



Regular Individual Enrollment Checklist

A Regular Individual Provider is a provider that owns his/her own practice. This provider will receive payments directly from SDMA for services rendered at their practice.

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The table below contains a list of required fields for each step when enrolling as a Regular Individual Provider. In the parenthesis you will find the options for that field. If there are a large number of options for the required fields, those options are located at the bottom of the document (See Required Field Names in bold)

Step 1 Provider Basic Information		
Required Field	Prior Selection (If field is conditional required)	Your Data
Tax Identifier Type (FEIN, SSN)		
FEIN	Tax Identifier Type: FEIN	
Organization Name	Tax Identifier Type: FEIN	
Organization Business Name	Tax Identifier Type: FEIN	
SSN	Tax Identifier Type: SSN	
Provider First Name	Tax Identifier Type: SSN	
Provider Last Name	Tax Identifier Type: SSN	
Servicing Type (Regular Individual, Servicing only)	Tax Identifier Type: SSN	
NPI		
W-9 Entity Type		
W-9 Entity Type (If Other)	W-9 Entity Type: Other	
Enrollment Request Date		
Step 2 Locations		
Required Field	Prior Selection (If field is conditional required)	Your Data
Location Type (Base and Servicing)		
Location Name		
Accept New Recipient (Yes, No)		
Business Name at This Location		
Contact First Name		
Contact Last Name		
Address		
Phone Number		
Communication Preference (Standard Mail, E-Mail)		
E-Mail Address	Communication Preference: E-Mail	
VFC Provider (Yes, No)		
Do you have Malpractice Insurance at this Location (Yes, No)		
Type of Address (Mailing, Pay-to, Prior Authorization)		
Step 3 Specializations		
Required Field	Prior Selection (If field is conditional required)	Your Data
Location (select from previously entered locations)		
Administration		
Provider Type		
Specialty (Depends on Provider Type selected)		
Associated Subspecialties (Depends on Specialty selected)		

Regular Individual Enrollment Checklist

Step 4 Ownership Details		
Required Field	Prior Selection (If field is conditional required)	Your Data
Owner Type (Individual Ownership, Organization Ownership)		
SSN/FEIN		
Parent Organization		
Parent Organization (If Other)	Parent Organization: Other	
Percentage Owned		
Relationship to Provider (Child, None, Parent, Self, Sibling, Spouse)		
Ownership Start Date		
Address of Owner		
Operator Type (Lessee, Management Contract, Sublessee)		
Operator SSN/FEIN		
Operator Doing Business As		
Operator Organization Name		
Operator Start Date		
Operator Address		
Managing or convicted employee name(s)		
Step 5 License/Certification		
Required Field	Prior Selection (If field is conditional required)	Your Data
Location (chosen from dropdown list)		
License/Certification Type		
License/Certification #		
Effective Date		
End Date		
Step 8 Indicators		
Required Field	Prior Selection (If field is conditional required)	Your Data
Location (chosen from dropdown list)		
Indicator Type (Managed Care Indicator)		
Indicator Value (Accepting New Patients, Accepting OB Patients Only, Not Accepting New Patients, Not a PCP)		
Start Date		
Step 9 Malpractice Insurance Information		
Required Field	Prior Selection (If field is conditional required)	Your Data
Location (chosen from dropdown list)		
Malpractice Insurance Name		
Step 10 Federal Tax Details		
Required Field	Prior Selection (If field is conditional required)	Your Data
Address		
Phone Number		
Step 11 Claim Submission Method		

Regular Individual Enrollment Checklist

Required Field	Prior Selection (If field is conditional required)	Your Data
None (It is recommended that you select at least one Mode.) (Web Batch, Billing Agent/Clearinghouse, FTP Secured Batch, Online(Direct Data Entry))		
Claim Submission Method	Required Step	
Web Batch	Step 12: Add EDI Billing Software Details Step 14: Add EDI Contact Information	
Billing Agent	Step 13: Add EDI Submitter Details	
FTP Secure Batch	Step 12: Add EDI Billing Software Details	
Online (Direct Data Entry)	NA	
Step 12 EDI Billing Software Details		
Required Field	Prior Selection (If field is conditional required)	Your Data
Software Vendor Company Name		
Software Product Name		
Software Version		
Software Protocol		
Contact Title (Software Vendor)		
Contact First Name (Software Vendor)		
Contact Last Name (Software Vendor)		
Phone Number (Software Vendor)		
Address (Software Vendor)		
Step 13 EDI Submitter Details		
Required Field	Prior Selection (If field is conditional required)	Your Data
Billing Agent/Clearinghouse SD MEDX ID		
Start Date		
Transaction Response (At least one must be selected)		
Transaction Response Start Date	Transaction Response: Yes	
Step 14 EDI Contact Information		
Required Field	Prior Selection (If field is conditional required)	Your Data
EDI Contact Title		
EDI Contact First Name		
EDI Contact Last Name		
EDI Contact Phone Number		
EDI Contact Address		
Associated Transactions		
Step 15 Billing Provider Information		
Required Field	Prior Selection (If field is conditional required)	Your Data

Regular Individual Enrollment Checklist

NPI or SD MEDX ID		
Step 16 Payment Details		
Required Field	Prior Selection (If field is conditional required)	Your Data
Location		
Payment Method		
Bank Name		
Routing Number		
Account Number		
Account Type		
Payment Notification Preference (E-Mail, Letter)		
E-mail Address	Payment Notification Preference: E-mail	
Step 17 Complete Enrollment Checklist		
Required Information		Comment if answer is Yes
Have you or any employee ever had an Assessment taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had an Administrative Sanction taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Suspension of Payment taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Restitution Order taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Program Exclusion taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Program Debarment taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Pending Criminal Judgment taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Pending Civil Judgment taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Judgment Pending Under False Claims Act taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Criminal Fine taken against you? (Yes, No) (If Yes, a comment is required)		
Have you or any employee ever had a Civil Monetary Penalty taken against you? (Yes, No) (If Yes, a comment is required)		
Has applicant or employees ever been placed on the MED, LEIE, or similar database? (Yes, No) (If Yes, a comment is required)		
Has applicant or employees ever been charged with or convicted of any theft or fraud type crime(s)? (Yes, No) (If Yes, a comment is required)		
Has any state or federal health care program ever taken any type of administrative action against applicant or employees? (Yes, No) (If Yes, a comment is required)		
Has Applicant, or employees, ever been charged with or convicted of any health related crimes? (Yes, No) (If Yes, a comment is required)		
Has Applicant, or employees, ever been charged with or convicted of a crime involving the abuse of a child or an elderly adult? (Yes, No) (If Yes, a comment is required)		

Regular Individual Enrollment Checklist

Step 18 View/Upload Attachments		
Required Field	Prior Selection (If field is conditional required)	Your Data
Wheelchair Addendum (if applicable)		
Verification of Service (Out of State Provider) (if applicable)		
School Addendum (if applicable)		
PCP Addendum (if applicable)		
Licenses and Certifications (if applicable)		
EDI Required Documentation (if applicable)		
Contracts and Agreements (if applicable)		
Attestation Form (if applicable)		
Step 19 Submit Enrollment Application for Review		
Required Field	Prior Selection (If field is conditional required)	
None		

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Regular Individual Enrollment Checklist

List of options for required fields	
W-9 Entity Type: (Corporation, Governmental Entity, Hospital Exempt from Tax or Government Owned, Individual/Sole Proprietor, LLC Filing as Corporation, LLC Filing as Disregarded Entity, LLC Filing as a Partnership, LLC Filing as Sole Proprietor, LTC Facility Exempt from Tax or Government Owned, Other, Partnership)	BACK
Provider Type: (10 - Behavioral Health & Social Service Providers, 11 - Chiropractic Providers, 12 - Dental Providers, 13 - Dietary & Nutritional Service Providers, 15 - Eye and Vision Services Provider, 16 - Nursing Service Providers, 17 - Other Service Providers, 18 - Pharmacy Service Providers, 19 – Group, 20 - Allopathic & Osteopathic Physicians, 21 - Podiatric Medicine & Surgery Service Providers, 22 - Respiratory, Developmental, Rehabilitative and Restorative Service Providers, 23 - Speech, Language and Hearing Service Providers, 24 - Technologists, Technicians & Other Technical Service Providers, 25 – Agencies, 26 - Ambulatory Health Care Facilities, 27 - Hospital Units, 28 – Hospitals, 29 – Laboratories, 30 - Managed Care Organizations, 31 - Nursing & Custodial Care Facilities, 32 - Residential Treatment Facilities, 33 – Suppliers, 34 - Transportation Services, 36 - Physician Assistants & Advanced Practice Nursing Providers, 37 - Nursing Service Related Providers, 38 - Respite Care Facility)	BACK
Parent Organization: (Accredo Health Group, Alegent Health, Allina Hospitals and Clinics, Apria Healthcare, Avera Health, Banner Health, Bethesda Health Group, Catholic Health Initiatives, Evangelical Lutheran Good Samaritan Society, Fairview, Golden Living, Hennepin Healthcare System, Horizon Healthcare, Innovis Health, Lutheran Social Services, Mayo Health Clinic, MedCenter One Health, Mercy Health Network, Meritcare Health System, None, Other, Planned Parenthood, Regional Health, Sanford Health, Volunteers of America)	BACK
License/Certification Type: (ABCD Certification, AOA Certification, ASL Certification, Agency/Facility License, Air Ambulance License, Ambulance License, Ambulatory Surgical Center Certification, American Diabetes Association Certification, American Speech Hearing Language Association Certification, Board Certification by the American Board of Sleep Medicine, Business License, CARF/CORF Certification, CHAP Certification, CLIA Certification, CMS Supplier Number, CNOR Certification, COA Certification, COLA Certification, Completion of Oral Surgery Residency Certification, Conscious Sedation Permit, DEA Number, DHHS/BDS License, Dentistry License, General Anesthesia Permit, Graduation of Residency of Psychiatric Program Certification, HRSA Certification, Home Health Agency License, Hospice License, Hospital License, JCAHO Certification, Letter of Registration, Medicare Certification, NCQA Certification, Nursing Home License, PROF. BD Certification, Pharmacy License, Polysomnograph Technologist Registration, Professional License, RNFA Certification, Radiology Technologist Certification, SD Dept of Health Diabetes Recognition Letter, SD Dept of Human Services Program Certification, Sleep Lab Accreditation by the American Academy of Sleep Medicine, Swingbed License, X-Ray Technologist Registration)	BACK
Associated Transactions: 270 - Eligibility Inquiry, 271 - Eligibility Response, 276 - Claim Status Inquiry, 277 - Claim Status Response, 277U - Unsolicited Claims Status Response, 278 - Prior Authorization Request, 278 - Prior Authorization Response, 820 - Premium Payment (For MCO Providers Only), 834 - Benefit Enrollment (For MCO Providers Only), 835 - Healthcare Claim Payment Advice, 837D - Dental Claim outbound, 837D - Dental Claim, 837I - Institutional Claim outbound, 837P - Professional Claim, 837P - Professional Claim outbound	Back