Mississippi Division of Medicaid
HURRICANE KATRINA
TEMPORARY EMERGENCY ENROLLMENT FORM
for
Out-of-State Providers

This short enrollment form is for Temporary Enrollment due to Hurricane Katrina	Your State Medicaid Provider Number	Pl or

Provider information and location

Provider Name (DBA name if applicable) (Individuals: Last Name, First Name, Middle Initial)		Area Code & Telephone # ( ) -	DEA # -
Physical Street Address - Can Mail Be Received at this address: ☐ Y ☐ N		Mailing Address (if different)	
Physical City	State / Zip Code	Mailing Address City	State / Zip Code
Contact person	NABP#	Contact telephone number/fax #	

Provider Attestation of Information

I, the undersigned, certify to the following:

1. I have read the contents of this enrollment and the information contained herein is true, correct and complete;
2. I understand that it is my responsibility to maintain current information on the Mississippi Medicaid files and failure to do so may result in delayed payments or closure of the Medicaid Provider Number;
3. I understand that the Mississippi Medicaid files will be updated with information supplied on these forms.
4. I understand that reimbursement will be issued by paper checks.
5. I understand that this number is a temporary and emergency number.

Print Provider's Name _____ **Provider's Signature** _____ **Date** _____

ALL PROVIDERS MUST COMPLETE ENTIRE FORM– INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION

ACS Healthcare Information
Provider/Beneficiary Services
1-800-884-3222
or
601-206-3000
To verify eligibility
1-866-597-2675, ext. 0
601-206-3090

Fax form to 601-206-3015