

Individual Therapist Enrollment Instructions

1. Go to <http://peu.momed.com/momed/presentation/commongui/PeHome.jsp> to start the enrollment process.
2. Read through the instructions given on the web page before clicking at the bottom of the page.
3. Select “New Provider Enrollment Application”
4. Select “46 Speech Therapist” or “47 Occupational Therapist” or “48 Physical Therapist” from the drop down box under Provider Type depending on the type of service provided. This will start the enrollment application process. Enter the information required in each of the following fields.

RED = NOT REQUIRED FIELDS

PART 1

Field 1 - Business Name: Enter the Individual Therapist Name

Field 2 – Business Telephone Number: Enter the main telephone number for the district.

Field 3 – Provider Address: Enter the main address for the district.

Field 4 – City: Enter the city for the district.

Field 5 – State: Choose MO from the drop down box.

Field 6 – Zip Code: Enter the zip code of the district.

Field 7 – County: Enter the county of the district.

Field 8 – Social Security Number: Enter the social security number of the therapist.

Field 9 – Date of Birth: Enter the date of birth of the therapist. .

Field 10 – License Number: Enter the license number of the therapist. If the therapist only has a teaching certificate, enter “Teacher Certificate”.

Field 11 – Payee Name Registered with IRS: Enter the DISTRICT name as registered with the IRS. The district will need to fax a tax document with the signature page from the IRS with business name and tax id.

Field 12 – Payee Address: Enter the district address as registered with the IRS.

Field 13 – Tax ID#: Enter the DISTRICT Tax ID number as registered with the IRS.

Field 14 – Type of Practice: Choose “5 – City, Municipal, County, District, State” from the drop down box.

Field 15 – Choose Specialty: Choose “T1 – School Districts” from the drop down box.

Field 15a – National Provider Identifier: Enter the NPI if known, if not, leave blank.

Field 15b – Enter Valid Taxonomy Code: Not required, leave blank.

Field 16 – CLIA Number: Not required, leave blank.

Field 17 – Certified by the Dept of HSS: Select NO for all three options.

Field 18 – Optical and Audiology Services: Select NO.

Field 19 – Collaborative Practice Agreement: Select NO.

Field 20 – Rural Health Clinic: Select NO.

Field 21 – Medicare Provider Number: Not required, leave blank.

Field 22 – Case Management Services: Select No.

Field 23 – Rural Health Status: Not required, leave blank.

ENTER EMAIL ADDRESS FOR THERAPIST **OR** MAIN CONTACT UNDER “PROVIDERS EMAIL ADDRESS FIELD”

PART 2

Applicant Name: Enter the name of the individual therapist.

Contact Person: Enter the name of the district contact.

Phone: Enter the phone number for the district contact. May be the main number for district.

Contact Person email: Enter the email address for the district contact.

Section 1: If known, enter the Clinic/Group number of the school district. This number should begin with a “50”

Section 2: Select NO from the drop down box. This application is being made due to regulation changes, not because of any of the reasons listed on the application. Leave the rest of the fields in this section blank.

Section 3: Enter the name of the board members of the school district in this section or fax a list with the signature page.

Section 4: Select School district under the options listed.

Section 5-16: Answer the questions listed. For district employed therapists, the answer should be no for all questions. If any answers are yes, please explain and list a date.

Part 3 – This section is optional since the district will receive the payment.

Routing Number: Enter the routing number of the bank for electronic deposits for the district.

Depositor Account Number: Enter the account number of the bank for electronic deposits for the district.

Type of Account: Select Checking or Savings as the account type.

Financial Institution Name: Enter the name of the bank.

Address: Enter the address of the bank.

Branch Name: Not required, leave blank.

Telephone Number: Enter the telephone number of the bank.

Check YES for each item to agree to all of the terms and conditions in order to participate in direct deposit.

Part 4

Check YES for each item to agree to all of the terms and conditions in order to enroll as a Medicaid provider.

Part 5

Have the Therapist sign the Provider Agreement Form and fax all required documentation to (573) 634-3105.

AFTER COMPLETING THE MISSOURI MEDICAID PROVIDER ENROLLMENT FOR THE INDIVIDUAL THERAPIST, PLEASE GO TO <https://nppes.cms.hhs.gov/NPPES/Welcome.do> AND ENROLL FOR A NATIONAL PROVIDER IDENTIFIER (NPI).