SD MEDX

South Dakota Medical Electronic Data Exchange
SD Department of Social Services

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Tribal or IHS Enrollment Checklist

A Tribal or Indian Health Services provider is an entity that provides health care services. A Tribal or IHS provider would receive a Type 2 NPI and rendering/servicing providers would associate to the Tribal or IHS provider.

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The table below contains a list of required fields for each step when enrolling as a Tribal or IHS. 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**
Organization Name		
Organization Business Name		
FEIN	Tax Identifier Type: FEIN	
NPI		
W-9 Entity Type		
W-9 Entity Type (If Other)	W-9 Entity Type: Other	
Enrollment Request Date		
Step 2 Add Locations		
Required Field	**Prior Selection (If field is conditional required)**	**Your Data**
Location Type (Base and Servicing)		
Accept New Recipient (Yes, No)		
Business Name at This Location		
Contact First Name		
Contact Last Name		
Address		
Phone Number		
Communication Preference		
E-Mail Address	Communication Preference: E-Mail	
VFC Provider (Yes, No)		
Do you have Malpractice Insurance at this Location (Yes, No)		
Do you see patients at this location		
Type of Address (Mailing, Pay-to, Prior Authorization)		
Step 3 Add Specializations		
Required Field		**Your Data**
Location (select from previously entered locations)		
Administration		
Provider Type		
Specialty (Depends on Provider Type selected)		
Associated Subspecialties (Depends on Specialty selected)		
Step 4 Add License/Certification		
Required Field		**Your Data**
Location (chosen from dropdown list)		
License/Certification Type		
License/Certification #		
Effective Date		
End Date		
Step 6 Add Indicators		
Required Field		**Your Data**
Location (chosen from dropdown list)		

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Indicator Type (Managed Care Indicator)		
Indicator Value (Managed Care Indicator values are Accepting New Patients, Accepting OB Patients Only, Not Accepting New Patients)		
Start Date		
Step 7 Add Malpractice Insurance Information		
Required Field		**Your Data**
Location (chosen from dropdown list)		
Malpractice Insurance Name		
Step 8 Add Federal Tax Details		
Required Field		**Your Data**
Address		
Phone Number		
Step 9 Add Claim Submission Method		
Required Field		**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 10: Add EDI Billing Software Details Step 12: Add EDI Contact Information
Billing Agent	Step 11: Add EDI Submitter Details
FTP Secure Batch	Step 10: Add EDI Billing Software Details
Online (Direct Data Entry)	NA

Step 10 Add EDI Billing Software Details		
Required Field		**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 11 Add 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 12 Add EDI Contact Information		
Required Field		**Your Data**
EDI Contact Title		
EDI Contact First Name		
EDI Contact Last Name		
EDI Contact Phone Number		

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EDI Contact Address		
Associated Transactions		
Step 15 Add 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 16 Add Tribal Health Details		
Required Field		**Your Data**
Type		
Available Tribal Affiliations		

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)	

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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)	

Step 18 View/Upload Attachments	
Required Field	**Your Data**
Verification of Service (Out of State Provider) (if applicable)	
Verification of Electronic Funds Transfer	
PCP Addendum (if applicable)	
Licenses and Certifications (if applicable)	
EDI Required Documentation (if applicable)	
Contracts and Agreements (if applicable)	

Step 19 Submit Enrollment Application for Review		
Required Field		**Your Data**
None		

Tribal or IHS 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)
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)
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)
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
Available Tribal Affiliations: Cheyenne River Sioux Tribe, Crow Creek Sioux Tribe, Flandreau-Santee Sioux Tribe, Lower Brule Sioux Tribe, Oglala Sioux Tribe, Rosebud Sioux Tribe, Sisseton-Wahpeton Sioux Tribe, Yankton Sioux Tribe