

Welcome to Pennsylvania Certified Perinatal Doula Enrollment Training



Primary topics:

- Affordable Care Act Overview
- What is a Perinatal Doula?
- Perinatal Doula Enrollment Requirements
- Accessing the Enrollment Application
- Enrollment Application Completion
- Resume Application
- Check Application Status
- Resources

ACA - Overview



- In accordance with federal Medicaid requirements at 42 CFR §§ 438.602(b) and 438.608(b), relating to state responsibilities and program integrity requirements under the contract, with regard to the screening, enrollment and revalidation of providers, a provider must be enrolled in the MA Program as a condition of being enrolled in a managed care network.
- Pennsylvania Certified Perinatal Doula's who wish to participate as MCO network providers to render services to MA beneficiaries under the MA managed care delivery system must be enrolled in the MA Program.
- The ACA and implementing regulations require states to revalidate the enrollment of providers every five years.

Please Note: This training does not address MCO credentialing or contracting questions or concerns.

What is a Perinatal Doula?

- Perinatal Doulas are trained professionals who provide non-medical support and guidance to pregnant individuals in various aspects including reproductive health and family services.
- Perinatal Doula services include emotional, physical, and informational support and guidance, advocacy, evidence-based education, and connections to any needed resources.

- Effective February 1, 2024, Perinatal Doulas may enroll in the Medical Assistance (MA) Program to allow for participation in the managed care networks within the MA managed care delivery system.
- Must have current certification from the Pennsylvania Certification Board as a Certified Perinatal Doula.
 - Provider Type 13 – Non-Traditional Provider
 - Specialty Code 130 Certified Doula



- Perinatal Doula wishing to enroll will need to complete a new enrollment application
 - Step 1:
 - Go to the Landing page of the PROMISE™ Portal.
 - website: promise.dpw.state.pa.us
 - Step 2:
 - Select “New Application” from the Provider Enrollment Section of the Landing Page.
 - Step 3:
 - Complete the application using the Doula’s information and submit.

Accessing Enrollment Application



Login

PROMISe™ Internet

Home

Home

Thursday 07/20/2023 10:58 AM EST

Provider Login



*User ID

[Log In](#)

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)



Broadcast Messages

NOTE: Providers will begin to receive communications from donotreply@gainwelltechnologies.com. Please be sure to check your spam folder and add this email address to your contact list to ensure receipt of notifications.

Welcome to PROMISe™

A blurred background image of three young children smiling and laughing.

Provider Enrollment



[New Application](#)



[Reactivation](#)

[Resume Application](#)

[Application Status](#)

The Commonwealth of Pennsylvania Department of Human Services offers state of the art technology with PROMISe™, the claims

Application Tracking Number (ATN)



- Each online provider enrollment application is assigned a unique Application Tracking Number (ATN).
- An email containing the 10-digit ATN will be sent to the email address entered in the Contact Information.
- Additionally, the ATN will display at the top of the application.
- The ATN is required to resume or check the status of the application.

The electronic enrollment system will send email notices to providers at key points during the application submission and determination process. The emails will be generated from a 'do not reply' email address. The following are the types of emails generated:

- Online Application Initiated
- Online Application Submitted
- Online Application Returned to Provider for Revisions
- Online Application Initiated – Expiring
- Online Application Returned to Provider – Expiring

Perinatal Doula Enrollment Application Completion

Request Information Page



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Enrollment Information - Contact Information - Help

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ATN: 1000008163 Provider Number: Pending Type: New Enrollment Start Date: 11/13/2023 Completion By: 01/12/2024

Request Information

You are initiating a provider enrollment application for the Pennsylvania Department of Human Services (DHS) Medical Assistance (MA) program and/or the Pennsylvania Children's Health Insurance Program (CHIP). If you are enrolled as a MA provider and provide CHIP services at this service location, a separate CHIP enrollment application is not required.

If you exit the application before it has been submitted, you can resume your provider enrollment application at a later time by providing the system generated Application Tracking Number (ATN), the Federal Tax Identification Number (FEIN or SSN) and password you established.

In addition, once submitted, you can check the status of your application at any time by selecting the "Application Status" link from the PROMISE portal landing page on the left side under "Provider Enrollment", entering the ATN, SSN/FEIN, and password fields and clicking "submit". The Application Summary section will display on the page showing the current status of the application.

- * Indicates a required field.
- 📎 Indicates an attachment is required.

Initial Enrollment Information

Verify your program type, provider type and enrollment type selections prior to saving this page. Once this information is saved, it cannot be changed. If this information is incorrect, you will need to begin a brand new application.

* Program Type	Pennsylvania Medical Assistance (PA/MA)
* Provider Type	13 - Non-Traditional Provider
* Enrollment Type	Individual with SSN

Tax Identifier

Based on the Enrollment Type selected above, you are required to specify either a Social Security Number (SSN) or Federal Tax Identification Number (FEIN). A Federal Tax Identification Number (FEIN) is used to identify a business entity. A Social Security Number (SSN) is used to identify an individual.

* Social Security Number (SSN)	<input type="text"/>	📎
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* Confirm Social Security Number (SSN)	<input type="text"/>	📎
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Name of Enrollee

Based on the Enrollment Type selected above, you are required to specify either an Entity Name or an Individual's Name.

* Last Name	<input type="text" value="Doula"/>		
* First Name	<input type="text" value="Provider"/>	Middle Initial	<input type="text"/>

Medicare Enrollment Information

* Are you a Medicare participating Provider? Yes No

Contact Information

Contact information will be used for correspondence regarding this application. This is not required to be the provider's contact information, but rather should be the contact information of the person who is completing the application and can assist with questions regarding this application. In addition, email notifications will be sent to the contact email address provided, at key points during the application process:

- Online application initiated
- Online application submitted
- Online application returned to provider for revisions
- Online application expiring

* Last Name	<input type="text" value="Elias"/>		
* First Name	<input type="text" value="Lana"/>		
Title	<input type="text"/>		
* Phone Number	<input type="text" value="717-634-1567"/>	Phone Extension	<input type="text"/>
Toll Free Number	<input type="text" value="###-###-####"/>	Toll Free Extension	<input type="text"/>
Fax Number	<input type="text" value="###-###-####"/>		
* Email	<input type="text" value="lana.elias@gainwelltechnologies.com"/>		
* Confirm Email	<input type="text" value="lana.elias@gainwelltechnologies.com"/>		

🔙 Finish Later

💾 Save & Continue

Service Location Address Page



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Service Location Address

Complete the fields on this page and select the Save and Continue button to continue with this application.
* Indicates a required field.
📎 Indicates an attachment is required.

Service Location Physical Address

This address must be a physical address where a practitioner maintains an office, holds office hours/sets appointments and renders services. A post office box is not a valid Service Location Physical Address.
Verify your selection of the service location physical address state prior to saving this page. Once this information is saved, it cannot be changed. If this information is incorrect, you will need to begin a brand new application.

* Street	<input type="text" value="10 Apple Lane"/>	Room/Suite	<input type="text"/>
* City	<input type="text" value="Hometown"/>	* State	<input type="text" value="PA - Pennsylvania"/>
* Zip+4	<input type="text" value="18001-1234"/>	* County	<input type="text" value="Schuylkill"/>
* Email	<input type="text" value="lana.elias@gainwelltechnologies.com"/>	* Confirm Email	<input type="text" value="lana.elias@gainwelltechnologies.com"/>
* Phone Number	<input type="text" value="717-634-1567"/>	Phone Extension	<input type="text"/>
Fax Number	<input type="text" value="0000-0000-0000"/>		

After this information is saved, you will have the option to enter different address information for Mail-To, Pay-To, and Home Office Addresses on a separate page.

General & Historical Questions

The following questions pertain to the service location you are enrolling.

* Does the office have exterior steps leading to the main entrance doorway?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
* Does the office have interior steps leading to the main entrance doorway?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
* Is this address an active Rural Health Clinic or FQHC?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Has screening been performed at this location for this provider within the last 12 months by:		
* Medicare?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
* Children's Health Insurance Program (CHIP)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
* Another state's Medicaid? 📎	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

[Finish Later](#)

[Save & Continue](#)

Other Addresses Page



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Other Addresses

On this page you have the option to assign a Mail-To, Pay-To or Home Office address that is different from the Service Location Physical Address.

Below is the physical address of your service location. This address is currently being set as the default address for all other address types. If you would like to specify a different address, please check the box next to the corresponding address type. Leaving a box unchecked will default that address to your service locations address.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.

Service Location Physical Address

Street	10 Apple Lane	Room/Suite	
City	Hometown	State	PA - Pennsylvania
Zip+4	18001-1234		

Other Address Information

Select the address type that you would like to be different than the Service Location Physical Address:

- Mail-To
- Pay-To
- Home Office

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information:
<https://www.dhs.pa.gov/providers/Providers/Pages/Electronic-Funds-Transfer.aspx>

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

*Would you like to receive E-Mail notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used. Yes No

[Finish Later](#)

[Save & Continue](#)

Specialties Page



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Specialties

The provider type was established on the Request Information page. Specialties that may be associated with this provider type can be added on this page. At least one specialty is required for enrollment. The first specialty assigned will be designated as the primary specialty. Not all specialties allowed for a provider type can be designated as the primary specialty.

Additional specialties can be assigned by selecting the add button once the primary specialty has been established. For specialties requiring a license, a license must be added. Pennsylvania Medicaid requires you to be licensed by the state where you perform services. Therefore, the issuing state for the license will automatically be set to the state assigned to the Service Location Address on the address page.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.

Indicates an attachment is required.

Associated Specialties

Specialty	Sub-Specialty	Primary
▼ 130 - Doula		Yes

ProviderType	13 - Non-Traditional Provider		
* Specialty	<input type="text" value="130 - Doula"/>	Sub-Specialty	<input type="text" value="Not Applicable"/>
License, Certificate & Permit Information			
* Issuing Entity	<input type="text" value="PA CERTIFICATION BO"/>	Issuing State	PA
* Number	<input type="text" value="D12345"/>		
* Issuing Date	<input type="text" value="12/01/2023"/>	* Expiration Date	<input type="text" value="12/31/2024"/>

[+ Add Additional Specialty](#)

[Finish Later](#)

[Save & Continue](#)

Program Eligibility Program (PEP) Page



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Provider Eligibility Program (PEP)

Provider Eligibility Programs (PEPs) that may be associated with the provider type and specialties selected earlier in the application process can be added on this page. At least one PEP is required for enrollment.

Complete the fields on this page and select the Save and Continue button to continue with this application.

- Indicates a required field.

Requested Effective Date

By default, the requested effective date for this application will be set to the submission date of the application when the application is submitted.

▪ **Is a requested effective date prior to the application submission date required for this enrollment?**

Yes No

Associated PEPs

You may select more than one Provider Eligibility Program (PEP) by clicking on the appropriate PEPs.

▪ Provider Eligibility Program (PEP)

Enrollment Not Paid

Click below to download a listing of the Provider Eligibility Programs (PEP) and their descriptions.

[Download](#)

[Finish Later](#)

[Save & Continue](#)

Provider Identification Page



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ATN: 1000098163 Provider Number: Pending Type: New Enrollment Start Date: 11/13/2023 Completion By: 01/12/2024

Provider Identification

Additional information identifying the provider is collected on this page. Complete the fields on this page and select the Save and Continue button to continue with this application.

- * Indicates a required field.
- Indicates an attachment is required.

Provider IRS/Legal Name and Address

Enter the Legal Name as it is filed with the IRS and as it appears on the IRS generated document. The address entered below is where your 1099 tax document will be sent.

Copy Name from "Request Information" page Copy Address from "Service Location Address" page

* Last Name	<input type="text" value="Doula"/>	Middle Name	<input type="text"/>
* First Name	<input type="text" value="Provider"/>	Room/Suite	<input type="text"/>
* Street	<input type="text" value="10 Apple Lane"/>	* State	<input type="text" value="PA - Pennsylvania"/>
* City	<input type="text" value="Hometown"/>		
* Zip+4	<input type="text" value="18001-1234"/>		

Contact IRS/Legal Name and Address

Enter the contact information for the IRS address.

Copy Contact from "Request Information" page

* Last Name	<input type="text" value="Elias"/>	Phone Extension	<input type="text"/>
* First Name	<input type="text" value="Lana"/>	Toll Free Extension	<input type="text"/>
Title	<input type="text"/>		
* Phone Number	<input type="text" value="717-634-1567"/>		
Toll Free Number	<input type="text" value="###-###-####"/>		
Fax Number	<input type="text" value="###-###-####"/>		
* Email	<input type="text" value="iana.elias@gainwelltechnologies.com"/>		
* Confirm Email	<input type="text" value="iana.elias@gainwelltechnologies.com"/>		

Individual Provider

* Birth Date	<input type="text" value="01/01/1960"/>	* Gender	<input type="text" value="Female"/>
Title/Degree	<input type="text" value="Doula"/>		

Finish Later

Save & Continue

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Additional Information

Additional information for the provider is collected on this page.
Complete the fields on this page and select the Save and Continue button to continue with this application.

- Indicates a required field.
- 📎 Indicates an attachment is required.

Enrollment Languages

*** In addition to English, do you or your staff communicate with patients in another language?** Yes No

🕒 Finish Later

💾 Save & Continue

Provider Disclosure Page



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Provider Disclosures

Respond to the following provider disclosure questions and select the Save and Continue button to continue with this application.

- Indicates a required field.
- Indicates an attachment is required.

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.
Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Have you ever:

- Had clinical privileges or hospital privileges denied, suspended, restricted, revoked, or not renewed; either voluntarily or involuntarily for an agreed to definite or indefinite period of time? Yes No
- Had any judgments entered against you or settlements been agreed to in any professional liability cases? Yes No
- Are there any professional liability lawsuits pending against you at the present time? Yes No
- Do you have physical or mental health condition(s) which in any way impairs your ability to practice your profession, with or without accommodations? Yes No
- Do you have any physical or mental health condition(s) which in any way poses a risk of harm to your patients? Yes No
- Are you currently using, or have you used in the past five years, drugs or any other chemical substance that has or may impair your ability to practice your profession? Yes No

Have you or anyone in your employ ever:

- Been terminated, excluded, precluded, suspended, debarred from or had your participation in any federal or state health care program or hospital privileges limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time? Yes No
- Been the subject of a disciplinary proceeding by any licensing or certifying agency, had your license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? Yes No
- Had a controlled drug license withdrawn? Yes No
- Been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? Yes No
- Been convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? Yes No
- Been convicted of interference with or obstruction of any investigation? Yes No
- In connection with the delivery of a health care item or service, or with respect to any act or omission in a health care program, been convicted of any criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? Yes No
- Been in default on repayments of scholarship obligations or loans in connection with your education as a health professional? Yes No
- Been subject to a civil penalty or assessment for any act or omission related to Medicare, Medicaid, or a state health care program? Yes No

Finish Later

Save & Continue

Ownership/Control Interest Page



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Ownership/Control Interest

Note: Ownership and control information is required in accordance with Federal Regulations 42 CFR Part 455, Subpart B published July 17, 1979, and expanded through additional subparts on February 02, 2011 through the Provider Enrollment and Screening provisions of the Affordable Care Act

- Indicates a required field.
- Indicates an attachment is required.

Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

- An individual, agency, or organization to which a provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Managing Employee or Agent Disclosure	
* Does the enrolling individual practitioner have any Managing Employees or Agents?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Direct Or Indirect Ownership	
* Are there any subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Criminal Offense	
* Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Significant Business Transactions	
* Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Finish Later	Save & Continue



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Attachments


For each of the required attachments below you must upload the corresponding documents.

Use the [Browse...](#) to navigate to the document you wish to upload. Once you have chosen your document, please save the document to your application by clicking on [Upload](#). Portable Document Format (PDF) is the only accepted document type for upload. Each file that you upload is limited to a maximum of **4MB** in size. Click on the appropriate link for more information on creating a PDF document when using [Microsoft Windows](#) or [Apple macOS](#).

Some attachments require the use of a form that is available to download. If a form is required, the download icon  will be displayed next to the Required Attachment's name. You can click this button to download the form as a PDF.

When available, additional information regarding the attachment/file can be displayed by clicking on the  information icon.

Provider

Required Attachments (1 Total)	File
Copy of PA Certification Board	PCB123456L 

[Finish Later](#)

[Save & Continue](#)

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS**

Provider Agreement for Outpatient Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

Provider Doula (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.
2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.
3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania Medical Assistance Program.
4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.
5. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
6. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:
 - A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
 - B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request.
7. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
8. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.
9. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).
10. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.
11. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

* Please sign by typing your full name here:

Provider Doula

Today's Date: 11/13/2023

Finish Later

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▼ Provider Information

Program Type	Pennsylvania Medical Assistance (PA MA)			
Provider Type	13 - Non-Traditional Provider			
Enrollment Type	Individual with SSN			
Last Name	Doula	First Name	Provider	Middle Initial
Social Security Number (SSN)	987654321			

Are you a Medicare participating Provider? No

▼ Contact Information

Last Name	Elias	First Name	Lana	Title
Phone Number	(717) 634-1567	Extension		
Toll Free Number		Extension		
Fax Number				
Email	lana.ellias@gainwelltechnologies.com			

▼ Service Location

Street	10 Apple Lane	Room/Suite		
City	Hometown	State	PA - Pennsylvania	
Zip+4	18001-1234	County	Schuylkill	
Email	lana.ellias@gainwelltechnologies.com			
Phone Number	(717) 634-1567	Extension		
Fax Number				

General & Historical Questions

Does the office have exterior steps leading to the main entrance doorway? No

Does the office have interior steps leading to the main entrance doorway? No

Is this address an active Rural Health Clinic or FQHC? No

Has screening been performed at this location for this provider within the last 12 months by:

Medicare? No

Children's Health Insurance Program (CHIP)? No

Another state's Medicaid? No



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Enrollment Application Individual

Provider and Contact Information



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ATN: 1100000000

Provider Number: Pending

Type: New Enrollment

Start Date: 11/16/2023

Completion By: 12/16/2023

Provider Information

Program Type Pennsylvania Medical Assistance (PA MA)

Provider Type 13 Certified Perinatal Doula

Enrollment Type SSN

Last Name	First Name	Middle Initial
Smith	John	

Social Security Number (SSN)

Are you a Medicare participating Provider? Yes

Contact Information

Last Name	First Name	Title
Smith	John	credentialing

Phone Number	Extension
(215) 111-1111	

Toll Free Number	Extension

Fax Number

Email JJohn@newapp

Service Location Information



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Service Location

Street	111 Holiday Ave	Room/Suite	
City	Philadelphia	State	PA - Pennsylvania
Zip+4	11111-2434	County	Philadelphia
Email	ekiss@gainwelltechnologies.com		
Phone Number	(215) 7894897	Extension	
Fax Number			

General & Historical Questions

Does the office have exterior steps leading to the main entrance doorway? No

Does the office have interior steps leading to the main entrance doorway? No

Is this address an active Rural Health Clinic or FQHC? No

Has screening been performed at this location for this provider within the last 12 months by:

Medicare? No

Children's Health Insurance Program (CHIP)? No

Another state's Medicaid? No

Other Addresses



Other Addresses

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information: Electronic Funds Direct Transfer (<https://www.dhs.pa.gov/providers/Providers/Pages/Electronic-Funds-Transfer.aspx>)

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

Would you like to receive **E-Mail** notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used. Yes

Mail-To Address :

Street	111 B Street	Room/Suite	
City	Philadelphia	State	PA - Pennsylvania
Zip+4	11111-4106	County	Philadelphia
Email			
Phone Number	(215) 707-2433	Extension	
Fax Number			

Check here if this address should be applied to all active service locations associated with this legal entity.



Specialties

Primary Specialty

Sub-Specialty

Primary

130 - Certified Doula

Yes

ProviderType 13 - Non-Traditional Provider

Specialty 130 - Certified Doula

Sub-Specialty

License, Certificate & Permit Information

Issuing Entity PA CERTIFICATION BOARD

Issuing State PA

Number PCB123456L

Issuing Date 01/01/2018

Expiration Date 12/31/2035

Provider Eligibility Program (PEP)



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Provider Eligibility Program (PEP)

Requested Effective Date

Is a requested effective date prior to the application submission date required for this enrollment? No

Associated PEPs

Provider Eligibility Program (PEP)

Enrollment Not Paid

Provider Identification



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Provider Identification

Provider IRS/Legal Name and Address

Last Name	First Name	Middle Name
Street	Room/Suite	
City	State	PA - Pennsylvania
Zip+4		

Contact IRS/Legal Name and Address

Last Name	First Name	Title
Phone Number	Extension	
Toll Free Number	Extension	
Fax Number		
Email	ekiss@gainwelltechnologies.com	

We DO NOT accept a W9 as verification of the Tax ID

Provider Identification



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Individual Provider

Birth Date 04/02/1987
Title/Degree

Gender M

NPI

NPI 1609853225

Taxonomy

B74J00000X - Nursing Service Related Providers: Doula



Additional Information

Enrollment Languages

In addition to English, do you or your staff communicate with patients in another language? No

Fee Assignments

Would you like to be fee assigned (linked) to a group? No

Provider Disclosures

Have you ever:

Had clinical privileges or hospital privileges denied, suspended, restricted, revoked, or not renewed; either voluntarily or involuntarily for an agreed to definite or indefinite period of time? No

Had any judgments entered against you or settlements been agreed to in any professional liability cases? No

Are there any professional liability lawsuits pending against you at the present time? No

Do you have physical or mental health condition(s) which in any way impairs your ability to practice your profession, with or without accommodations? No

Do you have any physical or mental health condition(s) which in any way poses a risk of harm to your patients? No

Are you currently using, or have you used in the past five years, drugs or any other chemical substance that has or may impair your ability to practice your profession? No

Provider Disclosures (cont.)



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Have you or anyone in your employ ever:

Been terminated, excluded, precluded, suspended, debarred from or had your participation in any federal or state health care program or hospital privileges limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time? No

Been the subject of a disciplinary proceeding by any licensing or certifying agency, had your license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? No

Had a controlled drug license withdrawn? No

Been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? No

Been convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? No

Been convicted of interference with or obstruction of any investigation? No

In connection with the delivery of a health care item or service, or with respect to any act or omission in a health care program, been convicted of any criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? No

Been in default on repayments of scholarship obligations or loans in connection with your education as a health professional? No

Been subject to a civil penalty or assessment for any act or omission related to Medicare, Medicaid, or a state health care program? No



Ownership / Managing Individuals

Managing Employee or Agent Disclosure

Does the enrolling individual practitioner have any Managing Employees or Agents? No

Direct Or Indirect Ownership

Are there any subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more? No

Criminal Offense

Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? No

Significant Business Transactions

Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? No



Provider

Required Attachment

Copy of PA CERTIFICATION BOARD

Uploaded File Name

PCB123456L

Provider Agreement



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Provider Agreement for Outpatient Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

John Smith (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.
2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.
3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania Medical Assistance Program.
4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.
5. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
6. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:
 - A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
 - B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request.
7. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
8. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.

Provider Agreement (cont.)



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9. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).
10. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.
11. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

Please sign by typing your full name here:

John Smith

Today's Date: 11/16/2023

Submission Details



Submission Details

I have reviewed the information in this enrollment application and affirm that the information submitted in or with this application is true, accurate and complete.

I understand that I am responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if I become aware that any of the information is not true, accurate or complete.

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities.

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of my enrollment in the Pennsylvania Medical Assistance (PA MA).

Please sign by typing your full name here: **John Smith**

Date of Submission: **11/16/2023**

⚠ Prepared on 11/16/2023 by the PA Department of Human Services Provider Enrollment On-line Application.



Enrollment Application Group

Provider and Contact Information



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Provider Information

Program Type Pennsylvania Medical Assistance (PA MA)
Provider Type 13 - Non-Traditional Provider
Enrollment Type Group
Entity Name Doula Group

FEIN 254131333

Are you a Medicare participating Provider? Yes

Contact Information

Last Name	doula	First Name	darla	Title
Phone Number	(254) 131-3334	Extension		
Toll Free Number		Extension		
Fax Number				
Email	ekiss@gainwelltechnologies.com			



Service Location

Street	320 woodruff way	Room/Suite	
City	harrisburg	State	PA - Pennsylvania
Zip+4	17112-1234	County	Dauphin
Email	ekiss@gainwelltechnologies.com		
Phone Number	(254) 131-3133	Extension	
Fax Number			



General & Historical Questions

Do you bill for a mobile medical unit from this location? No

Do you bill for a mobile dental unit from this location? No

Does the office have exterior steps leading to the main entrance doorway? No

Does the office have interior steps leading to the main entrance doorway? No

Is this address an active Rural Health Clinic or FQHC? No

Other Addresses

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information:
Electronic Funds Direct Transfer (<https://www.dhs.pa.gov/providers/Providers/Pages/Electronic-Funds-Transfer.aspx>)

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

Would you like to receive E-Mail notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used. Yes

Mail-To Address : *Same As Service Location*

Pay-To Address : *Same As Service Location*

Home-Office Address : *Same As Service Location*



Specialties

Primary Specialty

130 - Certified Doula

Sub-Specialty

Primary

Yes

ProviderType 13 - Non-Traditional Provider

Specialty 130 - Certified Doula

Sub-Specialty

Provider Eligibility Program (PEP)

Requested Effective Date

Is a requested effective date prior to the application submission date required for this enrollment? No

Associated PEPs

Provider Eligibility Program (PEP)

Enrollment Not Paid

Provider Identification

Provider IRS/Legal Name and Address

Entity Name	Doula Group		
Street	320 woodruff way	Room/Suite	
City	harrisburg	State	PA - Pennsylvania
Zip+4	17112-1234		

Contact IRS/Legal Name and Address

Last Name	doula	First Name	darla	Title	
Phone Number	(254) 131-3334	Extension			
Toll Free Number		Extension			
Fax Number					
Email	ekiss@gainwelltechnologies.com				

We DO NOT accept a W9 as verification of the Tax ID



Organizational Structure

Type Business Corporation, For Profit

Does the provider operate under a Fictitious business / doing business as (d/b/a) name? No

NPI

NPI 1821872698

Taxonomy

374J00000X - Nursing Service Related Providers: Doula



Enrollment Languages

In addition to English, do you or your staff communicate with patients in another language? No

Tax Exempt Status

Do you currently have tax exempt status? No

Fee Assignments

Would you like to associate members to your group? Yes

*** Provider Number**

300604780-0001

Ekiss, Doula



Have you, any agent, or managing employee ever:

Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

No

Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? No

Had a controlled drug license withdrawn? No

Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation? No

In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? No

Ownership / Managing Individuals



Managing Employee or Agent Disclosure

Does the enrolling disclosing entity have any Managing Employees or Agents? Yes

Name

doula debbie Managing Employee

Last Name	doula	First Name	debbie	Middle Initial
Birth Date	1983-01-09			

Social Security Number (SSN) 552178787

Street	320 woodruff way	Room/Suite	
City	harrisburg	State	PA - Pennsylvania
Zip+4	17112-1234		

Is this individual a managing employee or agent? Managing Employee

Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? No

Ownership / Managing Individuals



Individuals with an Ownership or Control Interest in The Disclosing Entity

Do any individuals have at least 5% direct or indirect ownership and/or control interest (i.e. serve as officers/board members) in the disclosing entity? Yes

Entity Name

doula

donnald

Last Name	First Name	Middle Initial
doula	donnald	
Birth Date	1987-08-15	

Social Security Number (SSN) 870011548

Street	320 woodruff way	Room/Suite	
City	harrisburg	State	PA - Pennsylvania
Zip+4	17112-1234		

Ownership / Managing Individuals



If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity. If the individual listed above has no ownership interest but has a controlling interest (i.e. holds a position as board member, director, or officer), please enter 0% ownership.

Direct Percent	100
Indirect Percent	0
Name of Entity Owned	

What position is held by the individual listed above?

Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity?
No

Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity? No

Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"? No

Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? No

Ownership / Managing Individuals



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Corporate Entities with Ownership or Control Interest in Disclosing Entity

Do any corporate entities have at least 5% direct or indirect ownership interest in the disclosing entity? No

Individuals with an Ownership or Control Interest in Subcontractors

Are there any individuals with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more? No

Corporate Entities with an Ownership or Control Interest in Subcontractors

Are there any corporate entities with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more? No

Subcontractors of Disclosing Entity

Does the disclosing entity have a direct or indirect ownership interest of 5% or more in any subcontractors? No

Ownership or Control Interest in Other Entities

Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"? No

Significant Business Transactions

Has the disclosing entity had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? No

Corporate Entities with Ownership or Control Interest in Disclosing Entity

Do any corporate entities have at least 5% direct or indirect ownership interest in the disclosing entity?

This question is followed by questions regarding Subcontractor ownership. These questions are asking about the disclosed Corporate owner and if they own other entities.

After this section is completed, you will need to upload verification documentation to be able to submit the application. Please note as you answer questions in the portal any item that has a paperclip will require a document to be uploaded here.

All entity and individual provider applications will require signature of a provider Agreement. This agreement must be signed by the individual or on an entity application the signature must be from an individual in the organization that can make Business decisions on behalf of the entity.

Attachments



Provider

Required Attachment	Uploaded File Name
Copy of Federal IRS Tax Document	Enroll Attach.pdf
Copy of Department of State Corporation Bureau or Business Partnership Agreement	Enroll Attach.pdf
Completed Group Members Form	Enroll Attach.pdf

Submission Details



The provider represents and warrants that the person signing this application is a duly authorized representative of the provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the provider that is seeking to enroll in the Pennsylvania Medical Assistance (PA MA).

I have reviewed the information in this enrollment application and affirm on behalf of the provider seeking to enroll in the Pennsylvania Medical Assistance (PA MA) that the information submitted in or with this application is true, accurate and complete.

I understand that the provider is responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if the provider becomes aware that any of the information is not true, accurate or complete

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities.

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of the provider from the Pennsylvania Medical Assistance (PA MA).

Please sign by typing your full name here: **donald doula**
Title **ceo**

Date of Submission: **12/21/2023**

⚠ Prepared on 12/21/2023 by the PA Department of Human Services Provider Enrollment On-line Application.

After the agreement and the application is signed, you will have to review all of the sections of the application prior to submitting it to the department.

Please note: All application pass through automated checks that can take Up to 15 days prior to appearing in the departments work queues.

The Department cannot see an ATN prior to the ATN being completed and submitted.



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How to Resume or Check Enrollment Application Status

- Resume application
 - Allows a provider to resume an application that has been started but not yet submitted.
 - Or resume an application that was returned to the provider for corrections.
 - Items needed to Resume Application
 - Application Tracking Number (ATN)
 - FEIN or SSN of provider on the application
 - Password created when saving the application

- To resume an application
 - Step 1:
 - Go to the Landing page of the PROMISe™ Portal
 - website: promise.dpw.state.pa.us
 - Step 2:
 - Select “Resume Application” from the Provider Enrollment Section of the Landing Page
 - Step 3:
 - This link opens a window requesting the Application Tracking Number (ATN), Tax Id or SSN and Password
 - Once supplied and verified, the provider can resume an application that has not been submitted or resume and application that has been returned for corrections

Resume Application



Login

PROMISe™ Internet

Home

Home

Wednesday 11/29/2023 10:26 AM EST

Provider Login



*User ID

[Log In](#)

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)



Broadcast Messages

Attention Provider Groups and Individuals: Effective 10/27/2023: The Department has added functionality to the Provider Enrollment system to allow one application to revalidate multiple Individual and Group locations. Providers can utilize this functionality if they are enrolled as one of the following Provider types 09, 14, 15, 17, 18, 19, 20, 23, 27, 31, 32, 33 and meet specific match criteria. For more details, please review Quick Tip #270 PROMISeQuickTip270 (pa.gov).

NOTE: Providers will begin to receive communications from donotreply@gainwelltechnologies.com. Please be sure to check your spam folder and add this email address to your contact list to ensure receipt of notifications.

Provider Enrollment



[New Application](#)

[Reactivation](#)

[Resume Application](#)



[Application Status](#)

Quick Links

...

Welcome to PROMISe™



Resume Application



Enrollment Information ▾ Co

Resume Application

Enter your application tracking number (ATN), Federal Tax Identification Number (FEIN or SSN) and password in order to resume your existing provider enrollment application.

If you have any questions about completing an electronic enrollment application, please call the appropriate phone number shown on the [Important Phone Numbers and Addresses](#) page of this site.

- Indicates a required field.

▪ **Application Tracking Number (ATN)**

▪ **SSN or FEIN**


▪ **Password**

[Forgot Password?](#)

I'm not a robot



reCAPTCHA
[Privacy](#) - [Terms](#)

 Submit

- Application Status
 - Allows a provider to check on the status of an existing application either submitted or incomplete.
 - Items needs to check Application Status
 - Application Tracking Number (ATN)
 - FEIN or SSN of provider on the application
 - Password created when saving the application

- To check the status of a submitted application
 - Step 1:
 - Go to the Landing page of the PROMISe™ Portal
 - website: promise.dpw.state.pa.us
 - Step 2:
 - Select “Application Status” from the Provider Enrollment Section of the Landing Page
 - Step 3:
 - This link opens a window requesting the Application Tracking Number (ATN), tax Id or SSN and Password.
 - Once supplied and verified, the provider can view the status of a current application whether submitted or not. The provider can also view the application PDF of a submitted application from this page.

Application Status



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Login

PROMISe™ Internet

Home

Home

Wednesday 11/29/2023 10:26 AM EST

Provider Login



*User ID

Log In

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)



Broadcast Messages

Attention Provider Groups and Individuals: Effective 10/27/2023: The Department has added functionality to the Provider Enrollment system to allow one application to revalidate multiple Individual and Group locations. Providers can utilize this functionality if they are enrolled as one of the following Provider types 09, 14, 15, 17, 18, 19, 20, 23, 27, 31, 32, 33 and meet specific match criteria. For more details, please review Quick Tip #270 PROMISeQuickTip270 (pa.gov).

NOTE: Providers will begin to receive communications from donotreply@gainwelltechnologies.com. Please be sure to check your spam folder and add this email address to your contact list to ensure receipt of notifications.

Provider Enrollment



[New Application](#)

[Reactivation](#)

[Resume Application](#)


[Application Status](#)



Quick Links



Application Status



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Enrollment Information - Contact Information - Help

Application Status

Enter your application tracking number (ATN), Federal Tax Identification Number (FEIN or SSN) and password in order to review your application status.


If you have any questions about completing an electronic enrollment application, please call the appropriate phone number shown on the Important Phone Numbers and Addresses page of this site.

* Indicates a required field.

*Application Tracking Number (ATN)

*SSN or FEIN

*Password [Forgot Password?](#)

I'm not a robot 

[Search](#)

Application Status Summary

This is the most current information regarding your Pennsylvania Medical Assistance (PA MA) provider enrollment application.

Application Tracking Number (ATN):	100006626
Start Date:	10/13/2022
Date Submitted:	10/18/2022
Status:	Application Approved
Status Date:	10/18/2022
Application Submission PDF:	Download

Approved Application Summary

Below are the details regarding your approved Pennsylvania Medical Assistance (PA MA) provider enrollment application.

Provider ID:	300594890-0001
Effective Date:	10/14/2022
Revalidation Date:	10/24/2027



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Resources

Electronic Provider Enrollment Application

- <https://promise.dpw.state.pa.us>

Provider Enrollment Information

- [Enrollment Information \(pa.gov\)](#)
- Includes information regarding requirements for each Provider Type

Provider Enrollment and Screening Requirements of the Affordable Care Act

- [ACAforproviders \(pa.gov\)](#)
- Includes the most current information from the Department relating to the ACA federally mandated regulations

Medicaid Information

- [Medicaid | Medicaid](#)
- Provides information about the ACA federally mandated regulations and how they relate to the Medicaid program

Resources (continued)



Department of Human Services Website

- <http://www.dhs.pa.gov/>

Provider Quick Tip

#265 - How to Check the Status of Your Electronic Provider Enrollment Application/Actions to Take if Your Application Was Returned for Additional Information

- [Quick Tips \(pa.gov\)](#)

Medical Assistance Bulletins

MAB xx-xx-xx – Doula Enrollment in the Medical Assistance (MA) Program

MAB 99-16-10 – Revalidation of Medical Assistance (MA) Providers

- [Bulletin Search \(pa.gov\)](#)

DHS Provider Services Center – 800/537-8862 option 2; option 4 for Enrollment



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Questions