



District of Columbia
Department of Health Care Finance

Provider Data Management System (PDMS)

How to Enroll in DC Medicaid Using the DC Provider Screening and Enrollment Web Portal (DBH Streamlined Applications)

Version 1

March 14, 2023

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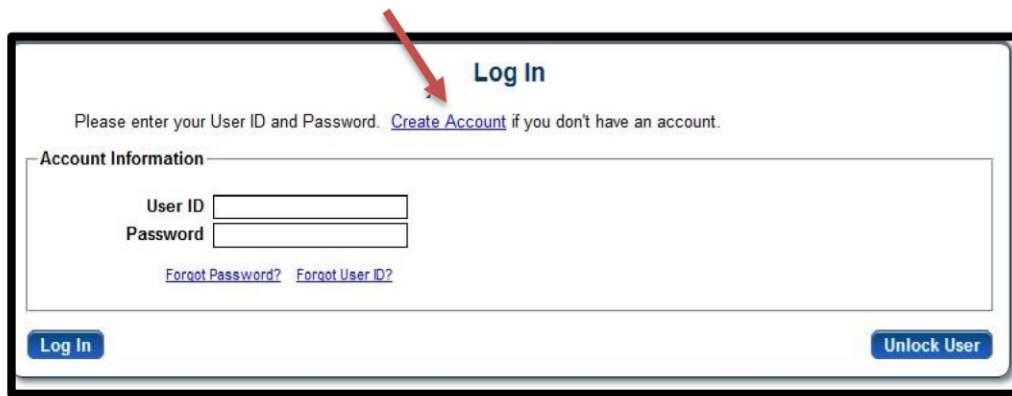
Overview

The PDMS Web Portal user guide provides step by step instructions on how to submit an electronic application. The PDMS dashboard displays data for each stage of the enrollment process and allows providers to start a new application or take action on previously submitted applications and re-enrollments. From their dashboard, Provider Enrollment Specialists can view the current status of new provider applications as well as initial/ongoing re-enrollments. Their dashboard tracks the aging of each provider application based on the workflow step/status of the application.

Creating a User Account

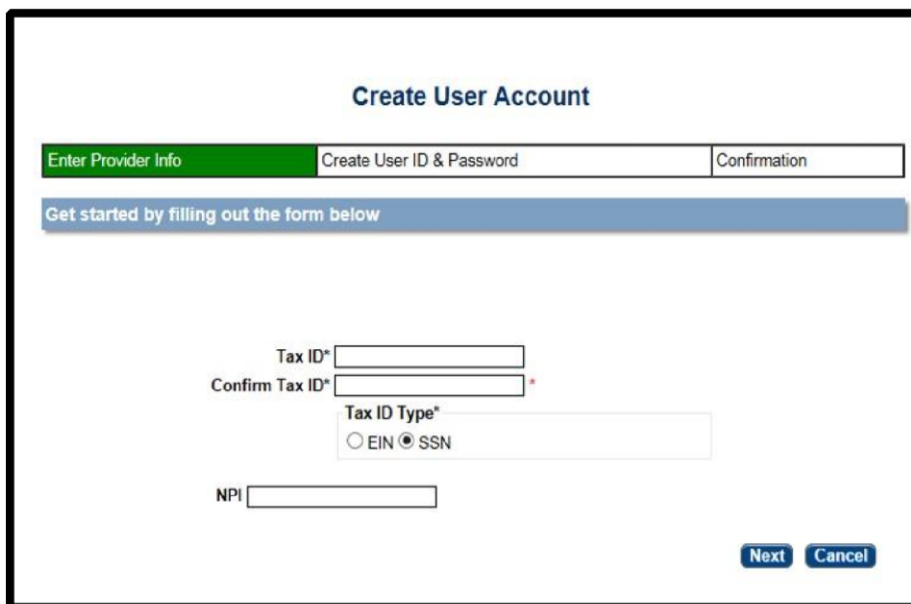
The first step to submitting an online application is to create User Account in the DC Provider Data Management System (PDMS) Web Portal.

Click on Create Account



The screenshot shows the 'Log In' page of the PDMS Web Portal. At the top, there is a 'Log In' link. Below it, a message says 'Please enter your User ID and Password. [Create Account](#) if you don't have an account.' The 'Account Information' section contains two input fields: 'User ID' and 'Password'. Below these fields are two links: 'Forgot Password?' and 'Forgot User ID?'. At the bottom of the form, there are two buttons: 'Log In' and 'Unlock User'. A red arrow points to the 'Log In' link at the top.

- Enter your Tax ID – Either your Social Security Number (Individual) or EIN (Organization)
- Select the correct Tax ID Type
- Enter your NPI
- Click Next



The screenshot shows the 'Create User Account' page. At the top, there is a 'Create User Account' link. Below it, there are three tabs: 'Enter Provider Info' (highlighted in green), 'Create User ID & Password', and 'Confirmation'. A blue banner below the tabs says 'Get started by filling out the form below'. The form contains the following fields: 'Tax ID*' (input field), 'Confirm Tax ID*' (input field with a red asterisk), 'Tax ID Type*' (radio buttons for 'EIN' and 'SSN', with 'SSN' selected), and 'NPI' (input field). At the bottom right, there are two buttons: 'Next' and 'Cancel'.

Creating a User Account Conti.

- Enter all required Information. See example below.
- Click Register.

Create User Account

Enter Provider Info	Create User ID & Password	Confirmation
---------------------	---------------------------	--------------

Please enter your contact information

Contact Name*

Jon Smith

Title*

Provider

Phone Number*

(402) 555-5555

Extension

Email Address*

provider@email.com

Confirm Email*

provider@email.com

* Designates a required field

Create your user id and password

User ID*

Jsmith

Password*

••••••••

Confirm Password*

••••••••

Answer your security question

Security Question*

In what city did you meet your spouse / significant other?

Answer*

Lincoln

Security Question*

In what city were you born?

Answer*

Lincoln

Previous

Register

Cancel

After successfully creating the account, a notification will appear and a confirmation email will be sent to the email address provided.

Create User Account

Enter Provider Info	Create User ID & Password	Confirmation
---------------------	---------------------------	--------------

Confirmation - Next Steps

Your online account creation was successful.

A confirmation email was sent to the email address used during account creation.

Please refer to the email for instructions on activating your account.

Return to Home Page

The email contains a link to the web portal to log in to your account using the user ID and password you created.

- Enter the User ID and password you created
- Click Log In

Log In

Please enter your User ID and Password. [Create Account](#) if you don't have an account.

Account Information

User ID

jsmith

Password

••••••••

Forgot Password?

Forgot User ID?

Log In

Unlock User

Provider Management Home Page

To ensure you are selecting the correct application please review the summary next to each application description, this summary will include any specific instructions for that application type.

Once you have selected your application, click ***Begin New Enrollment***

My Providers

Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	Location	Effective Date	Submit Date	Re-Enrollment Due Date
No providers found.									

☐ Standard Application - Use this application if you are applying to become a new and/or re-enrolling individual physician (including dentist), non-physician practitioner, group, facility or institutional (i.e. hospital, clinic, dialysis, DME etc.) provider for the District of Columbia Medicaid program.

- Mental health/substance abuse providers such as Free Standing Mental Health clinic (FSMHC), Mental Health Rehab Services (MHRS), Recovery Support Services (RSS), Psychosocial Rehabilitation Services (Clubhouse) and other similar behavioral health provider services must receive certification from the Department of Behavioral Health (DBH) prior to submitting a DC Medicaid application through this portal. For questions regarding the mental health/substance abuse provider certification process, please contact the District of Columbia Department of Behavioral Health, Office of Accountability at 202-673-2292.
- All other individual or group mental health/substance abuse providers such as licensed independent social worker (LISW), licensed professional counselor (LPC), psychologist, licensed marriage and family therapist (LMFT), etc. do NOT have to receive certification from DBH.

☐ IDD Waiver - Use this application if you are applying to provide IDD waiver services. You must fulfill mandatory requirements and receive a pre-approval notice from DC Developmental Disabilities Administration (DDA) before initiating this application. For questions regarding mandatory requirements and pre-approval notice please contact DDA at 202-730-1646.

☐ EPD-Waiver - Use this application if you are applying for elderly and persons with physical disabilities (EPD) waiver provider. You must fulfill mandatory requirements and receive a pre-approval notice from DHCF/Long Term Care before initiating this process. For questions regarding mandatory requirements and pre-approval notice, please contact the District of Columbia Department of Health Care Finance, Long Term Care at 202-442-9533 or dhcf.epdproviderenrollment@dc.gov.

☐ ADHP 1915(i) - Use this application if you are applying as a 1915(i) state plan home and community-based services provider. You must fulfill mandatory requirements and receive a pre-approval notice from DHCF/Long Term Care before initiating this process. Newly enrolling ADHP(i) providers must have a primary service address located in the District of Columbia. For questions regarding mandatory requirements and pre-approval notice, please contact the District of Columbia Department of Health Care Finance, Long Term Care via email at Adutdayhealthprogram@dc.gov

☐ Streamlined - Use this application if you are applying solely for the purpose of ordering/referring. Medical Residents use this application type.

☐ Crossover/QMB - Use this application if you are interested in rendering services to Qualified Medicare Beneficiaries (QMB). To provide these services you must enroll in the DC Medicaid program. Please note that participation in this program is limited to rendering services to QMB enrollees ONLY. Also, claims may be submitted up to 365 days from the date the service was rendered.

☐ Emergency-OOS - Use this application on a one-time basis if you are a provider that has rendered reimbursable services to DC Medicaid-eligible recipients. This application is not intended for providers who will provide services to the general DC Medicaid population. The enrollment term only covers the date(s) of services stated on the submitted medical claim form(s). Claims may be submitted up to 365 days from the date the service was rendered.

☐ PCA Aide - Use this application if you are a Personal Care Assistant Aide working through a Home Health Agency or EPD Provider.

☐ Physician Assistant - Use this application if you are a Physician Assistant working with a Physician, Dentist, Podiatrist, etc or a group.

☐ MCO Only - Use this application if you are an MCO Rendering Provider.

☐ PERS - Use this application if you are applying as a Durable Medical Equipment – Personal Emergency Response System (DME-PERS) provider. You must fulfill mandatory requirements per local and federal regulations before initiating this process. For questions regarding mandatory requirements, please contact the District of Columbia Department of Health Care Finance, Long Term Care at 202-442-9533 or dhcf.epdproviderenrollment@dc.gov.

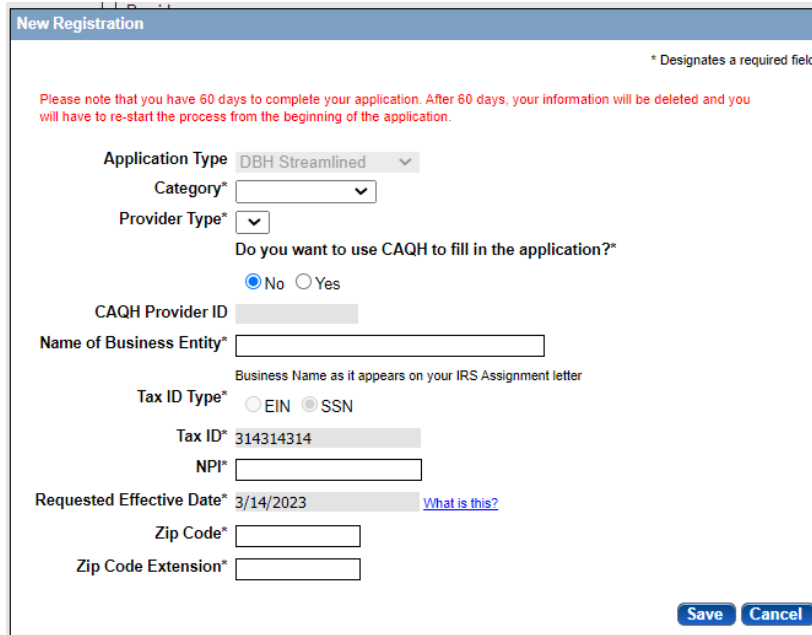
☒ DBH Streamlined - Use this application if you are an individual rendering provider already affiliated with a Department of Behavioral (DBH) health related program/facility. Please note enrollment is limited to non-billing individual rendering providers who are ONLY affiliated with a DBH related program/facility.

Begin New Enrollment

Application and Provider Types

Enter information in all required fields.

Please note that you have 60 days to complete your application. After 60 days, your information will be deleted and you will have to re-start the process from the beginning of the application.

A screenshot of a web form titled "New Registration". At the top right, it says "* Designates a required field". Below this, a red warning message states: "Please note that you have 60 days to complete your application. After 60 days, your information will be deleted and you will have to re-start the process from the beginning of the application." The form contains several fields: "Application Type" (a dropdown menu with "DBH Streamlined" selected), "Category*" (a dropdown menu), "Provider Type*" (a dropdown menu), "Do you want to use CAQH to fill in the application?" (radio buttons for "No" and "Yes", with "No" selected), "CAQH Provider ID" (a text field), "Name of Business Entity*" (a text field), "Business Name as it appears on your IRS Assignment letter" (a text field), "Tax ID Type*" (radio buttons for "EIN" and "SSN", with "SSN" selected), "Tax ID*" (a text field with "314314314" entered), "NPI*" (a text field), "Requested Effective Date*" (a text field with "3/14/2023" entered and a "What is this?" link), "Zip Code*" (a text field), and "Zip Code Extension*" (a text field). At the bottom right, there are "Save" and "Cancel" buttons.

For each required field select and enter the appropriate information

- Category: Individual/Solo, Group, Facility/Institution, Pharmacy
- Provider Type
- Name of Business Entity (Or First and Last Name if Individual/Solo)
- Tax ID Type (EIN or SSN)
- Tax ID
- NPI (If applicable)
- Requested Effective Date [The date in the field will be auto populated with today's date. If you are requesting a retro effective date enter the date manually.]
- Zip Code

Zip Code (If 4-digit extension is unknown, use 1234. The system will validate the address and populate the correct 4-digit extension)

Click Save.

Date of Birth* 01/01/1970

Zip Code* 20005

Zip Code Extension* 1234

Select Taxonomy code from the list.

Taxonomy* ▼

Save Cancel

A drop-down menu will appear for you to select a taxonomy.

Please note that only the taxonomies you have listed in the NPPES NPI Registry are available to select. Click save.

Identification- Provider Information Screen

US Citizen

Identification - Provider Information **Save Cancel Next**

This is a required section.

Provider Information

Name of Business Entity* KYZ DOCTOR DOCTOR ✕

Business Name as it appears on your IRS assignment letter.

DBA

Citizenship Status ☒ I am a Citizen of the United States
☐ I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status and alien number are as follows:

First Name* KYZ DOCTOR

Middle Initial

Last Name* DOCTOR

Title

Tax ID* 147147147 ?

NPI 1013006048 ?

NPI Start Date 8/13/2018

NPI End Date

Gender* ☐ Female ☒ Male ☐ Unknown

Date of Birth* 5/11/1983

Date of Death

Provider Type* Physician MD ?

Requested Effective Date* 08/13/2018 [What is this?](#)

End/Revalidation Date Not Set Yet

Enrollment Status Not Set Yet

Qualified Alien

Identification - Provider Information **Save Cancel Next**

This is a required section.

Provider Information

Name of Business Entity* KYZ DOCTOR DOCTOR ✕

Business Name as it appears on your IRS assignment letter.

DBA

Citizenship Status ☐ I am a Citizen of the United States
☒ I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status and alien number are as follows:

Immigration Status ▼

Alien Number

Upload a copy of your USCIS (Immigration) form

Are you ECFMG certified? ☐ Yes ☐ No

USMLE/ECFMG Number

If you don't have a USMLE/ECFMG number please visit [LINK](#)

Issue Date

First Name* KYZ DOCTOR

Middle Initial

Last Name* DOCTOR

Title

Tax ID* 147147147 ?

NPI 1013006048 ?

NPI Start Date 8/13/2018

NPI End Date

Gender* ☐ Female ☒ Male ☐ Unknown

Date of Birth* 5/11/1983

Date of Death

Provider Type* Physician MD ?

Requested Effective Date* 08/13/2018 [What is this?](#)

End/Revalidation Date Not Set Yet

Enrollment Status Not Set Yet

Identification - Primary Contact Information

Complete all required (*) fields in the Primary Contact Information section.
Click Save.

Primary Contact Information

Name*

The Primary Contact is the main person responsible for the information submitted to District of Columbia PSE.

Title

Address*

Address 2

City*

State*

Quadrant

Ward

County

Zip*

Ext Zip

Phone Number*

Phone Extension

Fax Number

Email Address*

Office Manager

Address validation via USPS

Identification - Primary Contact Information

Save Cancel Previous Next

This is a required section.

Primary Contact Information

Name*

Crystal Doyle

The Primary Contact is the main person responsible for the information submitted to District of Columbia PSE.

Title

Office manager

Address*

1111 14th St

Address 2

City*

Washington

State*

District of Columbia

Quadrant

NW

Ward

4

County

Zip*

20005

Ext Zip

1234

Phone Number*

(202) 234-6929

Phone Extension

402

Fax Number

(202) 234-3692

Email Address*

test@test.com

Office Manager

Crystal Doyle

According to the USPS database, the address entered is inaccurate. The following address was found:

1111 14TH ST, NW
WASHINGTON, DC 20005-5804

Click on 'Accept' to accept the corrections.

Accept Cancel

Licenses & Classifications – Specialties


Click the green  symbol to add specialty

Fill out each section of the page via the available fields & drop-down menus and select “**save**”

Licenses & Classifications - Specialties Save Cancel Previous Next

This is not a required section. To skip this section click on Next button.

Specialties

No records found 

Help Text: Enter the American Board of Medical Specialties (ABMS) member board name for your specialty certification. If not applicable for your Specialty, leave blank.

Specialty*

☐ Is Primary Specialty


State Certified

Specialty Board Name


Start Date*

End Date

Uploaded Documents

Licenses & Classifications - Specialties (71633)  Save Cancel Previous Next

License and Classifications- Taxonomies


Click on the  symbol to add any additional Taxonomy



Click Save and then click “Next”

Licenses & Classifications - Taxonomies Save Cancel Previous Next

This is a required section.


Taxonomies

Primary Taxonomy	Taxonomy Description	Primary	Start Date	End Date
231H00000X	Audiologist	Yes	06/07/2017	

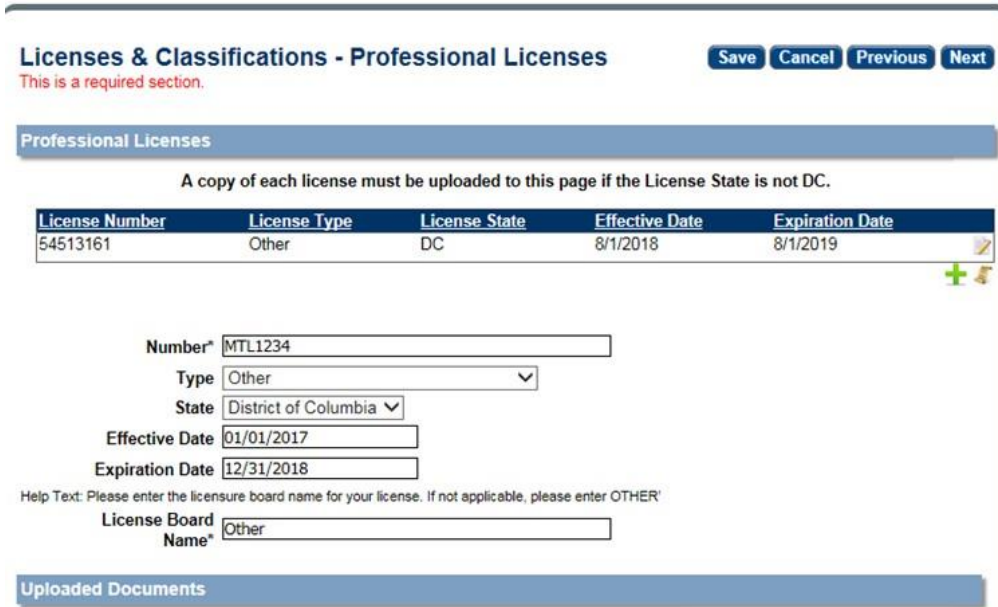
 

Uploaded Documents

Professional Licenses

Click on the  symbol to add all professional Licenses

Click Save and then click “Next”



Licenses & Classifications - Professional Licenses Save Cancel Previous Next

This is a required section.

Professional Licenses

A copy of each license must be uploaded to this page if the License State is not DC.

License Number	License Type	License State	Effective Date	Expiration Date
54513161	Other	DC	8/1/2018	8/1/2019

Number*

Type

State

Effective Date

Expiration Date

Help Text: Please enter the licensure board name for your license. If not applicable, please enter OTHER

License Board Name*

Uploaded Documents

Note: A copy of each license must be uploaded to this page if the License State is not DC.

Licenses and Classifications- Categories of Service

The Categories of Service is auto populated based on the provider type chosen. No actions should be taken in this section.



Licenses & Classifications - Categories of Service Save Cancel Previous Next

This is not a required section. To skip this section click on Next button.

Category Of Service

COS	Category Of Service Name	Start Date	End Date
18	Hearing Services		
41	Medicare Part B Services		

Uploaded Documents

Practice Locations- Primary Service Address

Primary Services Address is required. Billing/Payment Contact Information, Correspondence Information, Remittance Address and Other Address will be auto populated with the primary service address. To use a different address in those sections, clear the text box and type the new address.

Enter information in the required fields.

Zip Code (If 4-digit extension is unknown, use 1234. The system will validate the address and populate the correct 4-digit extension)

Practice Locations - Primary Service Address

Save Cancel Previous Next

This is a required section.

Primary Practice Location

Provider Name

John Smith

Address Line 1 cannot be a PO Box

Primary Service Address*

Address 2

City*

State*

Quadrant

Ward

County

Zip*

Ext Zip

Address Phone Number*

Fax Number

Contact Name

Contact Phone Number*

Email Address

- [Primary Service Address](#)
- [Billing Payment Contact Info](#)
- [Correspondence Information](#)
- [Remittance Address](#)
- [Other Address](#)



Affiliation Screen

1. Click the  to add your group member information.

Please note that all affiliations should be made from the group's registration after both the individual and the group have been approved to provide services.

Group And Facility Affiliation

This is not a required section. To skip this section click on Next button.

[Save](#)
[Cancel](#)
[Previous](#)
[Next](#)

Pending Group Affiliations

PA/PCA Aides cannot bill for their claims until the group/physician/HHA/EPD provider has added the affiliation to their account.

Group Name	NPI	Tax ID	Medicaid ID
No pending affiliations found.			

Deleting your affiliation entry in this section will not delete your confirmed group affiliation.

Confirmed Group Affiliations

Group Name	NPI	Tax ID	Medicaid ID	Start Date	End Date	Affiliation Status
No confirmed affiliations found.						

The grid above shows Groups where you are currently confirmed as a Group member (or have in the past been confirmed as a Group member)

Health Care Affiliations

Facility Name	Staff Category	Status of Privileges	Primary Facility	Start Date	End Date
No Health Care affiliations found.					

Uploaded Documents

Group And Facility Affiliation (71633)

[Save](#) [Cancel](#) [Previous](#) [Next](#)

2. Group Affiliation

Add Group Name

Add Medicaid ID of the group

Include NPI number if applicable

Enter Tax ID of the group

Group Affiliation

Group Name*

Medicaid ID

NPI

Tax ID

[Save](#) [Cancel](#)

Upload Required Documents

If other documents are needed for your application. You will upload them to this page

Upload Required Documents

Save

Cancel

Previous

Next

This is a required section.

If you have additional documentation to provide that were not available for upload on other pages, upload those here. You may upload multiple documents and you will be able to view and delete documents after uploading.

Uploaded Documents

No uploaded documents found.

Choose File

No file chosen

Name

Description

Upload file

Agreements

Check the box to agree and place the signature or initials of the person authorized to sign the form in the designated signature box. Enter characters in the image. Enter the password you used to log into the web portal. Click Save.

Agreements

This is a required section.

Save Cancel Previous

Provider Release of Information Felony/Misdemeanor Statement

☐ I agree that information provided can be used to obtain information to complete background checks which are required for approval as a provider. Form MC-199 is used to obtain information to complete background checks which are required for approval as a provider. This form is used to allow potential and renewing providers and/or their employees to self-disclose any current charges, pending indictments or any convictions they have had. Individual providers must complete the form every 12 months before their provider service agreement may be signed or renewed. For providers who provide the service in their home, each household member must also complete the form at the same time. Assisted Living providers must have each employee complete this form annually.

Streamlined Agreement

The effective date of enrollment shall be on the date the provider obtains participating status as determined by the Department under Federal and District regulations.

I attest under penalties of perjury that the information on this application form is true and correct to the best of my knowledge.

Please enter the name or initials of the person authorized to sign the form

Signature

Signature



Please enter the characters in the image above: Save

Enter password:

The password requested is your user login password.

Application complete pop up will appear

Your application is complete and has been saved. Please take time to review your application prior to submission.

Once your review is complete, **you must click 'Submit for Review' at the top of the Agreements page to submit your application.**



Click “OK”

Scroll back to the top of the page

Click “Submit for Review”



Submission Confirmation Screen

The Submission Confirmation screen lets you know that you have successfully submitted your application.

Click on Return to Home Page

Submission Confirmation

You have successfully submitted your application to The District of Columbia Medicaid.
Please allow at least 10 days for processing before attempting to submit any changes.

[Return to Home Page](#)