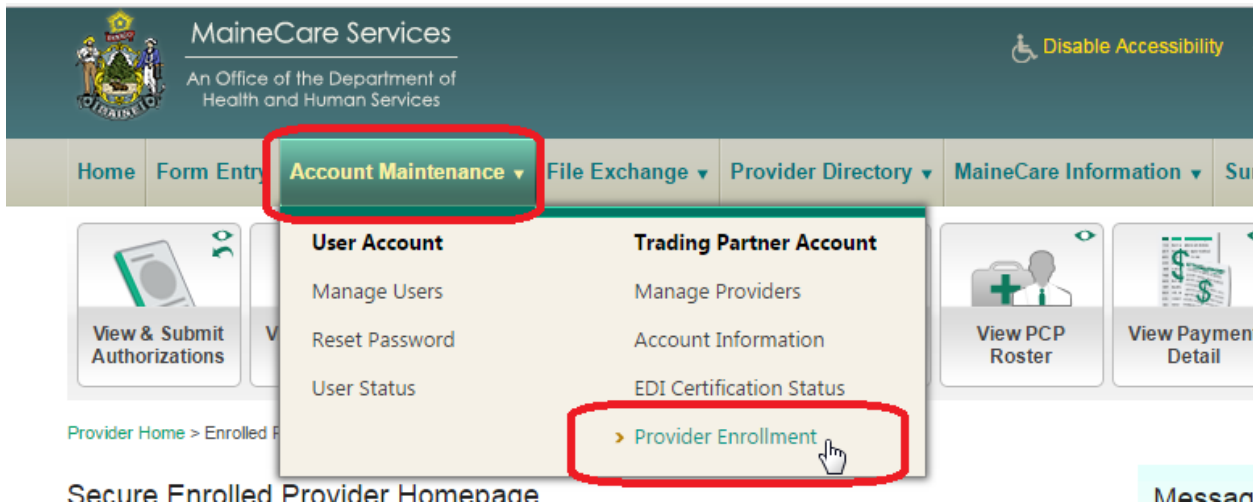


Adding a New Rendering Provider to MIHMS

- Log into the MIHMs portal - <https://mainecare.maine.gov/Default.aspx>
- Select Account Maintenance
- Select Provider Enrollment



- On the My Enrollment Applications page, select the arrows under the Actions column
- Select the Limited Maintenance drop down
- Write down your Enrollment Case Number

Enrollment Links to start new Enrollment

- > InState Provider Enrollment
- > Out of State Enrollment

To begin Maintenance or view your existing enrollment with MaineCare, please use the Action Button in the grid below

My Enrollment Applications

Case Number	Provider ID	Provider Name	Email Address	Enumeration Type	Enrollment Status	Enrollment Type	Actions
16	38	MSAD#	email@address.com	Type 2 - Organization	ENROLLED	REVALIDATION	

Note
Provider ID = NPI or API

Help Links and Guidance


- > AdvantageME Forms
- > Relevant Text Link 2
- > Relevant Text Link 3
- > Relevant Text Link 4
- > Relevant Text Link 5
- > Relevant Text Link 6
- > Relevant Text Link 7
- > Relevant Text Link 8
- > Relevant Text Link 9
- > Relevant Text Link 10

View Enrollment
Disenrollment
Limited Maintenance
Term Service Location
Term Rendering Provider
Update EFT Information
View Enrollment Summary
Download Enrollment PDF
Download Enrollment Excel

- Select the **Rendering Providers** tab
- Enter Provider's NPI number
- Enter Provider's DOB
- Enter Provider's Social Security Number
- Select "Yes" on the "Accepting New Patient" section
- Read "Rendering Provider Conviction" and select "Yes" or "No"
- Select Save and Continue

Service Location: **Rendering Providers** | Documents | Signature

Rendering Provider | ProviderType/Specialty | Affiliation | Rendering Provider Taxonomy |


 Billing Provider ID: Enrollment Case Number: Status: **ENROLLED - REVALIDATION**

Provider	First Name	Last Name	Accepting New Patients	Enrollment Status
No records to display.				

Rendering Provider NPI

Enter the Rendering Provider NPI. The application will check the current providers and the CMS NPI Registry and return this provider :

Provider ID(NPI)* :

Rendering Provider

Status : New

First Name* : Middle Name :
 Last Name* : Suffix : --Please Select--
 Email : Primary Phone* : ()- - -
 Emergency Phone : ()- - - Fax : ()- - -
 Date of Birth* : Gender* : --Please Select--
 Accepting New Patient* : Yes No SSN* :
 Term Date :

Home Address

Address Line 1 : Address Line 2 :
 Zip Code : Zip Code Extn : --Please Select--
 City : --Please Select-- County :
 State : Country : --Please Select--

Rendering Provider Conviction

Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing Medicare or MaineCare Program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program?* : Yes No

Select the **Provider Specialty - Verify Information** line

- Select Add
- Select Save and Continue

Business Info | Ownership Info | Service Locations | **Rendering Providers** | Ordering/Referring Providers | Documents | Signature | Bulk Upload

Rendering Provider | **ProviderType/Specialty** | Affiliation | Rendering Provider Taxonomy |

Provider Type/Specialty

Billing Provider ID: [REDACTED] Enrollment Case Number: [REDACTED] - 1 Status: **NEW - MAINTENANCE**

Rendering Provider NPI

Rendering Provider NPI

Specialties

You must enter your PRIMARY specialty first. The system defaults the first entry as the PRIMARY specialty.

Provider Type	Specialty	Begin Date	Term Date
Physician	OPHTHALMOLOGY	5/1/2016	

EDIT DELETE ADD

Provider Type/Specialty

ProviderType*: Physician Begin Date*: 5/1/2016
Specialty*: OPTHALMOLOGY Term Date:

Add PTSP

Do you have prescribing/dispensing privileges?*: Yes No

License

License Type	License#	Begin Date	Term Date	State
Doctor	[REDACTED]	5/1/2016	4/30/2019	Maine

EDIT DELETE ADD

Additional Information

School Graduated From: Attended From Date: Attended To Date: Degree: --Please Select--

SAVE CANCEL

BACK RESET SAVE **SAVE AND CONTINUE** CLOSE

Affiliations

- Select the Add button
- Select all schools listed
- Enter date the provider began delivering services in Begin Date. Term Date can be left blank.
- Select Save and Continue

Site Name	Affiliated?	Begin Date	Term Date
Family Practice	<input type="checkbox"/>		

- Under the Documents section, you will be asked to attest to some Additional Terms
- After reading and selecting Attest, select Save and Continue

Ch. I - Section 1: General Administrative Policies and Procedures* [Click to Read](#)
 Attest - I attest that I have read and agree to abide by the terms and conditions of the linked document(s).

Ch. II - Section 19: Home and Community-Based Benefits for the Elderly and for Adults with Disabilities* [Click to Read](#)
 Attest - I attest that I have read and agree to abide by the terms and conditions of the linked document(s).

Ch. II - Section 109: Speech and Hearing Services* [Click to Read](#)
 Attest - I attest that I have read and agree to abide by the terms and conditions of the linked document(s).

- Under the Signature tab, complete the required fields and select Submit
- Please note that you may use the school district’s tax ID number for the Signatory SSN or FEIN field

Service Locations | Rendering Providers | Documents | **Signature**

Rendering Provider | ProviderType/Specialty | Affiliation | Rendering Provider Taxonomy |

The Signature and Submission windows must be completed. The enrollment modification must be electronically signed by entering Provider Name, Signatory Name, Signatory SSN or FEIN and the current date (must be today’s date). Users must select the “*I Attest, All demographic information is up to date and correct.*” check box and click the Submit button, as shown in [Figure 4-44](#) below.

Signature

Billing Provider ID: Enrollment Case Number: Status: **NEW - MAINTENANCE**

Signature

- I certify that the information contained herein is true, correct, and complete.
- If I become aware that any information in this form is not true, correct, or complete, I agree to notify MaineCare or its fiscal agent of this fact immediately.
- I authorize MaineCare and/or its fiscal agent to verify the information contained herein.
- I understand that a change in the incorporation of my organization or my status as an individual or group may require a new application.

Incorrect information would lead to the denial of the application or delay the approval process. Please verify that all information is correct before submitting the application.

I Agree

Provider Application Enrollment Signature

Provider Name* :
Signatory Title* : Signatory Title
Signatory Name* : Signatory Name
Signatory SSN or FEIN* : *****4444
Date* : 9/18/2016
IP Address* : 10.10.87.68

I Attest, All demographic information is up to date and correct.

If you are required to pay a fee, you will need to have your credit card or debit card number, CVV, and expiration date information ready before you submit your application. If you have questions, please contact Provider Enrollment at 1-866-690-5585, Option 2.

BACK RESET SAVE CLOSE **SUBMIT**