SD MEDX

South Dakota Medical Electronic Data Exchange
SD Department of Social Services

SD MEDX

Servicing Individual Enrollment Checklist

A Servicing Individual is a provider who provides services through a Group, Facility, Agency, Organization, Institution, Pharmacy, Tribe, Indian Health Services or Regular Individual Provider.

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The table below contains a list of required fields for each step when enrolling as a Servicing 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**
SSN	Tax Identifier Type: SSN	
Provider First Name	Tax Identifier Type: SSN	
Provider Last Name	Tax Identifier Type: SSN	
Servicing Type (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 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)		
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 10 Federal Tax Details		
Required Field	**Prior Selection (If field is conditional required)**	**Your Data**
Address		
Phone Number		
Step 15 Billing Provider Information		
Required Field	**Prior Selection (If field is conditional required)**	**Your Data**
NPI or SD MEDX ID		
Start Date		

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)	

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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)	

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 Modification for Review

Required Field	Prior Selection (If field is conditional required)	
None		

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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
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