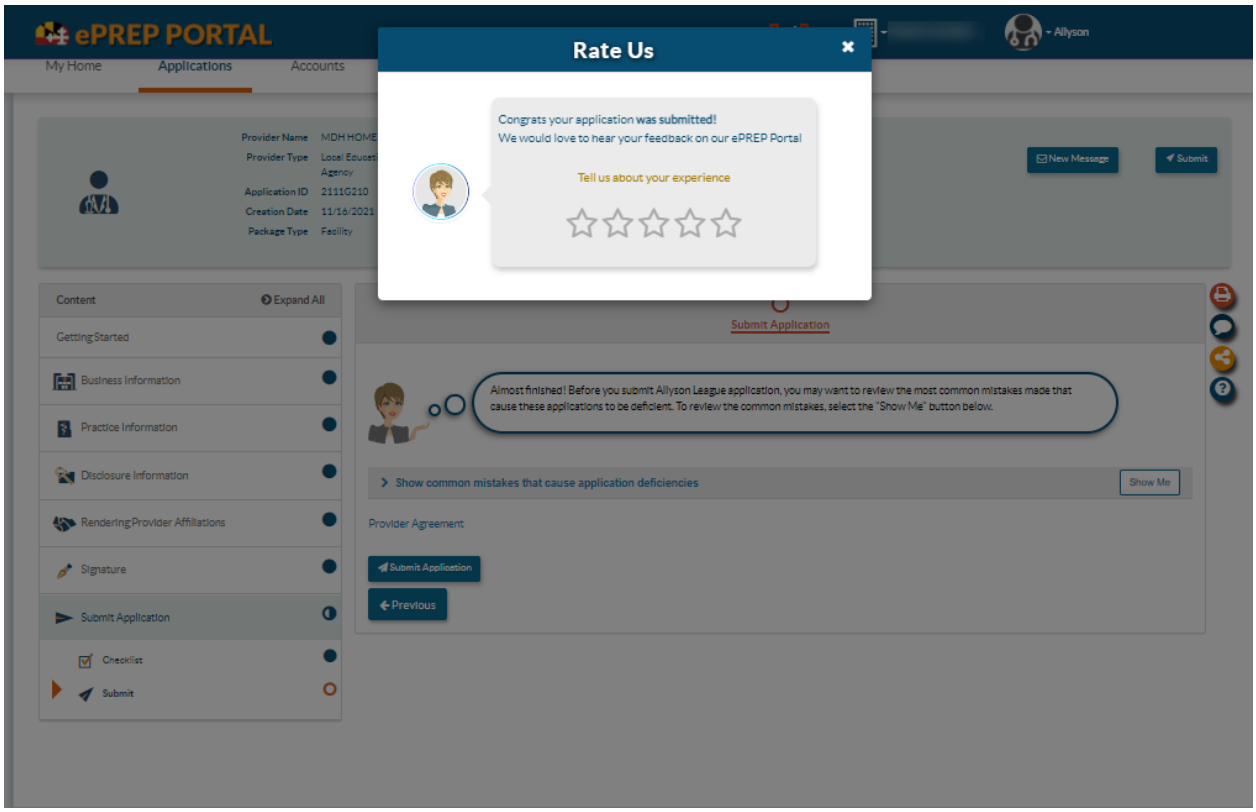


48. Once onto the signature portion, please fill out the required information and click submit.




Content
Expand All
Getting Started
Business Information
Practice Information
Disclosure Information
Rendering Provider Affiliations
Signature
E-Signature
Submit Application
Declarations
E-Signature
Summary
To continue with the e-Signature process, I need to verify your personal information.
After agreeing to the declaration, make sure your Social Security Number and Date of Birth are identical to what you entered in the Personal Information section of the Ownership/Control Interest sub-form.
Please treat this section the same way as if you were using your PIN at an ATM.
If you need help with this section, please watch this In-Context Tutorial about e-signing a Facility application.
I, Allyson League, agree that my electronic signature is attributable as defined in Commercial Law Article § 21-208.
SSN (last 4 digits)
###-##-____
Required value
Year of birth
##/##/____
Required value
Email address
allyson.league@maryland.gov
Password
Previous
Continue


Content
Expand All
Getting Started
Business Information
Practice Information
Disclosure Information
Rendering Provider Affiliations
Signature
Submit Application
Checklist
Submit
Submit Application
Almost finished! Before you submit Allyson League application, you may want to review the most common mistakes made that cause these applications to be deficient. To review the common mistakes, select the "Show Me" button below.
Show common mistakes that cause application deficiencies
Show Me
Provider Agreement
Submit Application
Previous



Please feel free to rate the ePREP system and leave any comments that pertain to your application submission.

Thank you for your time.

If you have any questions, please contact us at
mdh.providerenrollment@maryland.gov