~Roster Instructions for Health Care Authority (HCA) Providers only~

The Roster allows HCA only Groups and FAOI providers to upload bulk applications and bulk modifications for HCA Servicing Only providers that will be working for your business.

If you are providing services for any Agency other than HCA,
Please follow that Agency's instructions and guidelines.

Do not alter the Roster spreadsheet, as this may result in your spreadsheet not loading.

Important before getting started:
- This instructional document is for HCA Providers only
- Do Not Add or Delete Columns in this spreadsheet
- Do Not change formatting of document
- Do Not add comments to the document
- This Roster cannot be used to create applications for Billing Providers.
- The Billing Provider must already be enrolled in order to use this Roster
- If the Billing Provider has been closed due to Revalidation, the Billing Provider Revalidation must be completed before this Roster can be used for the servicing only providers
- All dates entered on the spreadsheet must be formatted as: mm/dd/yyyy
- The File Name of the spreadsheet should include the Billing Provider's NPI and Billing Provider Name.
- Before uploading the Roster, review the data entered in the spreadsheet for accuracy.

**If you are a Health Care Authority (HCA) provider with questions about the Roster,
Please send an email to providerenrollment@hca.wa.gov**

Color guide for HCA Providers:

Yellow = Required field	Blue = Optional field	Grey: DO NOT complete if you are an HCA only provider

How to complete the Roster:

A. National Provider Identifier (required) – Enter the Servicing Provider's NPI. The NPI number is required for all providers requesting enrollment. https://nppes.cms.hhs.gov/NPPES/Welcome.do

B. First Name (required) – Enter the Servicing Provider's Legal First Name

C. Middle Name or Middle Initial (optional) – Enter the Servicing Provider's Middle Name or Initial

D. Last Name (required) – Enter the Servicing Provider's Legal Last Name
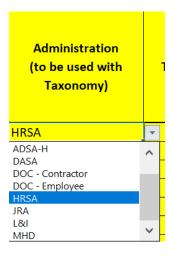
E. Agency (Basic Info screen) (<mark>required</mark>) –
Click on cell, from drop down menu, select **HCA.**

F. Correspondence Address Line 1 (Not required for HCA only providers)

G. Correspondence Address Line 2 (Not required for HCA only providers)

H. Correspondence Address Line 3 (Not required for HCA only providers)

I. Correspondence Zip Code (Not required for HCA only providers)

J. Administration (to be used with Taxonomy) (<mark>required</mark>) –
Click on cell, from drop down menu, select **HRSA.**

K. Taxonomy code 1 (<mark>required</mark>) –
Add the taxonomy code for the provider type and specialty of each Servicing Provider
*Do Not enter spaces or periods when entering a taxonomy. Ensure the taxonomy is not missing a digit or a letter.

L. Taxonomy 1 Start-Date (<mark>required</mark>) – Enter the Start-Date that the Servicing Provider will begin working for your Organization. Format must be: mm/dd/yyyy

M. Taxonomy 1 End-Date (<mark>required</mark>) – Enter the End-date that the Servicing Provider will stop working for your Organization. If you are unsure when they will stop providing services, you may enter 12/31/2999 as the End-Date.

N. Taxonomy code 2 (optional) – Add any additional taxonomy code that will be used to bill on a claim
   *Do Not enter spaces or periods when entering a taxonomy.

O. Taxonomy 2 Start-Date (optional) – Enter the Start-Date that the Servicing Provider will begin providing these services. Format must be: mm/dd/yyyy

P. Taxonomy 2 End-Date (optional) – Enter the End-Date that the Servicing Provider will stop working for your Organization. If you are unsure when they will stop providing services, you may enter 12/31/2999 as the End-Date.

Q. Taxonomy code 3 (optional) – Add any additional taxonomy code that will be used to bill on a claim
   *Do Not enter spaces or periods when entering a taxonomy.

R. Taxonomy 3 Start-Date (optional) – Enter the Start-Date that the Servicing Provider will begin providing these services. Format must be mm/dd/yyyy

S. Taxonomy 3 End-Date (optional) – Enter the End-Date that the Servicing Provider will stop working for your Organization. If you are unsure when they will stop providing services, you may enter 12/31/2999 as the End-Date.

T. Social Security Number (<mark>required</mark>) – Enter the Servicing Provider's Social Security Number
   *Enter <u>without</u> dashes, spaces, or periods.

U. Date of Birth (<mark>required</mark>) – Enter the Servicing Provider's Date of Birth
   *Format must be mm/dd/yyyy

V. NPI of associated Group / Facility (<mark>required</mark>) – Enter the Organizational NPI of the Organization that the Servicing Provider will be working for.
   *[The Group/Facility must be enrolled before this Roster can be used]

W. Medical Provider Location (<mark>required</mark>) -List all Group/Facility locations that the servicing provider will work at. For example, if the provider will only work at locations 00 and 02. Enter this information in column S as: *00, 02*. Make sure to include a comma to separate values. If the provider will work at all locations, you may type in: *All*. This will associate the provider to all active Group/Facility locations. If you have not associated taxonomies to your servicing locations you may only associate your providers to your 00 location.

X. NPI/P1 ID of Social Service Provider (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
   *HCA only providers should leave this column blank

Y. Social Service Provider Location (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
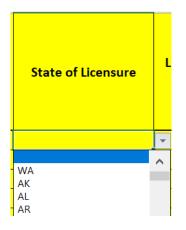   *HCA only providers should leave this column blank

Z. Start-date of association with Group / Facility (<mark>required</mark>)

~Cannot be a future date. Format must be mm/dd/yyyy

AA. End-date of association with Group / Facility or Social Service Servicing Only Provider (<mark>required</mark>)

~Enter 12/31/2999. Format must be mm/dd/yyyy

AB. Yes, to any question on the Enrollment Checklist? (<mark>required</mark>) –

~The list of Enrollment Checklist Questions can be found at the bottom of this document.
~A "no" is required under the enrollment checklist column. If a response to any of the checklist questions would be a "yes" for the Servicing Provider, then this template cannot be used to enroll the Servicing Provider. The Servicing Provider will need to be enrolled using the normal online enrollment process.

AC. Gender (<mark>required</mark>) – Enter <u>M</u> for Male, Enter <u>F</u> for Female

AD. License # if applicable (<mark>required if provider has a DOH license</mark>) – Enter the Servicing Provider's DOH Professional License

AE. State of Licensure (<mark>required if License # is entered on template</mark>) – Click on cell, from drop down menu, select the State that issued the Professional License.

AF. License # start-date (<mark>required if License # is entered on template</mark>) – Enter the start-date of when the professional license was originally issued. *Format must be mm/dd/yyyy

AG. License # end-date (<mark>required if License # is entered on template</mark>) – Enter the expiration date of the professional license. *Format must be mm/dd/yyyy

AH. DEA # (if available) (optional) – The DEA number is the number assigned by the Drug Enforcement Agency. Enter the Servicing Provider's DEA # (if available). Do not use spaces or special characters when entering the DEA #.

AI. DEA # start-date (optional but required if DEA # is entered in column AB) – Enter the start-date in which the DEA # was issued. *Format must be mm/dd/yyyy

AJ. DEA # end-date (optional but required if DEA # is entered in column AB) – Enter the end-date that the DEA # will expire. *Format must be mm/dd/yyyy

AK. Email Address (<mark>required</mark>) – Enter a good contact email in case there are issues when verifying the Servicing Provider's information.

AL. Training/Education Type (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AM. Place Completed (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AN. Name of Institution/Employer (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AO. Training/Education Start Date (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AP. Training/Education End Date (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AQ. Training/Education Date Completed (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AR. Identifier Type (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AS. Identifier Value (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AT. Identifier Start Date (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

AU. Identifier End Date (**DO NOT ENTER INFORMATION IN THIS COLUMN**)
  *HCA only providers should leave this column blank

Now that your spreadsheet is complete, you will need to upload the Roster to ProviderOne. For help on uploading the Roster, please use the "Instructions for Roster File Upload and Reviewing Roster Errors."

Before uploading the Roster, review the data entered in the spreadsheet for accuracy.

Enrollment Checklist Questions:

1. Had exclusion under Medicare, Medicaid, or any other federal health care program taken against them**?**

    ____Yes   ____No

2. Had civil money penalties or assessment imposed under Section 1128A of the Social Security Act**?**
    More Info: http://www.socialsecurity.gov/OP_Home/ssact/title11/1128A.htm

    ____Yes   ____No

3. Had a restriction or sanction imposed on their professional license, accreditation, or certification**?**

    ____Yes   ____No

4. Had a program exclusion taken against them**?**
    More info: http://exclusions.oig.hhs.gov and https://www.sam.gov/

    ____Yes   ____No

5. Been convicted of any health-related crimes as defined by Washington State Department of Health**?**
    RCW 18.130.180: http://apps.leg.wa.gov/rcw/default.aspx?cite=18.130
    WAC 246-16: http://apps.leg.wa.gov/wac/default.aspx?cite=246-16

    ____Yes   ____No

6. Been convicted of a criminal offense as described in Section 1128A (1), (2) or (3) of the Social Security Act**?** More Info: http://www.socialsecurity.gov/OP_Home/ssact/title11/1128A.htm

    ____Yes   ____No

7. **Been convicted of a crime involving the abuse, neglect, abandonment, or exploitation of a vulnerable person?** More info: WAC 388-71-0540
    http://apps.leg.wa.gov/WAC/default.aspx?cite=388 and
    RCW 74.34, http://apps.leg.wa.gov/RCW/default.aspx?cite=74.34

    ____Yes   ____No