BIBS – ENROLLMENT GUIDE

NOVEMBER 2022
VERSION 1.0

CONTENTS

1.0 Overview

This document has in-depth information regarding the enrollment process both for new enrollments and changes to an existing enrollment. There are different requirements for:

- Agencies and providers with an agency - An agency has multiple providers who work for the agency. There is an agency owner, and the agency could have employees who complete billing activities for providers
  - Agency Owners and Office Personnel, please review sections 4.1 through 4.2 under 4.0 Agency, and section 8.1 Agency User Types for more detailed information
  - Agency providers, please review sections 5.1 through 5.2 under 5.0 Agency Provider, and section 9.1 Agency User Types for more detailed information
- Independent Providers - A provider who works for themselves)
  - Please review sections 6.1 through 6.2 under 6.0 Independent Provider/Self-Employed, and section 8.2 Independent Provider/Self-Employed User Types for more detailed information
- District Employees (Providers)
  - EIC or Designees, please review section 7.1 under 7.0 District and section 8.3 District User Types for more detailed information
  - District providers, please review sections 7.2 under 7.0 District and section 8.3 District User Types for more detailed information

When enrolling in the Babies Can't Wait program for the first time, complete all applicable forms listed on the BCW BIBS Enrollment Checklist. All BIBS enrollment forms must be sent to your local District Early Intervention Coordinator (EIC) for the county where the Agency/Business or provider resides.

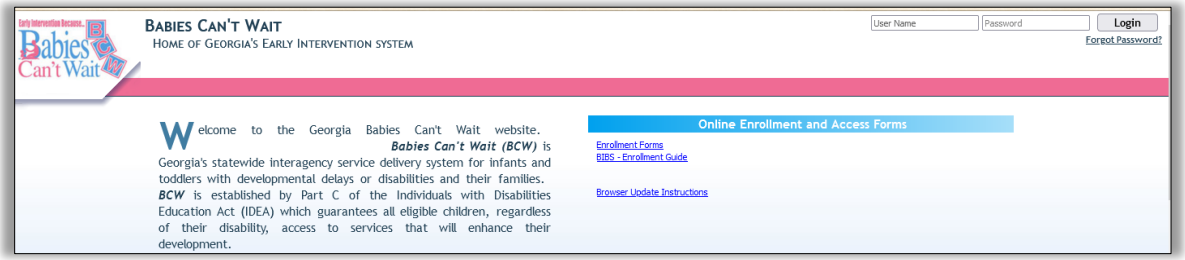
- Exception: The Direct Deposit/EFT Authorization form
  - A voided check or canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

The District will e-mail the forms to the State (bcw.contracts@dph.ga.gov). Once reviewed by the State the forms are forwarded to Gainwell Technologies for processing.

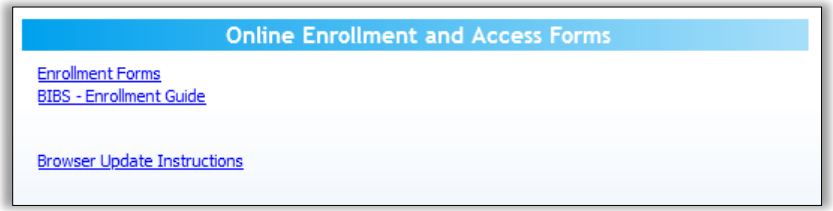
- If you have any questions, please contact the Provider Enrollment Unit at Gainwell Technologies at 1.855-708-6612 option 2

2.0 Access

The BCW BIBS enrollment forms can be accessed on the 'BIBS' website (https://www.bcw-bibs.com/) before logging in.



Click on the applicable link



3.0 Checklist by Enrollment Type

The graph below explains which **BCW BIBS Enrollment Checklist** an Agency/Business or provider/coordinator enrolling should reference to assist with the completion of the BCW BIBS enrollment. See section 9 for user types and definitions.

Enrollment Type	The person enrolling with BCW is a:
Agency *	Owner of an Agency
	A provider or coordinator who works for an Agency/Business
	A provider whose business is an LLC
	A provider whose business uses a Social Security number
Independent Provider/Self-Employed **	A provider whose business is an LLC Provider enrolling under their Social Security number
District	A provider or coordinator who will be an employee working at a District Office

***** Agency or Business (LLC or Social Security Number) who ***will or may have*** more than one BCW enrolled provider working for them

****** Provider owns an LLC or enrolling under a Social Security number who ***will not have*** other providers enrolled

4.0 Agency

4.1 New Agency

A new Agency enrolling with the BCW program will complete the following forms. These forms once completed will be submitted to the District Early Intervention Coordinator (EIC) for the county where the Agency/Business is located.

- **BCW BIBS Enrollment Form**
- **BCW- BIBS.COM Online Access**
- **Certification for Online Claims Form and Electronic Signature Agreement**
- **Direct Deposit/EFT Authorization Form * ***
- **W-9 Request for Taxpayer Identification Number and Certification Form * ***
- **Agency Checklist**

* * If the Agency will only be performing services in District 3-4 Lawrenceville/Gwinnett/East Metro these forms do not need to be completed. If additional districts are added later these forms must be completed

Agency Checklist			
✓	Form Name and Description	Original Signature Required?	District Approval Required?
	1. BCW BIBS Enrollment Form - ***Required*** - Complete this form to enroll as a contracted Agency - Complete this form to enroll as a Provider employed by an Agency	Yes	Yes
	2. BCW-BIBS.COM Online Access - ***Required*** - Complete this form to receive access to the BIBS system	Yes	Yes
	3. Certification for Online Claims Form and Electronic Signature Agreement- ***Required*** - Complete this form to perform direct data claim entry into the BIBS system and to certify authorization of your electronic signature for all actions within the BIBS system	Yes	No
	4. Direct Deposit/EFT Authorization Form – ***Required (Except 3-4 East Metro)*** - Complete this form to receive electronic payments instead of payments by check - A voided check will need to be submitted with the form	Yes	No
	5. W-9 Request for Taxpayer Identification Number and Certification Form – ***Required (Except 3-4 East Metro)*** - Complete this form to receive a 1099	Yes	No

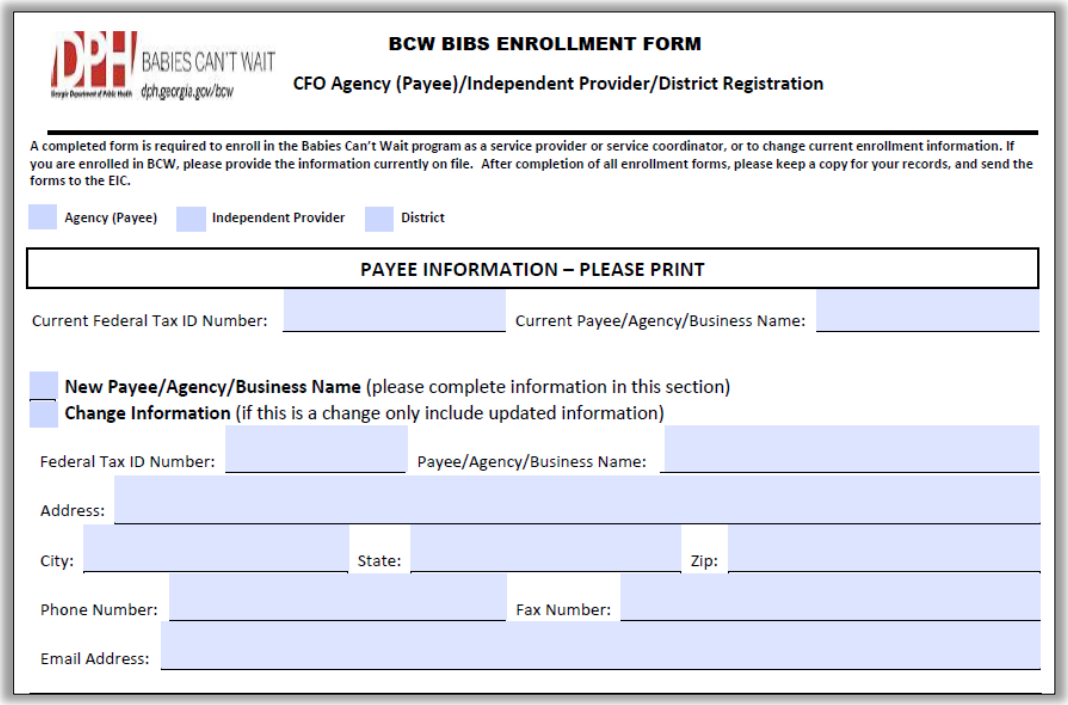
4.1.1 BCW BIBS Enrollment Form

Click the **Agency (Payee) checkbox** at the top of the form

In the Payee Information Section

- Click the checkbox in front of *New Payee/Agency/Business Name* to select
- Enter information in the fillable fields

> **NOTE:** Do not enter information in the Current Federal Tax ID Number or Current Payee/Agency Business Name fillable fields.



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

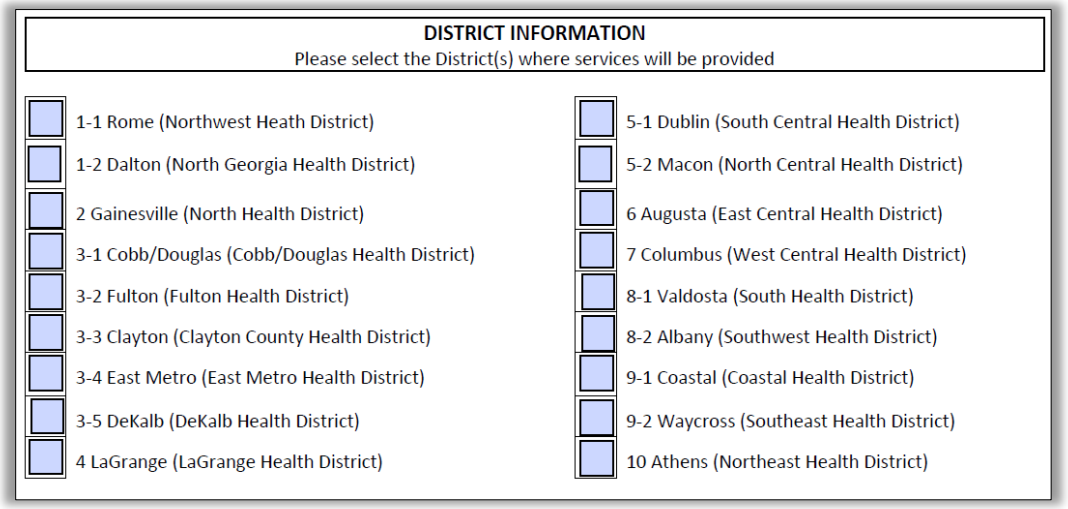
Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **District Information section**, select the District(s) where services will be provided by the agency's enrolled providers.



DISTRICT INFORMATION

Please select the District(s) where services will be provided

☐ 1-1 Rome (Northwest Heath District)	☐ 5-1 Dublin (South Central Health District)
☐ 1-2 Dalton (North Georgia Health District)	☐ 5-2 Macon (North Central Health District)
☐ 2 Gainesville (North Health District)	☐ 6 Augusta (East Central Health District)
☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)	☐ 7 Columbus (West Central Health District)
☐ 3-2 Fulton (Fulton Health District)	☐ 8-1 Valdosta (South Health District)
☐ 3-3 Clayton (Clayton County Health District)	☐ 8-2 Albany (Southwest Health District)
☐ 3-4 East Metro (East Metro Health District)	☐ 9-1 Coastal (Coastal Health District)
☐ 3-5 DeKalb (DeKalb Health District)	☐ 9-2 Waycross (Southeast Health District)
☐ 4 LaGrange (LaGrange Health District)	☐ 10 Athens (Northeast Health District)

At the bottom of the form complete the following:

- Provider Signature - the signature of the Agency/Business owner
- Date

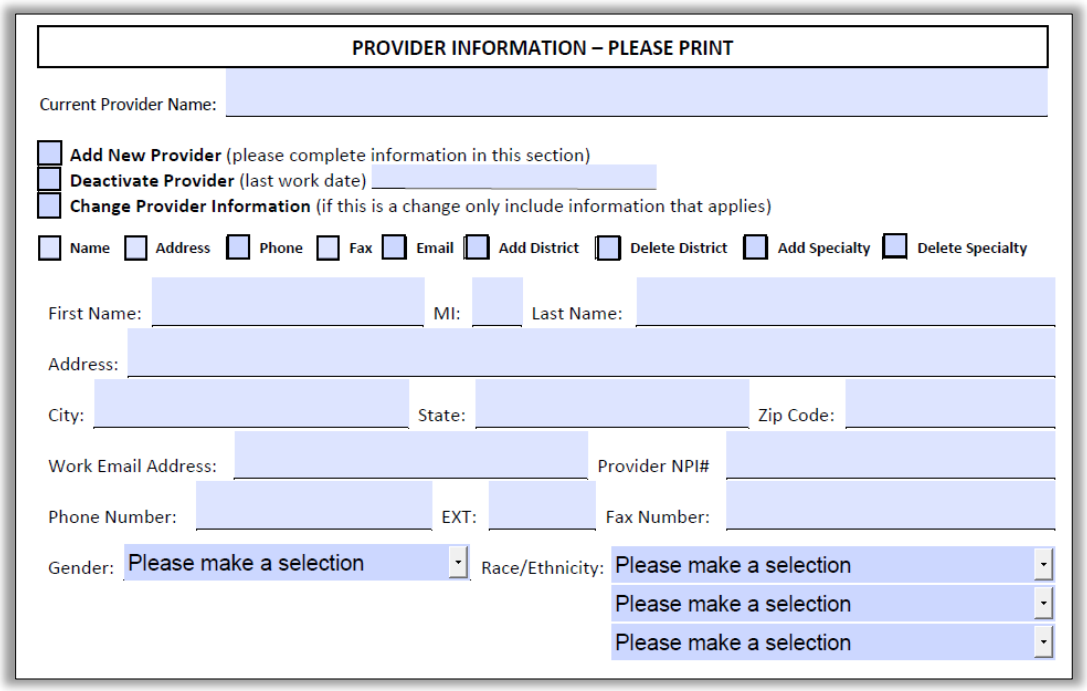
> **NOTE:** The District Signature, Date, District Contact Name, and Phone Number will be completed by the District

4.1.1.1 Owner Enrolling as Provider and/or Coordinator

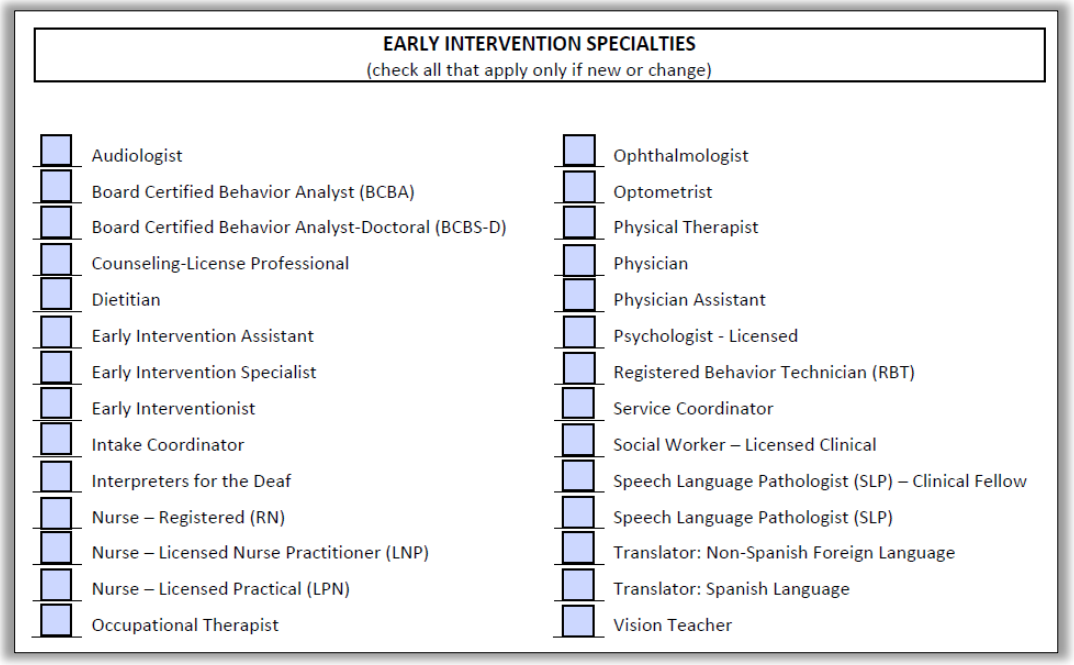
If the owner is enrolling as a provider and/or coordinator the following additional sections will need to be completed.

In the Provider Information section

- Add New Provider – click the checkbox to select
- Enter the owner's information into the fillable fields
  - Gender - **s**elect from the drop-down list
  - Race/Ethnicity - **s**elect from the drop-down list(s)



In the **Early Intervention Specialties section**, add the applicable specialties by clicking on the checkbox for that specialty



In the In-**Network Private Insurance Information section**, enter the information of any private insurance carriers listed where the owner is an In-Network Provider.

IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/COM Information section,** enter Medicaid or CMO information where the owner is an enrolled provider.

MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

At the bottom of the form complete the following:

- Provider Signature – the name of the owner
- Date

4.1.2 BCW-BIBS.Com Online Access

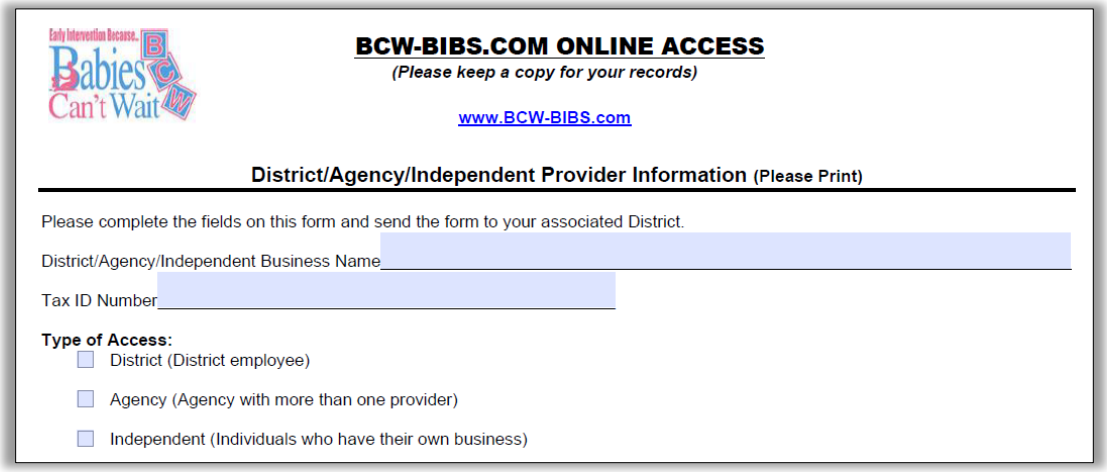
A separate **BCW-BIBS.Com Online Access form** must be completed by the owner(s) and any office personnel who will need access to the BCW-BIBS.com website.

- Never share or allow someone else to use your username and password
  - If someone in the office requires access to the website that person must complete a *BCW-BIBS.Com Online Access* to receive a username and password

> **NOTE:** It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password. This information will also be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access **- s**elect *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

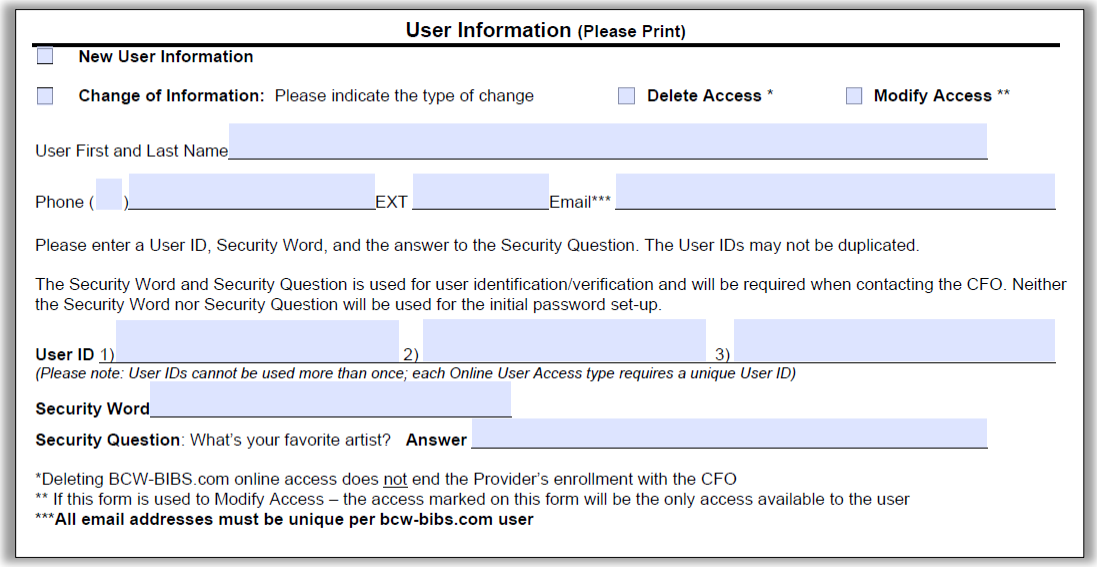
Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

In the **User Information section,** complete the following:

- New User Information - click the checkbox to select
- User First, Last Name, Phone, Ext, and Email of the person requesting access
- User ID – Enter 3 User IDs
- Security Word - a single word to identify yourself
- Security Question - the answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

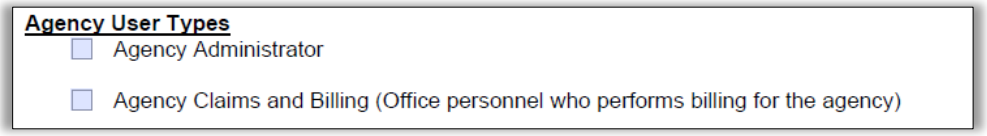
Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, click on the checkbox of the agency user type that is applicable. Only select one checkbox.



Agency User Types

- ☐ Agency Administrator
- ☐ Agency Claims and Billing (Office personnel who performs billing for the agency)

4.1.2.1 Owner Enrolling as Provider

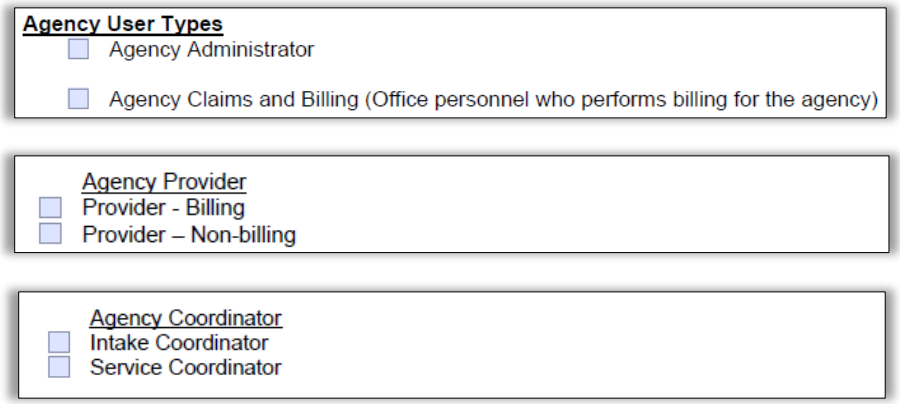
If the owner is enrolling as a provider with a specialty other than coordination in the **User Online Access Types section,** select Agency Administrator and one of the Agency Provider user types

4.1.2.2 Owner Enrolling as Coordinator

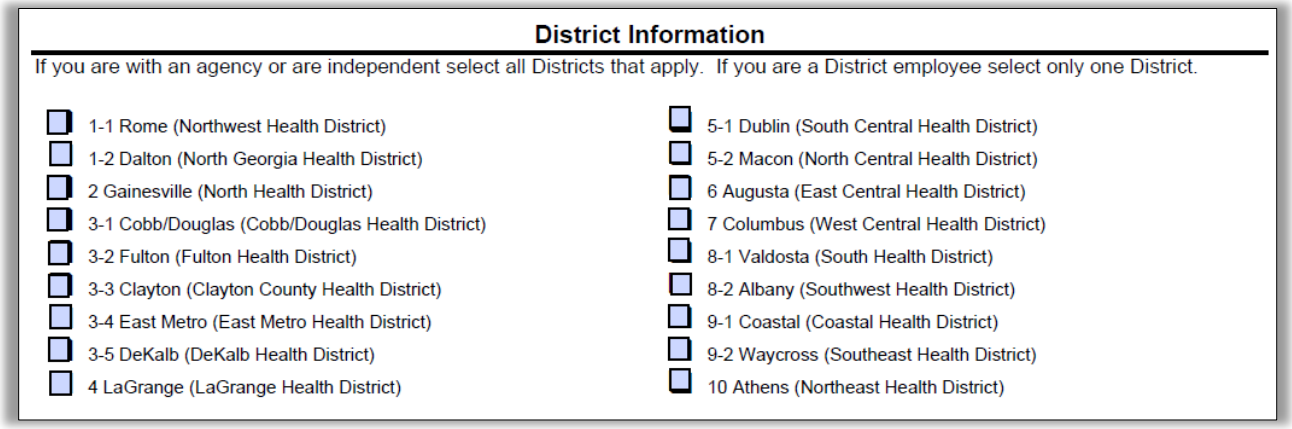
If the owner is enrolling as a coordinator and does not have another specialty complete in the **User Online Access Types section**, select Agency Administrator and one or both Agency Coordinator Types

4.1.2.3 Owner Enrolling as Provider and Coordinator

If the owner is enrolling as a provider and as a coordinator in the **User Online Access Types section**, select Agency Administrator, one of the Agency Provider User Types, and one or both Agency Coordinator User Types.

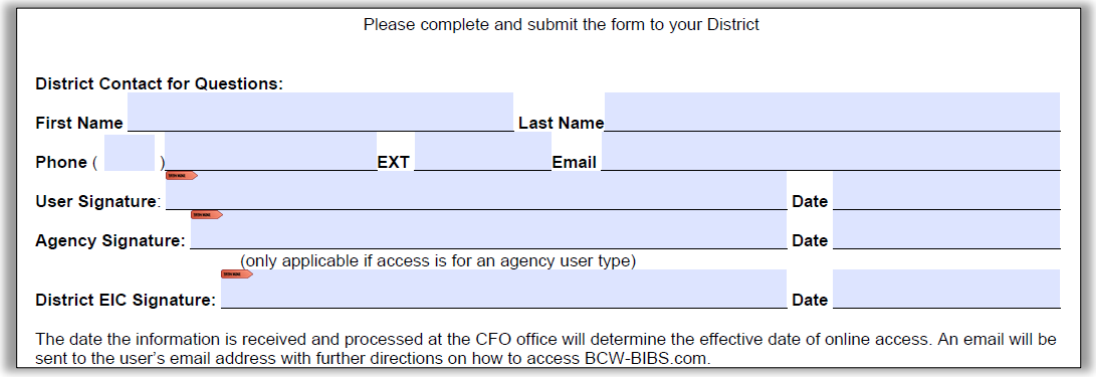


In the **District Information section**, select the checkbox(es) of the district(s) in which the Agency enrolled providers will be performing services. Only select the applicable districts, districts can be added later if necessary



At the bottom of the form complete the following:

- First Name, Last Name, Phone, EXT, and Email of the person requesting access
- User Signature - the **s**ignature of the person requesting access
- Date
- Agency Signature - the signature of the owner
- Date



4.1.2.3.1 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims Form and Electronic Signature Agreement** are required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

- A form must be completed for each owner and office personnel that will be entering claims on the BCW-BIBS.com website

4.1.2.3.2 Direct Deposit/EFT Authorization Form

Complete the **Direct Deposit/EFT Authorization form** for payments to be electronically transmitted into the agency's account. All funds must be designated to one account.

- A voided check or canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - These can be emailed directly to gaeienroll@gainwelltechnologies.com

NOTE: If there is any change to the bank information a *Direct Deposit EFT Authorization form* must be completed to ensure payments are put into the correct account. A voided/canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable.

- If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
- These can be emailed directly to gaeienroll@gainwelltechnologies.com

4.1.2.3.3 W-9 Request for Taxpayer Identification Number and Certification Form

A **W-9 form** must be completed to receive a 1099 form, all fields on the form are required.

4.2 Existing Agency

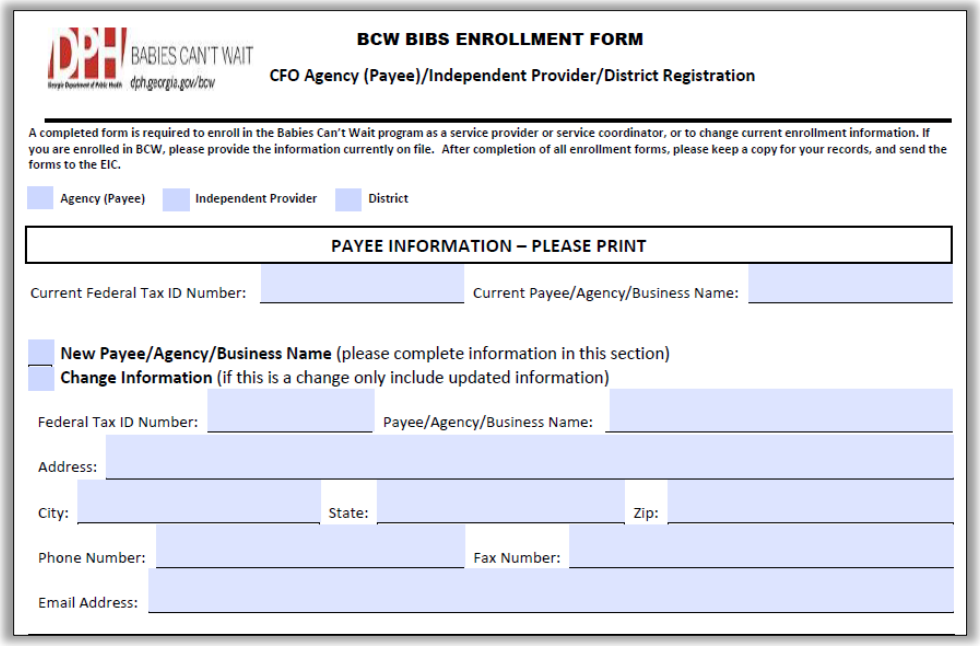
4.2.1 Change of Address, Phone/Fax Numbers, Or Email Address

To change the address, phone number, Fax number, or email address for an Agency complete the following: **BCW BIBS Enrollment** form

Click the Agency (Payee) checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number - enter the Federal Tax ID number of the agency
- Current Payee/Agency/Business Name - enter the name of the agency
- Change Information - click the checkbox to select
    - Only enter information that has changed in the applicable fillable fields



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

At the bottom of the form complete the following:

- Provider Signature - the signature of the owner
- Date

4.2.2 Add or Remove District(s)

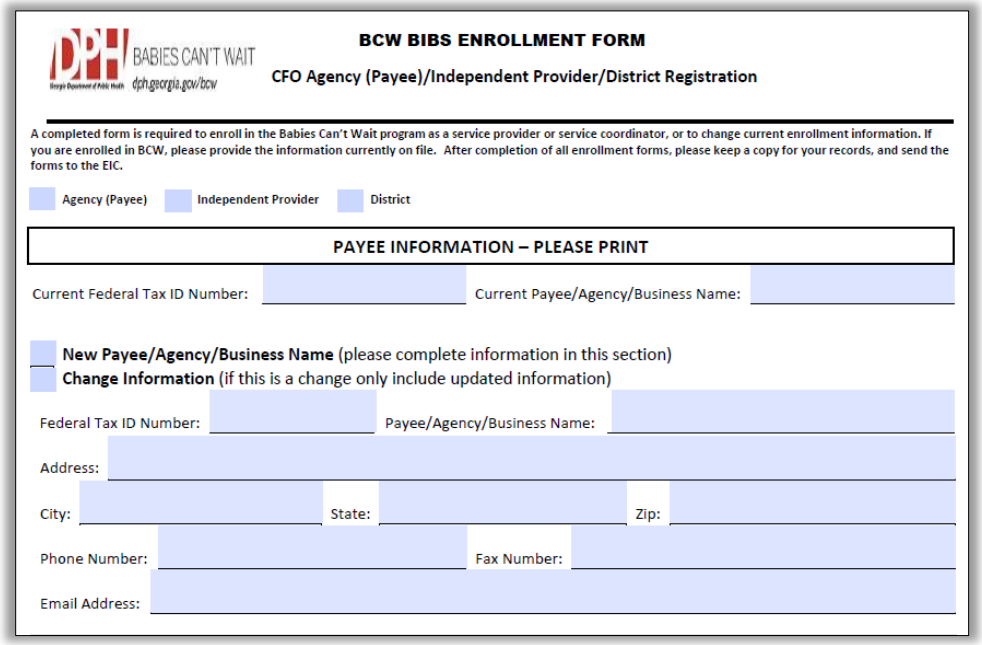
To remove a district(s) from an agency complete the following:

- **BCW BIBS Enrollment form**

Click the Agency (Payee) checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information - **c**lick the checkbox to select



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

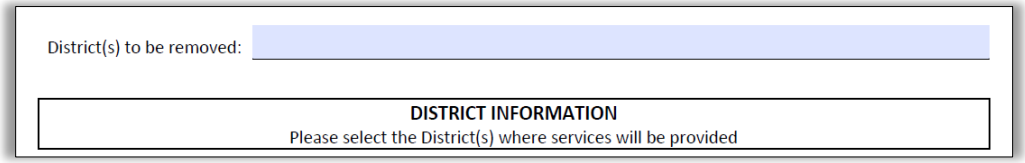
Address:

City: State: Zip:

Phone Number: Fax Number:

Email Address:

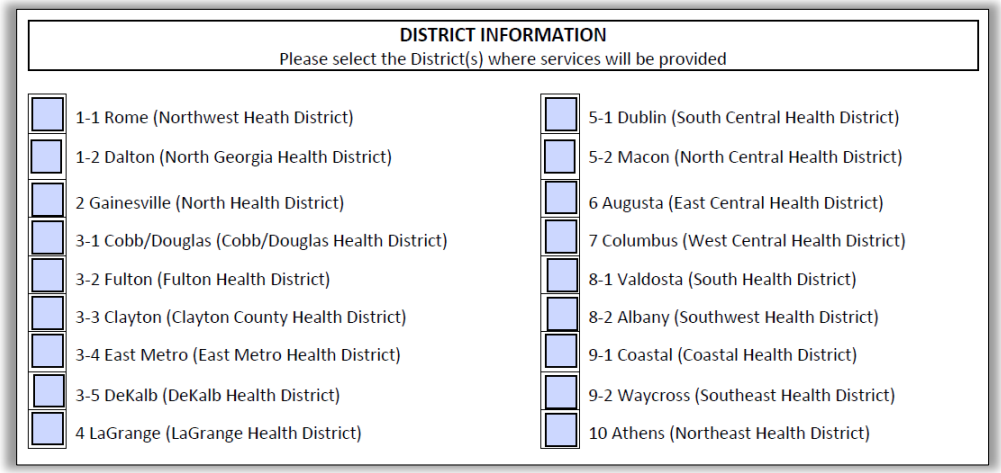
To remove districts, in the **District(s) to be removed text field** enter the name of the district(s) to be removed. Please enter a comma between the districts if multiple districts are entered.



District(s) to be removed:

DISTRICT INFORMATION
Please select the District(s) where services will be provided

To add a district(s), in the **District Information section** click on the checkbox(es) of the district(s) to be added.



DISTRICT INFORMATION
Please select the District(s) where services will be provided

- 1-1 Rome (Northwest Heath District)
- 1-2 Dalton (North Georgia Health District)
- 2 Gainesville (North Health District)
- 3-1 Cobb/Douglas (Cobb/Douglas Health District)
- 3-2 Fulton (Fulton Health District)
- 3-3 Clayton (Clayton County Health District)
- 3-4 East Metro (East Metro Health District)
- 3-5 DeKalb (DeKalb Health District)
- 4 LaGrange (LaGrange Health District)
- 5-1 Dublin (South Central Health District)
- 5-2 Macon (North Central Health District)
- 6 Augusta (East Central Health District)
- 7 Columbus (West Central Health District)
- 8-1 Valdosta (South Health District)
- 8-2 Albany (Southwest Health District)
- 9-1 Coastal (Coastal Health District)
- 9-2 Waycross (Southeast Health District)
- 10 Athens (Northeast Health District)

At the bottom of the form complete the following:

- Provider Signature - the signature of the owner
- Date

4.2.3 Add A New Owner or Agency Office Personnel

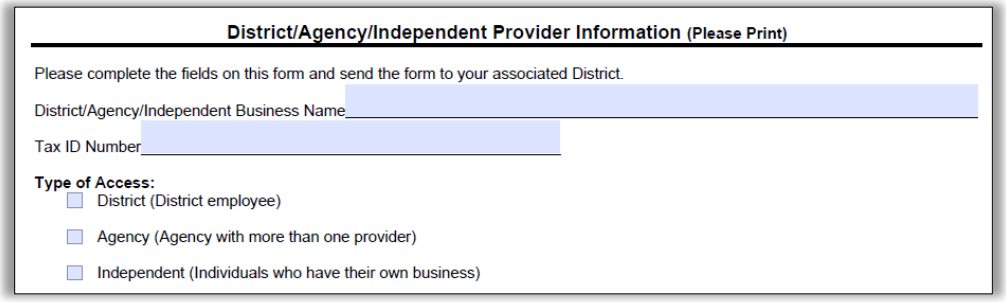
To add a new owner or Agency Office Personnel each person must complete the following forms:

- **BCW-BIBS.COM Online Access**
- **Certification for Online Claims and Electronic Signature Agreement**

4.2.3.1 BCW-BIBS.COM Online Access

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - click on *Agency* to select



District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

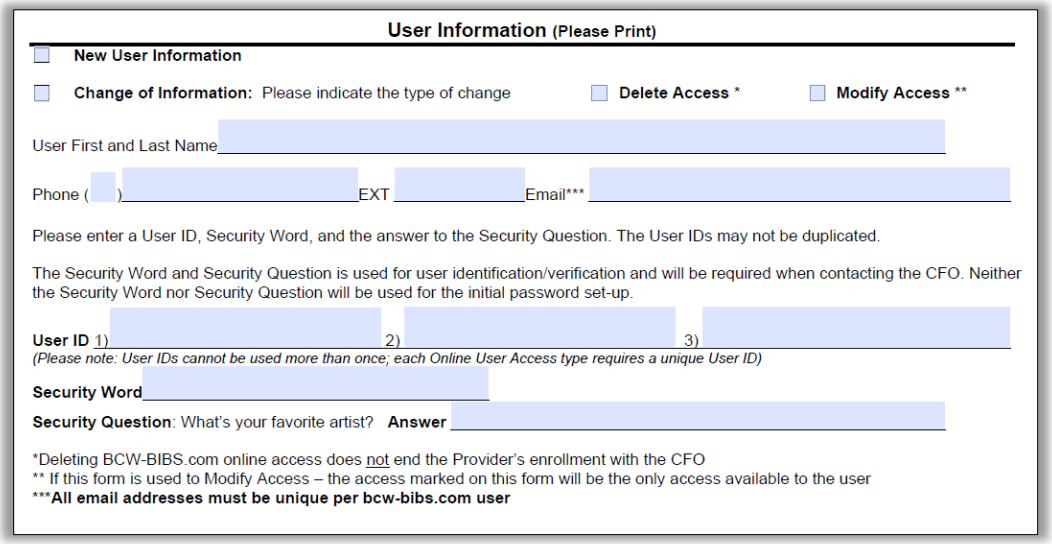
Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

In the **User Information section** complete the following information:

- New User Information - **c**lick the checkbox to select
- Enter the First Name, Last Name, Phone, Ext, and Email of the person requesting access
- User ID – Enter 3 User IDs
- Security Word - a single word to identify yourself
- Security Question - the answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

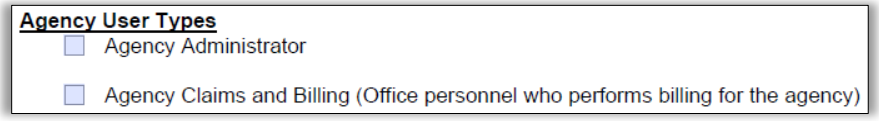
*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, select the applicable *Agency User Type*.

- An owner would select Agency Administrator
- Office Personnel would select Agency Claims and Billing



Agency User Types

- ☐ Agency Administrator
- ☐ Agency Claims and Billing (Office personnel who performs billing for the agency)

At the bottom of the form complete the following:

- Provider Signature - **t**he signature of the owner or the office personnel person
- Date

4.2.3.1.1 Owner Enrolling as Provider

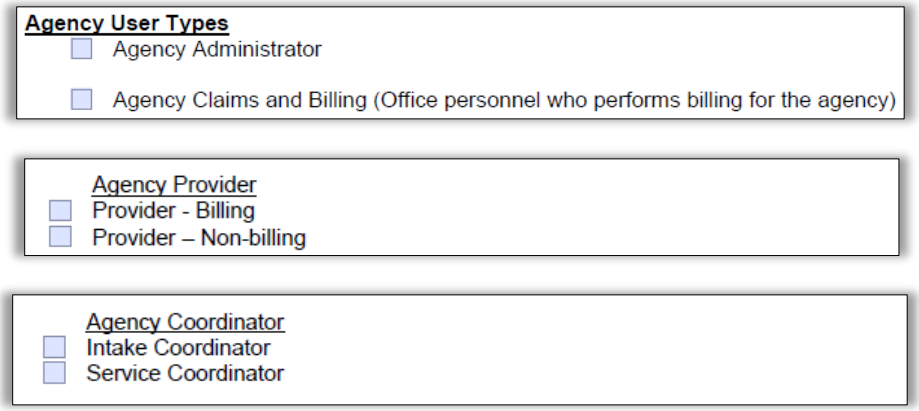
If the owner is enrolling as a provider with a specialty other than coordination, in the **User Online Access Types section** select Agency Administrator and one of the Agency Provider user types.

4.2.3.1.2 Owner Enrolling as Coordinator

If the owner is enrolling as a coordinator and does not have another specialty, in the **User Online Access Types section** select Agency Administrator and one or both Agency Coordinator types.

4.2.3.1.3 Owner Enrolling as Provider and as Coordinator

If the owner is enrolling as a provider and a coordinator, in the **User Online Access Types section** select Agency Administrator, an Agency Provider user type, and one or both Agency Coordinator user types.



At the bottom of the form complete the following:

- Provider Signature – the signature of the owner
- Date

4.2.3.2 Certification For Online Claims and Electronic Signature Agreement

The **Certification for Online Claims and Electronic Signature Agreement** is required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

4.2.4 Remove Owner Or Agency Office Personnel

When the owner or office personnel leaves the agency the person(s) access must be ended by completing a **BCW-BIBS.COM Online Access**.

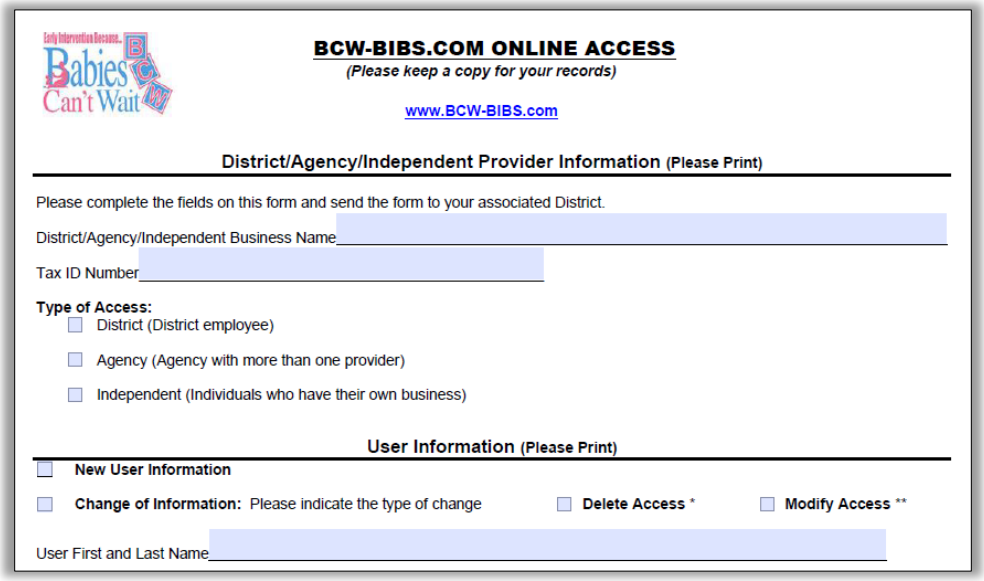
- If both owner and office personnel is leaving the agency each person will have to complete the form

In the **District/Agency/Independent Provider Information section,** complete the following:

- Agency Business Name
- Agency Tax ID number
- Type of Access - click the Agency checkbox to select

In the **User Information section,** complete the following:

- Change of Information - Click on the checkbox to select
- Delete Access - Click on the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name

Tax ID Number

Type of Access:

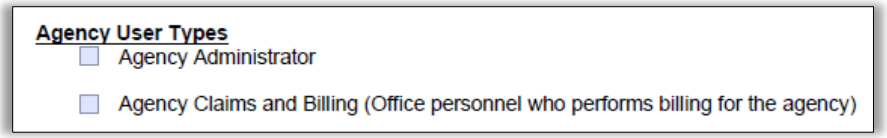
- District (District employee)
- Agency (Agency with more than one provider)
- Independent (Individuals who have their own business)

User Information (Please Print)

- **New User Information**
- **Change of Information:** Please indicate the type of change — **Delete Access** * — **Modify Access** **

User First and Last Name

In the **User Online Access Types section,** select the current user type of the person.



Agency User Types

- Agency Administrator
- Agency Claims and Billing (Office personnel who performs billing for the agency)

At the bottom of the form complete the following:

- Provider Signature - The signature of the agency owner
- Date

4.2.4.1 Remove An Owners Specialty(ties)

If the owner will no longer be performing services as a provider or Intake/Service Coordinator the following form(s) must be completed:

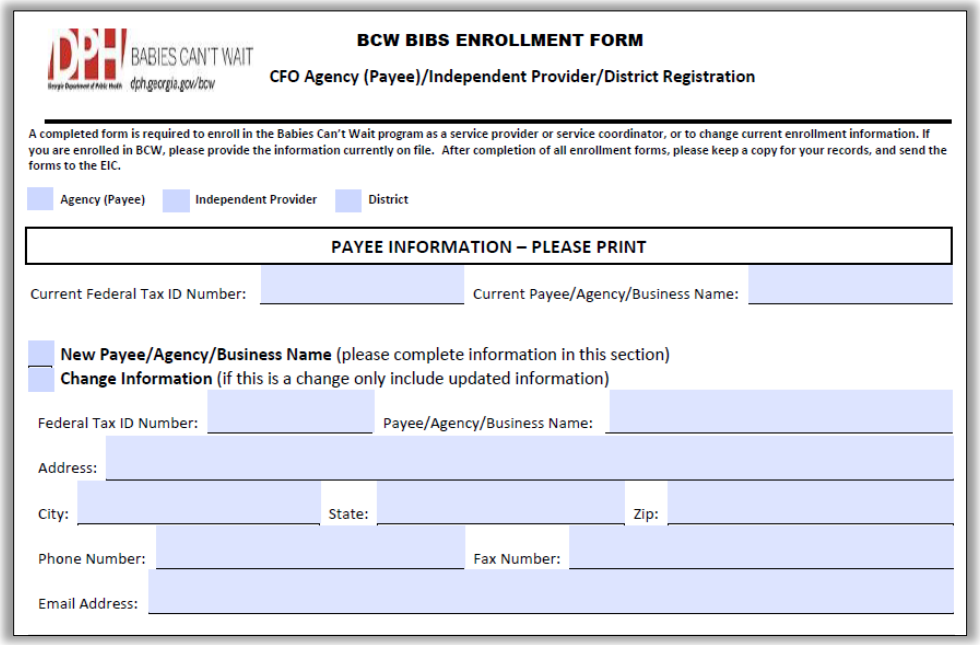
- **BCW BIBS Enrollment Form**
- **BCW-BIBS.COM Online Access**

4.2.4.1.1 BCW BIBS Enrollment Form

Click the Agency (Payee) checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information - click the checkbox to select



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

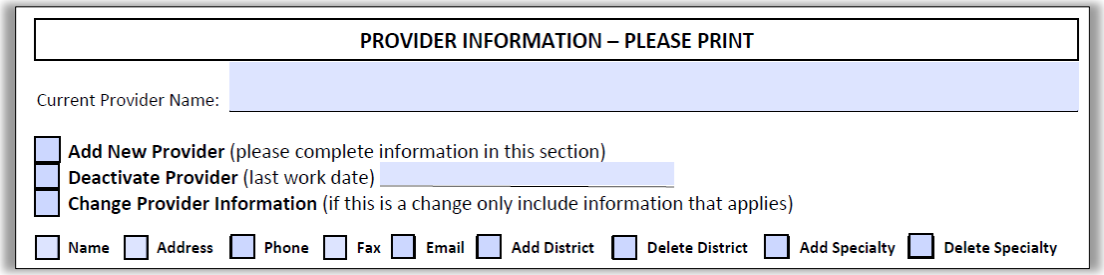
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Current Provider Name – enter the owner's name
- Change Provider Information – click the checkbox to select
- Delete Specialty – click the checkbox to select



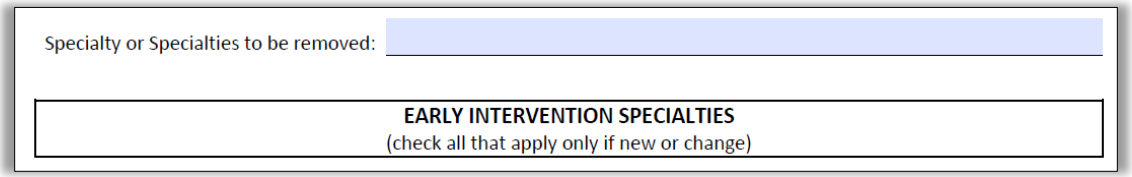
PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

In the **Specialty or Specialties to be removed text field** enter the specialty(ties) to be removed. Please enter a comma between each specialty entered.



Specialty or Specialties to be removed:

EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

At the bottom of the form complete the following:

- Provider Signature - The signature of the owner
- Date

4.2.4.1.2 BCW-BIBS.COM Online Access

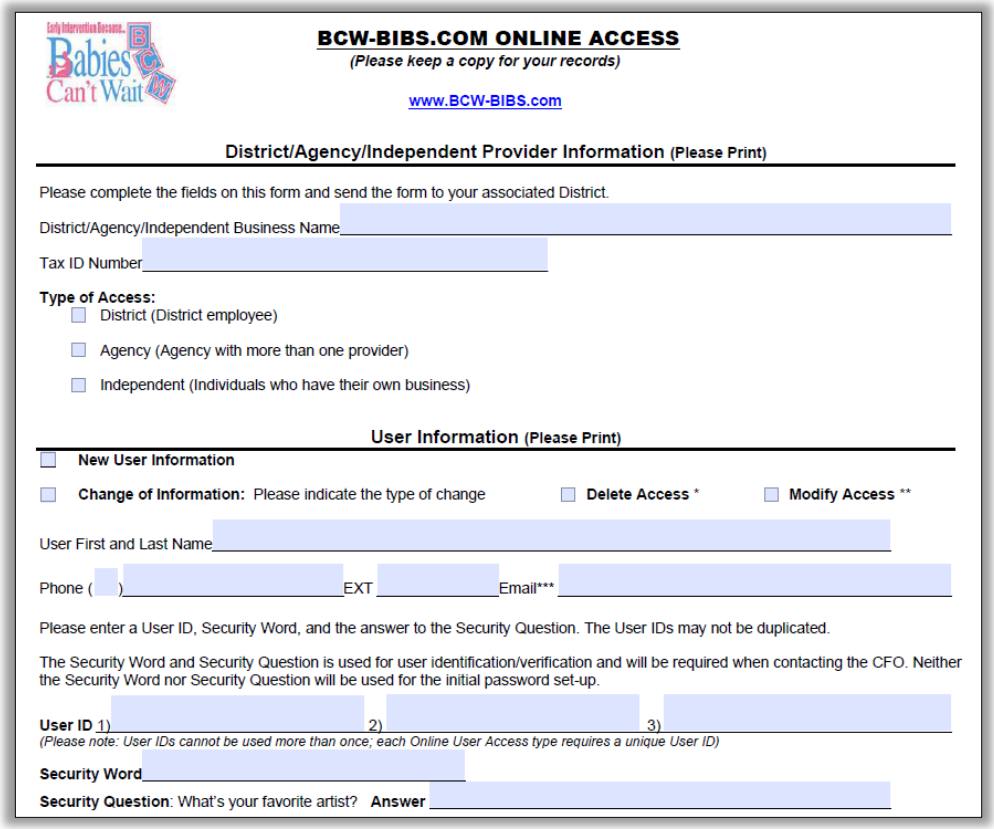
In the **District/Agency/Independent Provider Information section,** complete the following:

- Agency Business Name
- Agency Tax ID number
- Type of Access - click the *Agency* checkbox to select

In the **User Information section,** complete the following:

- Change of Information - Click on the checkbox to select
- Delete Access - Click on the checkbox to select

- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

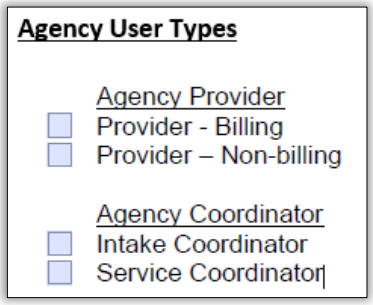
User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Online Access Types section,** click the checkboxes of all applicable user types that should be ended.



Agency User Types

Agency Provider
- ☐ Provider - Billing
- ☐ Provider – Non-billing

Agency Coordinator
- ☐ Intake Coordinator
- ☐ Service Coordinator

At the bottom of the form complete the following:

- Provider Signature - The signature of the owner
- Date

4.2.4.2 Removing Owner Who is A Provider and/or Intake/Service Coordinator

To remove an owner who is a provider and/or Intake/Service Coordinator the following forms must be completed:

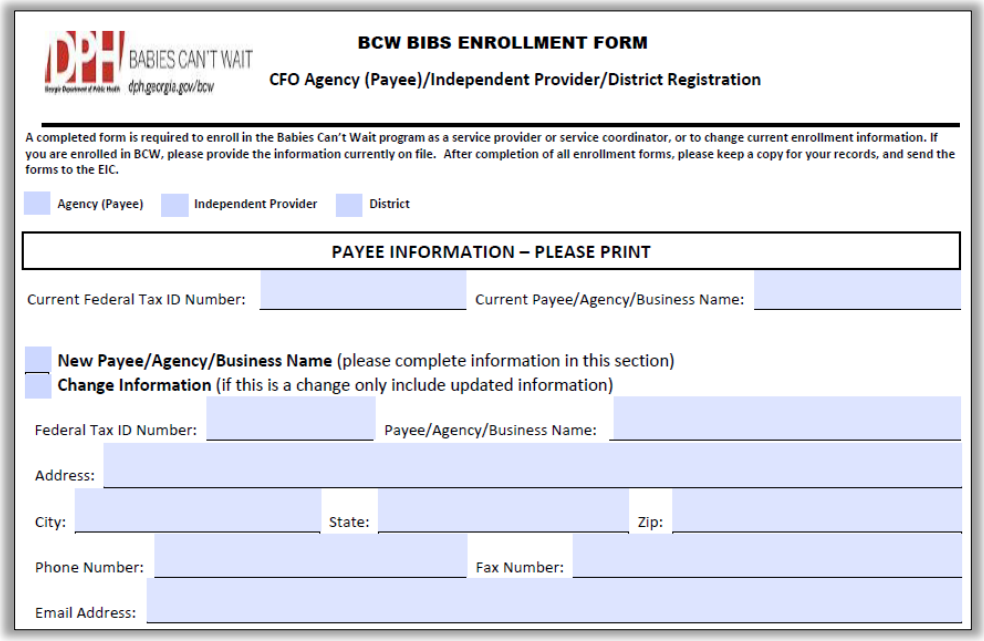
- **BCW BIBS Enrollment Form**
- **BCW-BIBS.COM Online Access**

4.2.4.2.1 BCW BIBS Enrollment Form

Select the **Agency (Payee) checkbox** at the top of the form

In the **Payee Information section** complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information – click on the checkbox to select



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

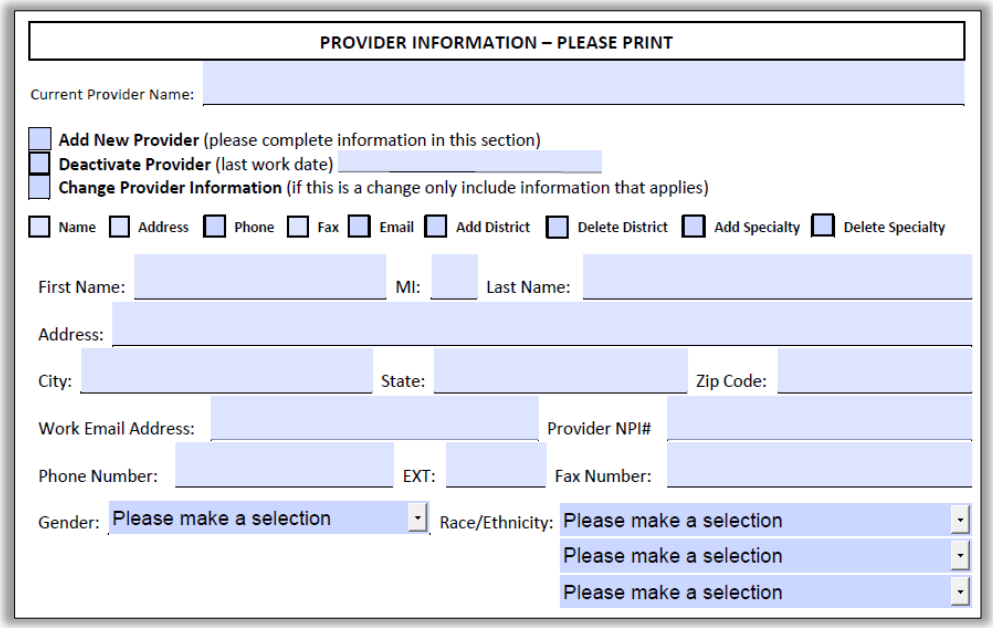
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Current Provider Name – enter the owner's name
- Deactivate Provider – click in the checkbox to select
- (last work date) – enter the date



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection

Please make a selection

Please make a selection

At the bottom of the form complete the following:

- Provider signature – the signature of the owner
- Date

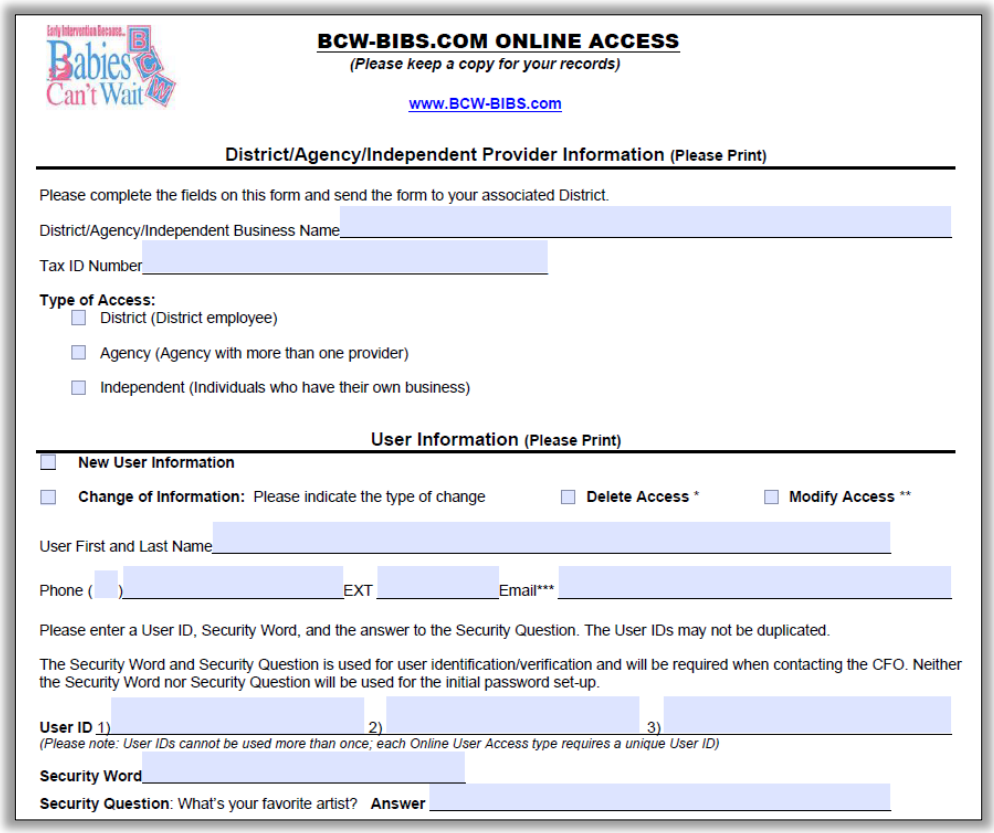
4.2.4.2.2 BCW-BIBS.COM Online Access

In the **District/Agency/Independent Provider Information section,** complete the following:

- Agency Business Name
- Agency Tax ID number
- Type of Access - click the *Agency* checkbox to select

In the **User Information section,** complete the following:

- Change of Information - Click on the checkbox to select
- Delete Access - Click on the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

☐ District (District employee)

☐ Agency (Agency with more than one provider)

☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

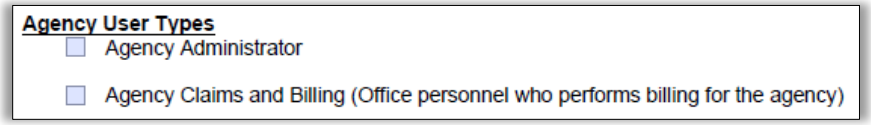
User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

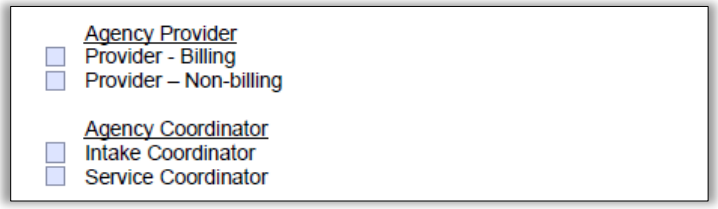
In the **User Online Access Types section** select Agency Administrator, the applicable agency provider user type, and the applicable agency coordinator user type(s).



Agency User Types

☐ Agency Administrator

☐ Agency Claims and Billing (Office personnel who performs billing for the agency)



Agency Provider

☐ Provider - Billing

☐ Provider – Non-billing

Agency Coordinator

☐ Intake Coordinator

☐ Service Coordinator

At the bottom of the form complete the following:

- Provider Signature - The signature of the owner
- Date

4.2.5 Updating Bank Information

If the agency has changed banks or has a new bank account a new **Direct Deposit/EFT Authorization Form** must be completed. A voided/canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable.

- If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
- It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

The Direct Deposit/EFT Authorization will not have to be completed if the agency only performs services in District 3-4 Lawrenceville/Gwinnett/East Metro

4.2.6 Tax ID Change

4.2.6.1 Tax ID Change Only

If the Agency is changing only its Tax ID number, the following forms must be completed:

- **BCW BIBS Enrollment Form**
- **BCW-BIBS.COM Online Access**
- **Certification for Online Claims Form and Electronic Signature Agreement**
- **Direct Deposit/EFT Authorization Form**
- **W-9 Request for Taxpayer Identification Number and Certification Form**
- **Agency Checklist**

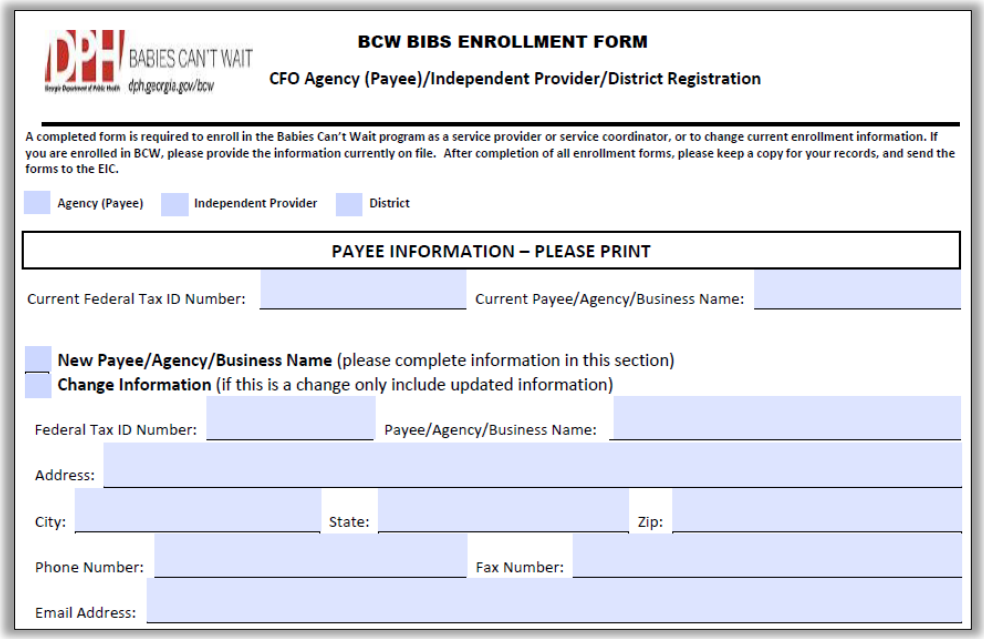
> **NOTE:** The providers associated with the existing agency that will be enrolled with the new Agency must also complete forms. See section 5.2.6 for more information.

4.2.6.1.1 BCW BIBS Enrollment Form

Select the **Agency (Payee) checkbox** at the top of the form

In the **Payee Information section** complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information – click on the checkbox to select
- Federal Tax ID Number – enter the agency's new Federal Tax ID number



DPH BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

At the bottom of the form complete the following:

- Provider Signature – enter the signature of the agency's owner
- Date

4.2.6.1.2 BCW-BIBS.Com Online Access

A separate **BCW-BIBS.Com Online Access form** must be completed by the owner(s) and any office personnel who will need access to the BCW-BIBS.com website.

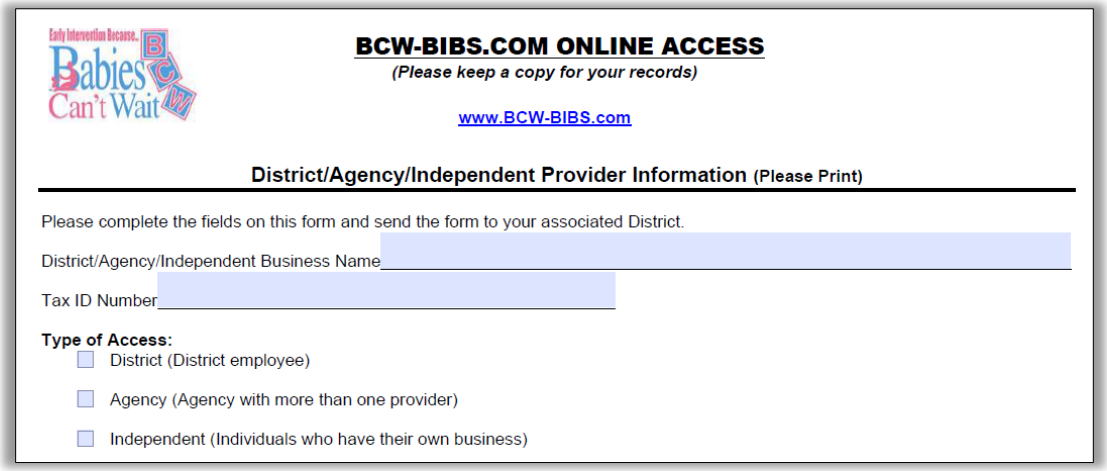
- Never share or allow someone else to use your username and password

- If someone in the office requires access to the website that person must complete a *BCW-BIBS.Com Online Access* to receive a username and password

NOTE: It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password. This information will also be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - **s**elect *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

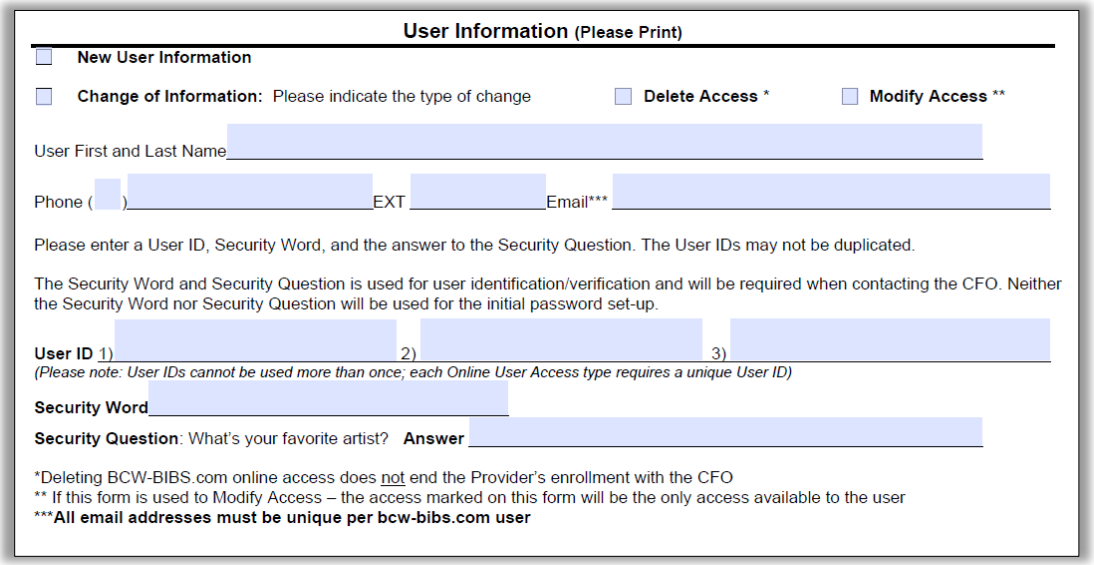
☐ District (District employee)

☐ Agency (Agency with more than one provider)

☐ Independent (Individuals who have their own business)

In the **User Information section,** complete the following:

- New User Information - click the checkbo*x* to select
- User First, Last Name, Phone, Ext, and Email of the person requesting access
- User ID – Enter 3 User IDs – user IDs must be different than the IDs used currently
- Security Word - a single word to identify yourself
- Security Question - **t**he answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

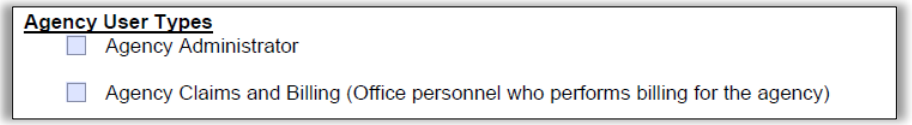
Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, click on the checkbox of the agency user type that is applicable. Only select one checkbox.



4.2.6.1.3 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims Form and Electronic Signature Agreement** are required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

- A form must be completed for each owner and office personnel that will be entering claims on the BCW-BIBS.com website
- Enter the agency's new Tax ID number in the Agency/Independent Provider/Self-Employed Tax ID field

4.2.6.1.4 Direct Deposit/EFT Authorization Form

A *Direct Deposit/EFT Authorization form* must be completed to ensure payments are put into the correct account.

- A voided/canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

4.2.6.1.5 W-9 Request for Taxpayer Identification Number and Certification Form

A **W-9 form** must be completed with the new Tax ID number to receive a 1099 form, all fields on the form are required.

4.2.6.2 Tax ID and Agency Name Change

If the Agency is changing its Tax ID and agency name, the following forms must be completed

- **BCW BIBS Enrollment Form**
- **BCW- BIBS.COM Online Access**
- **Certification for Online Claims Form and Electronic Signature Agreement**
- **Direct Deposit/EFT Authorization Form * ***
- **W-9 Request for Taxpayer Identification Number and Certification Form * ***
- **Agency Checklist**

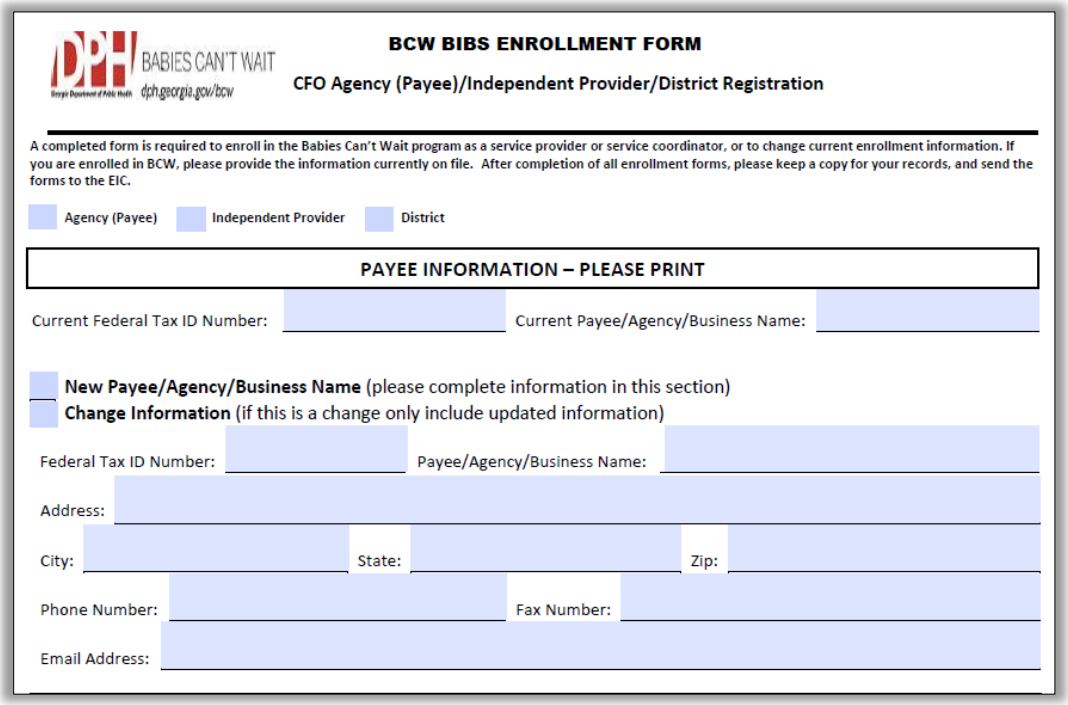
* * If the Agency will only be performing services in District 3-4 Lawrenceville/Gwinnett/East Metro these forms do not need to be completed. If additional districts are added later these forms must be completed

4.2.6.2.1 BCW BIBS Enrollment Form

Click the **Agency (Payee) checkbox** at the top of the form

In the Payee Information Section

- Enter the *Current Federal Tax ID Number*
- Enter the *Current Payee/Agency/Business Name*
- Click the checkbox in front of *Change Information* to select
- Federal Tax ID Number – enter the new Tax ID Number
- Payee/Agency/Business Name – enter the new name of the agency
- Enter information in these fields if the information has changed:
  - Address, City, State, Zip, Phone Number, Fax Number, Email Address



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

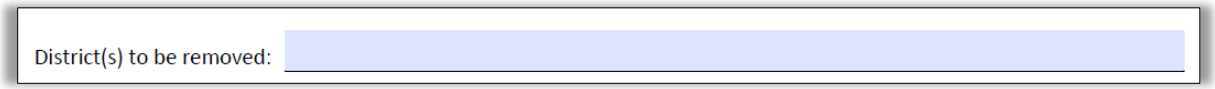
Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

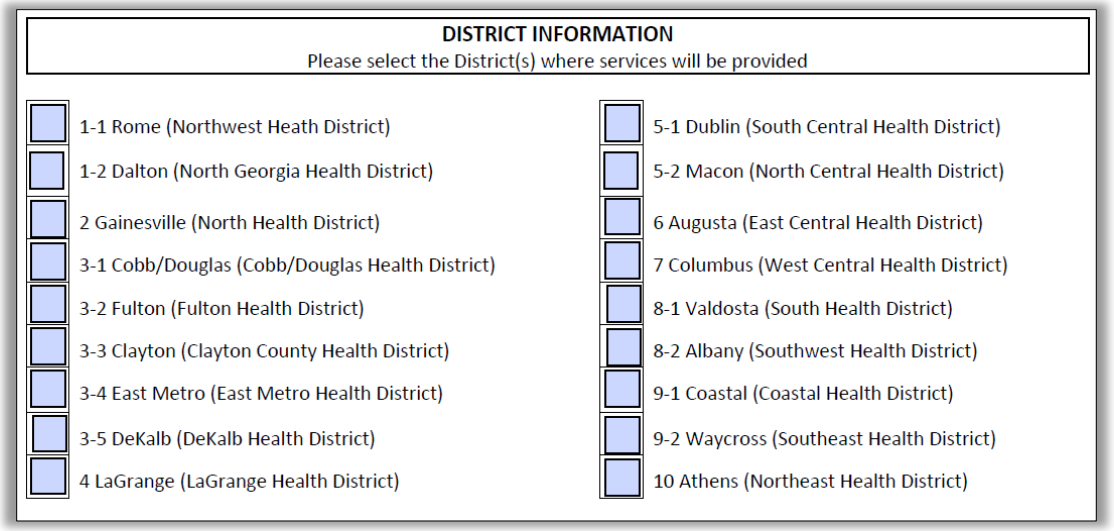
Email Address: _____

If districts are being removed, enter the districts in the District(s) to be removed, please add a comma between district names



District(s) to be removed: _____

In the **District Information section**, if District(s) are being added click the checkbox in front of the district(s).



DISTRICT INFORMATION

Please select the District(s) where services will be provided

☐ 1-1 Rome (Northwest Heath District)	☐ 5-1 Dublin (South Central Health District)
☐ 1-2 Dalton (North Georgia Health District)	☐ 5-2 Macon (North Central Health District)
☐ 2 Gainesville (North Health District)	☐ 6 Augusta (East Central Health District)
☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)	☐ 7 Columbus (West Central Health District)
☐ 3-2 Fulton (Fulton Health District)	☐ 8-1 Valdosta (South Health District)
☐ 3-3 Clayton (Clayton County Health District)	☐ 8-2 Albany (Southwest Health District)
☐ 3-4 East Metro (East Metro Health District)	☐ 9-1 Coastal (Coastal Health District)
☐ 3-5 DeKalb (DeKalb Health District)	☐ 9-2 Waycross (Southeast Health District)
☐ 4 LaGrange (LaGrange Health District)	☐ 10 Athens (Northeast Health District)

At the bottom of the form complete the following:

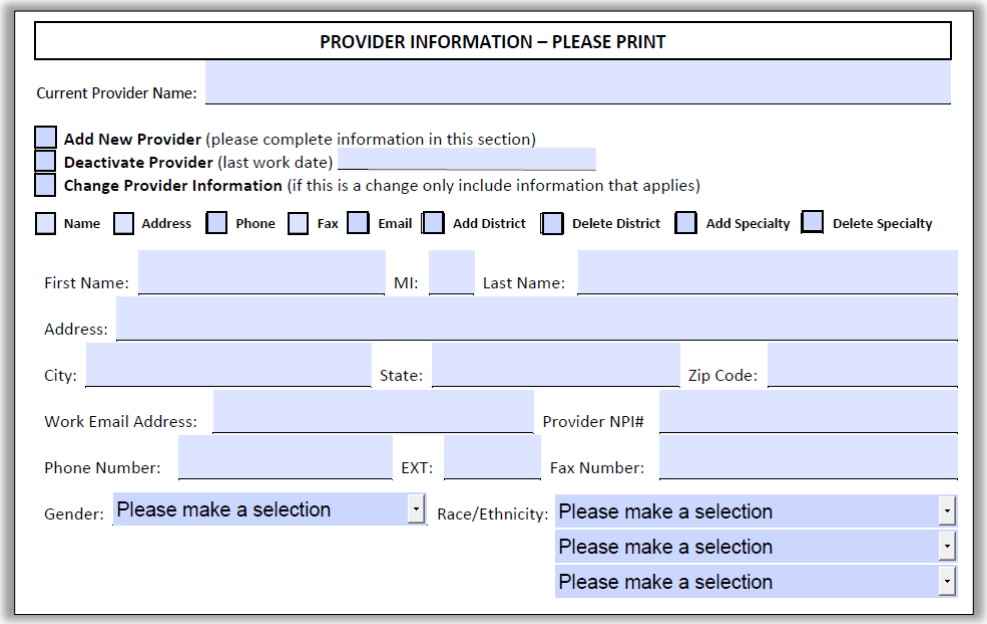
- Provider Signature - the signature of the Agency/Business owner
- Date

4.2.6.3 Owner Enrolling as Provider and/or Coordinator

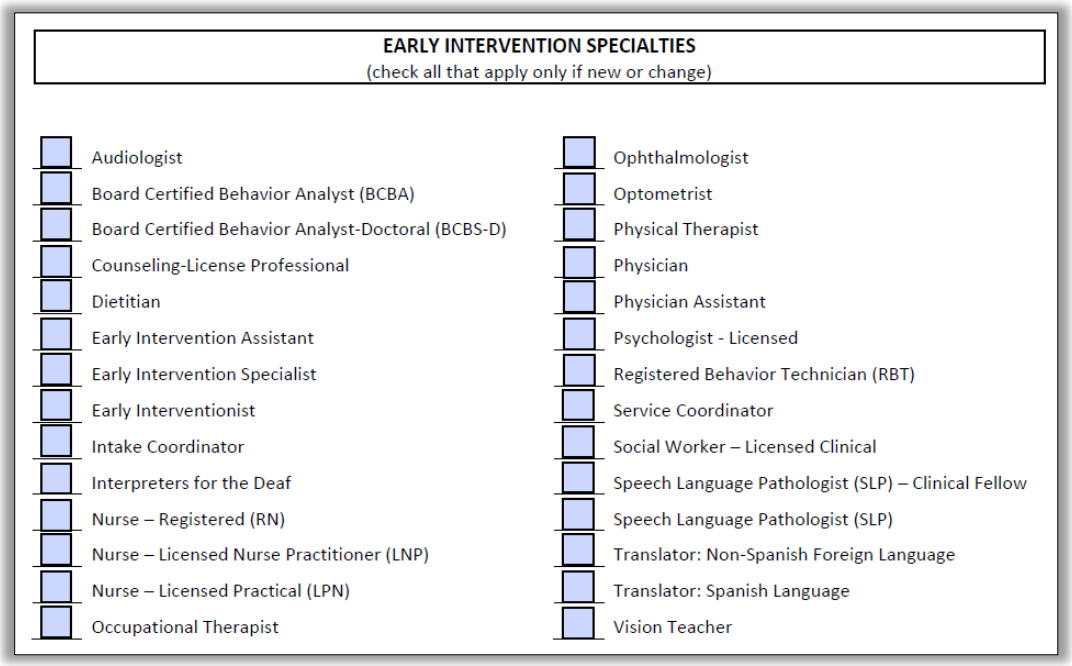
If the owner is enrolling as a provider and/or coordinator with the new business the following additional sections will need to be completed.

In the Provider Information section

- Add New Provider – click the checkbox to select
- Enter the owner's information into the fillable fields
  - Gender - **s**elect from the drop-down list
  - Race/Ethnicity - **s**elect from the drop-down list(s)



In the **Early Intervention Specialties section**, add the applicable specialties by clicking on the checkbox for that specialty



In the In-**Network Private Insurance Information section**, enter the information of any private insurance carriers listed where the owner is an In-Network Provider.

IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/COM Information section,** enter Medicaid or CMO information where the owner is an enrolled provider.

MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

At the bottom of the form complete the following:

- Provider Signature – the name of the owner
- Date

4.2.7 BCW-BIBS.Com Online Access

A separate **BCW-BIBS.Com Online Access form** must be completed by the owner(s) and any office personnel of the new agency who will need access to the BCW-BIBS.com website.

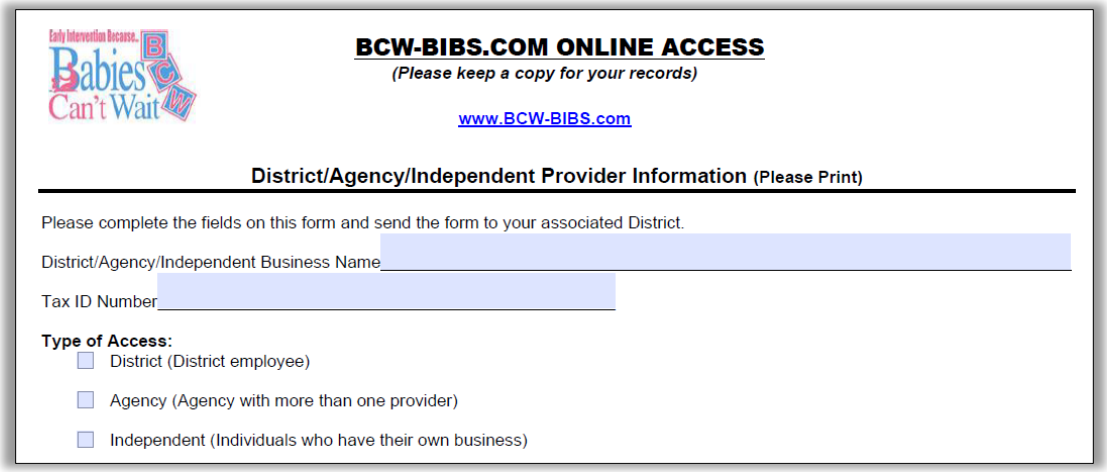
- Never share or allow someone else to use your username and password
  - If someone in the office requires access to the website that person must complete a *BCW-BIBS.Com Online Access* to receive a username and password

NOTE: It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password. This information will also be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information complete the following:

- District/Agency/Independent Business Name – the new agency name

- Tax ID Number – new agency Tax ID Number
- Type of Access - **s**elect *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

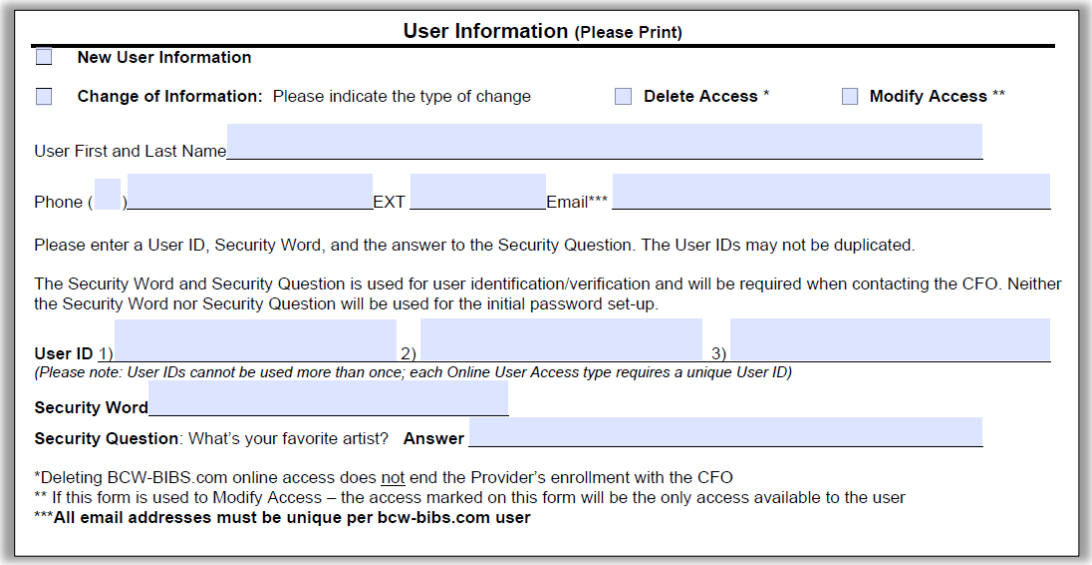
☐ District (District employee)

☐ Agency (Agency with more than one provider)

☐ Independent (Individuals who have their own business)

In the **User Information section,** complete the following:

- New User Information - click the checkbo*x* to select
- User First, Last Name, Phone, Ext, and Email of the person requesting access
- User ID – Enter 3 User IDs - cannot be the same User IDs used previously
- Security Word - a single word to identify yourself
- Security Question - **t**he answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

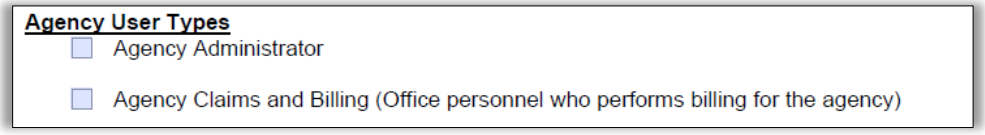
Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, click on the checkbox of the agency user type that is applicable. Only select one checkbox.



Agency User Types

☐ Agency Administrator

☐ Agency Claims and Billing (Office personnel who performs billing for the agency)

4.2.7.1 Owner Enrolling as Provider

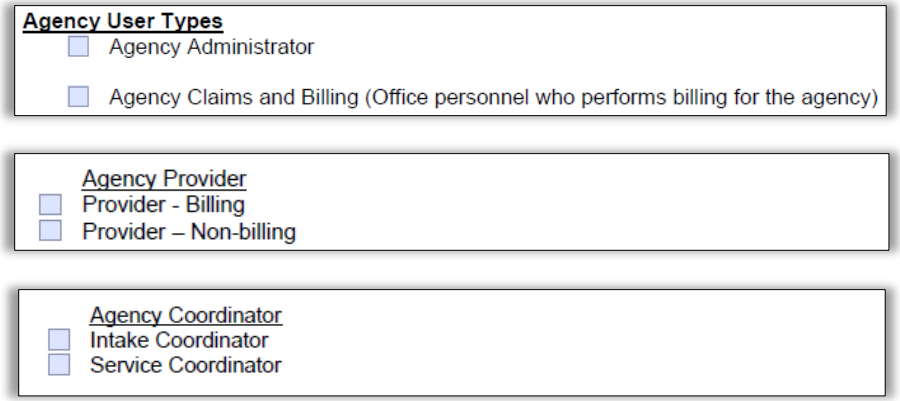
If the owner is enrolling as a provider with a specialty other than coordination in the **User Online Access Types section,** select Agency Administrator and one of the Agency Provider user types

4.2.7.2 Owner Enrolling as Coordinator

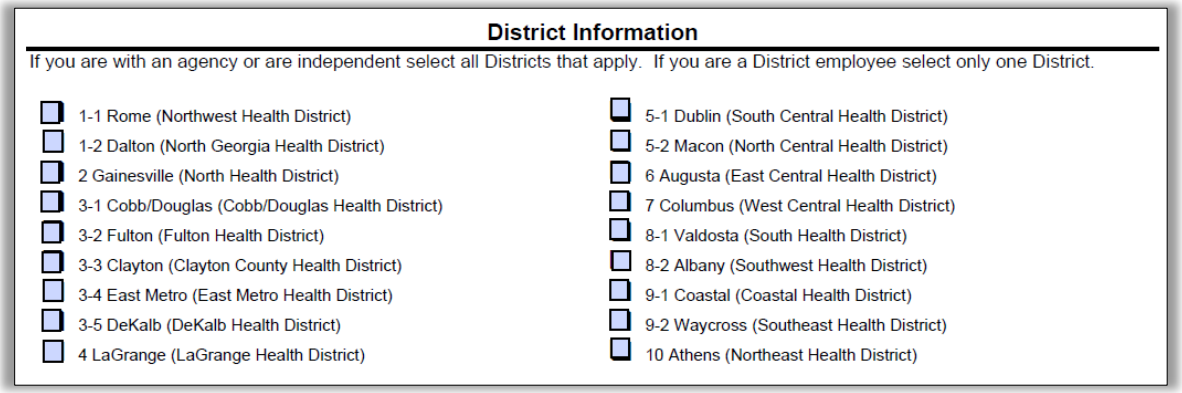
If the owner is enrolling as a coordinator and does not have another specialty complete in the **User Online Access Types section**, select Agency Administrator and one or both Agency Coordinator Types

4.2.7.3 Owner Enrolling as Provider and Coordinator

If the owner is enrolling as a provider and as a coordinator in the **User Online Access Types section**, select Agency Administrator, one of the Agency Provider User Types, and one or both Agency Coordinator User Types.

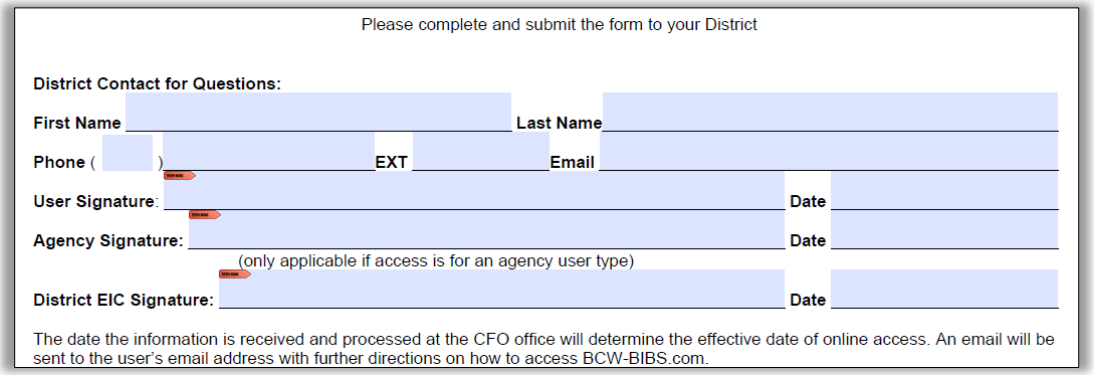


In the **District Information section**, select the checkbox(es) of the district(s) in which the Agency enrolled providers will be performing services. Only select the applicable districts, districts can be added later if necessary



At the bottom of the form complete the following:

- First Name, Last Name, Phone, EXT, and Email of the person requesting access
- User Signature - the **s**ignature of the person requesting access
- Date
- Agency Signature - the signature of the owner
- Date



4.2.8 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims Form and Electronic Signature Agreement** is required for the new agency to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

- A form must be completed for each owner and office personnel that will be entering claims on the BCW-BIBS.com website

4.2.9 Direct Deposit/EFT Authorization Form

Complete the **Direct Deposit/EFT Authorization form** for payments to be electronically transmitted into the agency's account. All funds must be designated to one account.

- A voided check or canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

4.2.10 W-9 Request for Taxpayer Identification Number and Certification Form

A **W-9 form** must be completed for the new agency to receive a 1099 form, all fields on the form are required.

4.2.11 Add A New Owner or Agency Office Personnel

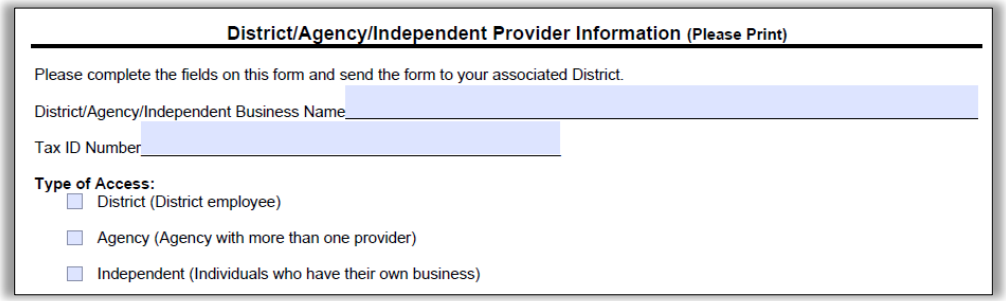
To add a new owner or Agency Office Personnel each person must complete the following forms:

- **BCW-BIBS.COM Online Access**
- **Certification for Online Claims and Electronic Signature Agreement**

4.2.11.1 BCW-BIBS.COM Online Access

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name – enter the new agency name
- Tax ID Number – enter the agency's new tax ID number
- Type of Access - click on *Agency* to select


District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name

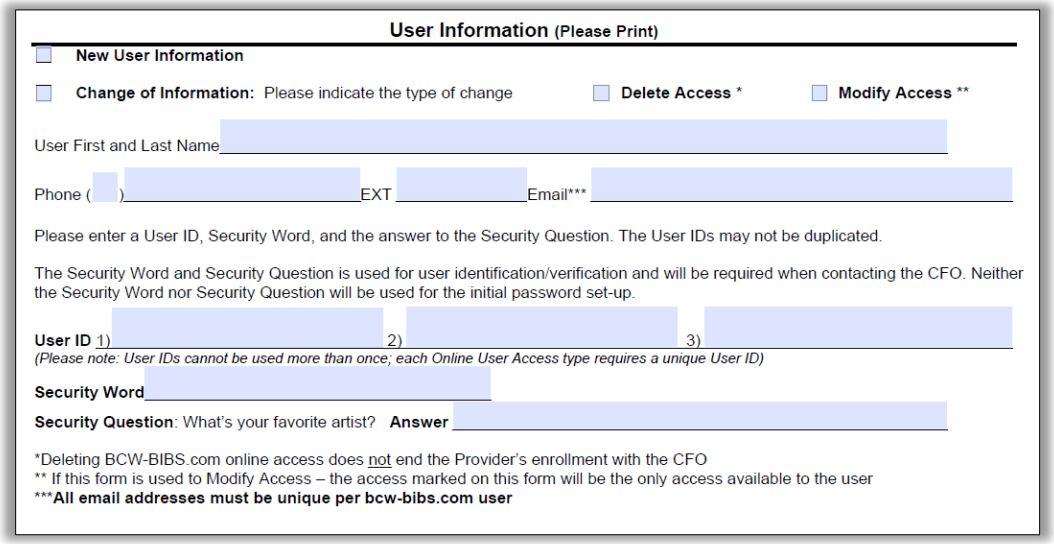
Tax ID Number

Type of Access:

- District (District employee)
- Agency (Agency with more than one provider)
- Independent (Individuals who have their own business)

In the **User Information section** complete the following information:

- New User Information - **c**lick the checkbox to select
- Enter the First Name, Last Name, Phone, Ext, and Email of the person requesting access
- User ID – Enter 3 User IDs
- Security Word - a single word to identify yourself
- Security Question - the answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

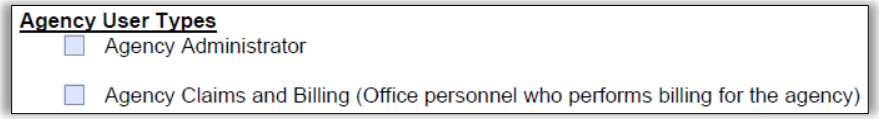
Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO
** If this form is used to Modify Access – the access marked on this form will be the only access available to the user
***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, select the applicable *Agency User Type*.

- An owner would select Agency Administrator
- Office Personnel would select Agency Claims and Billing



Agency User Types

☐ Agency Administrator

☐ Agency Claims and Billing (Office personnel who performs billing for the agency)

At the bottom of the form complete the following:

- Provider Signature - **t**he signature of the owner or the office personnel person
- Date

4.2.11.1.1 Owner Enrolling as Provider

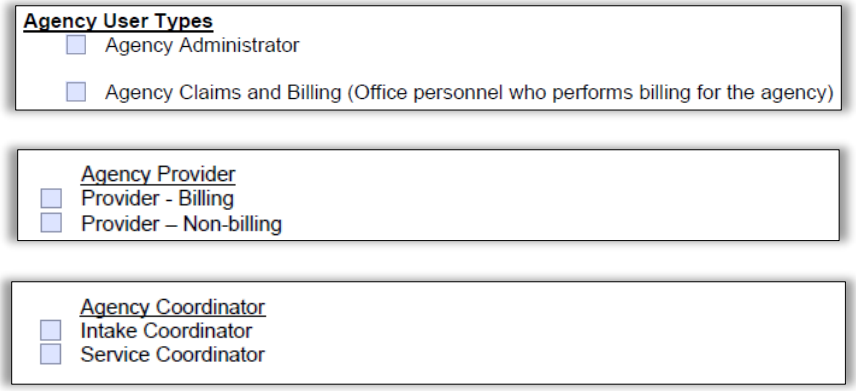
If the owner is enrolling as a provider with a specialty other than coordination, in the **User Online Access Types section** select Agency Administrator and one of the Agency Provider user types.

4.2.11.1.2 Owner Enrolling as Coordinator

If the owner is enrolling as a coordinator and does not have another specialty, in the **User Online Access Types section** select Agency Administrator and one or both Agency Coordinator types.

4.2.11.1.3 Owner Enrolling as Provider and as Coordinator

If the owner is enrolling as a provider and a coordinator, in the **User Online Access Types section** select Agency Administrator, an Agency Provider user type, and one or both Agency Coordinator user types.



Agency User Types

☐ Agency Administrator

☐ Agency Claims and Billing (Office personnel who performs billing for the agency)

Agency Provider

☐ Provider - Billing

☐ Provider – Non-billing

Agency Coordinator

☐ Intake Coordinator

☐ Service Coordinator

At the bottom of the form complete the following:

- Provider Signature – the signature of the owner

- Date

4.2.11.2 Certification For Online Claims and Electronic Signature Agreement

The **Certification for Online Claims and Electronic Signature Agreement** is required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

4.2.12 Remove Owner Or Agency Office Personnel

When the owner or office personnel leaves the agency the person(s) access must be ended by completing a **BCW-BIBS.COM Online Access**.

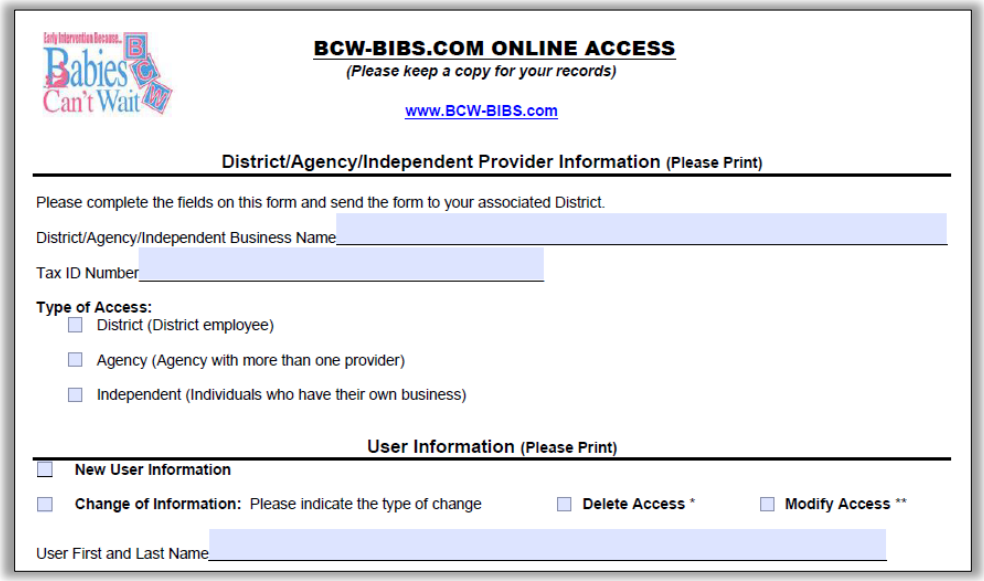
- If both owner and office personnel is leaving the agency each person will have to complete the form

In the **District/Agency/Independent Provider Information section,** complete the following:

- Agency Business Name
- Agency Tax ID number
- Type of Access - click the Agency checkbox to select

In the **User Information section,** complete the following:

- Change of Information - Click on the checkbox to select
- Delete Access - Click on the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name

Tax ID Number

Type of Access:

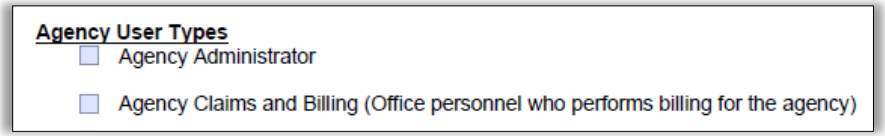
- District (District employee)
- Agency (Agency with more than one provider)
- Independent (Individuals who have their own business)

User Information (Please Print)

- **New User Information**
- **Change of Information:** Please indicate the type of change — **Delete Access** * — **Modify Access** **

User First and Last Name

In the **User Online Access Types section,** select the current user type of the person.



Agency User Types

- Agency Administrator
- Agency Claims and Billing (Office personnel who performs billing for the agency)

At the bottom of the form complete the following:

- Provider Signature - The signature of the agency owner
- Date

4.2.12.1 Remove An Owners Specialty(ties)

If the owner will no longer be performing services as a provider or Intake/Service Coordinator the following form(s) must be completed:

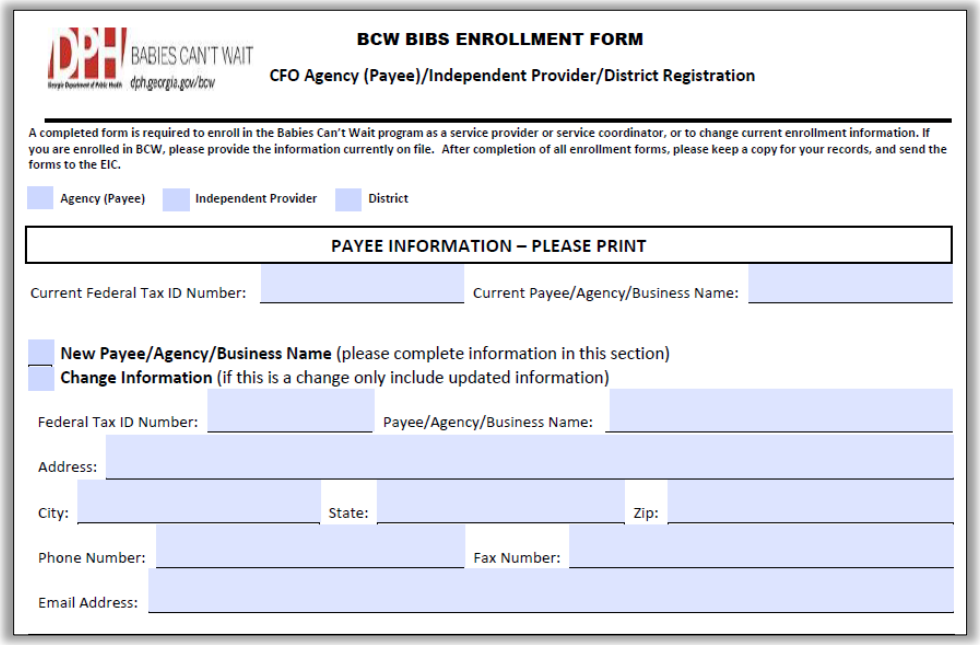
- **BCW BIBS Enrollment Form**
- **BCW-BIBS.COM Online Access**

4.2.12.1.1 BCW BIBS Enrollment Form

Click the Agency (Payee) checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information - click the checkbox to select



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

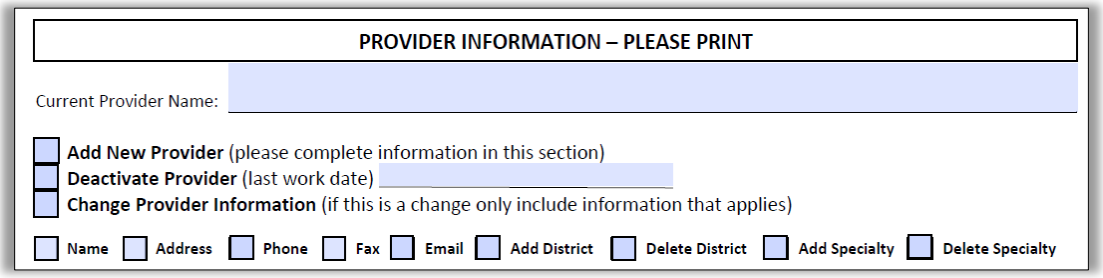
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **Provider Information section**, complete the following:

- Current Provider Name – enter the owner's name
- Change Provider Information – click the checkbox to select
- Delete Specialty – click the checkbox to select



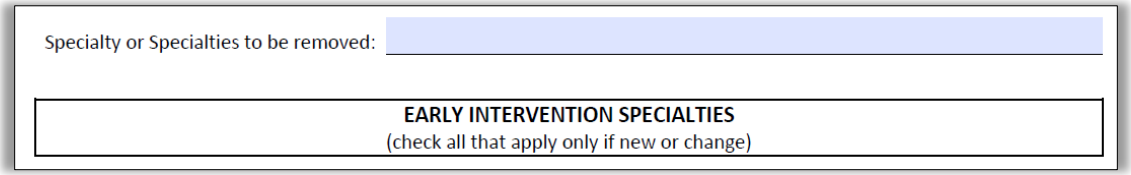
PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name: _____

☐ **Add New Provider** (please complete information in this section)
☐ **Deactivate Provider** (last work date) _____
☐ **Change Provider Information** (if this is a change only include information that applies)

☐ Name ☐ Address ☐ Phone ☐ Fax ☐ Email ☐ Add District ☐ Delete District ☐ Add Specialty ☐ Delete Specialty

In the **Specialty or Specialties to be removed text field** enter the specialty(ties) to be removed. Please enter a comma between each specialty entered.



Specialty or Specialties to be removed: _____

EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

At the bottom of the form complete the following:

- Provider Signature - The signature of the owner
- Date

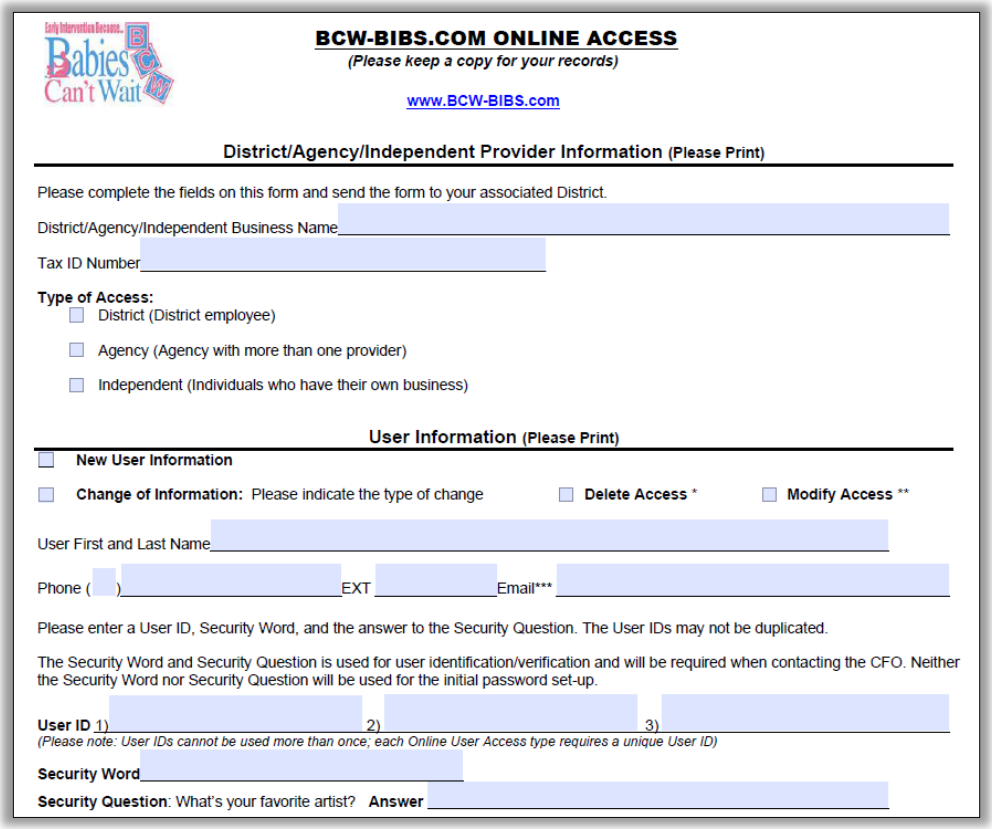
4.2.12.1.2 BCW-BIBS.COM Online Access

In the **District/Agency/Independent Provider Information section,** complete the following:

- Agency Business Name
- Agency Tax ID number
- Type of Access - click the *Agency* checkbox to select

In the **User Information section,** complete the following:

- Change of Information - Click on the checkbox to select
- Delete Access - Click on the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

- ☐ **New User Information**
- ☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

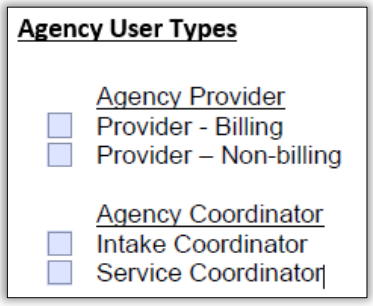
User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Online Access Types section,** click the checkboxes of all applicable user types that should be ended.



Agency User Types

Agency Provider
- ☐ Provider - Billing
- ☐ Provider – Non-billing

Agency Coordinator
- ☐ Intake Coordinator
- ☐ Service Coordinator

At the bottom of the form complete the following:

- Provider Signature - The signature of the owner
- Date

4.2.12.2 Removing Owner Who is A Provider and/or Intake/Service Coordinator

To remove an owner who is a provider and/or Intake/Service Coordinator the following forms must be completed:

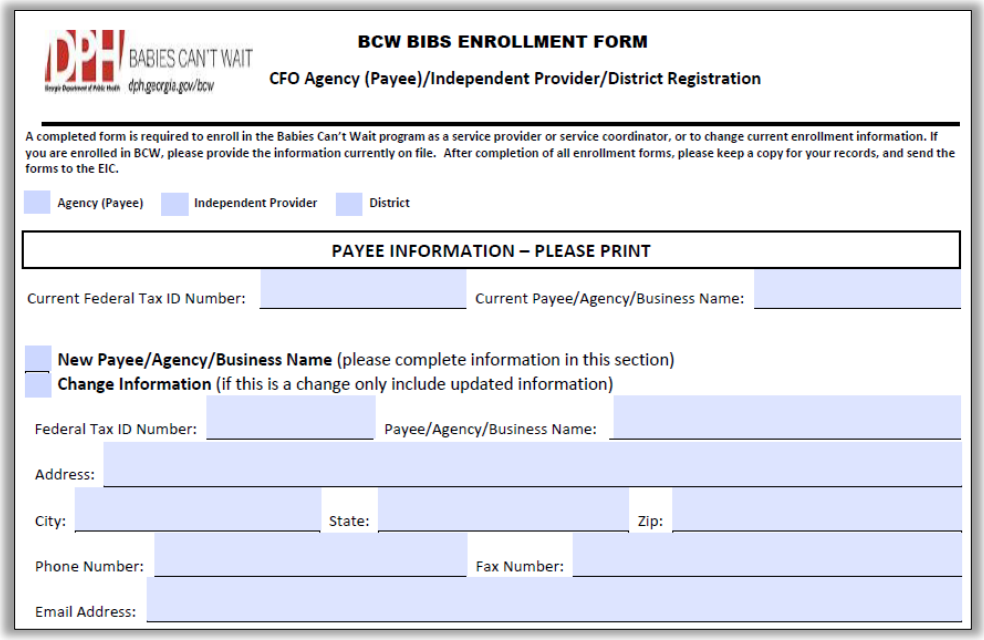
- **BCW BIBS Enrollment Form**
- **BCW-BIBS.COM Online Access**

4.2.12.2.1 BCW BIBS Enrollment Form

Select the **Agency (Payee) checkbox** at the top of the form

In the **Payee Information section** complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information – click on the checkbox to select



DPH BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

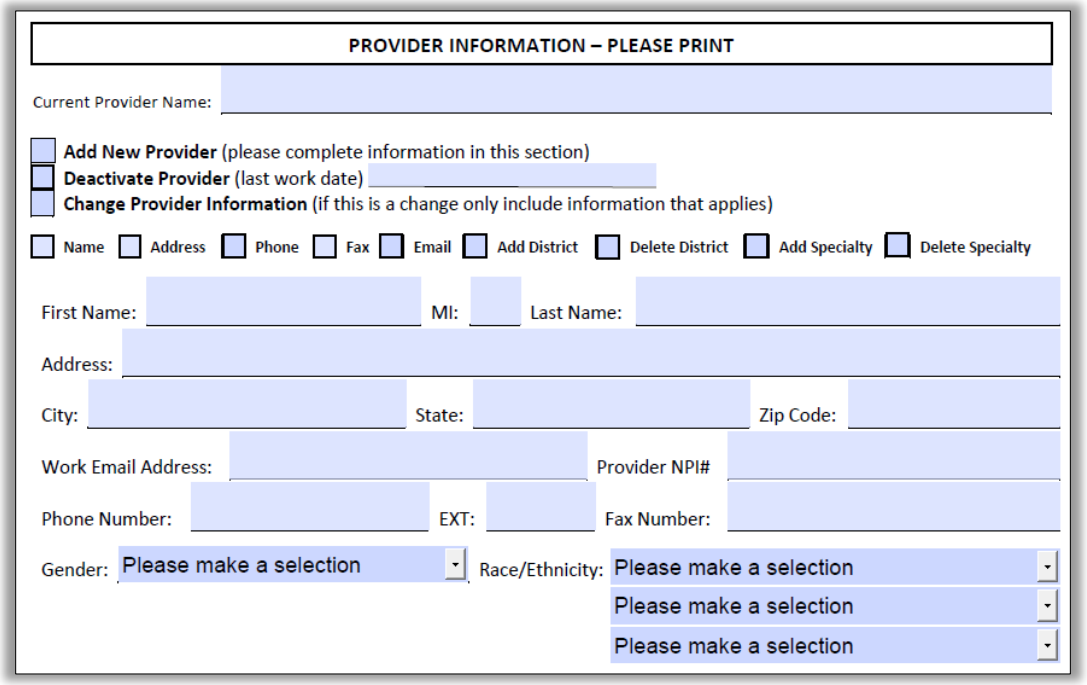
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **Provider Information section**, complete the following:

- Current Provider Name – enter the owner's name
- Deactivate Provider – click in the checkbox to select
- (last work date) – enter the date



At the bottom of the form complete the following:

- Provider signature – the signature of the owner
- Date

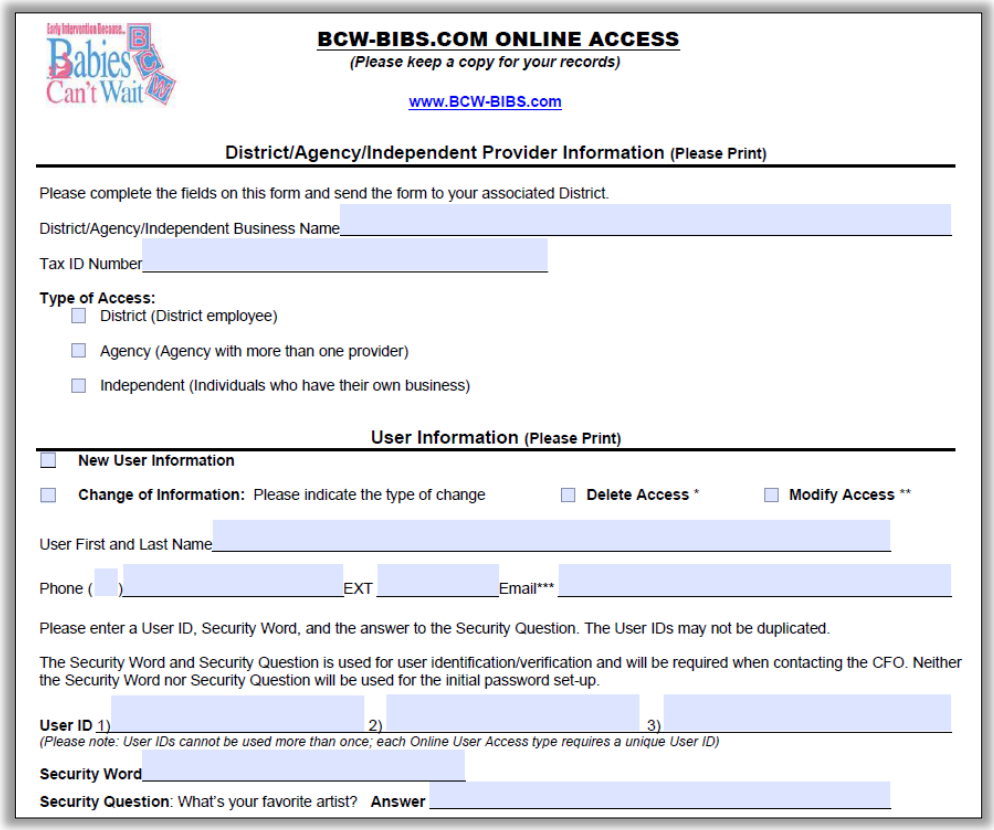
4.2.12.2.2 BCW-BIBS.COM Online Access

In the **District/Agency/Independent Provider Information section,** complete the following:

- Agency Business Name
- Agency Tax ID number
- Type of Access - click the *Agency* checkbox to select

In the **User Information section,** complete the following:

- Change of Information - Click on the checkbox to select
- Delete Access - Click on the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

- ☐ **New User Information**
- ☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

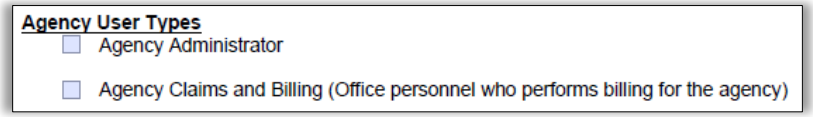
User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

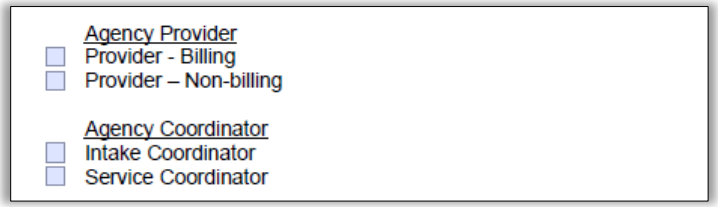
Security Question: What's your favorite artist? **Answer** _____

In the **User Online Access Types section** select Agency Administrator, the applicable agency provider user type, and the applicable agency coordinator user type(s).



Agency User Types

- ☐ Agency Administrator
- ☐ Agency Claims and Billing (Office personnel who performs billing for the agency)



Agency Provider

- ☐ Provider - Billing
- ☐ Provider – Non-billing

Agency Coordinator

- ☐ Intake Coordinator
- ☐ Service Coordinator

At the bottom of the form complete the following:

- Provider Signature - The signature of the owner
- Date

5.0 Agency Provider

5.1 New Provider (New Or Existing Agency)

To add a new provider to a new or existing Agency the following forms must be completed:

- **BCW BIBS Enrollment**
- **BCW-BIBS.COM Online Access**
- **Certification For Online Claims and Electronic Signature Agreement**
- **Agency Checklist**

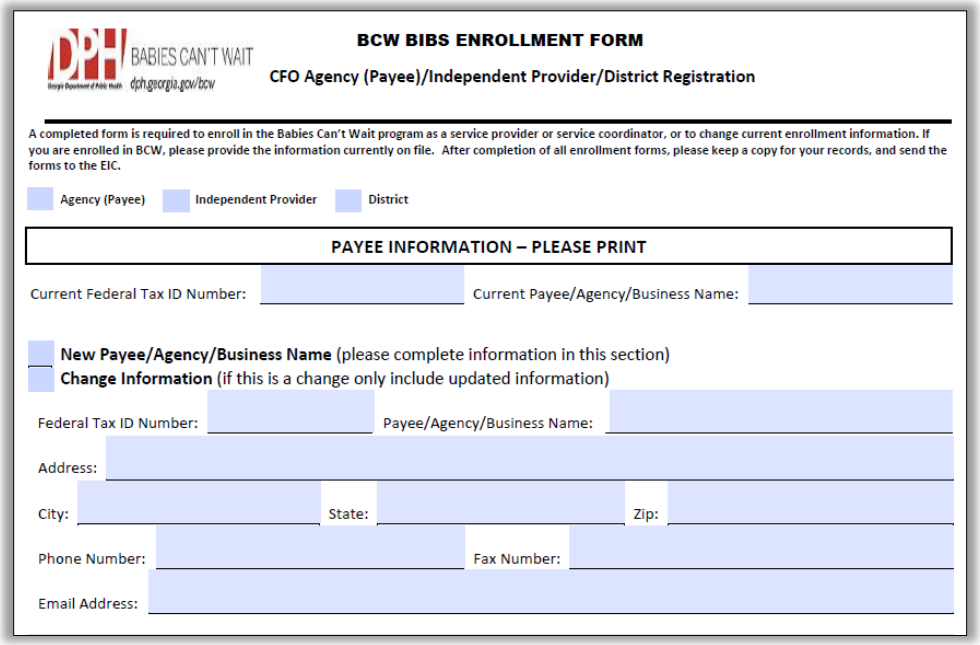
Agency Checklist			
✓	Form Name and Description	Original Signature Required?	District Approval Required?
	1. BCW BIBS Enrollment Form - *Required* - Complete this form to enroll as a contracted Agency - Complete this form to enroll as a Provider employed by an Agency	Yes	Yes
	2. BCW-BIBS.COM Online Access - *Required* - Complete this form to receive access to the BIBS system	Yes	Yes
	3. Certification for Online Claims Form and Electronic Signature Agreement- *Required* - Complete this form to perform direct data claim entry into the BIBS system and to certify authorization of your electronic signature for all actions within the BIBS system	Yes	No
	4. Direct Deposit/EFT Authorization Form – *Required (Except 3-4 East Metro)* - Complete this form to receive electronic payments instead of payments by check - A voided check will need to be submitted with the form	Yes	No
	5. W-9 Request for Taxpayer Identification Number and Certification Form – *Required (Except 3-4 East Metro)* - Complete this form to receive a 1099	Yes	No

5.1.1 BCW BIBS Enrollment

Click the **Agency (Payee) checkbox** at the top of the form

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BABIES CAN'T WAIT
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BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

City: State: Zip:

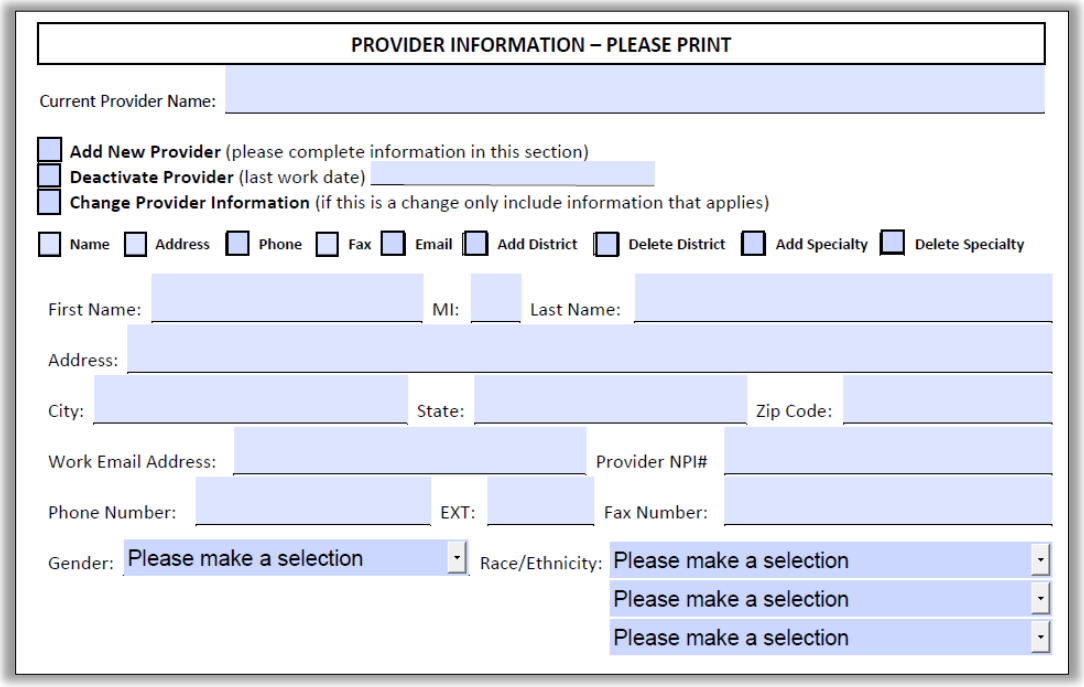
Phone Number: Fax Number:

Email Address:

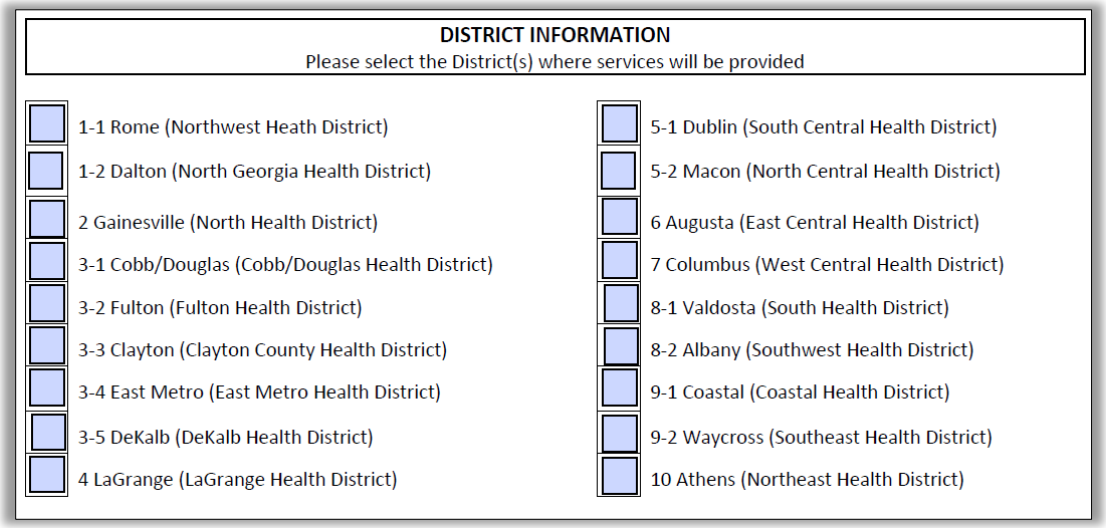
In the **Provider Information section**, complete the following:

- Add New Provider - Click in the checkbox to select

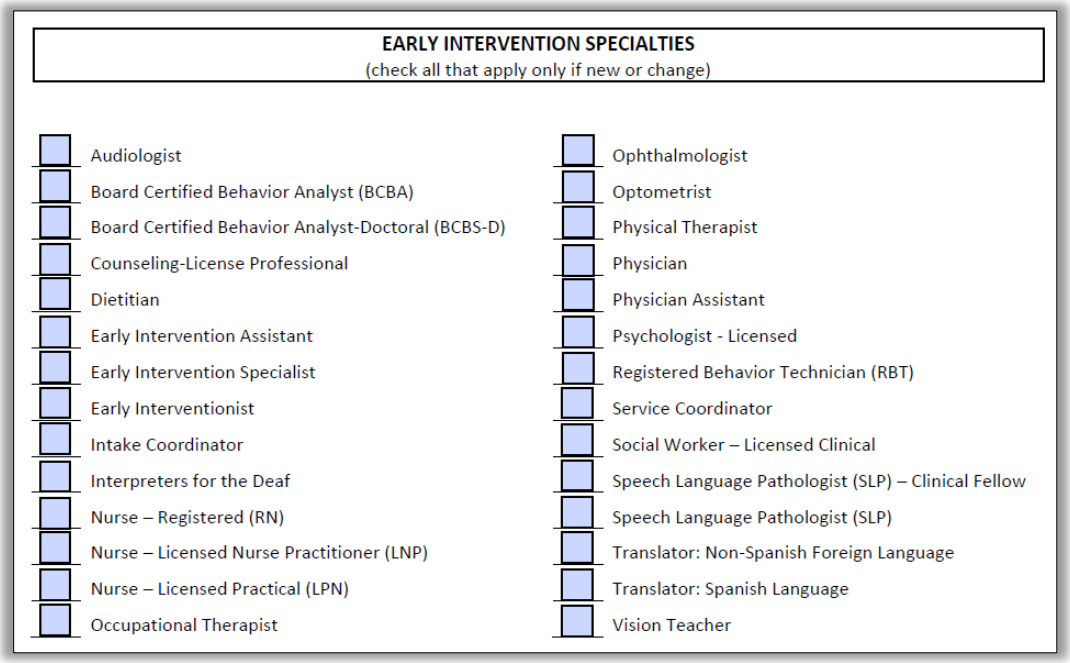
- Enter the provider's information
  - Gender - Select from the drop-down
  - Race/Ethnicity - Select from the drop-down(s)



In the **District Information section**, select the District(s) where services will be provided by the provider. Only select the applicable districts.



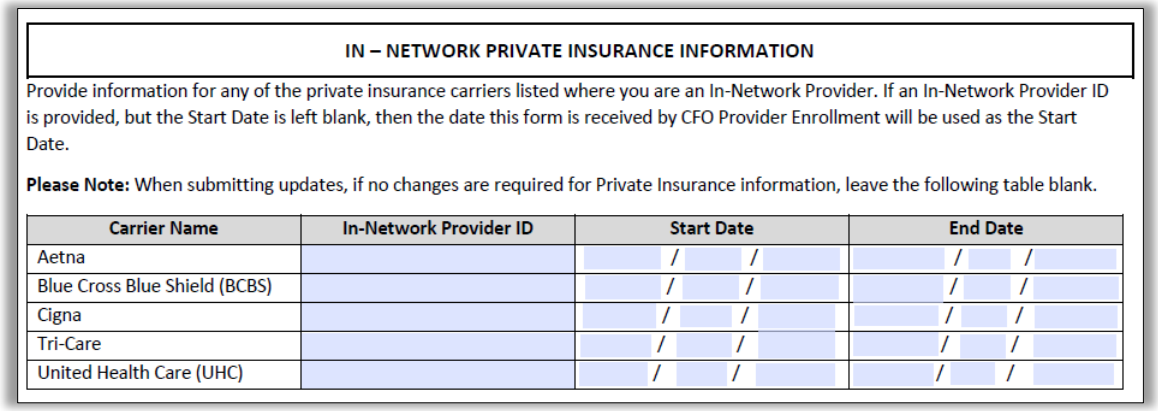
In the **Early Intervention Specialties section**, click on the checkboxes of all applicable specialties for the provider.



EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

- ☐ Audiologist
- ☐ Board Certified Behavior Analyst (BCBA)
- ☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)
- ☐ Counseling-License Professional
- ☐ Dietitian
- ☐ Early Intervention Assistant
- ☐ Early Intervention Specialist
- ☐ Early Interventionist
- ☐ Intake Coordinator
- ☐ Interpreters for the Deaf
- ☐ Nurse – Registered (RN)
- ☐ Nurse – Licensed Nurse Practitioner (LNP)
- ☐ Nurse – Licensed Practical (LPN)
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychologist - Licensed
- ☐ Registered Behavior Technician (RBT)
- ☐ Service Coordinator
- ☐ Social Worker – Licensed Clinical
- ☐ Speech Language Pathologist (SLP) – Clinical Fellow
- ☐ Speech Language Pathologist (SLP)
- ☐ Translator: Non-Spanish Foreign Language
- ☐ Translator: Spanish Language
- ☐ Vision Teacher

In the **In-Network Private Insurance Information section**, enter the information for any private insurance carriers listed where the provider is an In-Network provider.



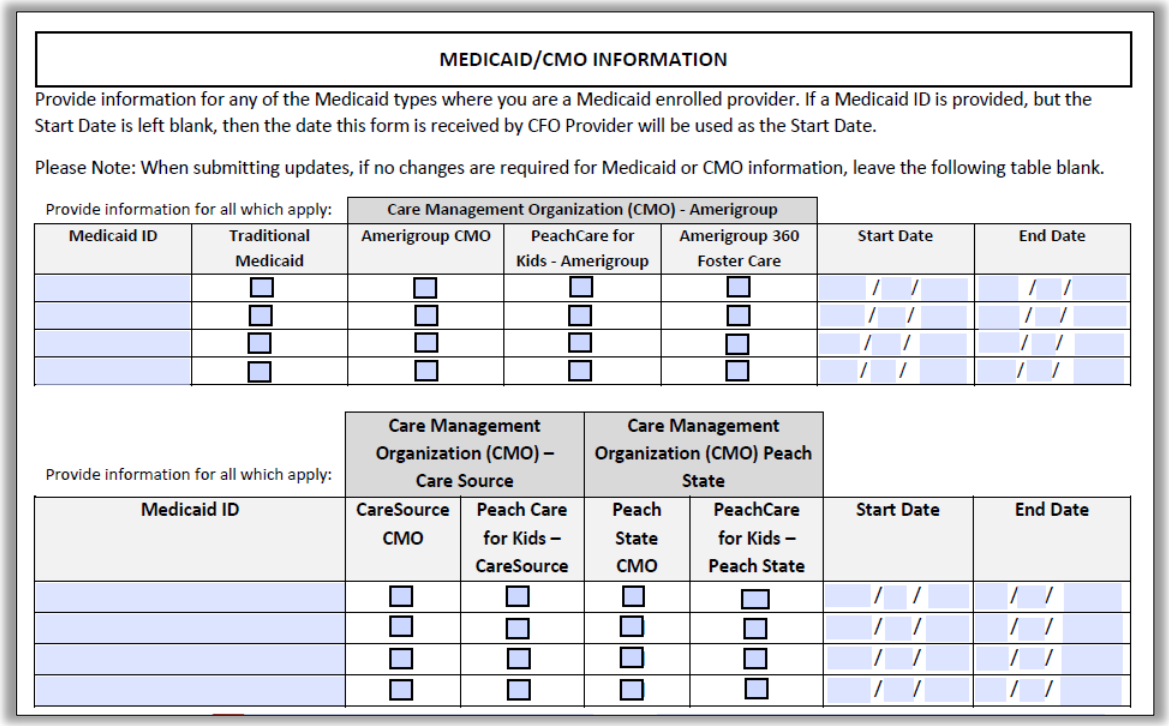
IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/CMO Information section**, enter the information for any Medicaid or CMOs the provider is enrolled with.



MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

At the bottom of the form complete the following:

- Provider Signature - The signature of the provider
- Date

5.1.2 BCW-BIBS.Com Online Access

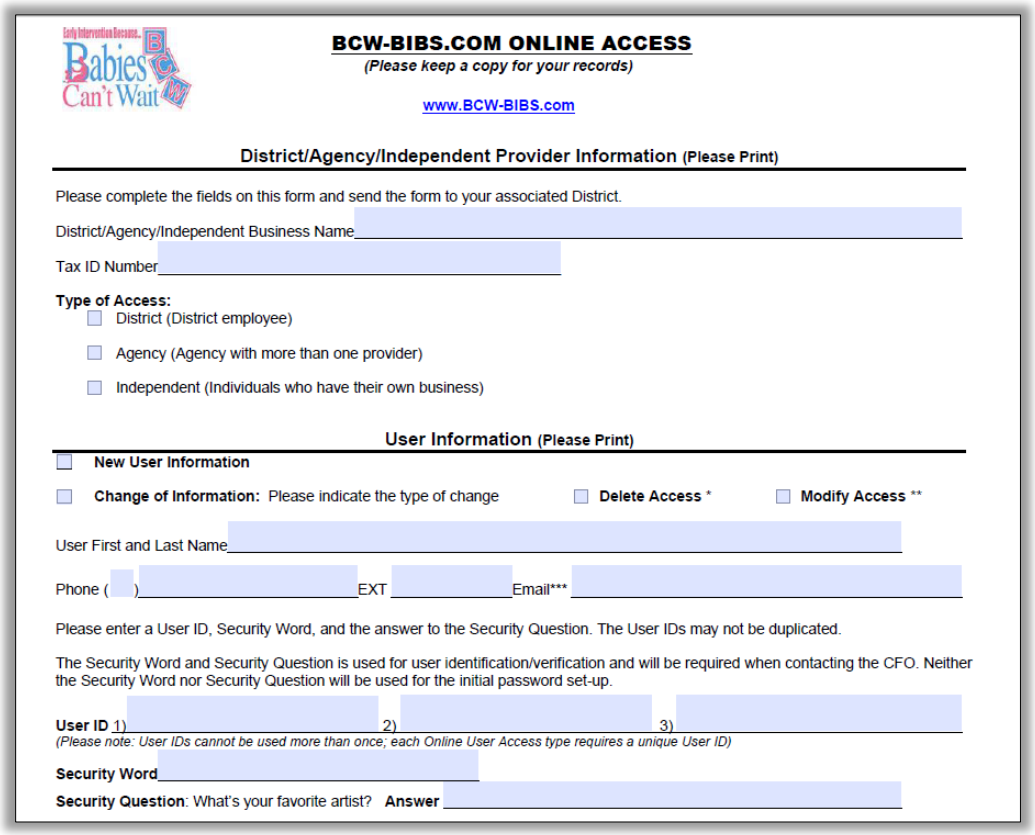
A **BCW-BIBS.Com Online Access form** must be completed by the provider to access the BCW-BIBS.com website.

- Never share or allow someone else to use your username and password

> **NOTE:** It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password and will be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone (___)_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

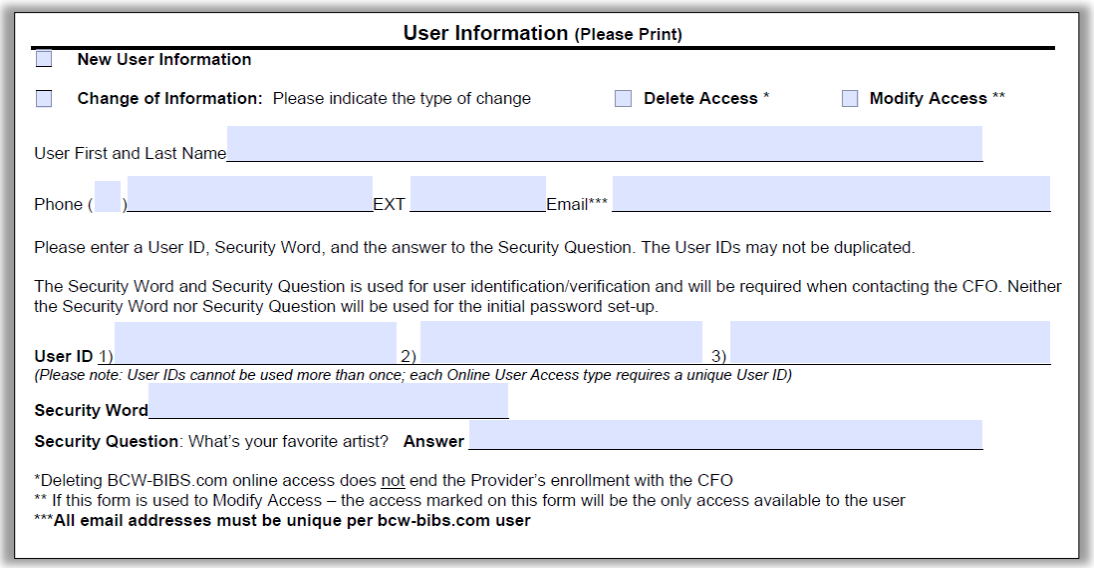
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- New User Information - click the checkbox to select
- Enter the First and Last Name, Phone, EXT, and Email of the person requesting access
- User ID – enter 3 user IDs
- Security Word - a single word to identify the provider
- Security Question - The answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone (___)_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

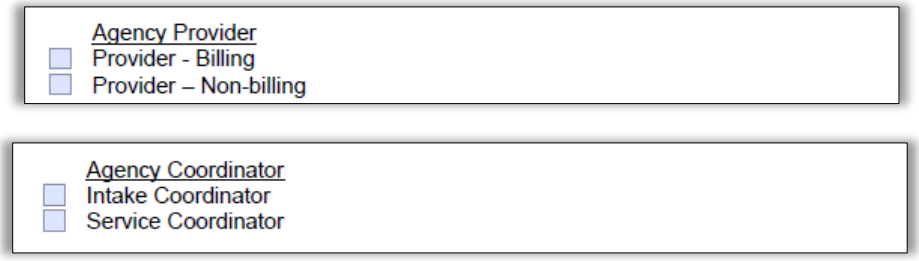
*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

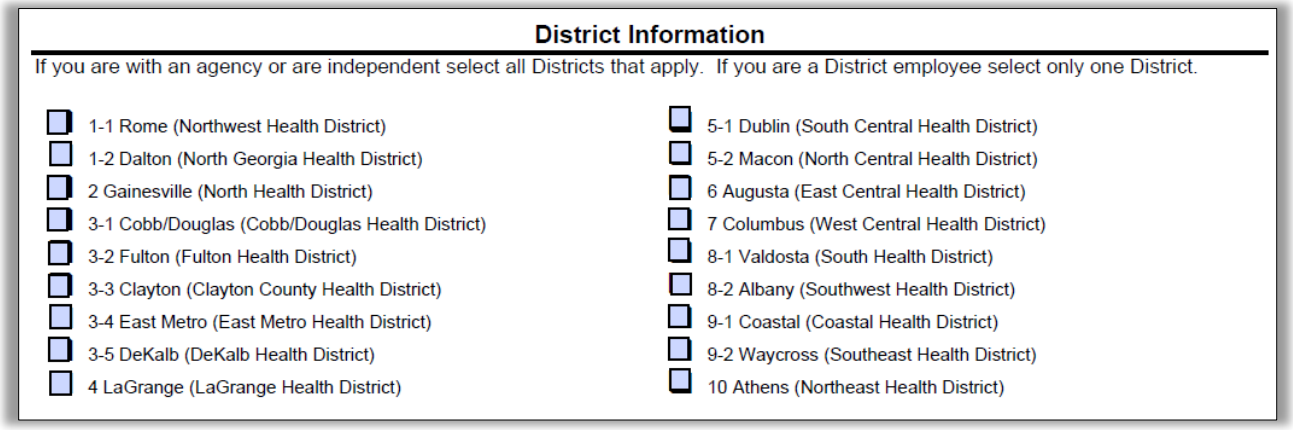
***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section,** the user access selected will depend on the provider's specialties.

- If the provider's specialty is not Intake or Service Coordination, select one of the Agency Provider user types
- If the provider is enrolling as an Intake and Service Coordinator select both Agency Coordinator user types
- If the provider is enrolling as a provider and Intake/Service Coordinator, select one of the agency provider user types and one or both agency coordinator user types depending on the specialties of the provider



In the **District Information section**, select the checkbox(es) of the district(s) in which the provider will be performing services.



At the bottom of the form complete the following:

- Enter the First Name, Last Name, Phone, EXT, and Email of the provider
- User Signature - Signature of the provider requesting access
- Date
- Agency Signature - Signature of the owner
- Date

5.1.3 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims Form and Electronic Signature Agreement** are required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

5.2 Existing Providers

5.2.1 Add Or Remove A Specialty

To add a specialty to an existing enrolled provider a **BCW BIBS Enrollment form** must be completed.

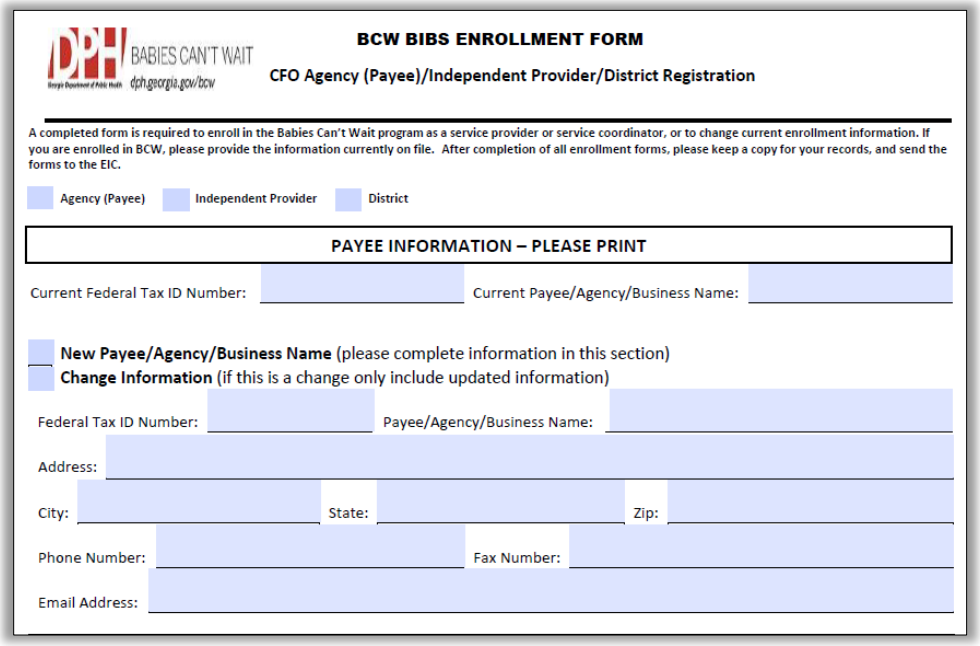
- If adding Intake and/or Service Coordination specialties to a provider, a **BCW-BIBS.Com Online Access form** will also have to be completed

5.2.1.1 BCW BIBS Enrollment Form

Click the Agency (Payee) checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

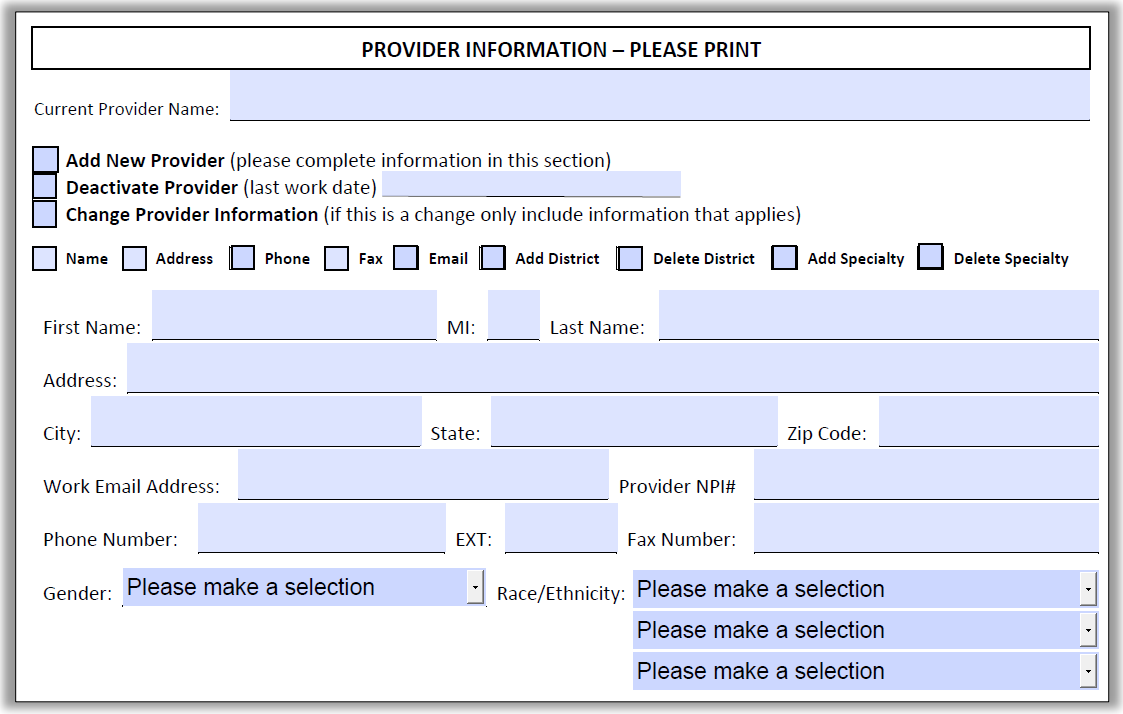
City: State: Zip:

Phone Number: Fax Number:

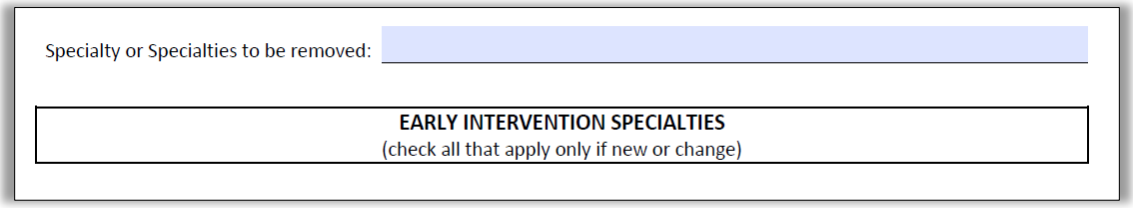
Email Address:

In the **Provider Information section**, complete the following:

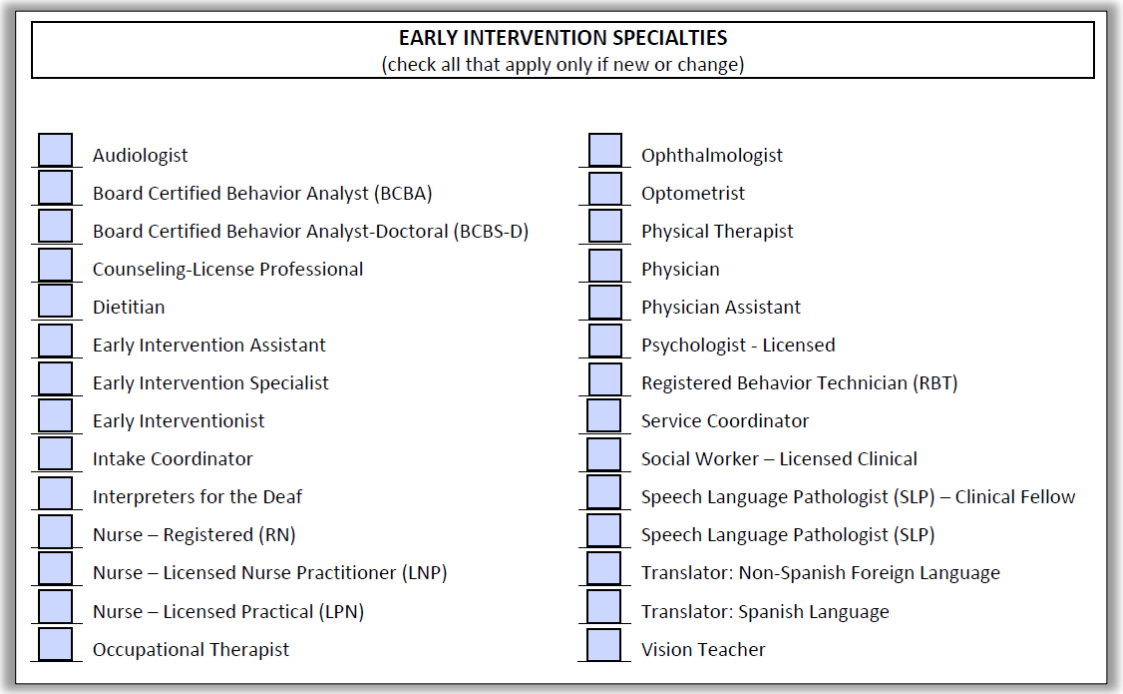
- Current Provider Name
- Change Provider Information – Click the checkbox to select
- Add Specialty – Click the checkbox to select



To remove a specialty on a provider, in the **Specialty or Specialties to be removed text field** enter the specialty/specialties to be removed. Please add a comma between the specialties.



To add a specialty to a provider, in the Early Intervention Specialties section click the checkbox (s) of the specialty(ties) being added.



At the bottom of the form complete the following:

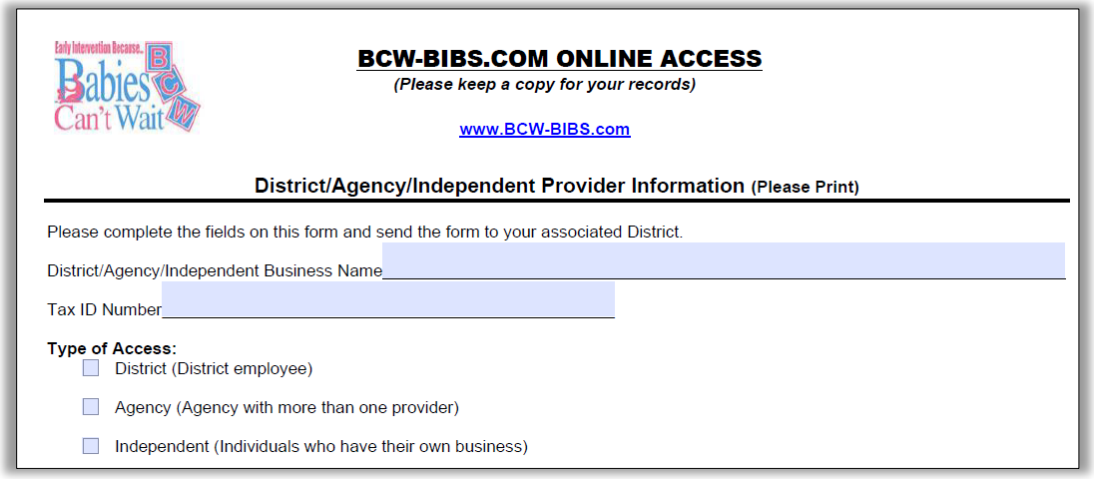
- Provider Signature – the signature of the provider
- Date

5.2.1.2 BCW-BIBS.Com Online Access

If adding the specialty of Intake and/or Service Coordinator to the existing enrolled provider a **BCW-BIBS.COM Online Access** form but be completed.

In the District/Agency/Independent Provider section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

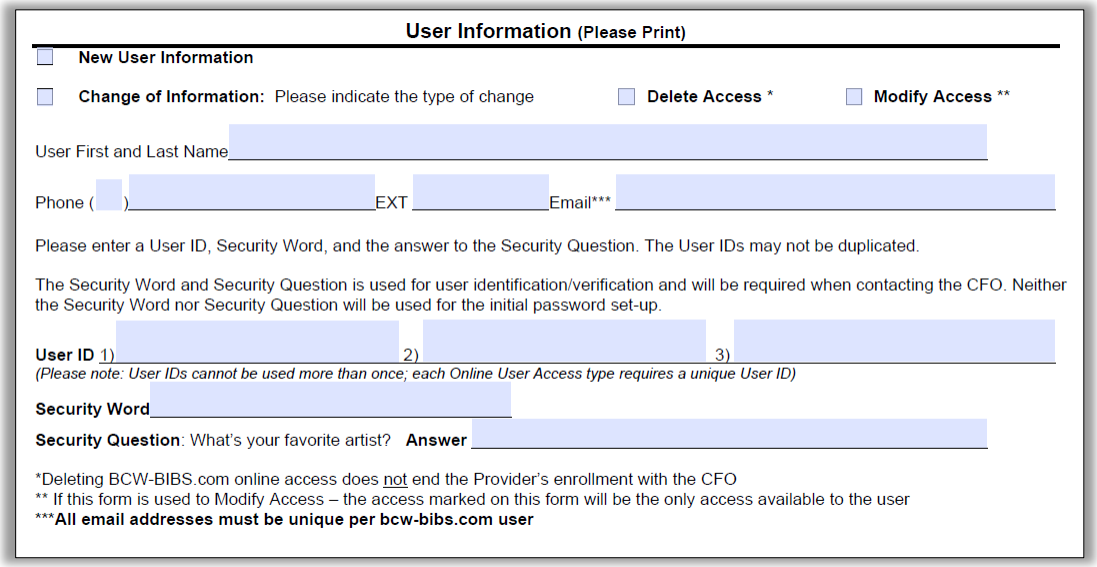
☐ District (District employee)

☐ Agency (Agency with more than one provider)

☐ Independent (Individuals who have their own business)

In the **User Information section**, complete the following:

- Change of Information - click the checkbox to select
- Modify Access **–** click the checkbox to select
- Enter the provider's First and Last Name



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

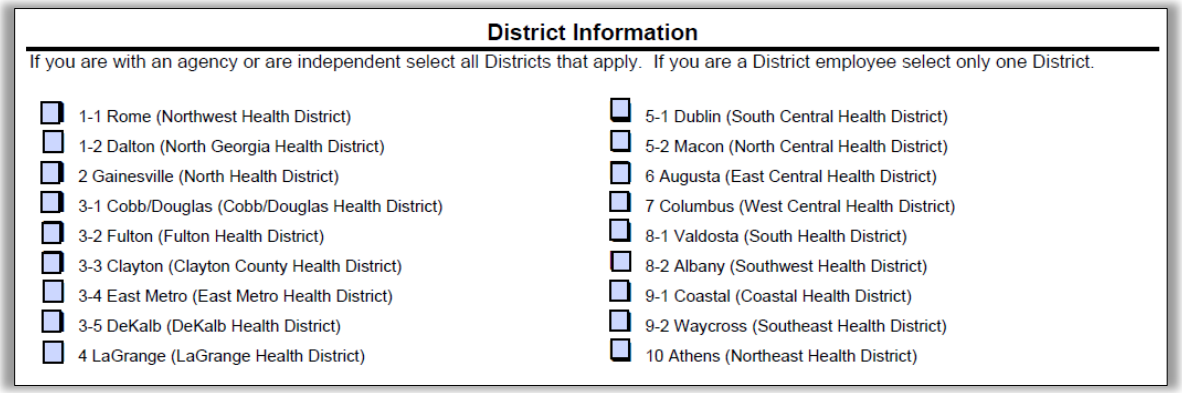
*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, select one or both Agency *Coordinator* types depending on the provider's enrolled specialties.

In the **District Information section**, select the district checkbox(es) where coordination services will be performed. Only select the applicable districts, districts can be added later if necessary.



At the bottom of the form complete the following:

- Enter the provider's First Name, Last Name, Phone, EXT, and Email
- User Signature - the **s**ignature of the provider
- Date
- Agency Signature **–** the **s**ignature of the owner
- Date

5.2.2 Provider Name, Phone Or Email Address Change

To change a provider's name or email address the following two forms must be completed:

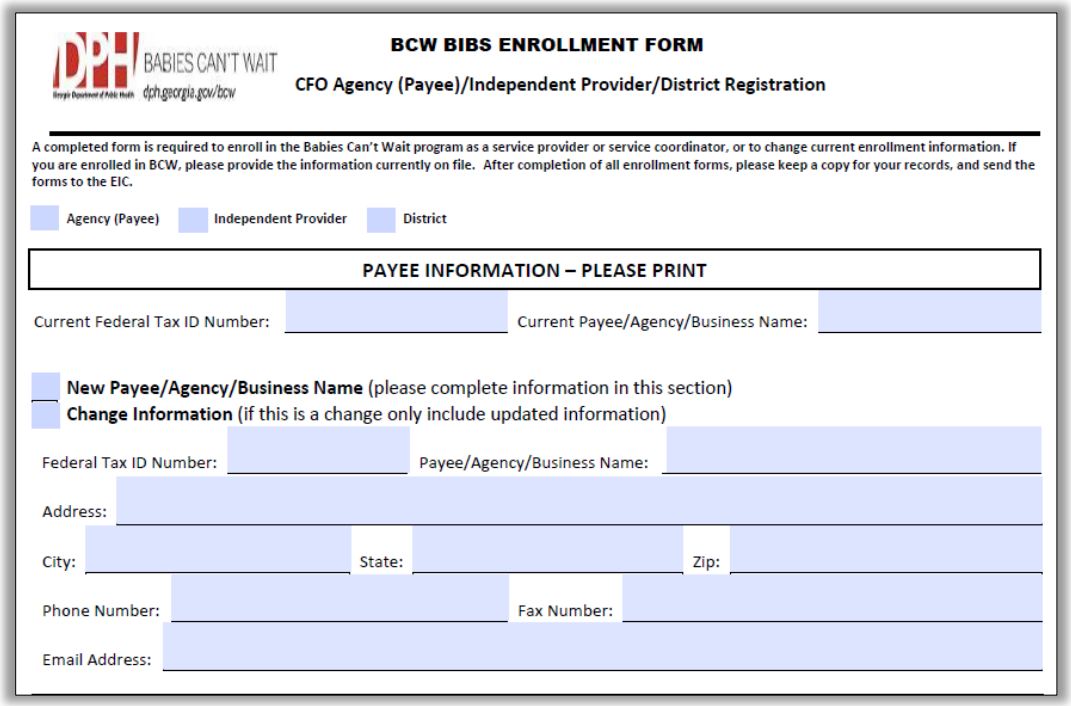
- **BCW BIBS Enrollment Form**
- **BCW-BIB.COM Online Access.**

5.2.2.1 BCW BIBS Enrollment Form

Click the Agency (Payee) checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

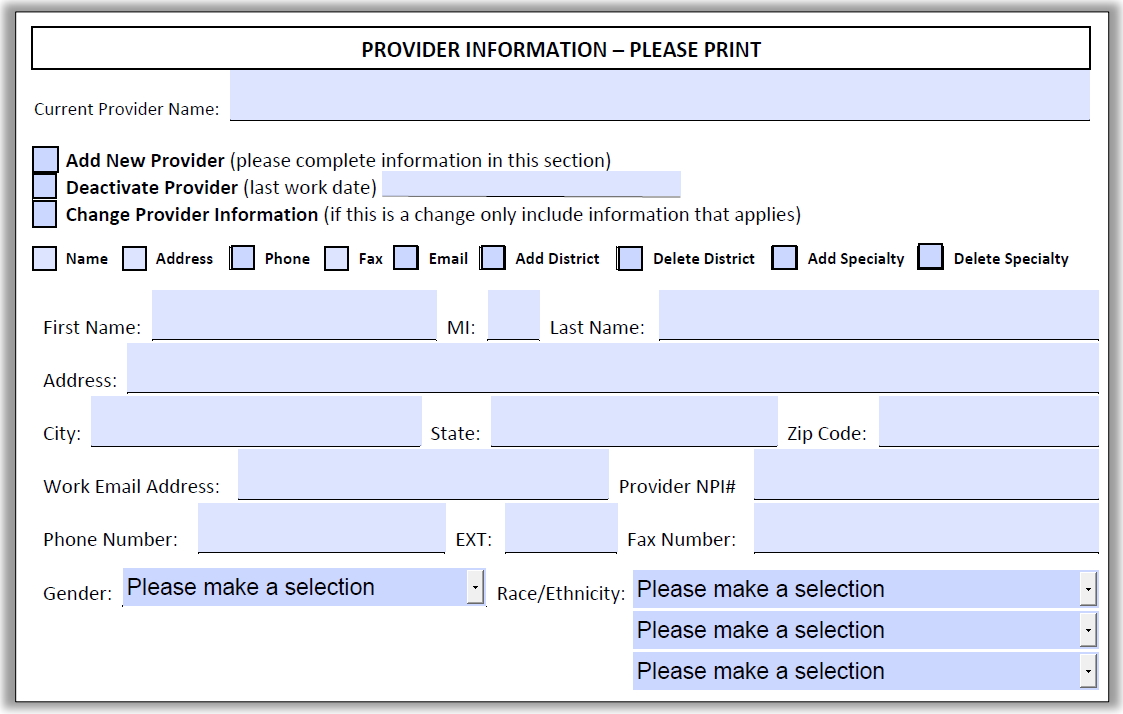
- Current Provider Name
- Change Provider Information – Click the checkbox to select

Click the applicable checkboxes below depending on the information that is changing

- Name
- Phone
- Email Address

Enter the information that changed in the applicable fields

- Name Change - enter the new name in the First Name, MI, and Last Name fields
- Phone Change - enter the new phone number in the Phone Number and EXT fields
  - Leave EXT blank if there is no extension number
- Email Change - enter the new email address in the Work Email Address field


PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

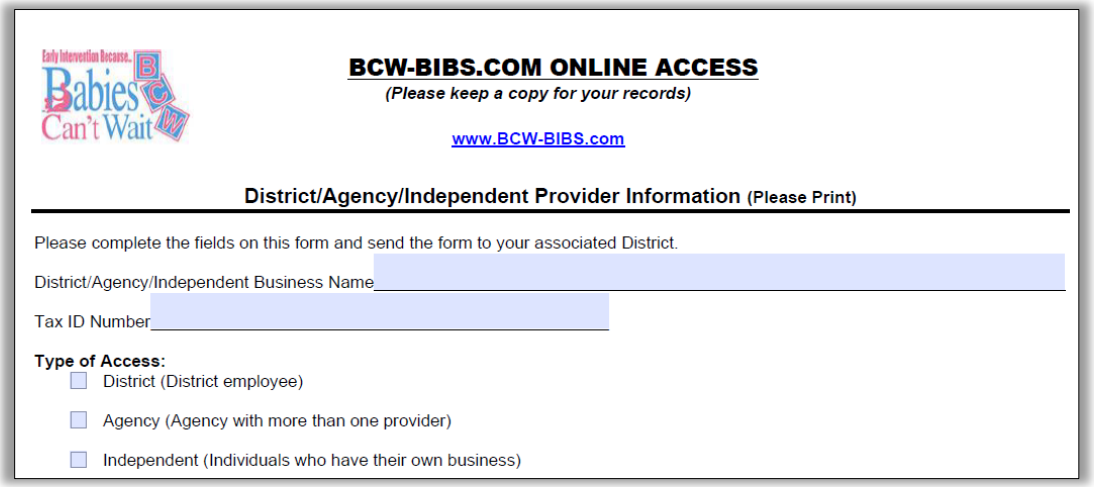
At the bottom of the form complete the following:

- Provider Signature – the signature of the provider
- Date –

5.2.2.2 BCW-BIBS.Com Online Access

In the **District/Agency/Independent Provider Information Section,** complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *Agency*


BCW-BIBS.COM ONLINE ACCESS
(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

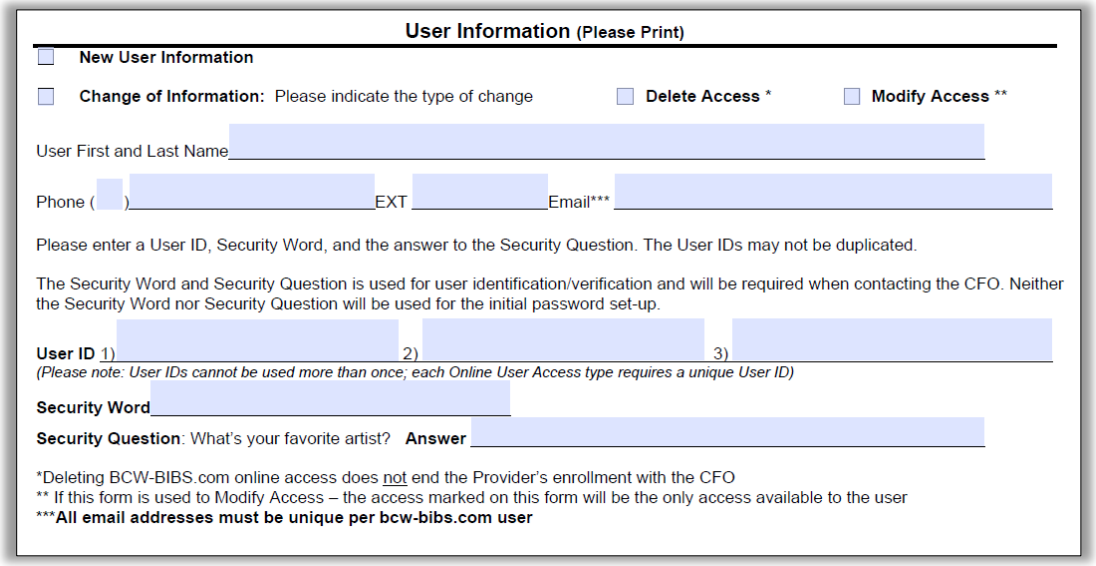
District/Agency/Independent Business Name

Tax ID Number

Type of Access:
- District (District employee)
- Agency (Agency with more than one provider)
- Independent (Individuals who have their own business)

In the **User Information section**, complete the following:

- Change of Information - click the checkbox to select
- User First and Last Name
  - If the provider's name has changed enter the current name and then the provider's new name
- Email – if the email has changed due to the name change enter the new email address



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO
** If this form is used to Modify Access – the access marked on this form will be the only access available to the user
***All email addresses must be unique per bcw-bibs.com user

At the bottom of the form complete the following:

- Enter the provider's First Name, Last Name, Phone, EXT, and Email
- User Signature – the signature of the provider
- Date
- Agency Signature – the signature of the owner
- Date

5.2.3 Provider No Longer With Agency Or Contracted With BCW

If a provider is no longer working for an agency or contracted with the BCW program the following must be completed:

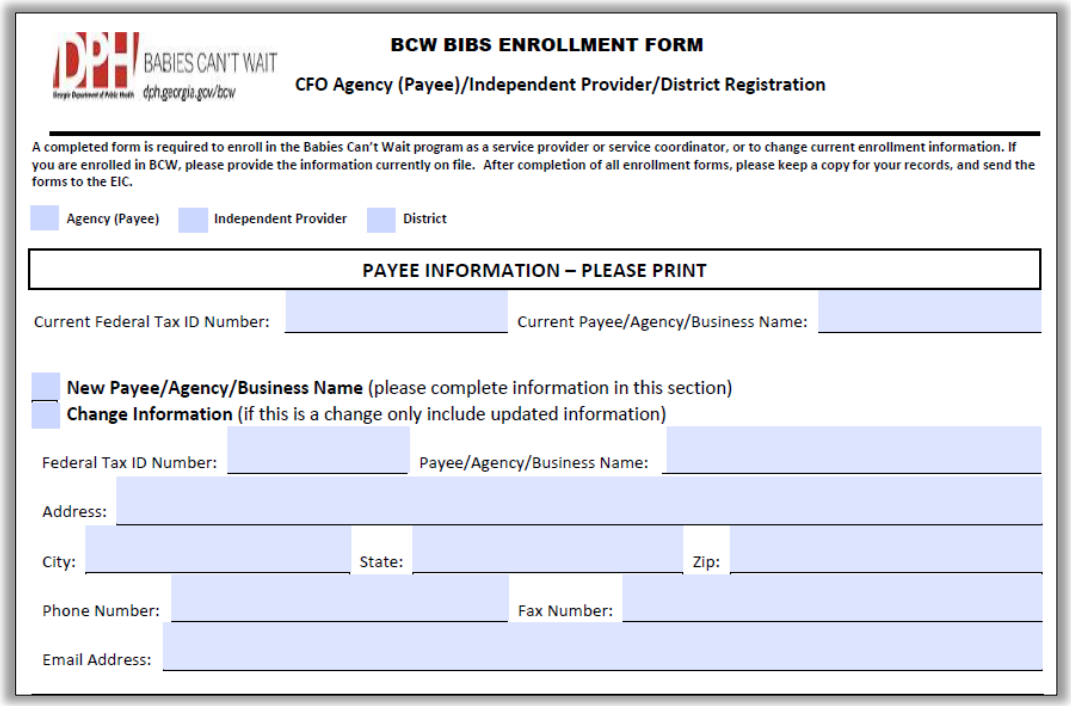
- **BCW BIBS Enrollment Form**
- **BCW-BIB.COM Online Access.**

5.2.3.1 BCW BIBS Enrollment Form

Click the Agency (Payee) checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

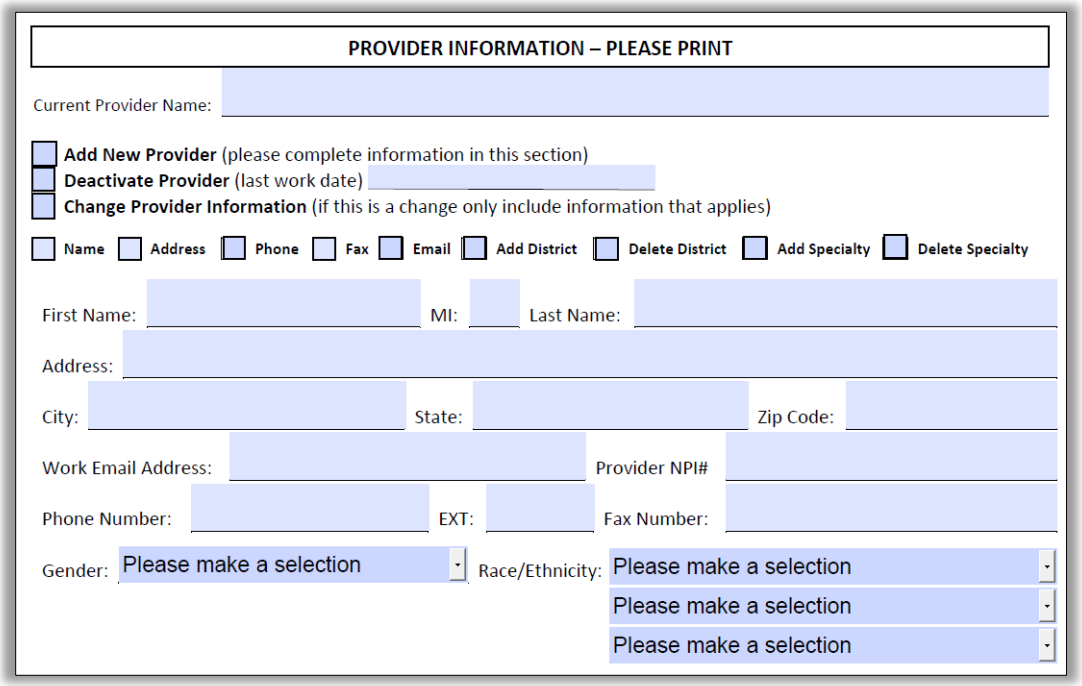
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **Provider Information section,** complete the following:

- Current Provider Name
- Deactivate Provider – click the checkbox to select
  - Enter the date the provider will no longer be with the agency or contracted with the BCW program



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name: _____

☐ **Add New Provider** (please complete information in this section)
☐ **Deactivate Provider** (last work date) _____
☐ **Change Provider Information** (if this is a change only include information that applies)

☐ Name ☐ Address ☐ Phone ☐ Fax ☐ Email ☐ Add District ☐ Delete District ☐ Add Specialty ☐ Delete Specialty

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Work Email Address: _____ Provider NPI# _____

Phone Number: _____ EXT: _____ Fax Number: _____

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

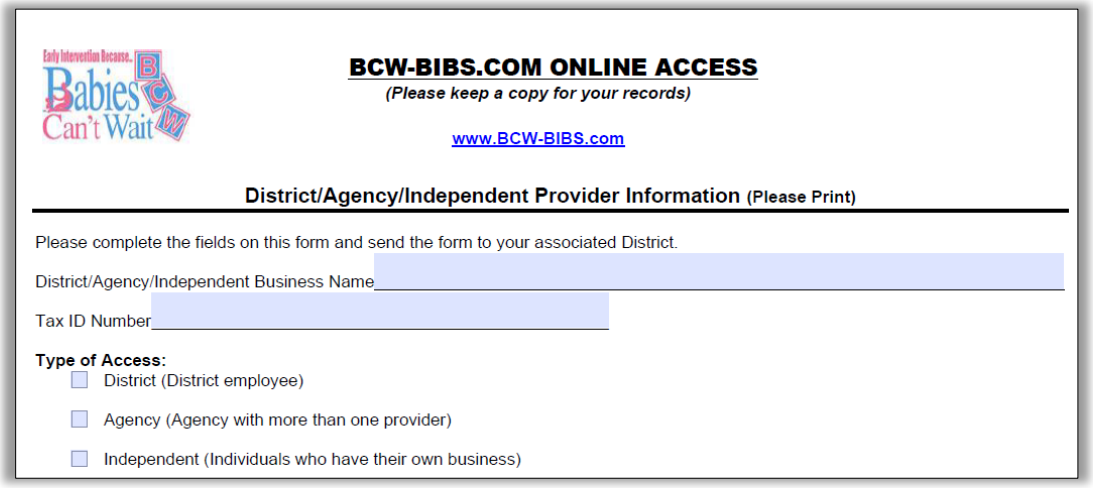
At the bottom of the form complete the following:

- Provider Signature – enter the name of the provider
- Date

5.2.3.2 BCW-BIBS.Com Online Access

In the **District/Agency/Independent Provider Information section,** complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

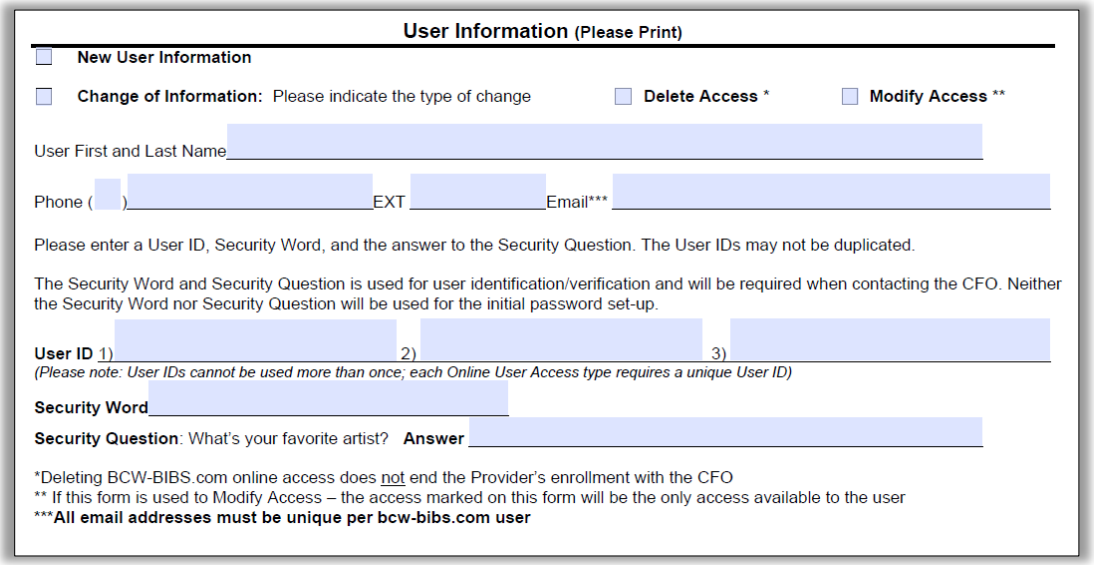
Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

In the **User Information section**, complete the following:

- Change of Information - click the checkbox to select
- Delete Access **–** click the checkbox to select
- User First and Last Name – enter the name of the user whose access is being deleted



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

At the bottom of the form complete the following:

- Enter the provider's First Name and Last Name
- Agency Signature – the signature of the owner
- Date

5.2.4 Adding A District(s) To A Provider

If the agency is already enrolled in the District(s), and the provider is not a Service or Intake Coordinator, no action needs to be taken. A provider's district(s) is based on the districts associated with the agency.

- If the agency is not enrolled in the District(s), a **BCW BIBS Enrollment form** must be completed to add the districts to the agency

> **NOTE:** If the provider is a Service or Intake Coordinator, a **BCW-BIBS.COM Online Access form** must be completed adding the new district(s).

5.2.5 Removing A District From A Provider

An agency provider cannot be removed from a district(s) if the agency is enrolled with that district(s). A **BCW BIBS Enrollment** form must be completed to remove the district(s) from the agency.

If the agency provider is an Intake or Service Coordinator the districts must be removed from their BIBS user access by completing a **BCW-BIBS.Com Online Access form**.

- In the District Information section, click on the checkbox(es) of the district(s) being removed
  - Write Remove to the right of the district name

5.2.6 Agency Tax ID Number Change

5.2.6.1 Tax ID Number Change Only

If the agency has a new Tax ID number, the following forms must be completed:

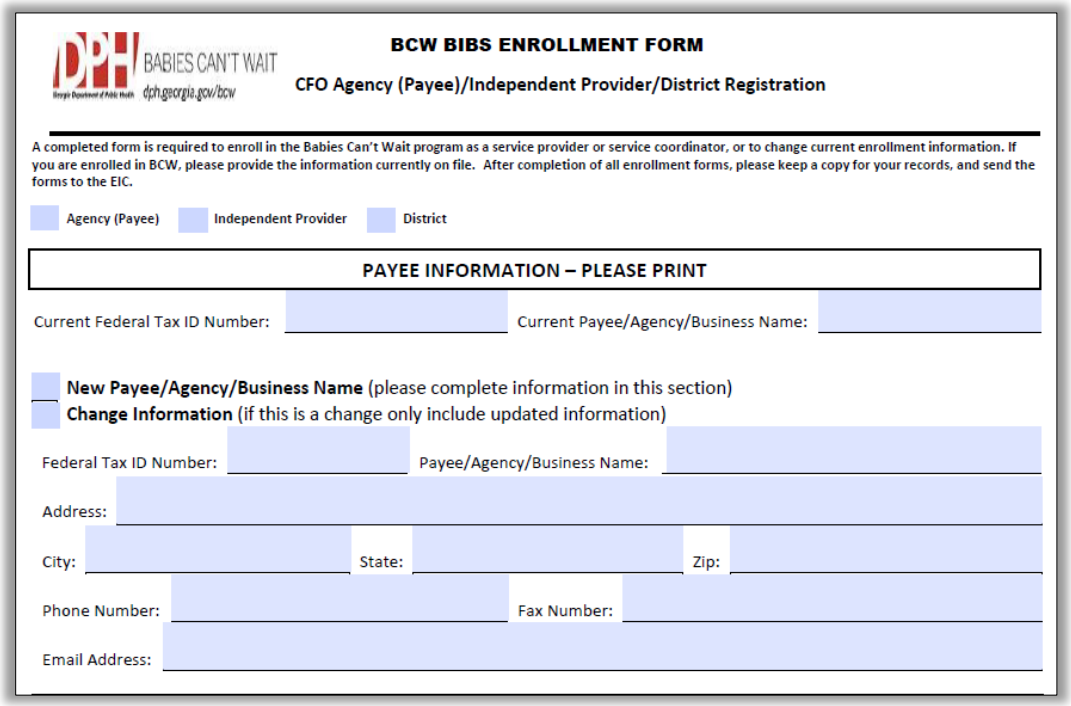
- **BCW BIBS Enrollment**
- **BCW-BIBS.COM Online Access**
- **Certification For Online Claims and Electronic Signature Agreement**
- **Agency Checklist**

5.2.6.1.1 BCW BIBS Enrollment

Click the **Agency (Payee) checkbox** at the top of the form

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Click the checkbox in front of *Change Information* to select
- Federal Tax ID Number – enter the new Tax ID for the agency
- If any of the following has changed enter the new information
  - Address, City, State, Zip, Phone Number, Fax Number, Email Address



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

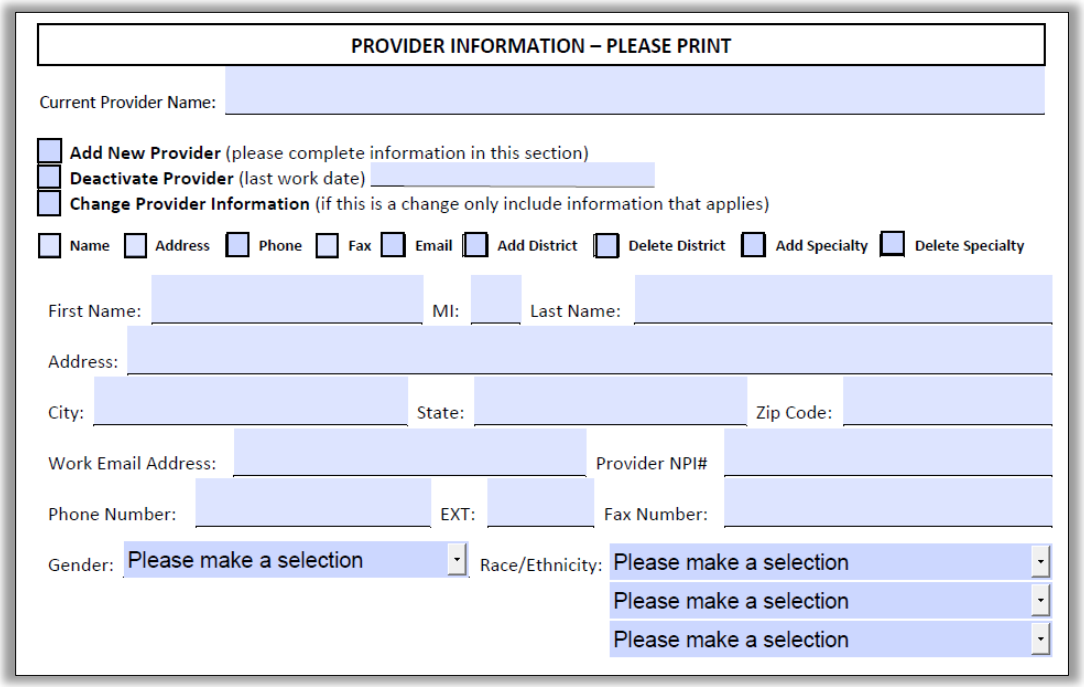
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Add New Provider - Click in the checkbox to select
- Enter the provider's information
  - Gender - Select from the drop-down
  - Race/Ethnicity - Select from the drop-down(s)



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

City: State: Zip Code:

Work Email Address: Provider NPI#

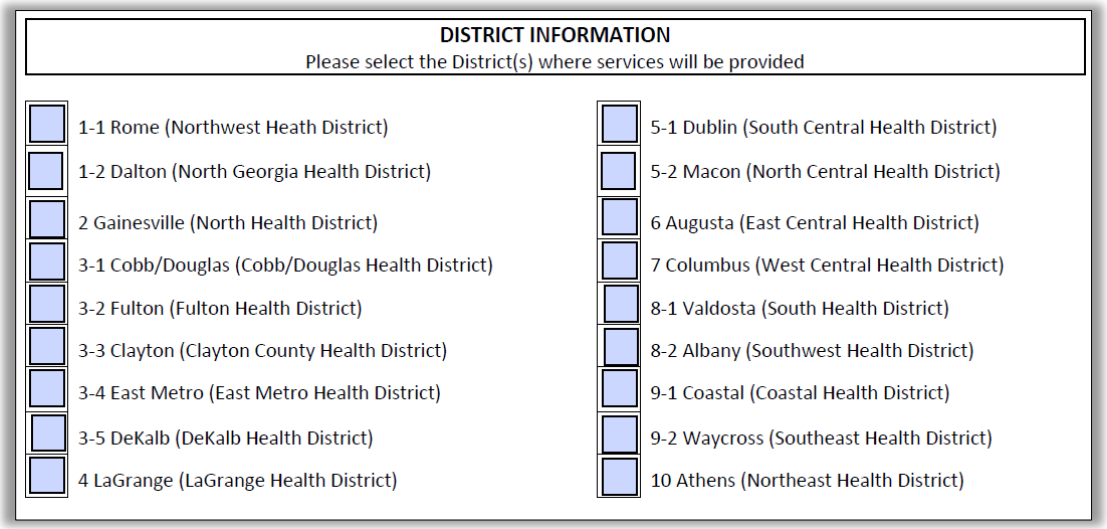
Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

If district(s) are being removed, enter the district names in the **District(s) to be removed section**, please enter a comma between district names.

District(s) to be removed:

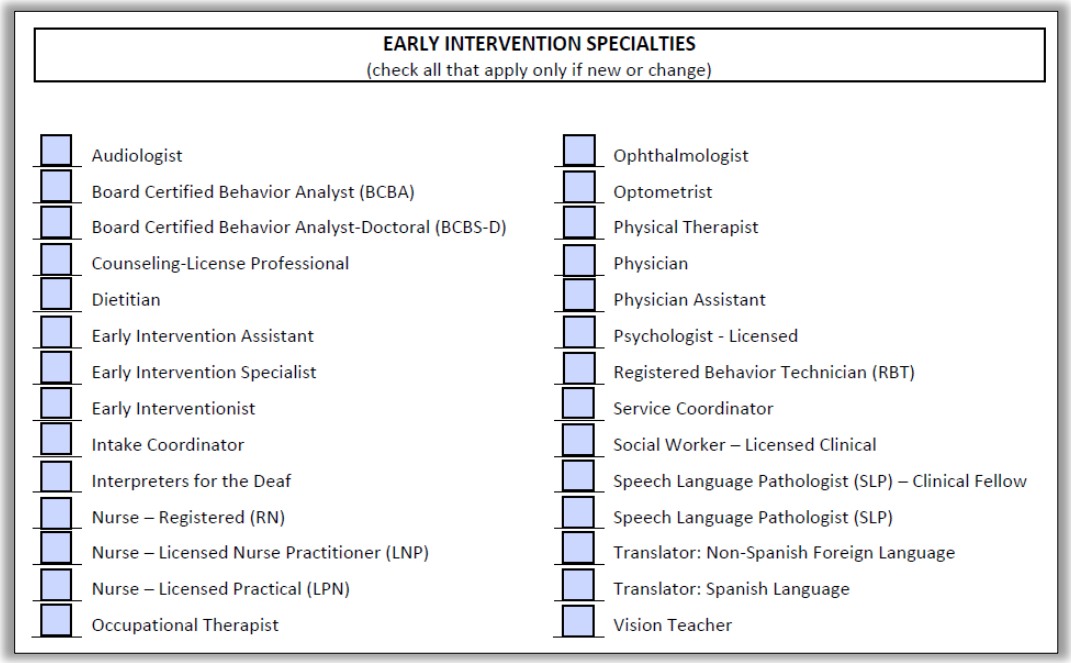
In the **District Information section**, if district(s) are being added select the District(s) where services will be provided by the provider. Only select the applicable districts.



DISTRICT INFORMATION
Please select the District(s) where services will be provided

- ☐ 1-1 Rome (Northwest Heath District)
- ☐ 1-2 Dalton (North Georgia Health District)
- ☐ 2 Gainesville (North Health District)
- ☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
- ☐ 3-2 Fulton (Fulton Health District)
- ☐ 3-3 Clayton (Clayton County Health District)
- ☐ 3-4 East Metro (East Metro Health District)
- ☐ 3-5 DeKalb (DeKalb Health District)
- ☐ 4 LaGrange (LaGrange Health District)
- ☐ 5-1 Dublin (South Central Health District)
- ☐ 5-2 Macon (North Central Health District)
- ☐ 6 Augusta (East Central Health District)
- ☐ 7 Columbus (West Central Health District)
- ☐ 8-1 Valdosta (South Health District)
- ☐ 8-2 Albany (Southwest Health District)
- ☐ 9-1 Coastal (Coastal Health District)
- ☐ 9-2 Waycross (Southeast Health District)
- ☐ 10 Athens (Northeast Health District)

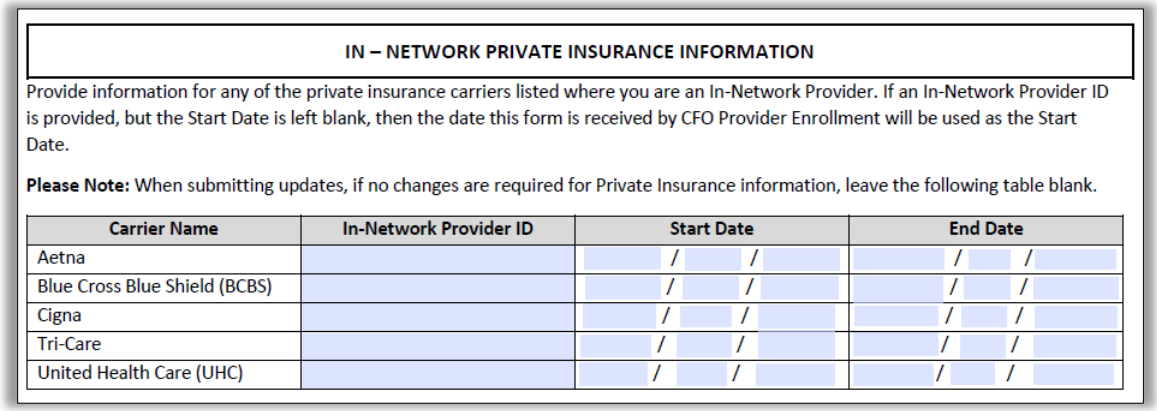
In the **Early Intervention Specialties section**, click on the checkboxes of all applicable specialties for the provider.



EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

- ☐ Audiologist
- ☐ Board Certified Behavior Analyst (BCBA)
- ☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)
- ☐ Counseling-License Professional
- ☐ Dietitian
- ☐ Early Intervention Assistant
- ☐ Early Intervention Specialist
- ☐ Early Interventionist
- ☐ Intake Coordinator
- ☐ Interpreters for the Deaf
- ☐ Nurse – Registered (RN)
- ☐ Nurse – Licensed Nurse Practitioner (LNP)
- ☐ Nurse – Licensed Practical (LPN)
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychologist - Licensed
- ☐ Registered Behavior Technician (RBT)
- ☐ Service Coordinator
- ☐ Social Worker – Licensed Clinical
- ☐ Speech Language Pathologist (SLP) – Clinical Fellow
- ☐ Speech Language Pathologist (SLP)
- ☐ Translator: Non-Spanish Foreign Language
- ☐ Translator: Spanish Language
- ☐ Vision Teacher

In the **In-Network Private Insurance Information section**, enter the information for any private insurance carriers listed where the provider is an In-Network provider.



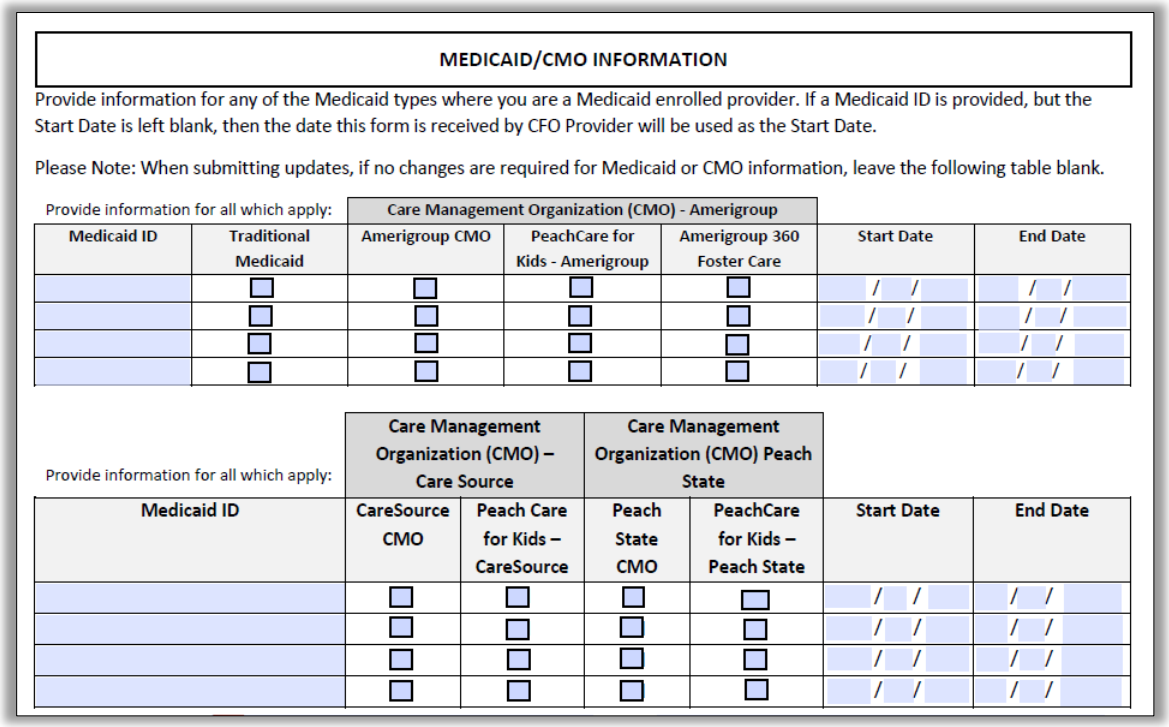
IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/CMO Information section**, enter the information for any Medicaid or CMOs the provider is enrolled with.



MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

At the bottom of the form complete the following:

- Provider Signature - The signature of the provider
- Date

5.2.6.1.2 BCW-BIBS.Com Online Access

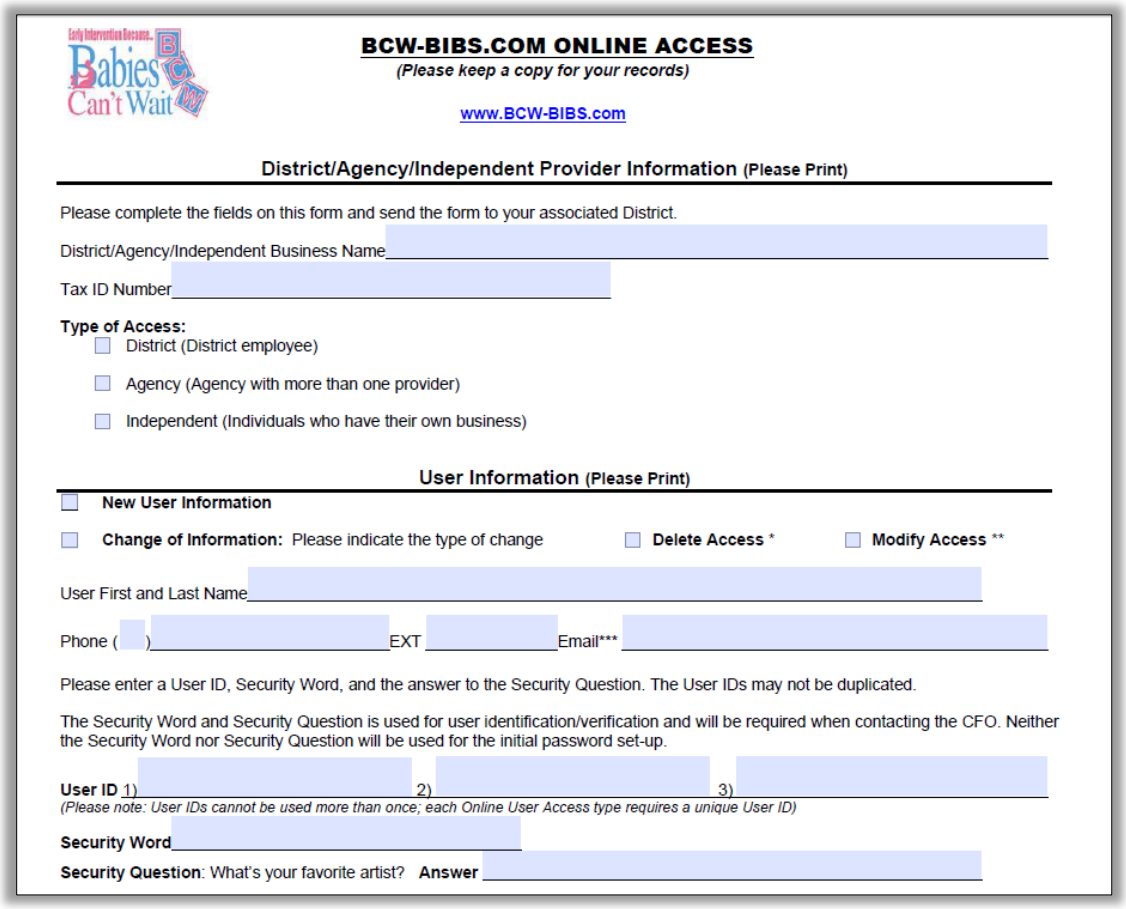
A **BCW-BIBS.Com Online Access form** must be completed by the provider to access the BCW-BIBS.com website.

- Never share or allow someone else to use your username and password

> **NOTE:** It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password and will be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number – enter the new Tax ID Number
- Type of Access - Select *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

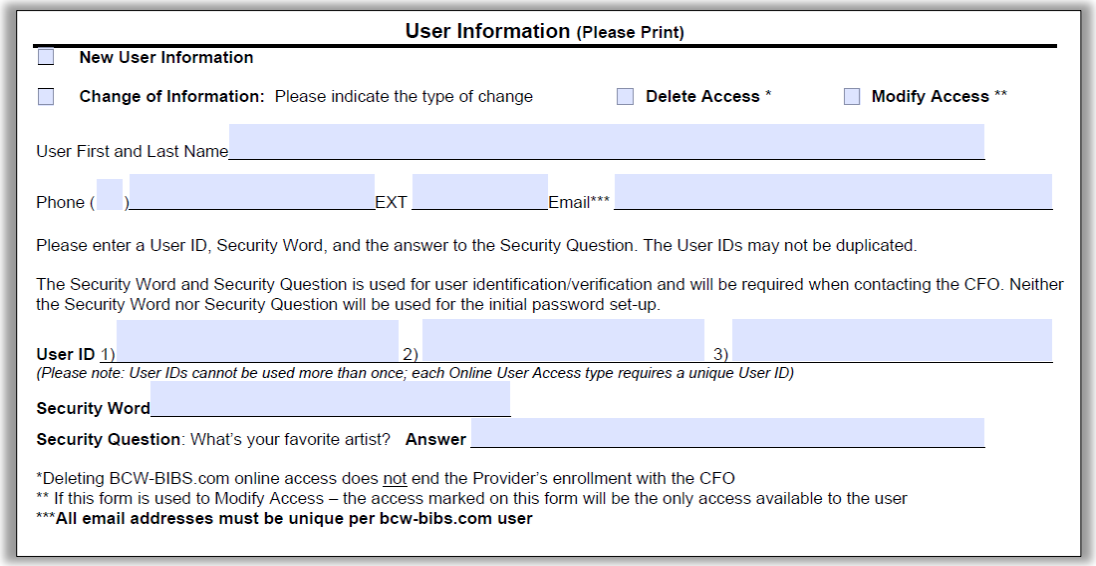
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- New User Information - click the checkbox to select
- Enter the First and Last Name, Phone, EXT, and Email of the person requesting access
- User ID – enter 3 user IDs
- Security Word - a single word to identify the provider
- Security Question - The answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

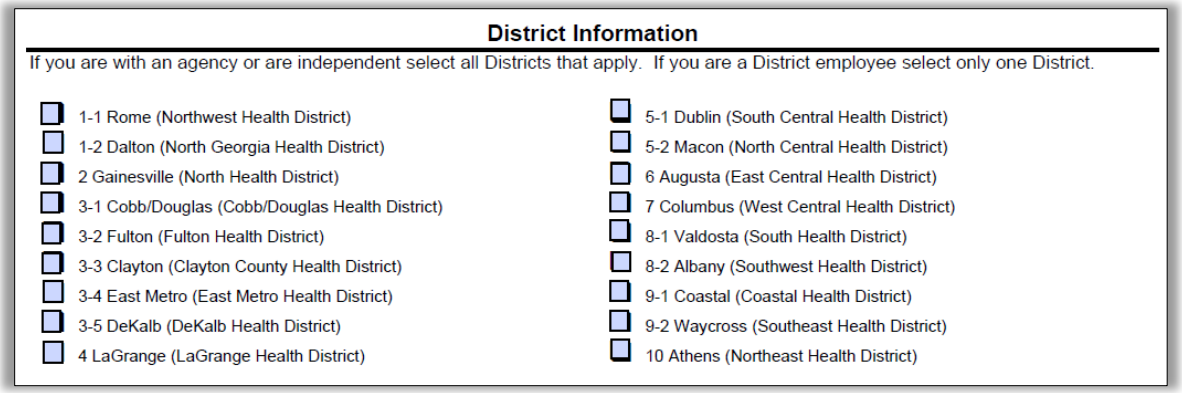
***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section,** the user access selected will depend on the provider's specialties.

- If the provider's specialty is not Intake or Service Coordination, select one of the Agency Provider user types
- If the provider is enrolling as an Intake and Service Coordinator select both Agency Coordinator user types

- If the provider is enrolling as a provider and Intake/Service Coordinator, select one of the agency provider user types and one or both agency coordinator user types depending on the specialties of the provider

In the **District Information section**, select the checkbox(es) of the district(s) in which the provider will be performing services.



At the bottom of the form complete the following:

- Enter the First Name, Last Name, Phone, EXT, and Email of the provider
- User Signature - Signature of the provider requesting access
- Date
- Agency Signature - Signature of the owner
- Date

5.2.6.1.3 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims Form and Electronic Signature Agreement** are required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

5.2.6.2 Tax ID Number and Agency Name Change

If the agency has a new Tax ID number and agency name, the following forms must be completed:

- **BCW BIBS Enrollment**
- **BCW-BIBS.COM Online Access**
- **Certification For Online Claims and Electronic Signature Agreement**
- **Agency Checklist**

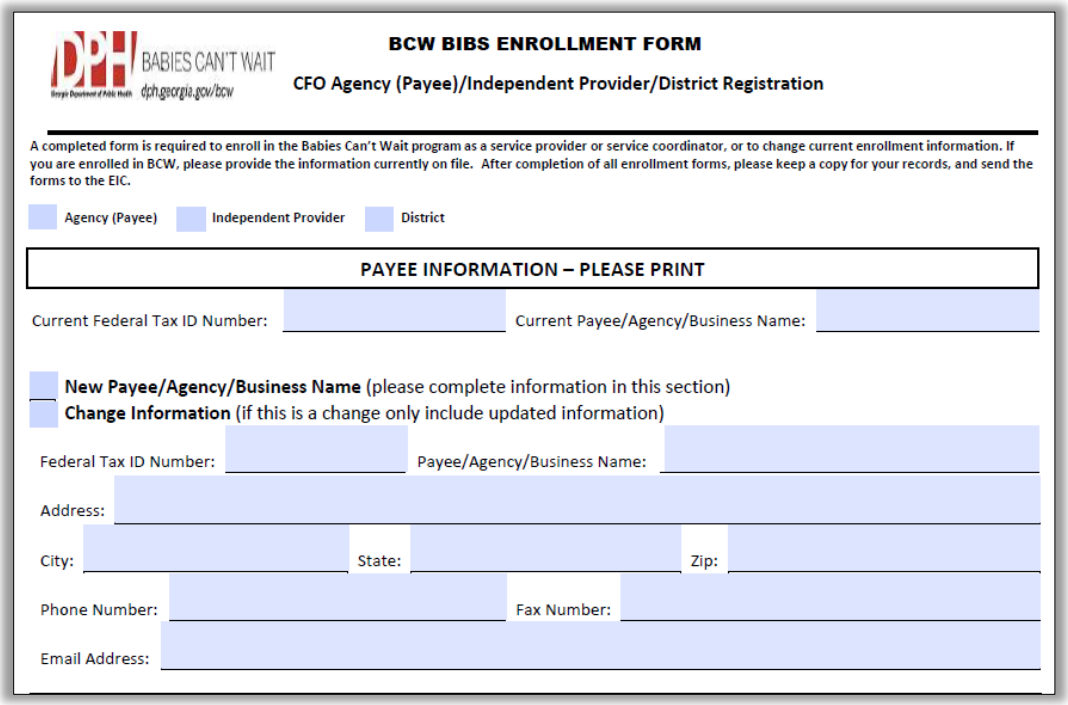
5.2.6.2.1 BCW BIBS Enrollment

Click the **Agency (Payee) checkbox** at the top of the form

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Click the checkbox in front of *Change Information* to select
- Federal Tax ID Number – enter the new Tax ID for the agency
- Payee/Agency/Business Name – enter the new name of the agency

- If any of the following has changed enter the new information
  - Address, City, State, Zip, Phone Number, Fax Number, Email Address



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

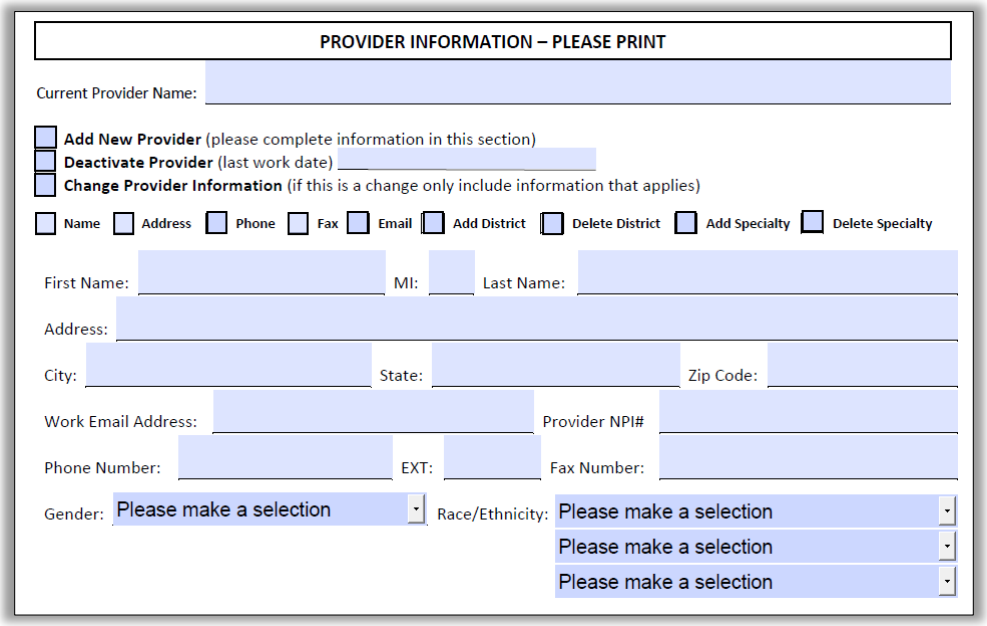
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **Provider Information section**, complete the following:

- Add New Provider - Click in the checkbox to select
- Enter the provider's information
  - Gender - Select from the drop-down
  - Race/Ethnicity - Select from the drop-down(s)



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name: _____

☐ **Add New Provider** (please complete information in this section)
☐ **Deactivate Provider** (last work date) _____
☐ **Change Provider Information** (if this is a change only include information that applies)

☐ Name ☐ Address ☐ Phone ☐ Fax ☐ Email ☐ Add District ☐ Delete District ☐ Add Specialty ☐ Delete Specialty

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Work Email Address: _____ Provider NPI# _____

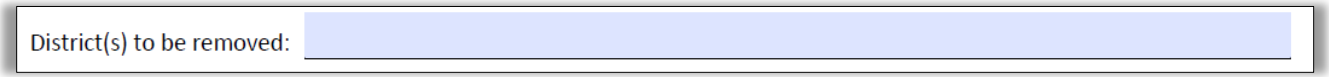
Phone Number: _____ EXT: _____ Fax Number: _____

Gender: Please make a selection Race/Ethnicity: Please make a selection

Please make a selection

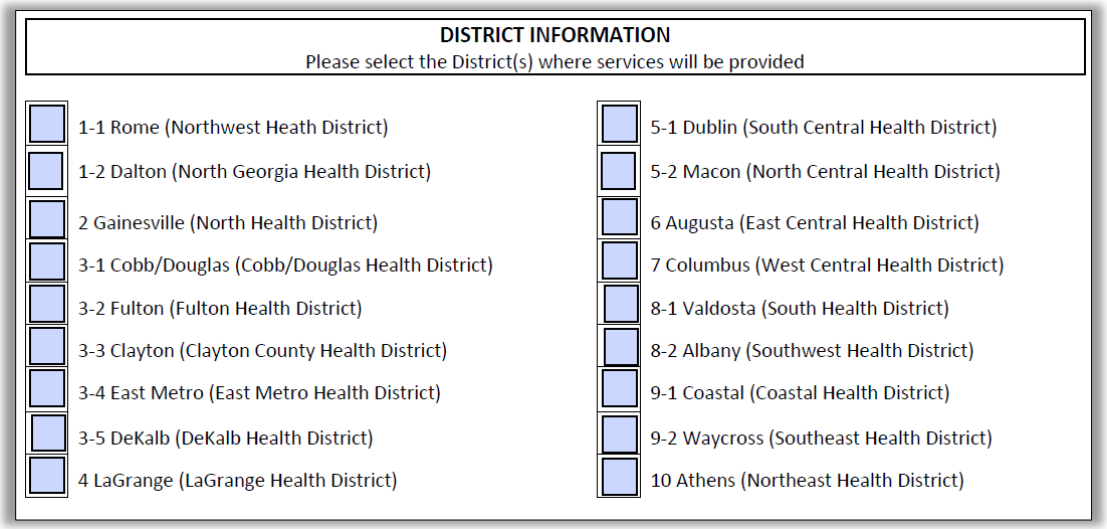
Please make a selection

If district(s) are being removed, enter the district names in the **District(s) to be removed section**, please enter a comma between district names.



District(s) to be removed: _____

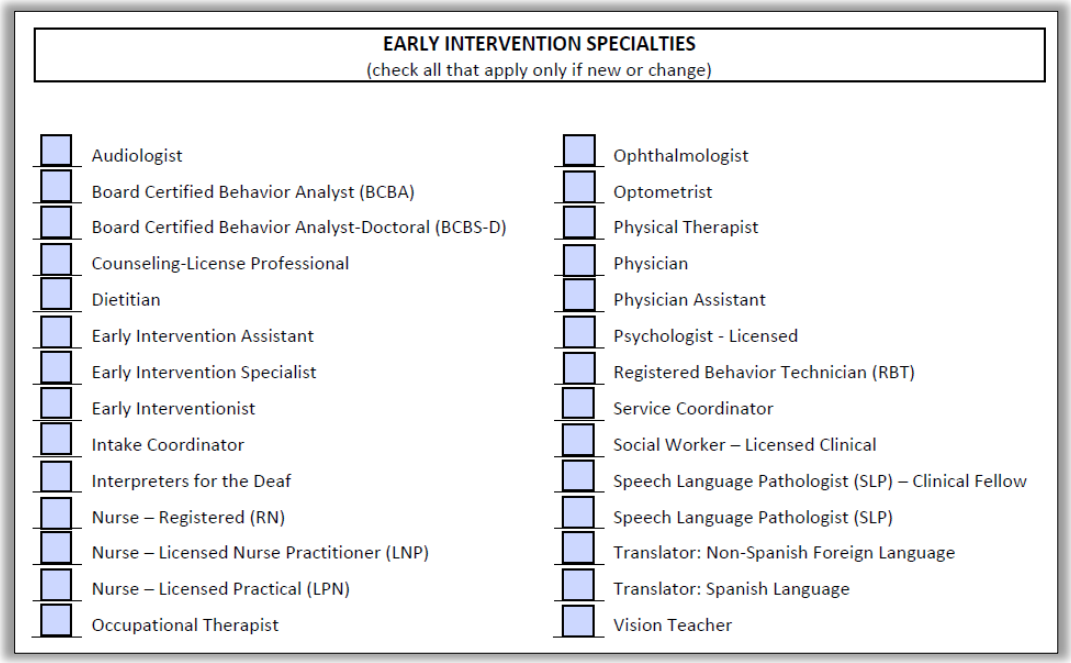
In the **District Information section**, if district(s) are being added select the District(s) where services will be provided by the provider. Only select the applicable districts.



DISTRICT INFORMATION
Please select the District(s) where services will be provided

- ☐ 1-1 Rome (Northwest Heath District)
- ☐ 1-2 Dalton (North Georgia Health District)
- ☐ 2 Gainesville (North Health District)
- ☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
- ☐ 3-2 Fulton (Fulton Health District)
- ☐ 3-3 Clayton (Clayton County Health District)
- ☐ 3-4 East Metro (East Metro Health District)
- ☐ 3-5 DeKalb (DeKalb Health District)
- ☐ 4 LaGrange (LaGrange Health District)
- ☐ 5-1 Dublin (South Central Health District)
- ☐ 5-2 Macon (North Central Health District)
- ☐ 6 Augusta (East Central Health District)
- ☐ 7 Columbus (West Central Health District)
- ☐ 8-1 Valdosta (South Health District)
- ☐ 8-2 Albany (Southwest Health District)
- ☐ 9-1 Coastal (Coastal Health District)
- ☐ 9-2 Waycross (Southeast Health District)
- ☐ 10 Athens (Northeast Health District)

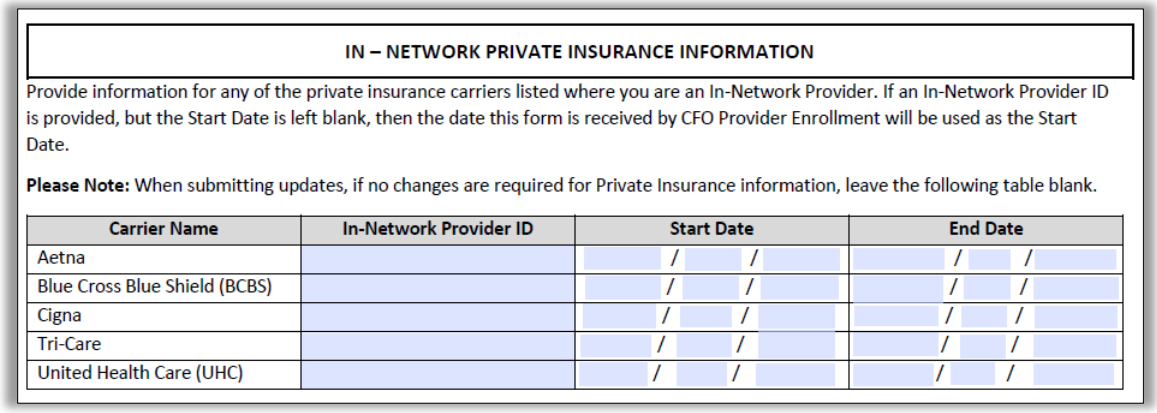
In the **Early Intervention Specialties section**, click on the checkboxes of all applicable specialties for the provider.



EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

- ☐ Audiologist
- ☐ Board Certified Behavior Analyst (BCBA)
- ☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)
- ☐ Counseling-License Professional
- ☐ Dietitian
- ☐ Early Intervention Assistant
- ☐ Early Intervention Specialist
- ☐ Early Interventionist
- ☐ Intake Coordinator
- ☐ Interpreters for the Deaf
- ☐ Nurse – Registered (RN)
- ☐ Nurse – Licensed Nurse Practitioner (LNP)
- ☐ Nurse – Licensed Practical (LPN)
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychologist - Licensed
- ☐ Registered Behavior Technician (RBT)
- ☐ Service Coordinator
- ☐ Social Worker – Licensed Clinical
- ☐ Speech Language Pathologist (SLP) – Clinical Fellow
- ☐ Speech Language Pathologist (SLP)
- ☐ Translator: Non-Spanish Foreign Language
- ☐ Translator: Spanish Language
- ☐ Vision Teacher

In the **In-Network Private Insurance Information section**, enter the information for any private insurance carriers listed where the provider is an In-Network provider.



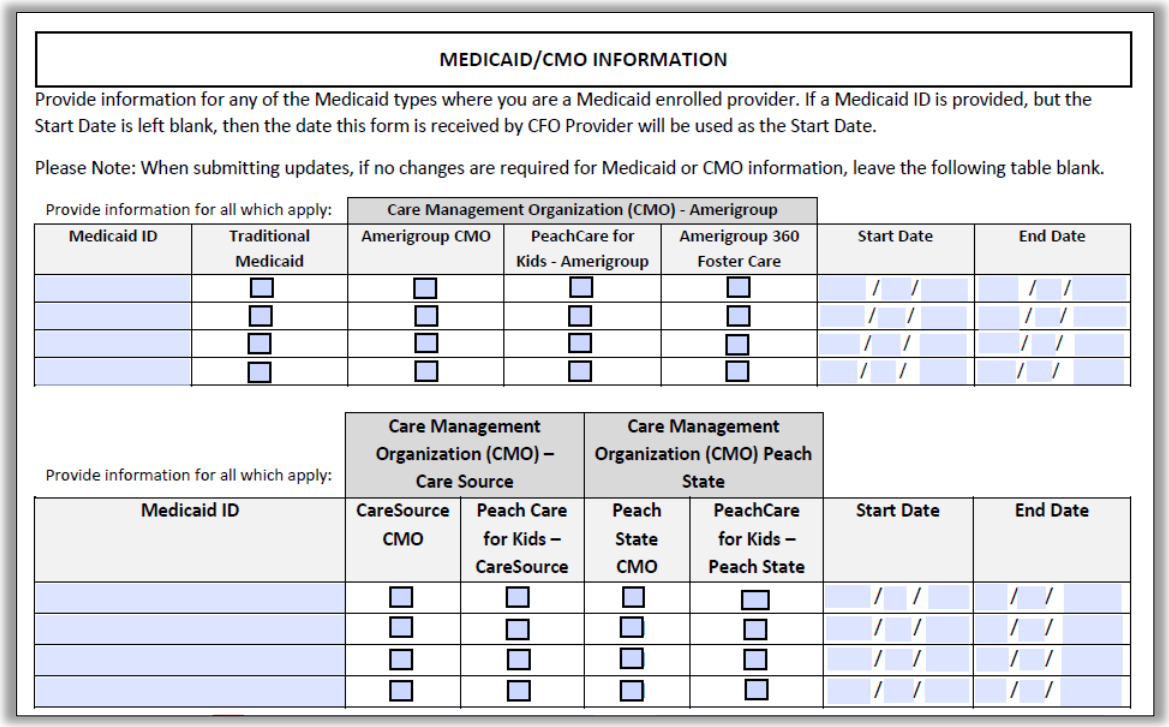
IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/CMO Information section**, enter the information for any Medicaid or CMOs the provider is enrolled with.



MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

At the bottom of the form complete the following:

- Provider Signature - The signature of the provider
- Date

5.2.6.2.2 BCW-BIBS.Com Online Access

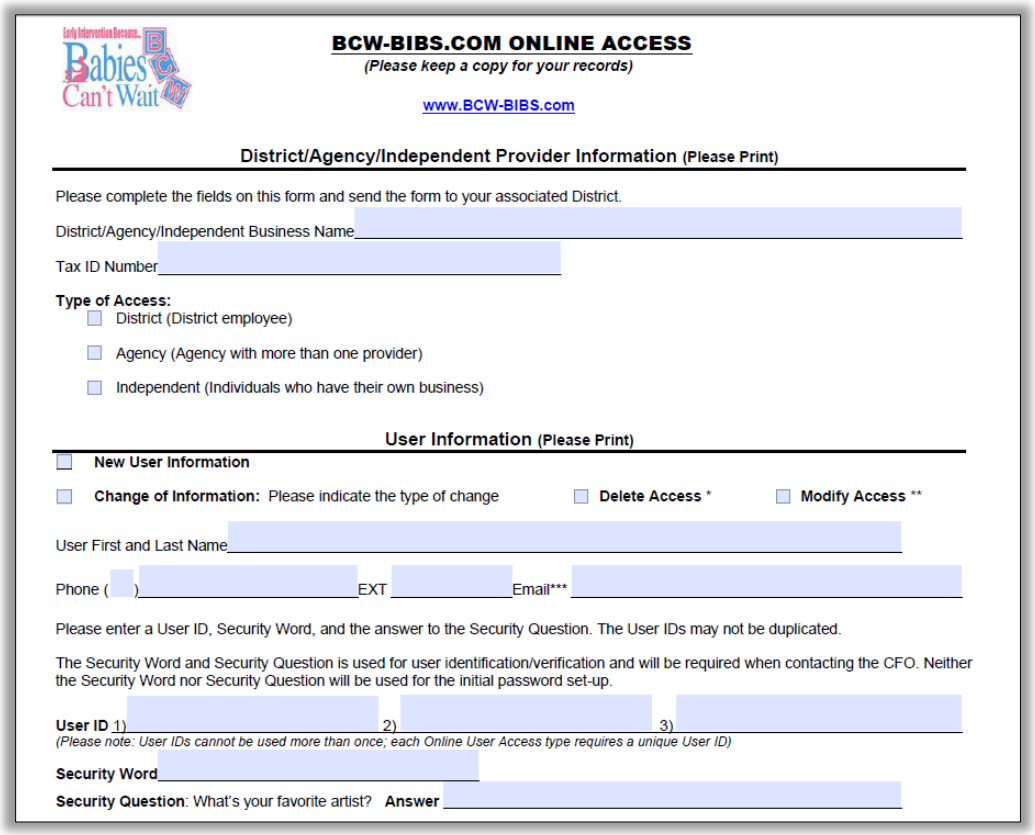
A **BCW-BIBS.Com Online Access form** must be completed by the provider to access the BCW-BIBS.com website.

- Never share or allow someone else to use your username and password

> **NOTE:** It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password and will be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name – enter the new name of the agency
- Tax ID Number – enter the new Tax ID Number
- Type of Access - Select *Agency*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone (___)_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

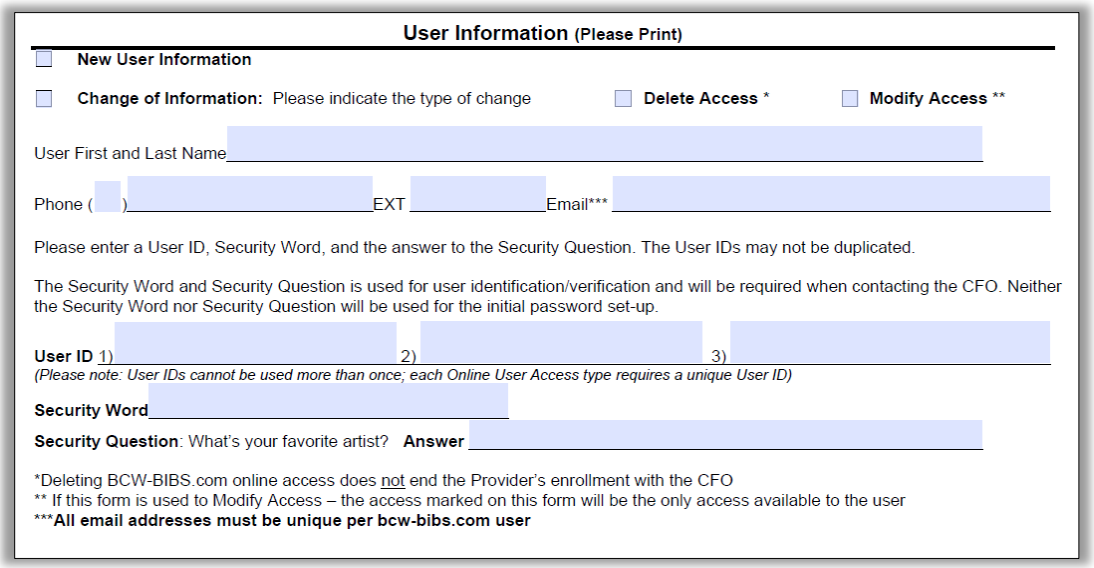
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- New User Information - click the checkbox to select
- Enter the First and Last Name, Phone, EXT, and Email of the person requesting access
- User ID – enter 3 user IDs – IDS must be different than the IDS previously used
- Security Word - a single word to identify the provider
- Security Question - The answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone (___)_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

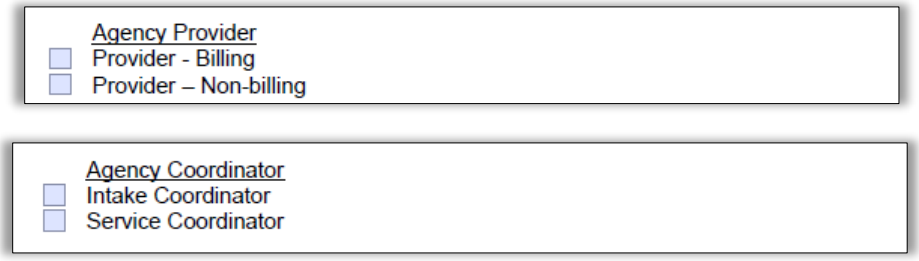
*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

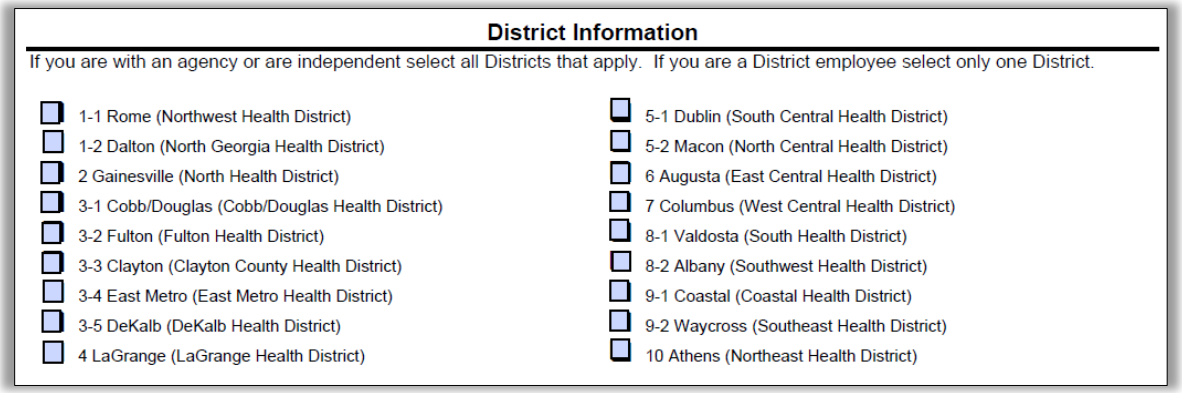
***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section,** the user access selected will depend on the provider's specialties.

- If the provider's specialty is not Intake or Service Coordination, select one of the Agency Provider user types
- If the provider is enrolling as an Intake and Service Coordinator select both Agency Coordinator user types
- If the provider is enrolling as a provider and Intake/Service Coordinator, select one of the agency provider user types and one or both agency coordinator user types depending on the specialties of the provider



In the **District Information section**, select the checkbox(es) of the district(s) in which the provider will be performing services.



At the bottom of the form complete the following:

- Enter the First Name, Last Name, Phone, EXT, and Email of the provider
- User Signature - Signature of the provider requesting access
- Date
- Agency Signature - Signature of the owner
- Date

5.2.6.2.3 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims Form and Electronic Signature Agreement** with the new agency's name and Tax ID number is required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

6.0 Independent Provider/Self-Employed

6.1 New Independent Provider

A new Independent Provider enrolling with the BCW program will complete the following:

- **BCW BIBS Enrollment Form**
- **BCW- BIBS.COM Online Access**
- **Certification for Online Claims Form and Electronic Signature Agreement**
- **Direct Deposit/EFT Authorization Form * ***
- **W-9 Request for Taxpayer Identification Number and Certification Form * ***
- **Independent Provider/Self-Employed Checklist**

*** *** If the Independent Provider will only be performing services in District 3-4 Lawrenceville/Gwinnett/East Metro these forms do not need to be completed. If additional districts are added later these forms must be completed

Independent Provider/Self-Employed Checklist			
✓	**Form Name and Description**	**Original Signature Required?**	**District Approval Required?**
	1. BCW BIBS Enrollment Form - *Required* - Complete this form to enroll as a contracted Agency - Complete this form to enroll as a Provider employed by an Agency	Yes	Yes
	2. BCW-BIBS.COM Online Access - *Required* - Complete this form to receive access to the BIBS system	Yes	Yes
	3. Certification for Online Claims Form and Electronic Signature Agreement- *Required* - Complete this form to perform direct data claim entry into the BIBS system and to certify authorization of your electronic signature for all actions within the BIBS system	Yes	No
	4. Direct Deposit/EFT Authorization Form – *Required (Except 3-4 East Metro)* - Complete this form to receive electronic payments instead of payments by check	Yes	No
	5. W-9 Request for Taxpayer Identification Number and Certification Form – *Required (Except 3-4 East Metro)* - Complete this form to receive a 1099	Yes	No

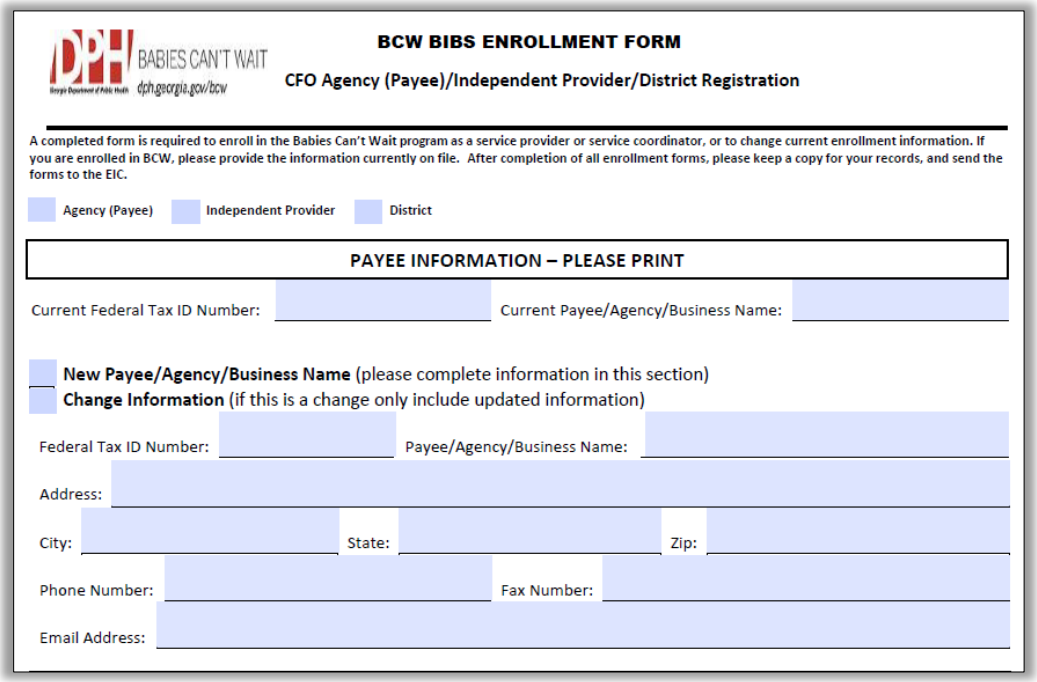
6.1.1 BCW BIBS Enrollment Form

Click the **Independent Provider checkbox** at the top of the form

In the **Payee Information Section** complete the following:

- New Payee/Agency/Business Name - Click the checkbox to select
- Federal Tax ID Number
- Payee/Agency/Business Name
- The Address, City, State, Zip, Phone Number, Fax Number, and Email Address information

> **NOTE:** Do not enter any information for Current Federal Tax ID Number or Current Payee/Agency Business Name.



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

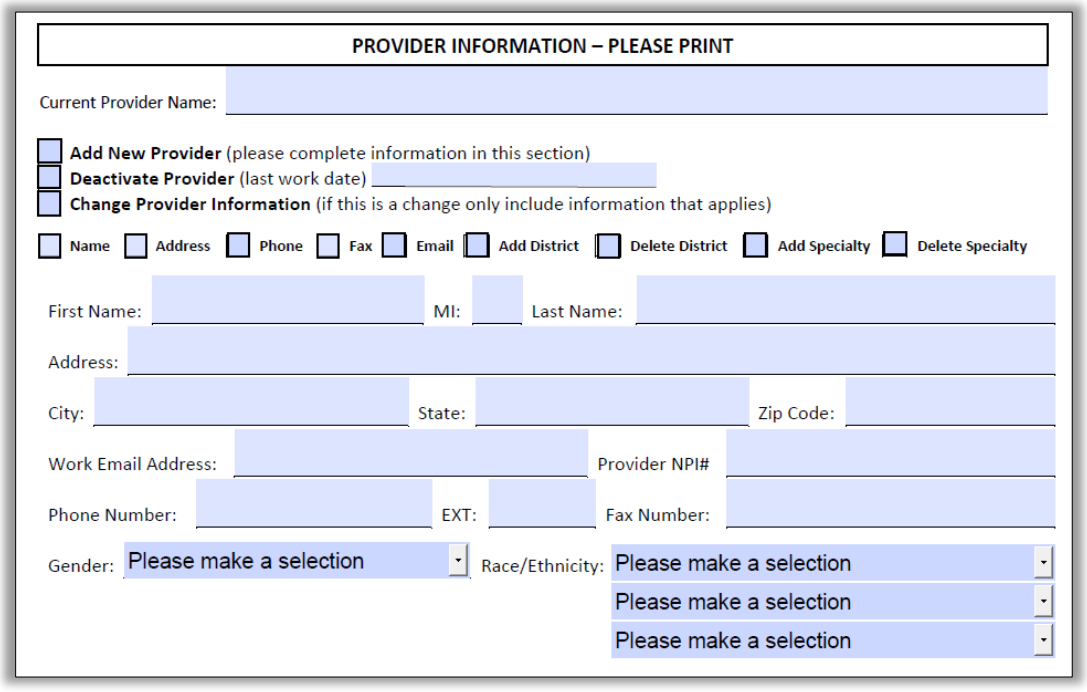
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Add New Provider - Click in the checkbox to select
- Enter your provider information
  - Gender - Select from the drop-down
  - Race/Ethnicity - Select from all applicable dropdowns



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

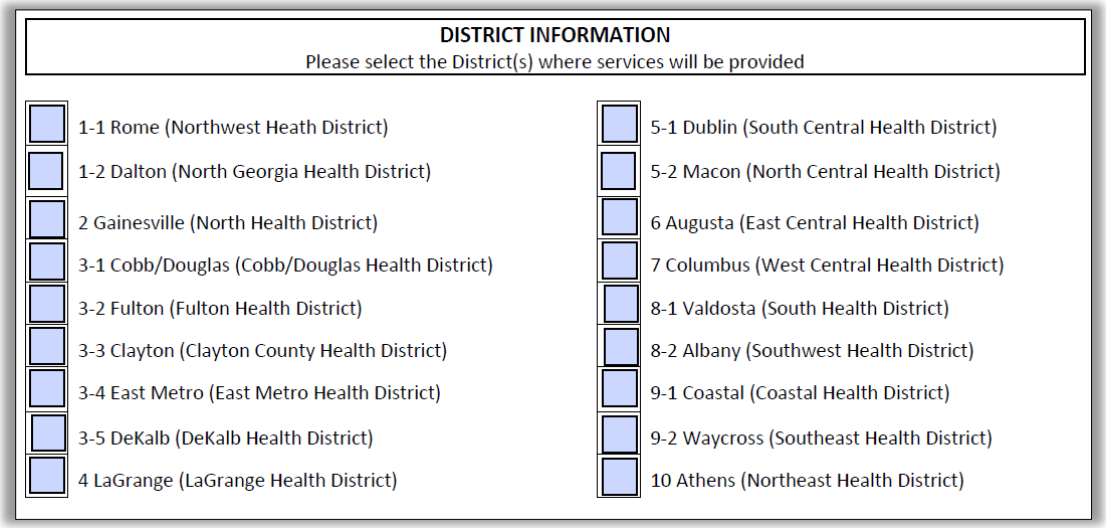
City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

In the **District Information section**, select the District(s) where services will be provided by you as the provider. Only select the applicable districts.

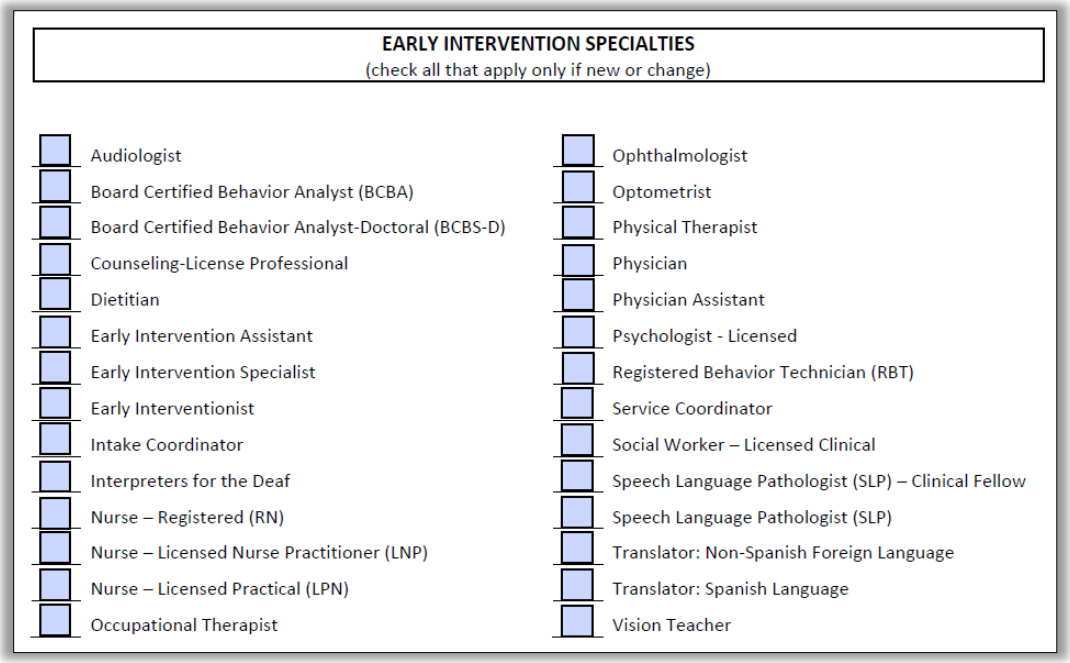


DISTRICT INFORMATION

Please select the District(s) where services will be provided

- ☐ 1-1 Rome (Northwest Heath District)
- ☐ 1-2 Dalton (North Georgia Health District)
- ☐ 2 Gainesville (North Health District)
- ☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
- ☐ 3-2 Fulton (Fulton Health District)
- ☐ 3-3 Clayton (Clayton County Health District)
- ☐ 3-4 East Metro (East Metro Health District)
- ☐ 3-5 DeKalb (DeKalb Health District)
- ☐ 4 LaGrange (LaGrange Health District)
- ☐ 5-1 Dublin (South Central Health District)
- ☐ 5-2 Macon (North Central Health District)
- ☐ 6 Augusta (East Central Health District)
- ☐ 7 Columbus (West Central Health District)
- ☐ 8-1 Valdosta (South Health District)
- ☐ 8-2 Albany (Southwest Health District)
- ☐ 9-1 Coastal (Coastal Health District)
- ☐ 9-2 Waycross (Southeast Health District)
- ☐ 10 Athens (Northeast Health District)

In the **Early Intervention Specialties section**, click on the checkboxes of all applicable Specialties for the provider.

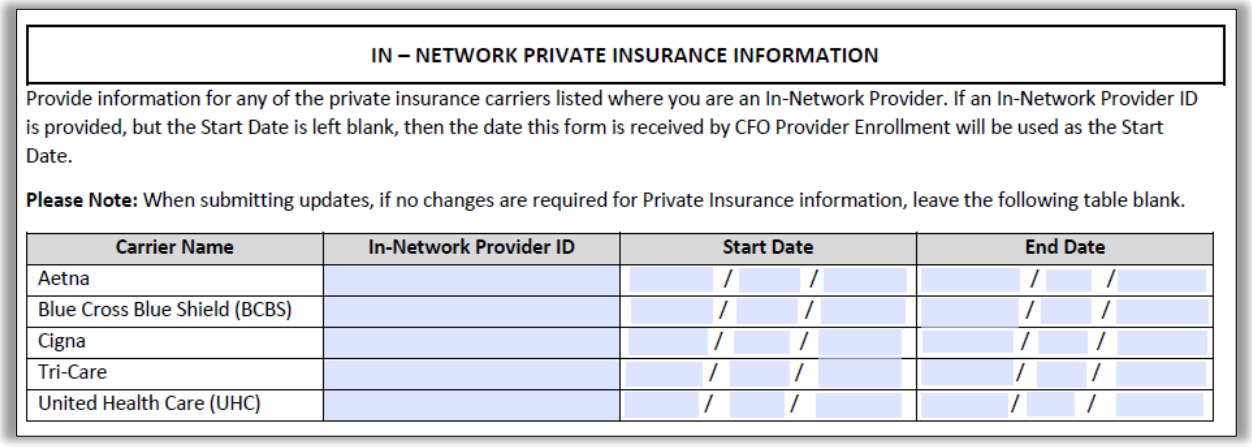


EARLY INTERVENTION SPECIALTIES

(check all that apply only if new or change)

- ☐ Audiologist
- ☐ Board Certified Behavior Analyst (BCBA)
- ☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)
- ☐ Counseling-License Professional
- ☐ Dietitian
- ☐ Early Intervention Assistant
- ☐ Early Intervention Specialist
- ☐ Early Interventionist
- ☐ Intake Coordinator
- ☐ Interpreters for the Deaf
- ☐ Nurse – Registered (RN)
- ☐ Nurse – Licensed Nurse Practitioner (LNP)
- ☐ Nurse – Licensed Practical (LPN)
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychologist - Licensed
- ☐ Registered Behavior Technician (RBT)
- ☐ Service Coordinator
- ☐ Social Worker – Licensed Clinical
- ☐ Speech Language Pathologist (SLP) – Clinical Fellow
- ☐ Speech Language Pathologist (SLP)
- ☐ Translator: Non-Spanish Foreign Language
- ☐ Translator: Spanish Language
- ☐ Vision Teacher

In the **In-Network Private Insurance Information section**, enter the information for any private insurance carriers listed where you are an In-Network provider.



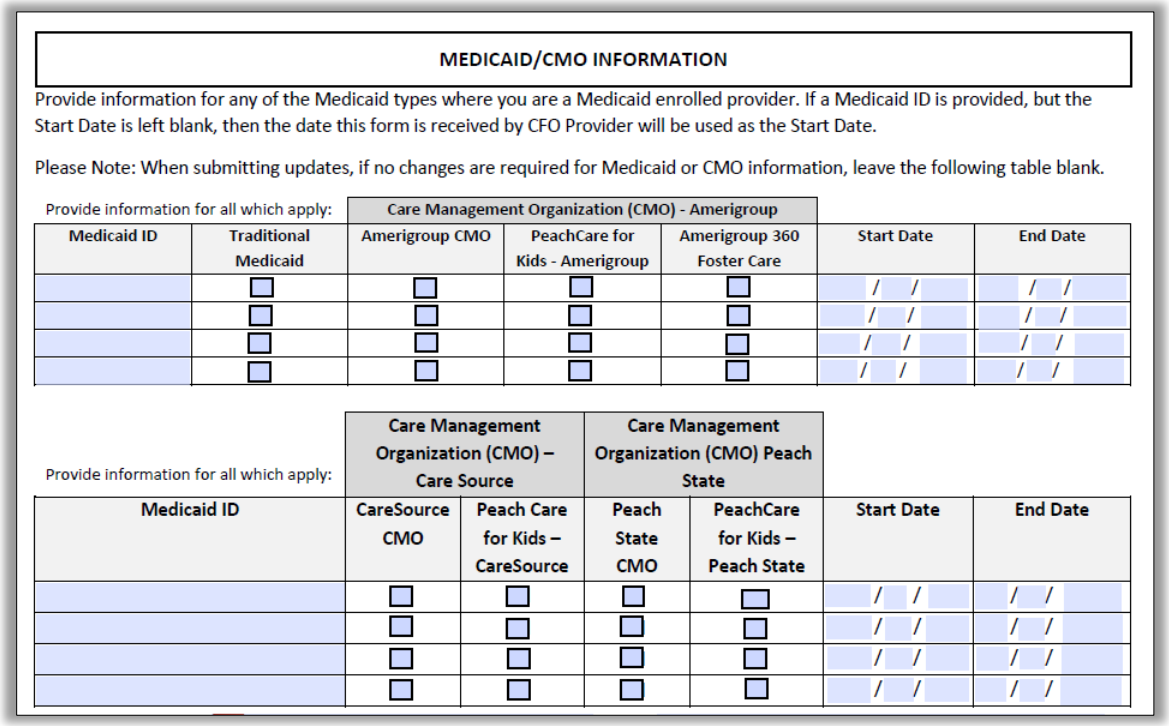
IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/CMO Information section**, enter the information for any Medicaid or CMOs you are enrolled with.



MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

At the bottom of the form complete the following:

- Provider Signature – your signature
- Date

6.1.2 BCW-BIBS.Com Online Access

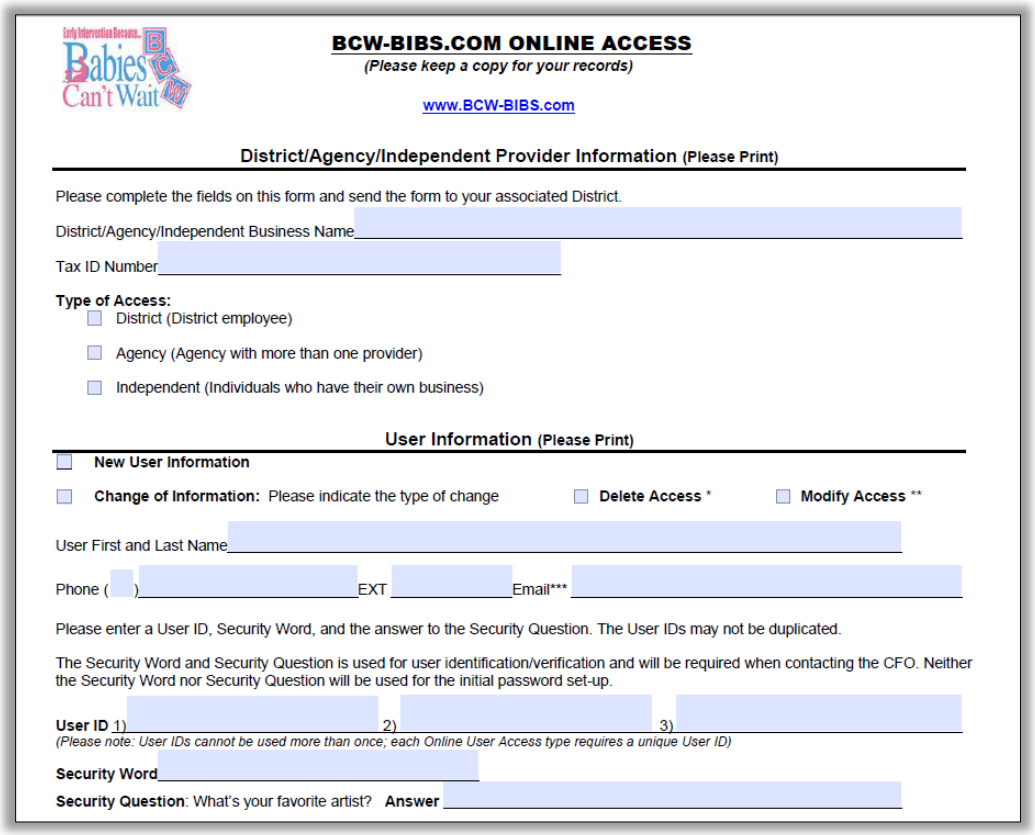
A **BCW-BIBS.Com Online Access form** must be completed to access the BCW-BIBS.com website.

- Never share or allow someone else to use your username and password

> **NOTE:** It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password and will be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - select *Independent (Individuals who have their own business)*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

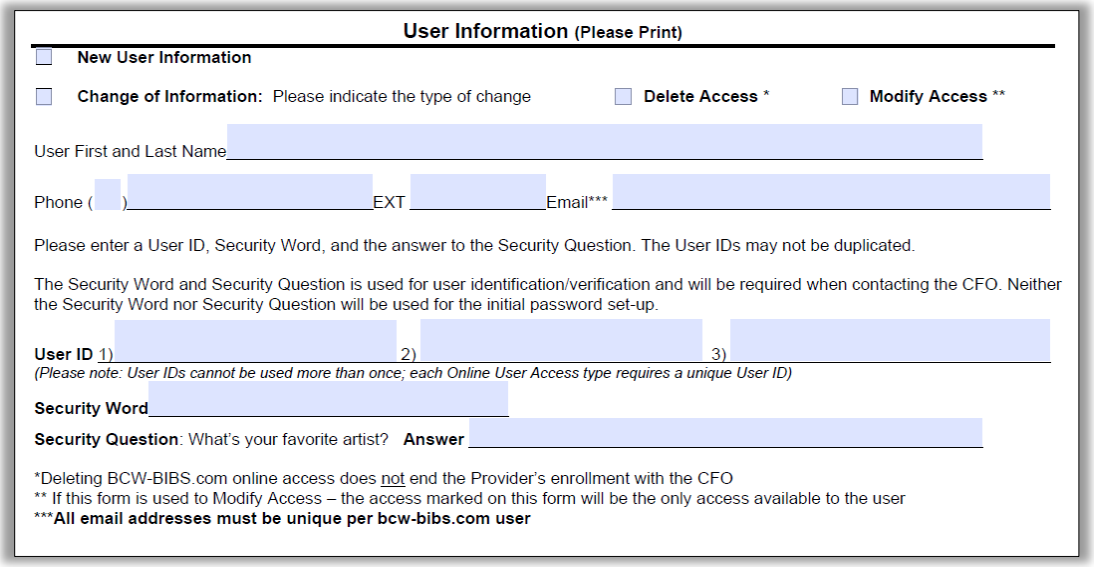
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- New User Information - Click the checkbox to select
- Enter First and Last Name, Phone, Ext, and Email
- User ID – Enter 3 User IDs
- Security Word - A single word to identify yourself
- Security Question - The answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

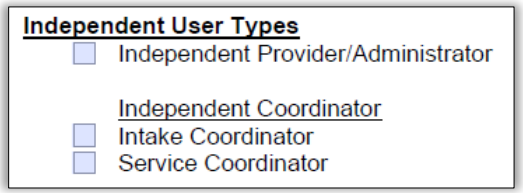
*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

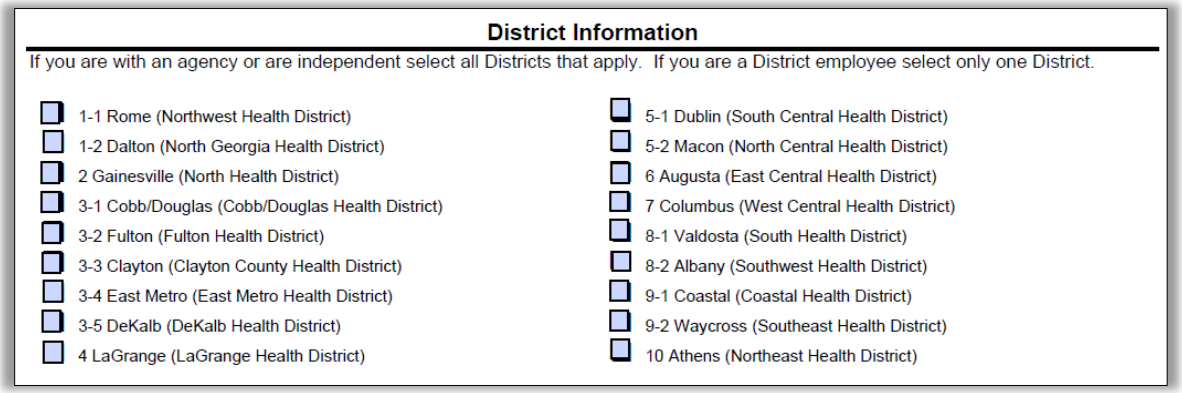
***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, if you are not enrolling with the specialties of Intake or Service Coordination only select Independent Provider/Administrator.

- If you are enrolling with the specialties of Intake or Service Coordination, select Independent Provider/Administrator and one or both Independent Coordinator types depending on your specialties



In the **District Information section**, select the checkbox(es) of the district(s) in which services will be performed. Only select the applicable districts, districts can be added later if necessary



At the bottom of the form complete the following:

- First Name and Last Name
- Phone, EXT, and Email
- User Signature – your signature
- Date
- Agency Signature – your signature as the owner
- Date

6.1.3 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims and Electronic Signature Agreement** is required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

6.1.4 Direct Deposit/EFT Authorization Form

Complete the **Direct Deposit/EFT Authorization form** for payments to be electronically transmitted into your account. All funds must be designated to one account.

- A voided or canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

NOTE: If there is any change to the bank information a Direct Deposit/EFT Authorization form must be completed to ensure payments are put into the correct account.

- A voided check or canceled check must be submitted with the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

6.1.5 W-9 Request for Taxpayer Identification Number and Certification Form

A **W-9 form** must be completed to receive a 1099 form, all fields on the form are required.

6.2 Existing Independent Provider/Business

6.2.1 Change of Address, Phone/Fax Numbers, Or Email Address

To change the address, phone number, fax number, or email address complete the **BCW BIBS Enrollment** form.

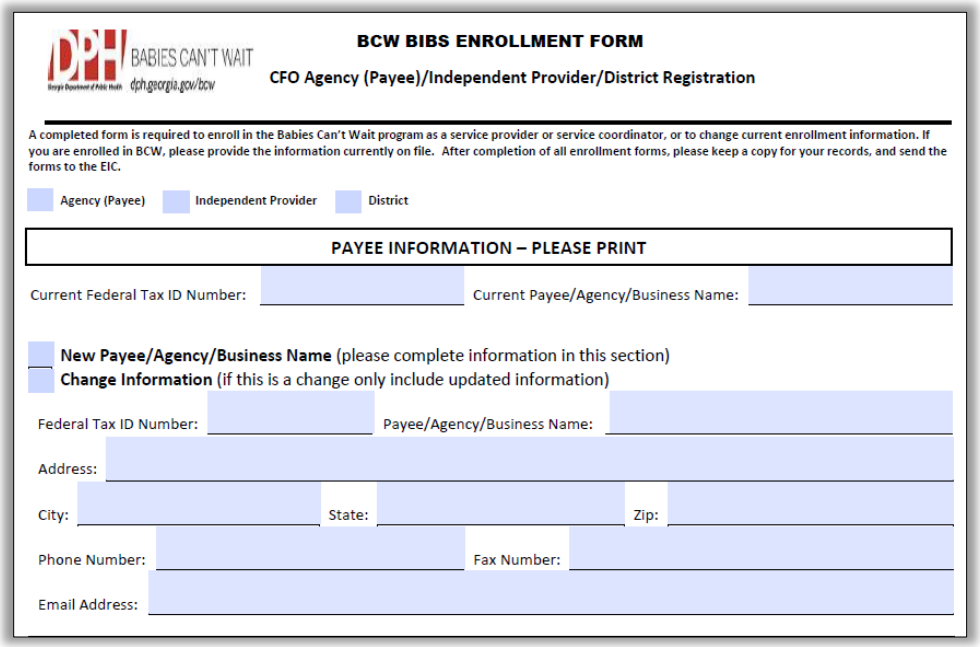
- If your phone number and/or email address is changing, a **BCW-BIBS.Com Online Access** form must also be completed

6.2.1.1 BCW BIBS Enrollment Form

Click the Independent Provider checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information - click the checkbox to select
    - Only enter information that has changed in the applicable fields



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

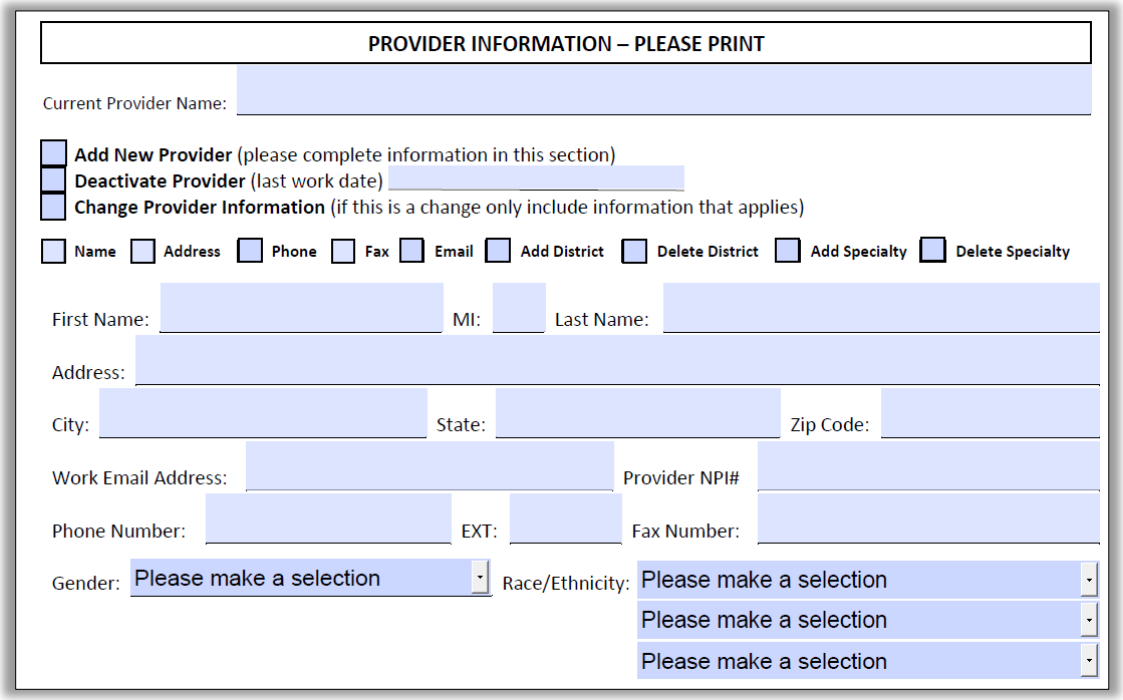
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Current Provider Name


PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

At the bottom of the form complete the following:

- Provider Signature – your signature
- Date

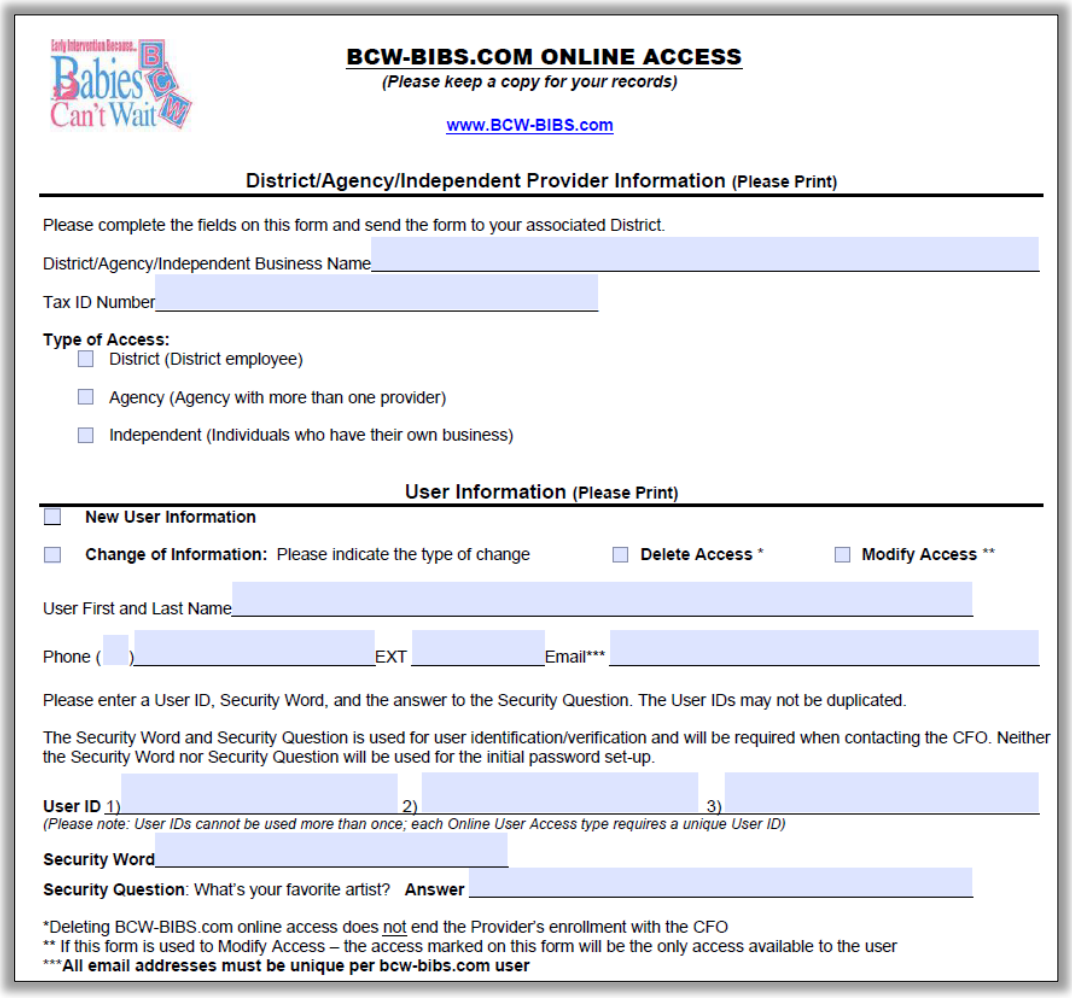
6.2.1.2 BCW-BIBS.Com Online Access Form

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - select *Independent (Individuals who have their own business)*

In the **User Information section,** complete the following:

- Change of Information – click in the checkbox to select
- Modify Access – click to select
- User First and Last Name
- Enter the new phone number or email address



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

At the bottom of the form complete the following:

- First Name and Last Name, Phone, EXT, and Email
- User Signature – your signature
- Date
- Agency Signature – your signature as the owner
- Date

6.2.2 Add or Remove District(s)

To remove a district(s) complete the following on the **BCW BIBS Enrollment** form.

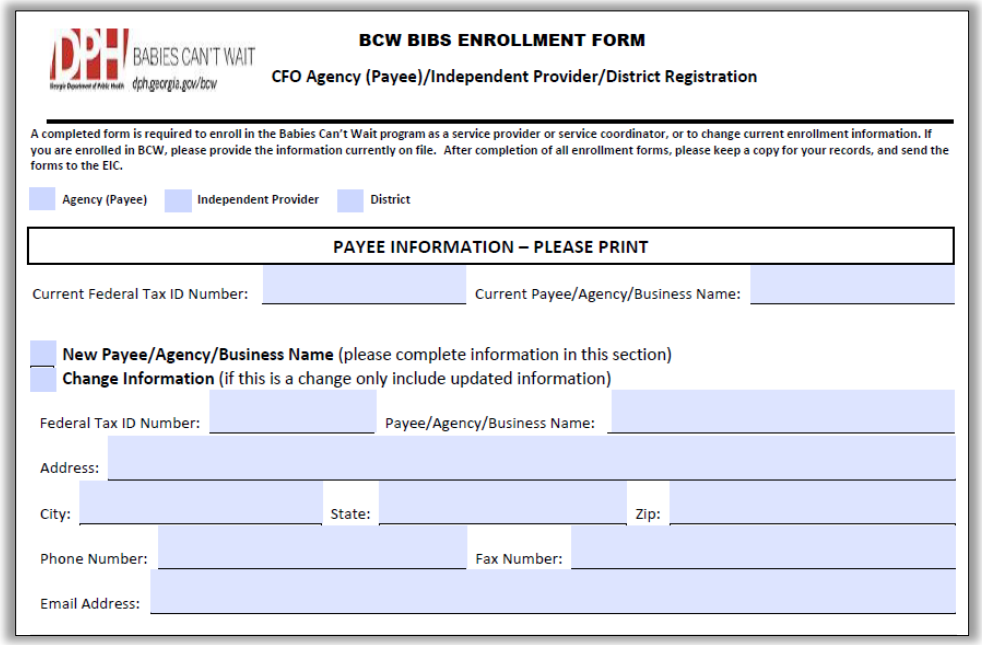
- If you have the specialties of Intake or Service Coordination a **BCW-BIBS.Com Online Access form** must also be completed

6.2.2.1 BCW BIBS Enrollment Form

Click the Independent Provider checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information - click the checkbox to select



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

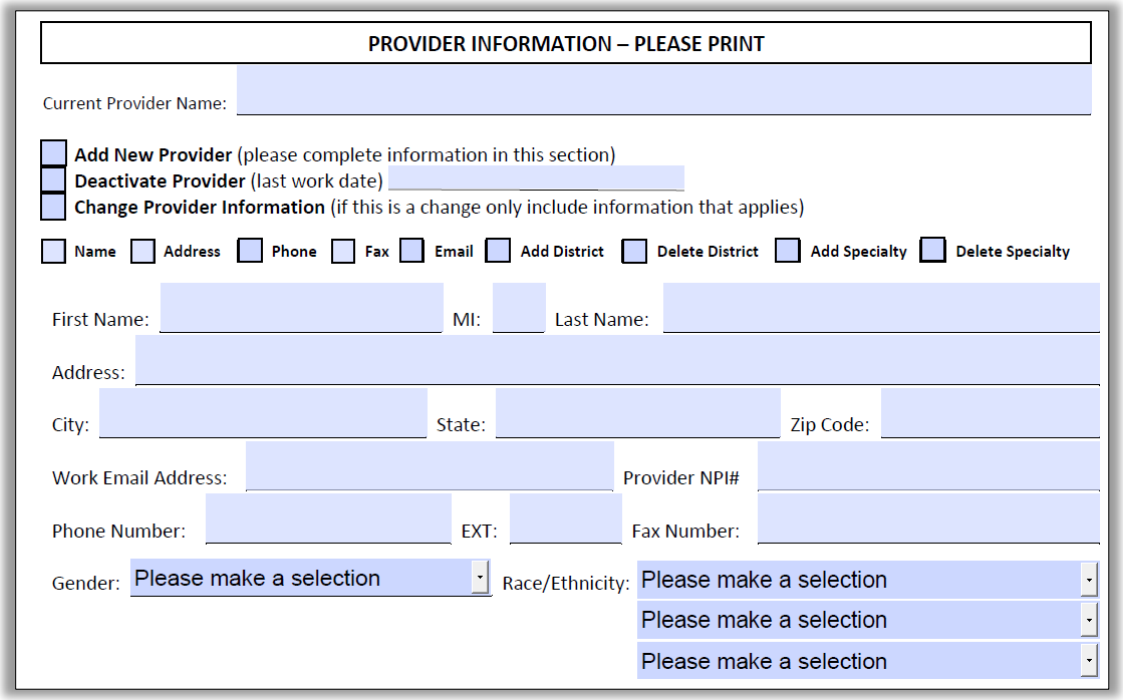
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Current Provider Name
- Add District – click the checkbox to select if adding a District(s)
- Delete District – click the checkbox to select if deleting a District(s)



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

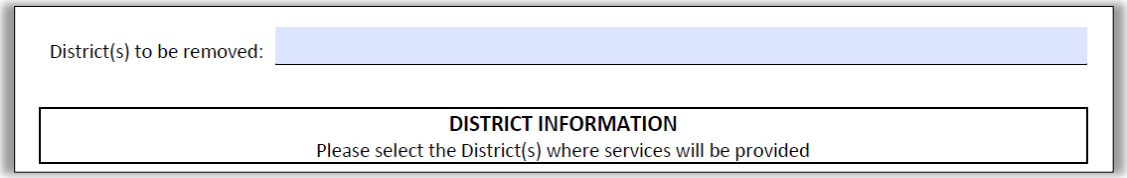
City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

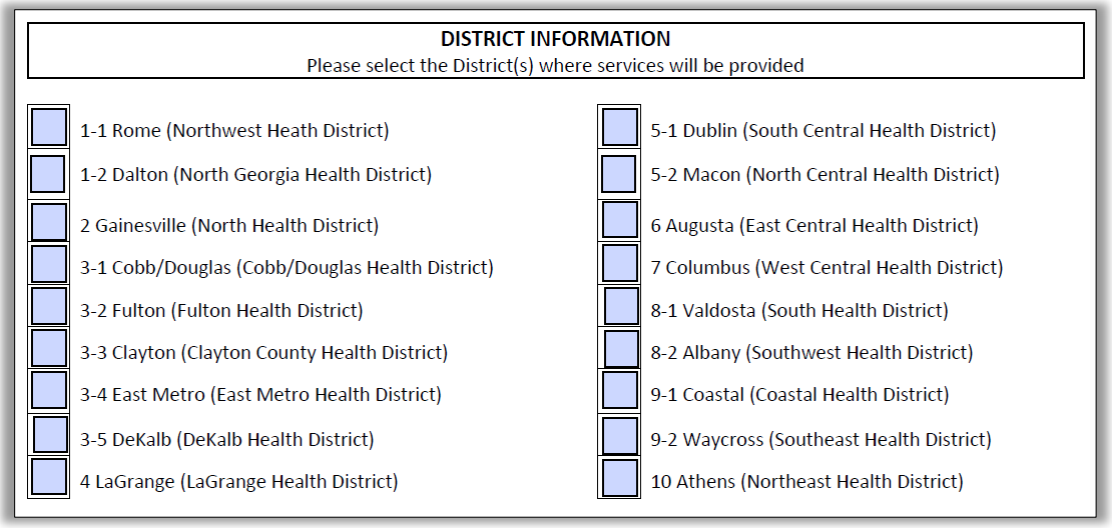
To remove a district(s), in the **District(s) to be removed text field** enter the name(s) of the district(s) to be removed. Please enter a comma between the districts if multiple districts are being removed.



District(s) to be removed:

DISTRICT INFORMATION
Please select the District(s) where services will be provided

To add a district(s), in the **District Information section** click on the checkbox(es) of the district(s) to be added.



DISTRICT INFORMATION

Please select the District(s) where services will be provided

☐ 1-1 Rome (Northwest Heath District)	☐ 5-1 Dublin (South Central Health District)
☐ 1-2 Dalton (North Georgia Health District)	☐ 5-2 Macon (North Central Health District)
☐ 2 Gainesville (North Health District)	☐ 6 Augusta (East Central Health District)
☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)	☐ 7 Columbus (West Central Health District)
☐ 3-2 Fulton (Fulton Health District)	☐ 8-1 Valdosta (South Health District)
☐ 3-3 Clayton (Clayton County Health District)	☐ 8-2 Albany (Southwest Health District)
☐ 3-4 East Metro (East Metro Health District)	☐ 9-1 Coastal (Coastal Health District)
☐ 3-5 DeKalb (DeKalb Health District)	☐ 9-2 Waycross (Southeast Health District)
☐ 4 LaGrange (LaGrange Health District)	☐ 10 Athens (Northeast Health District)

At the bottom of the form complete the following:

- Provider Signature – your signature
- Date

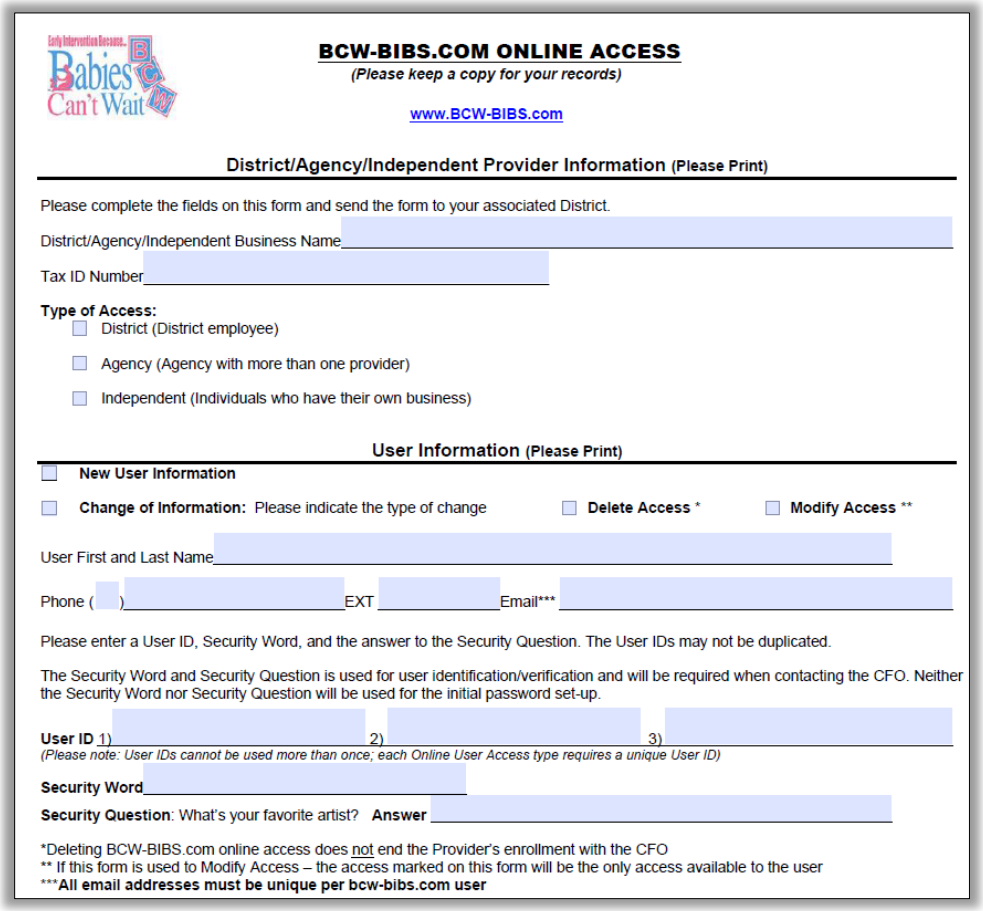
6.2.2.2 BCW-BIBS.Com Online Access

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - select *Independent (Individuals who have their own business)*

In the **User Information section**, complete the following:

- Change of Information – click in the checkbox to select
- Modify Access – click the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

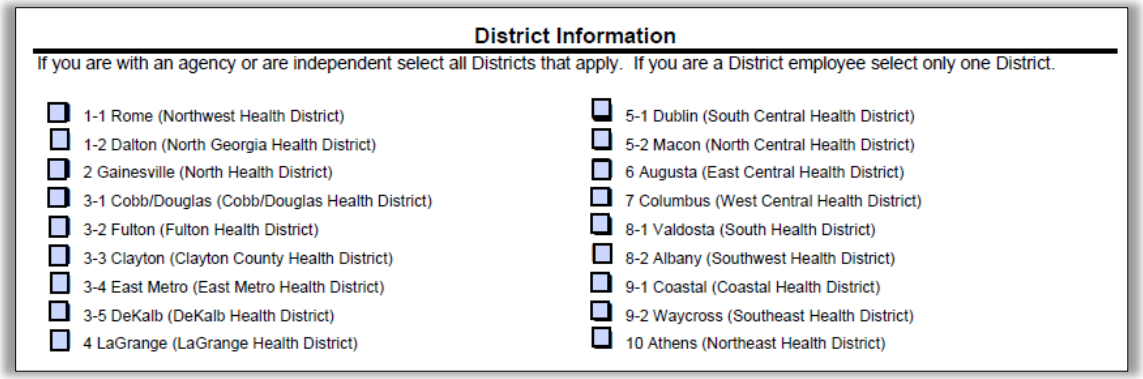
** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

To add a district(s), in the **District Information section** click on the checkbox(es) of the district(s) to be added.

To remove a district(s), in the **District Information Section** click on the checkbox(es) of the district(s) to be removed.

- Add the word remove to the right of the district name



District Information

If you are with an agency or are independent select all Districts that apply. If you are a District employee select only one District.

- ☐ 1-1 Rome (Northwest Health District)
- ☐ 1-2 Dalton (North Georgia Health District)
- ☐ 2 Gainesville (North Health District)
- ☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
- ☐ 3-2 Fulton (Fulton Health District)
- ☐ 3-3 Clayton (Clayton County Health District)
- ☐ 3-4 East Metro (East Metro Health District)
- ☐ 3-5 DeKalb (DeKalb Health District)
- ☐ 4 LaGrange (LaGrange Health District)
- ☐ 5-1 Dublin (South Central Health District)
- ☐ 5-2 Macon (North Central Health District)
- ☐ 6 Augusta (East Central Health District)
- ☐ 7 Columbus (West Central Health District)
- ☐ 8-1 Valdosta (South Health District)
- ☐ 8-2 Albany (Southwest Health District)
- ☐ 9-1 Coastal (Coastal Health District)
- ☐ 9-2 Waycross (Southeast Health District)
- ☐ 10 Athens (Northeast Health District)

At the bottom of the form complete the following:

- First Name and Last Name, Phone, EXT, and Email
- User Signature – your signature
- Date
- Agency Signature – your signature as the owner
- Date

6.2.3 Updating Bank Information

If you have changed banks or have a new bank account a **Direct Deposit/EFT Authorization Form** must be completed.

- A voided check or canceled check must be submitted with the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

The Direct Deposit/EFT Authorization form will not have to be completed if the Independent Provider only performs services in District 3-4 Lawrenceville/Gwinnett/East Metro

6.2.4 No Longer Contracting With BCW

If you will no longer be contracting with BCW the following forms must be completed:

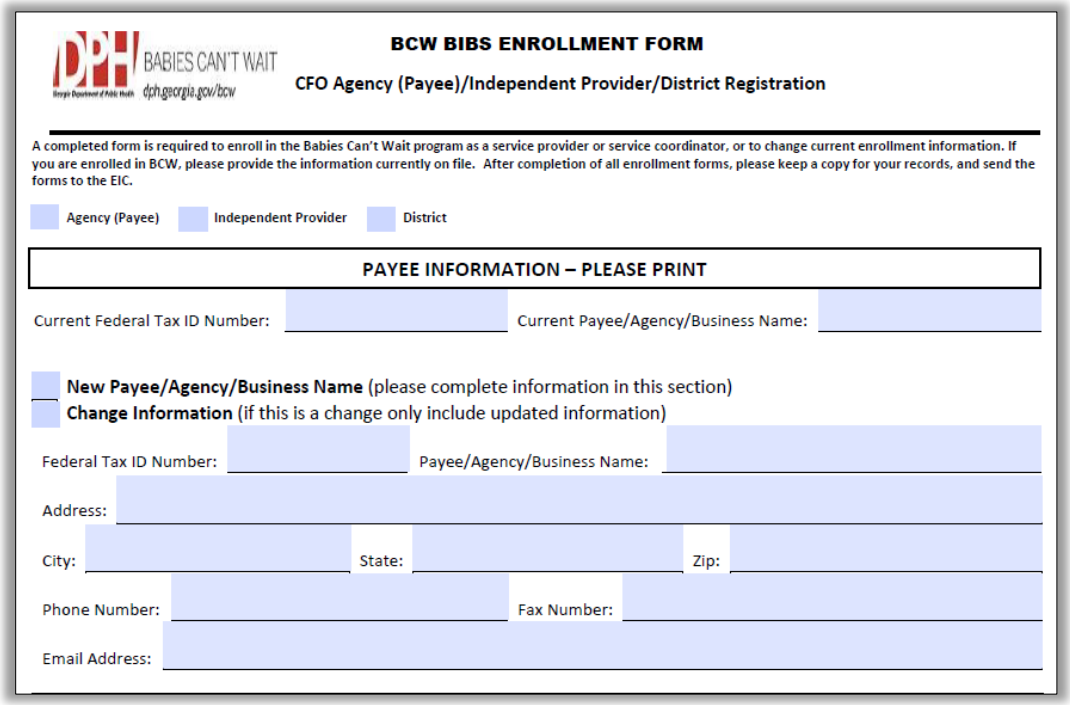
- **BCW-BIBS Enrollment**
- **BCW-BIBS.COM Online Access**

6.2.4.1 BCW-BIBS Enrollment Form

Click the Independent Provider checkbox to select

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name
- Change Information - **c**lick the checkbox to select



DPH BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

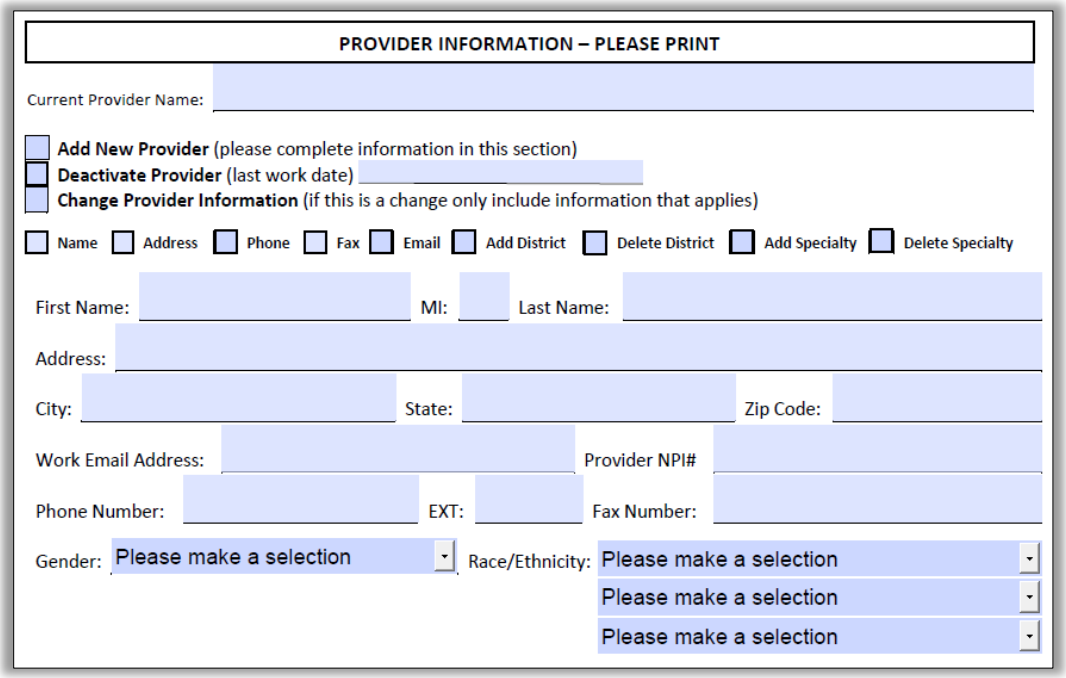
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **Provider Information section** complete the following:

- Current Provider Name
- Deactivate Provider – click on the checkbox to select
- (last work date) – enter the date you will no longer be contracting with BCW


PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

At the bottom of the form complete the following:

- Provider Signature – your signature
- Date

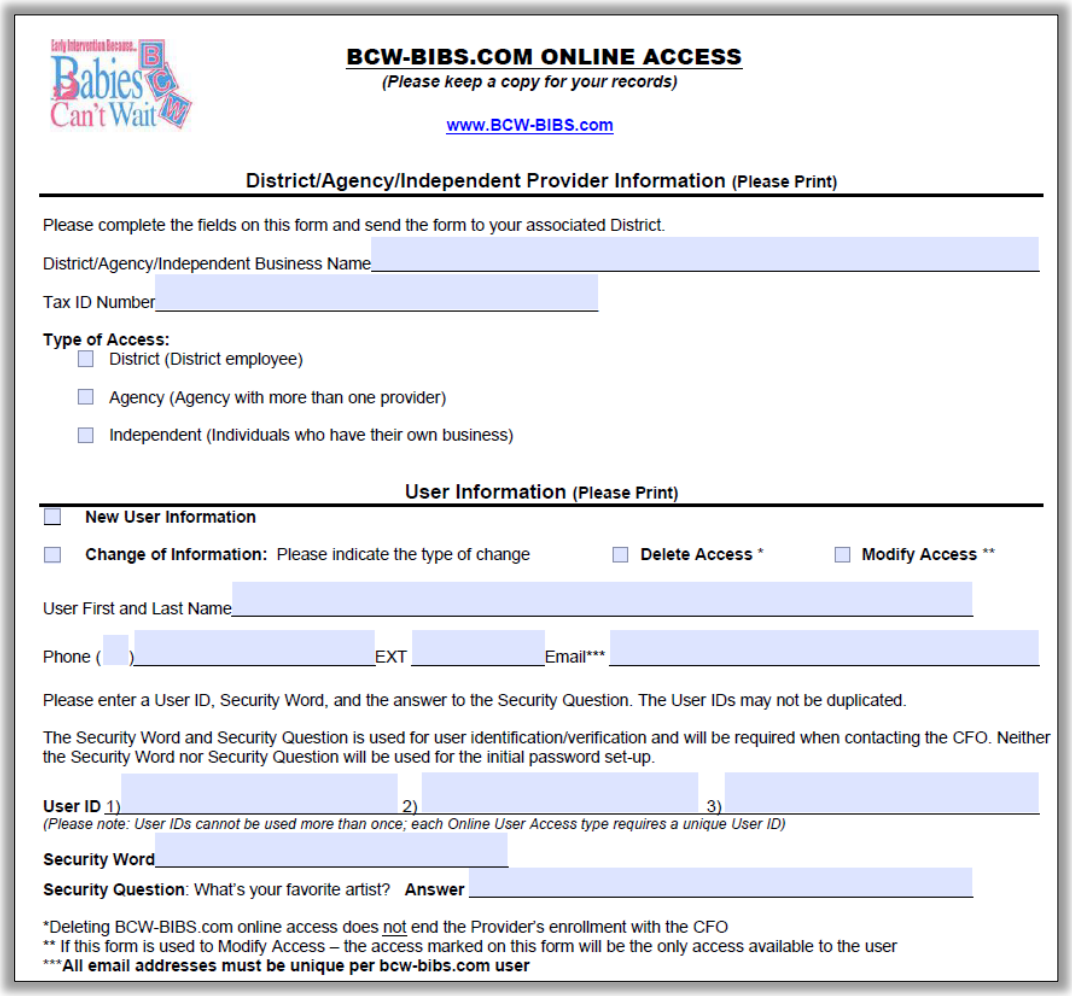
6.2.4.2 BCW-BIBS.COM Online Access Form

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - select *Independent (Individuals who have their own business)*

In the **User Information section**, complete the following:

- Change of Information – click in the checkbox to select
- Delete Access – click the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

At the bottom of the form complete the following:

- First Name and Last Name
- Phone, EXT, and Email
- User Signature – your signature
- Date
- Agency Signature – your signature as the owner
- Date

6.2.5 Tax ID/Name Change

6.2.5.1 Tax ID Change With or Without Business Name change

If an Independent Provider is changing from SSN to a FEIN, the following forms must be completed:

- **BCW BIBS Enrollment Form**
- **BCW- BIBS.COM Online Access**
- **Certification for Online Claims Form and Electronic Signature Agreement**
- **Direct Deposit/EFT Authorization Form * ***
- **W-9 Request for Taxpayer Identification Number and Certification Form * ***
- **Independent Provider/Self-Employed Checklist**

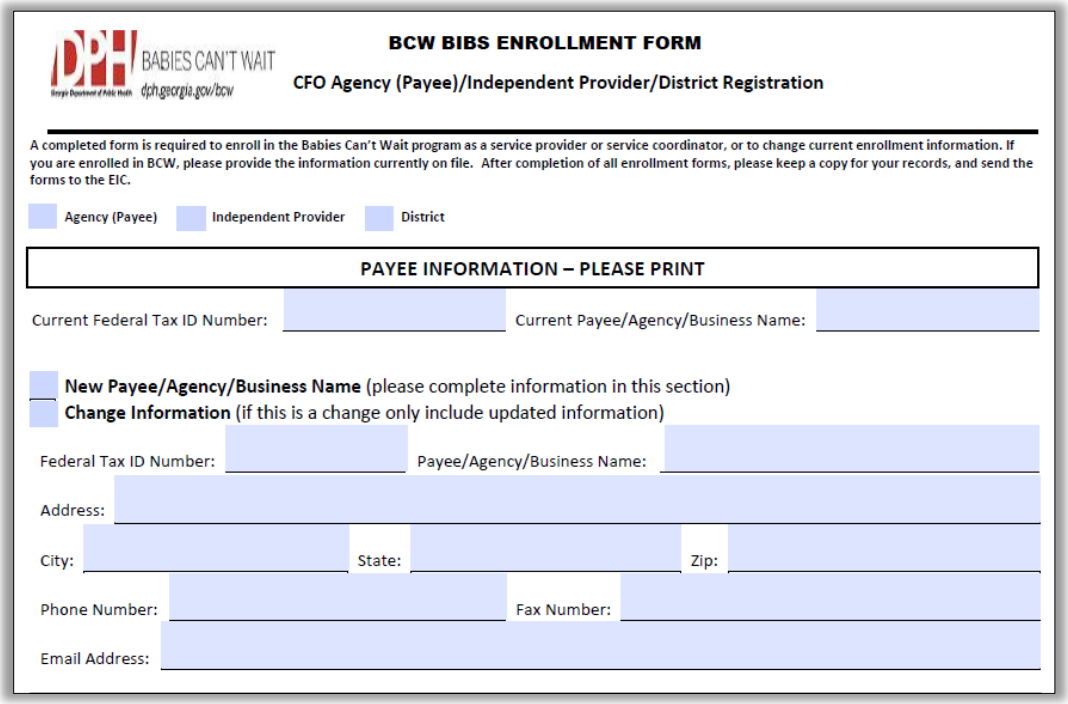
*** *** If the Independent Provider will only be performing services in District 3-4 Lawrenceville/Gwinnett/East Metro these forms do not need to be completed. If additional districts are added later these forms must be completed

6.2.6 BCW BIBS Enrollment Form

Click the **Independent Provider checkbox** at the top of the form

In the **Payee Information Section** complete the following:

- Current Federal Tax ID Number – enter SSN or current FEIN number
- Current Payee/Agency/Business Name
- Change Information - click the checkbox to select
- Federal Tax ID Number – enter the new FEIN number
- Payee/Agency/Business Name – if the business name is changing enter the new business name
- Enter the following information:
  - The Address, City, State, Zip, Phone Number, Fax Number, and Email Address



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

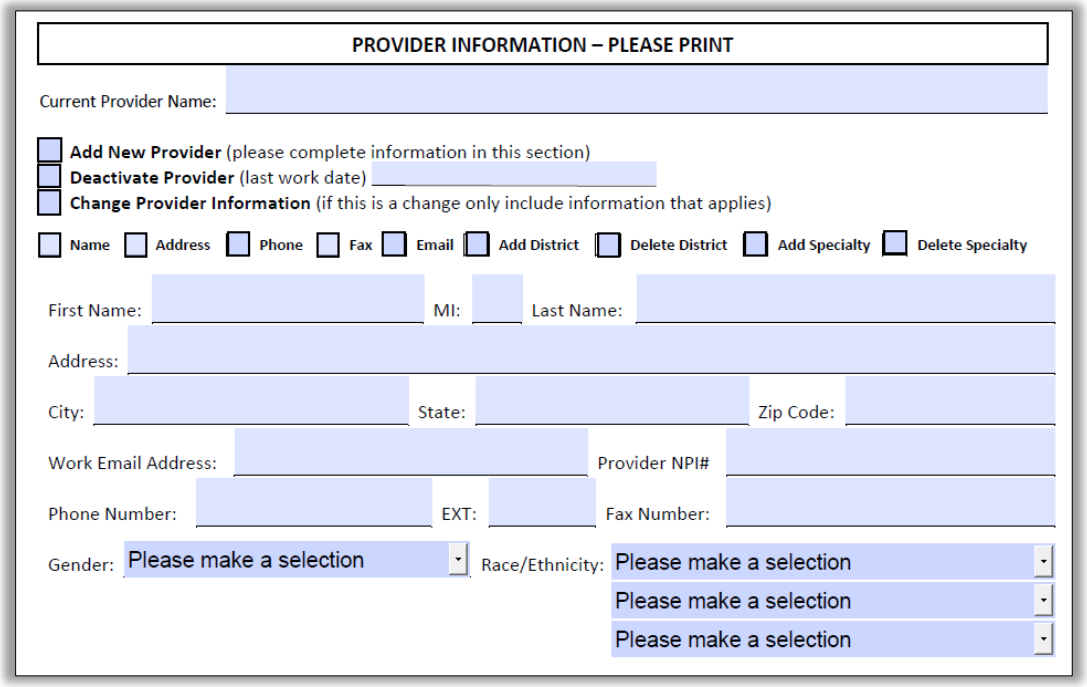
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

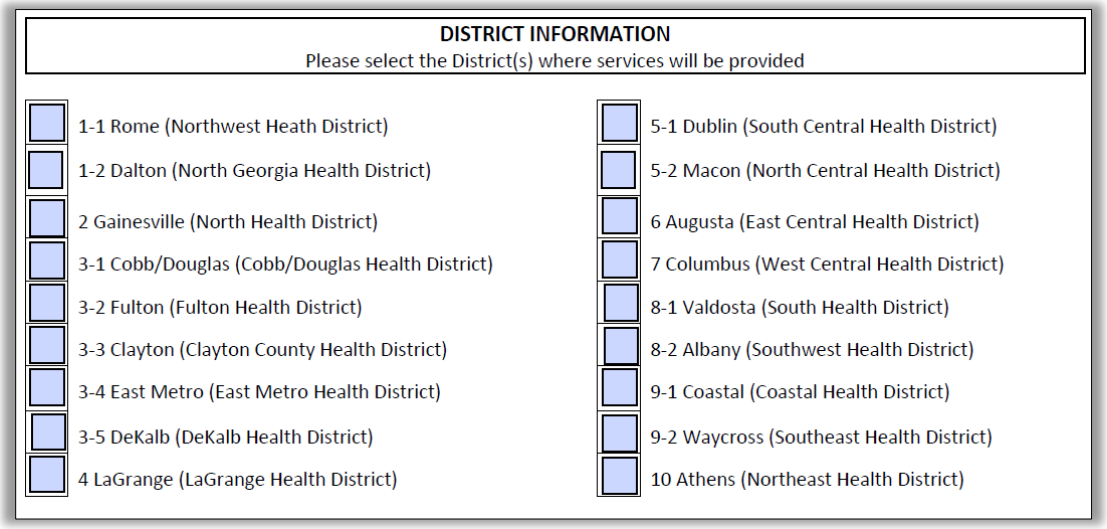
Email Address: _____

In the **Provider Information section**, complete the following:

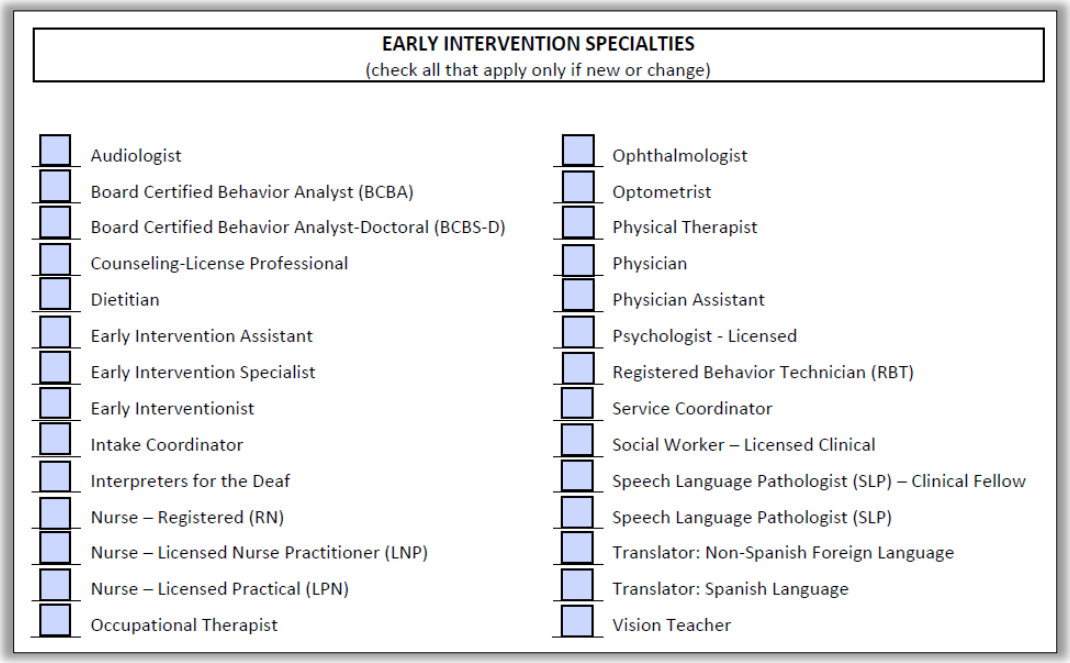
- Add New Provider - Click in the checkbox to select
- Enter your provider information
  - Gender - Select from the drop-down
  - Race/Ethnicity - Select from all applicable dropdowns



In the **District Information section**, select the District(s) where services will be provided by you as the provider. Only select the applicable districts.



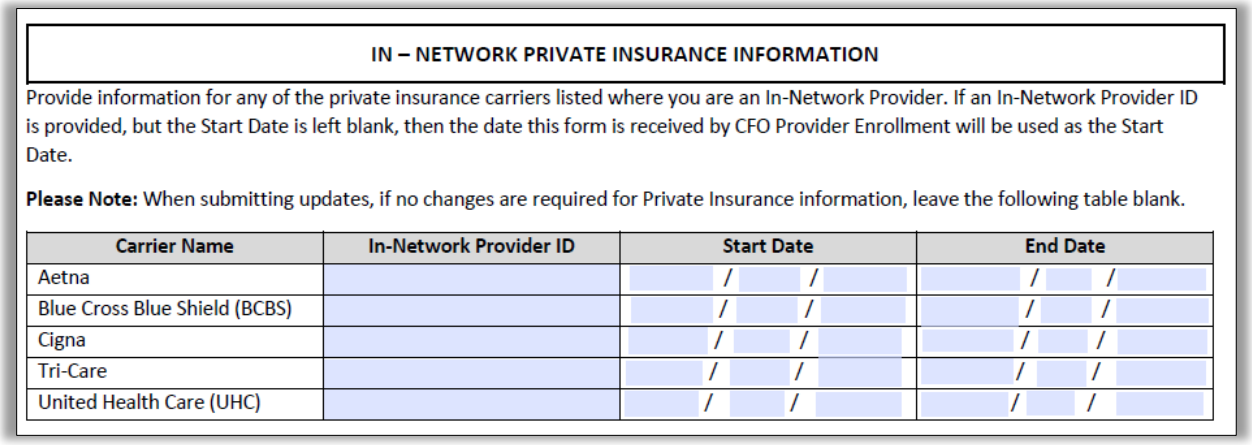
In the **Early Intervention Specialties section**, click on the checkboxes of all applicable Specialties for the provider.



EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

- ☐ Audiologist
- ☐ Board Certified Behavior Analyst (BCBA)
- ☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)
- ☐ Counseling-License Professional
- ☐ Dietitian
- ☐ Early Intervention Assistant
- ☐ Early Intervention Specialist
- ☐ Early Interventionist
- ☐ Intake Coordinator
- ☐ Interpreters for the Deaf
- ☐ Nurse – Registered (RN)
- ☐ Nurse – Licensed Nurse Practitioner (LNP)
- ☐ Nurse – Licensed Practical (LPN)
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychologist - Licensed
- ☐ Registered Behavior Technician (RBT)
- ☐ Service Coordinator
- ☐ Social Worker – Licensed Clinical
- ☐ Speech Language Pathologist (SLP) – Clinical Fellow
- ☐ Speech Language Pathologist (SLP)
- ☐ Translator: Non-Spanish Foreign Language
- ☐ Translator: Spanish Language
- ☐ Vision Teacher

In the **In-Network Private Insurance Information section**, enter the information for any private insurance carriers listed where you are an In-Network provider.



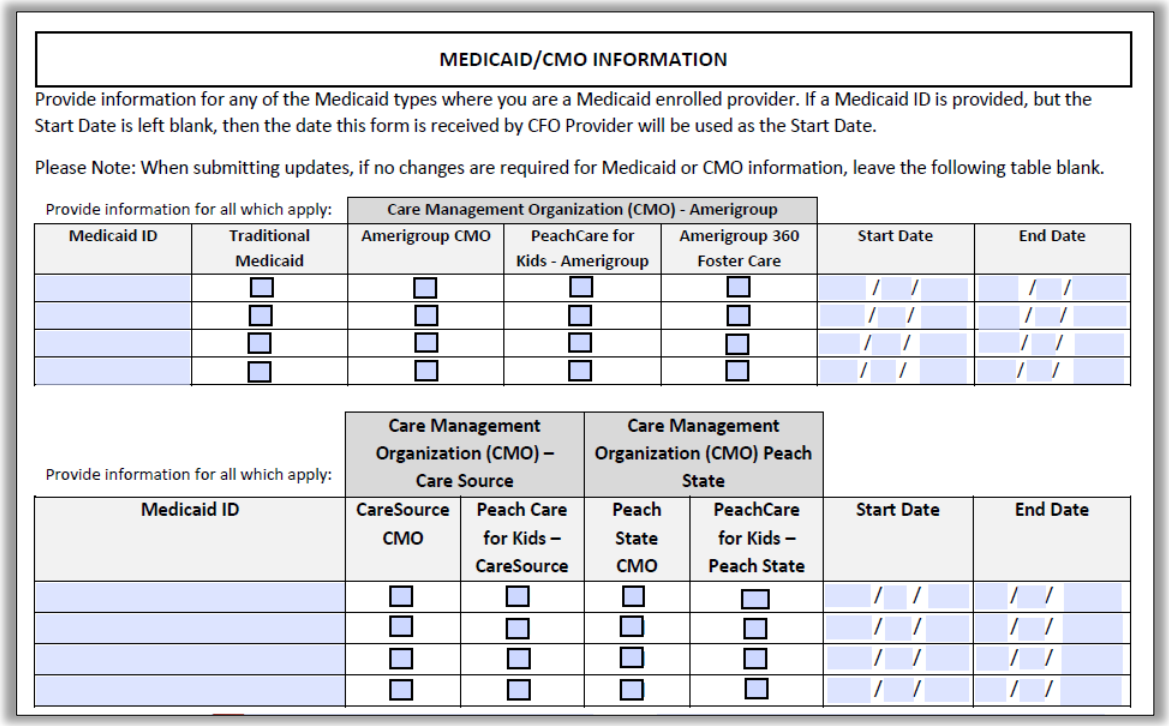
IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/CMO Information section**, enter the information for any Medicaid or CMOs you are enrolled with.



MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

At the bottom of the form complete the following:

- Provider Signature – your signature
- Date

6.2.7 BCW-BIBS.Com Online Access

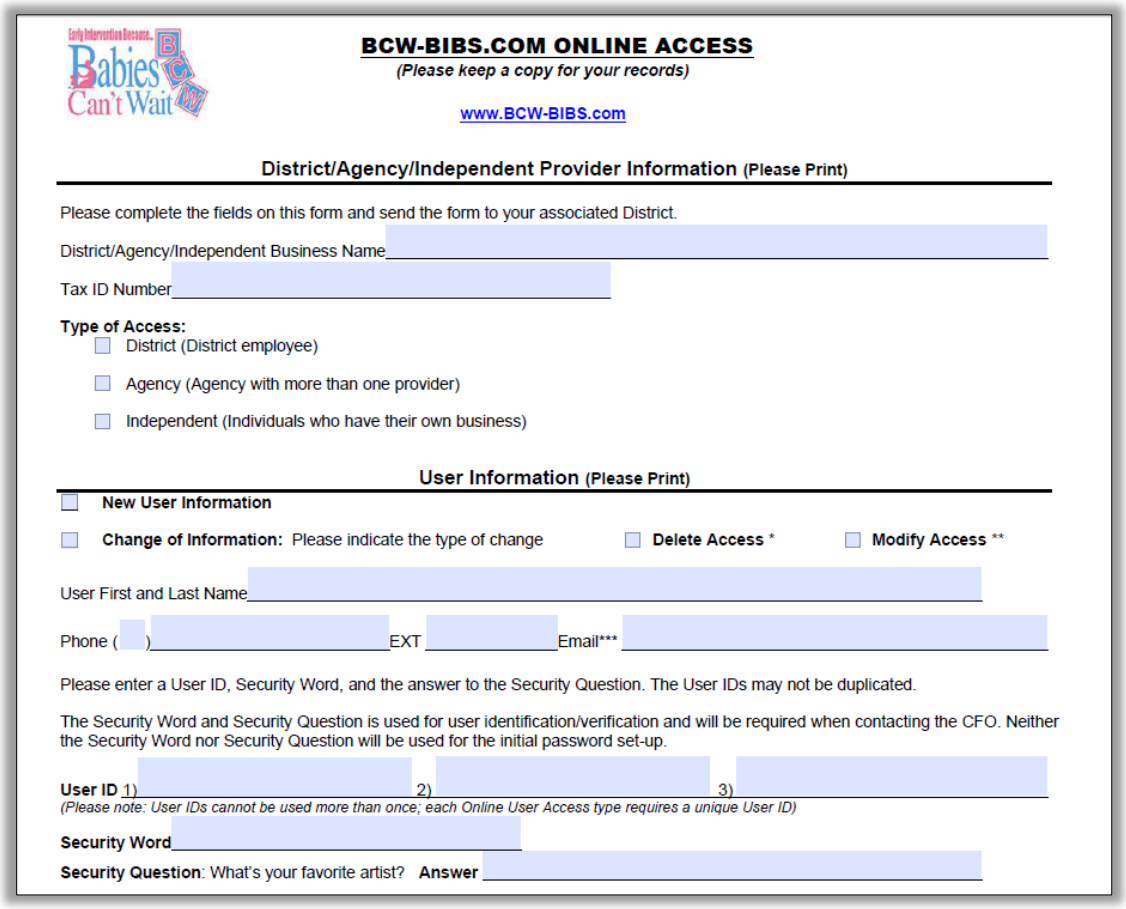
A **BCW-BIBS.Com Online Access form** must be completed to access the BCW-BIBS.com website.

- Never share or allow someone else to use your username and password

> **NOTE:** It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password and will be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
  - If the business name has changed enter the new business name
- Tax ID Number – enter in new FEIN number
- Type of Access - select *Independent (Individuals who have their own business)*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

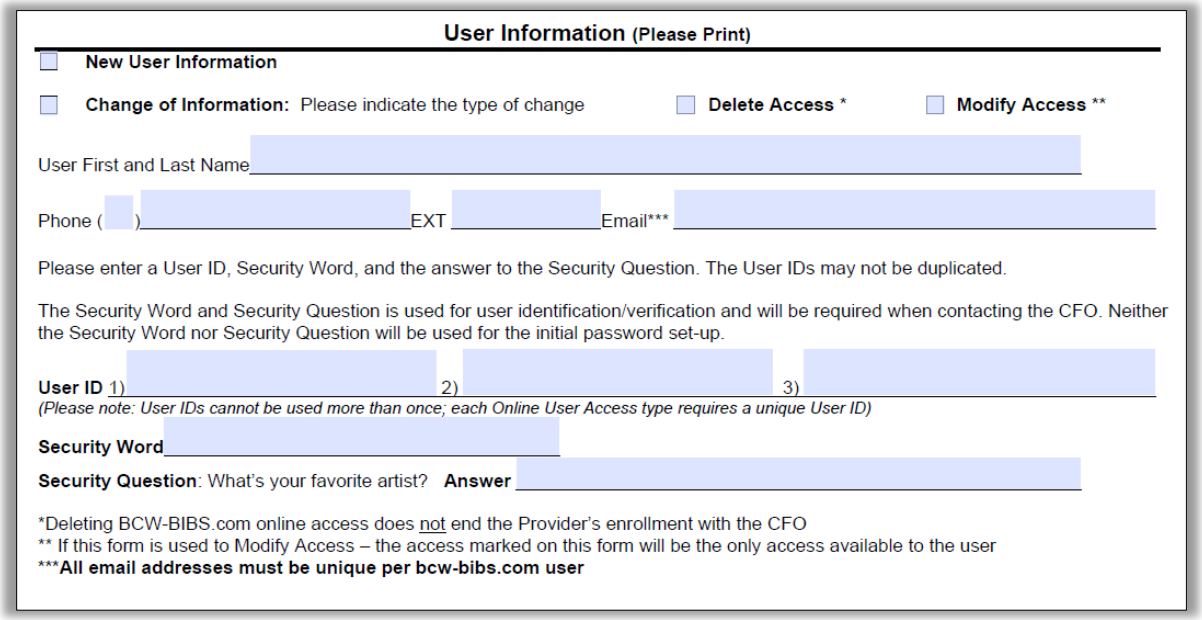
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- New User Information - Click the checkbox to select
- Enter First and Last Name, Phone, Ext, and Email
- User ID – Enter 3 User IDs - IDS must be different than those previously used
- Security Word - A single word to identify yourself
- Security Question - The answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

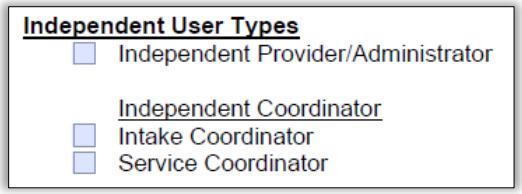
*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

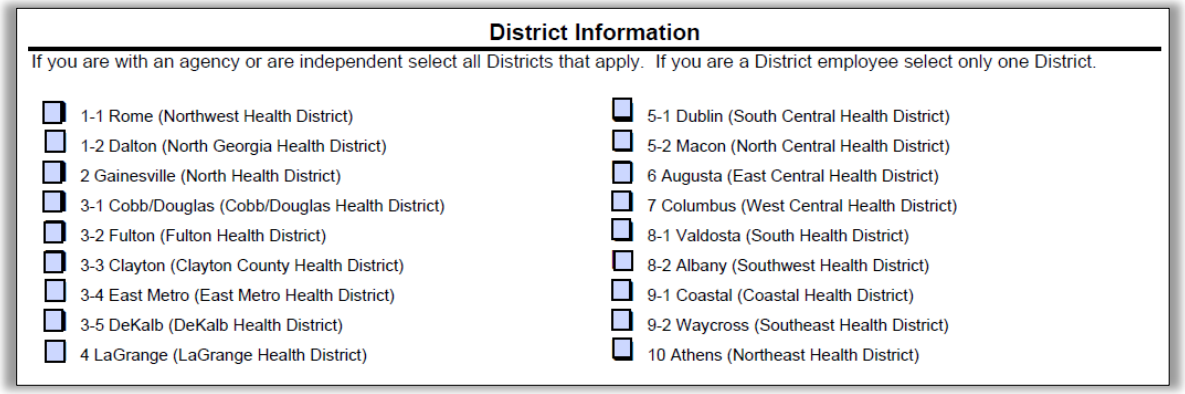
***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section**, if you are not enrolling with the specialties of Intake or Service Coordination only select Independent Provider/Administrator.

- If you are enrolling with the specialties of Intake or Service Coordination, select Independent Provider/Administrator and one or both Independent Coordinator types depending on your specialties



In the **District Information section**, select the checkbox(es) of the district(s) in which services will be performed. Only select the applicable districts, districts can be added later if necessary



At the bottom of the form complete the following:

- First Name and Last Name
- Phone, EXT, and Email
- User Signature – your signature
- Date
- Agency Signature – your signature as the owner
- Date

6.2.8 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims and Electronic Signature Agreement** is required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

- The form must be completed with the FEIN number and the new business name if applicable

6.2.9 Direct Deposit/EFT Authorization Form

Complete the **Direct Deposit/EFT Authorization form** for payments to be electronically transmitted into your account. All funds must be designated to one account.

- A voided check or canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

6.2.10 W-9 Request for Taxpayer Identification Number and Certification Form

A **W-9 form** must be completed with the new FEIN to receive a 1099 form, all fields on the form are required.

- The form must be completed with the FEIN number and the new business name is applicable

6.2.10.1 Name Change

If an Independent Provider is changing their name but the Tax ID number is not changing the following forms must be completed:

- **BCW BIBS Enrollment Form**
- **BCW- BIBS.COM Online Access**
- **W-9 Request for Taxpayer Identification Number and Certification Form * ***
  - Only needed if enrolled under your name

*** *** If the Independent Provider will only be performing services in District 3-4 Lawrenceville/Gwinnett/East Metro these forms do not need to be completed. If additional districts are added later these forms must be completed

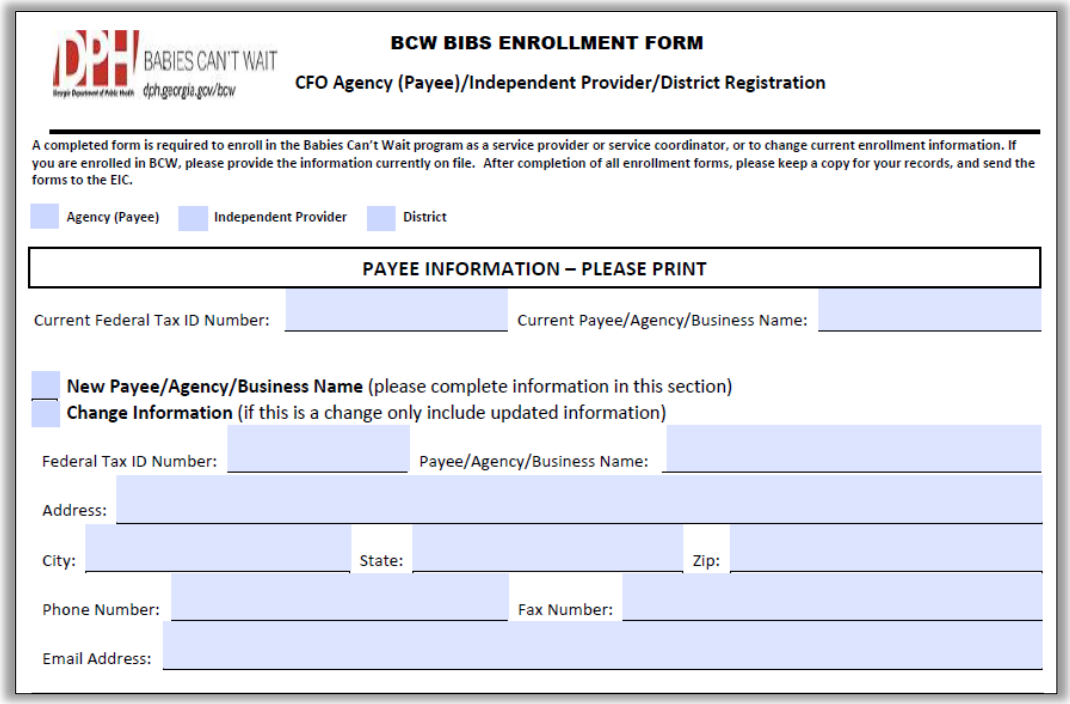
NOTE: Need a legal document of name change either a marriage certificate, divorce decree, or legal documentation

6.2.10.1.1 BCW BIBS Enrollment Form

Click the **Independent Provider checkbox** at the top of the form

In the **Payee Information Section** complete the following:

- Current Federal Tax ID Number – enter SSN or current FEIN number
- Current Payee/Agency/Business Name
- Change Information - click the checkbox to select
- Payee/Agency/Business Name – enter the new name of the business if changing
- Enter the following information:
  - The Address, City, State, Zip, Phone Number, Fax Number, and Email Address



DPH BABIES CAN'T WAIT dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

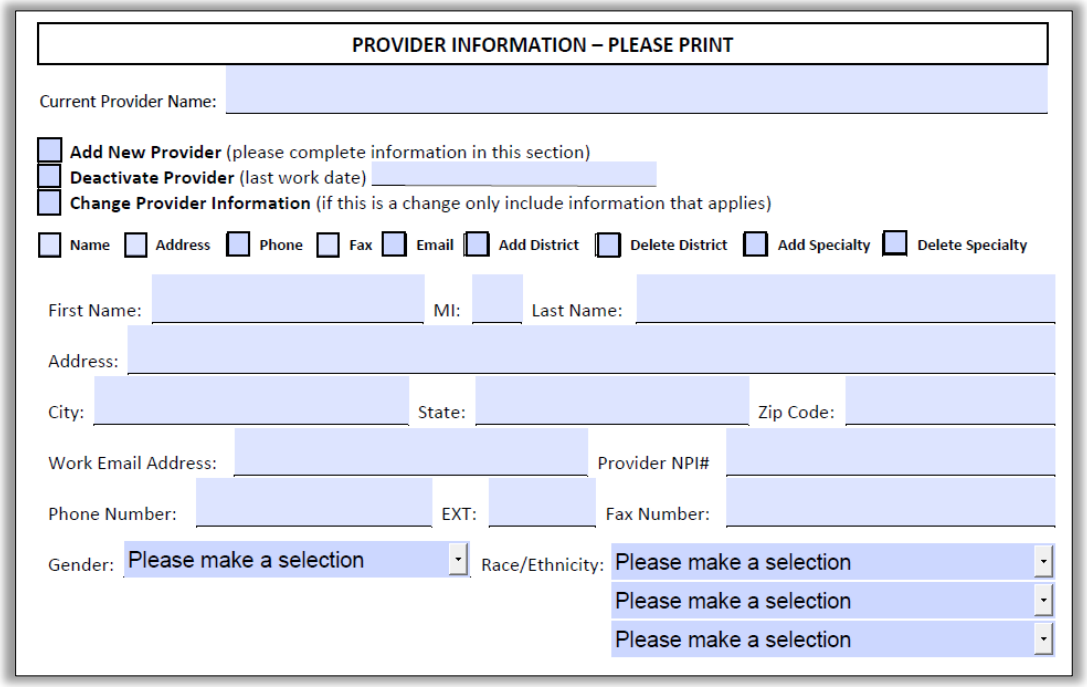
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **Provider Information section**, complete the following:

- Current Provider Name – Enter your previous name
- Change Provider Information – Click in the checkbox to select Name – Click in the checkbox to select
- First Name, MI, Last Name - Enter your new/current name



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

☐ **Add New Provider** (please complete information in this section)
☐ **Deactivate Provider** (last work date) _____
☐ **Change Provider Information** (if this is a change only include information that applies)

☐ Name ☐ Address ☐ Phone ☐ Fax ☐ Email ☐ Add District ☐ Delete District ☐ Add Specialty ☐ Delete Specialty

First Name: MI: Last Name:

Address:

City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection

Please make a selection

Please make a selection

At the bottom of the form complete the following:

- Provider Signature – your signature
- Date

6.2.10.1.2 BCW-BIBS.Com Online Access

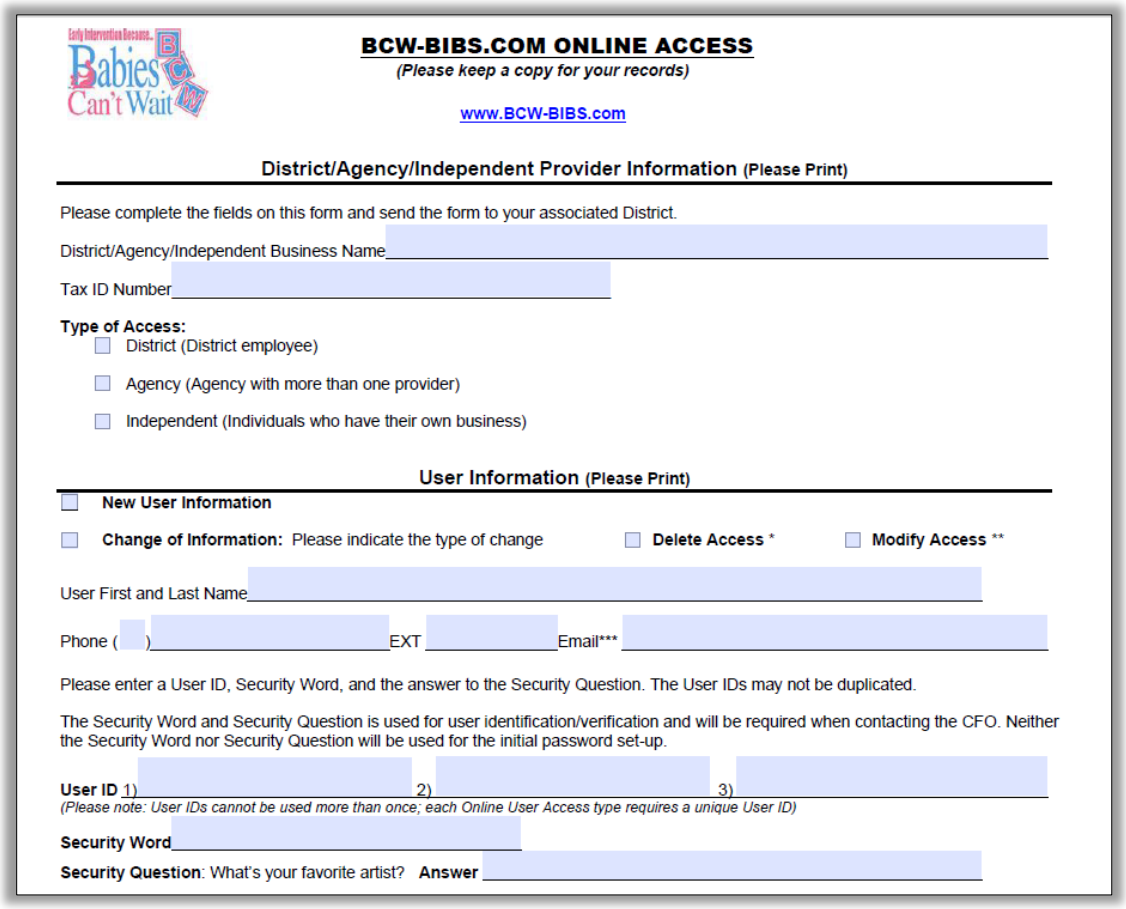
A **BCW-BIBS.Com Online Access form** must be completed to access the BCW-BIBS.com website.

- Never share or allow someone else to use your username and password

> **NOTE:** It is very important to make a copy of this form. The information on this form will be used to create your password after receiving your temporary password and will be used to identify yourself when contacting Gainwell Technologies (BIBS vendor) when you have questions or problems.

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
  - Enter the new name of the business if changing otherwise enter the current business name
- Tax ID Number – enter current SSN or FEIN
- Type of Access - select *Independent (Individuals who have their own business)*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

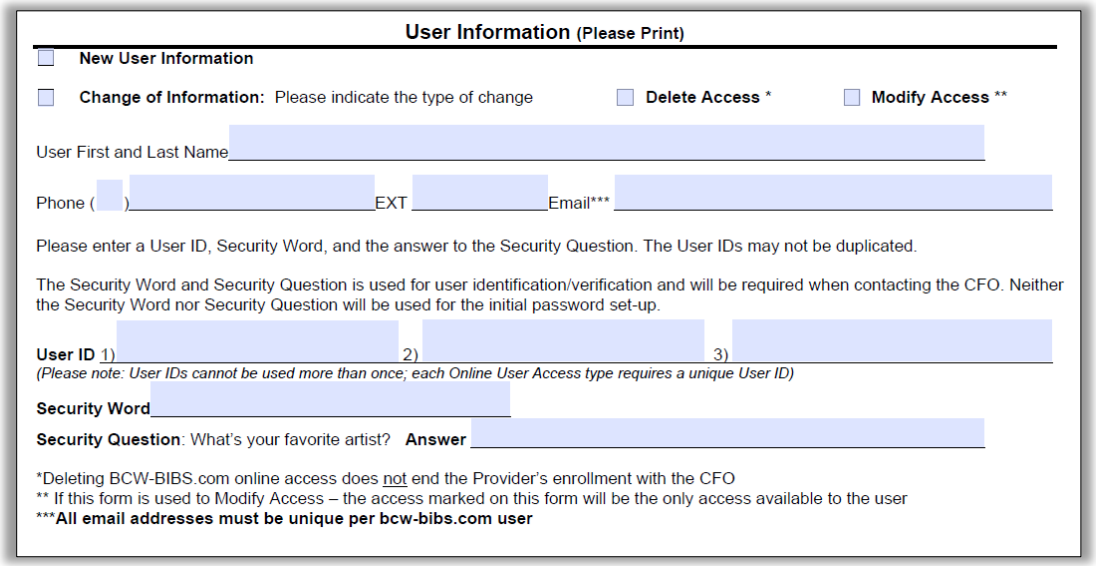
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- Change of Information - Click the checkbox to select
- Modify Access – Click the checkbox to select
- User First and Last Name- -Enter new/current name



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

At the bottom of the form complete the following:

- First Name and Last Name
- Phone, EXT, and Email
- User Signature – your signature

- Date
- Agency Signature – your signature as the owner
- Date

6.2.10.1.3 Direct Deposit/EFT Authorization Form

Complete the **Direct Deposit/EFT Authorization form** for payments to be electronically transmitted into your account if there is a name change on the bank account.

- A voided check or canceled check must accompany the Direct Deposit/EFT Authorization form, a copy is acceptable
  - If you do not have a check, a bank letter can be sent with the following required information: Routing number, Checking Account number, and Bank Name
  - It is acceptable to email these directly to gaeienroll@gainwelltechnologies.com

6.2.10.1.4 W-9 Request for Taxpayer Identification Number and Certification Form

A **W-9 form** must be completed with the new FEIN to receive a 1099 form, all fields on the form are required.

- The form must be completed with the FEIN number and the new business name is applicable

6.2.11 Changing from an Independent Provider To An Agency

If an independent provider is going to hire other providers, the independent provider must be enrolled as an agency.

The Independent's provider's business and provider will be ended including their Online User Access. The independent provider must complete the forms as an agency and owner (see section 4.1).
The providers hired by the independent provider must complete forms for an agency provider (see section 5.1)

7.0 District

7.1 EIC or Designee

7.1.1 Add A New EIC or Designee (EIC Access Only)

To add an EIC or Designee to a district, complete the following forms:

- **BCW-BIBS.COM Online Access**
- **Certification For Online Claims and Electronic Signature Agreement**
- **District Checklist**

> **NOTE:** If the new EIC or Designee will be enrolling as a provider, Intake, and/or Service Coordinator additional forms will need to be completed. See section 7.2.1 for information regarding additional forms and how to complete the BCW-BIBS.COM Online Access form.

District Checklist

✓	Form Name and Description	Original Signature Required?	District Approval Required?
	1. BCW BIBS Enrollment Form – *Required* - Complete this form to enroll as a Provider employed by the District	Yes	No
	2. BCW-BIBS.COM Online Access Form - *Required* - Complete this form to receive access to the BIBS system	Yes	Yes
	3. Certification for Online Claims Form and Electronic Signature Agreement Form – *Required* - Complete this form to perform direct data claim entry into the BIBS system and to certify authorization of your electronic signature for all actions within the BIBS system	Yes	Yes

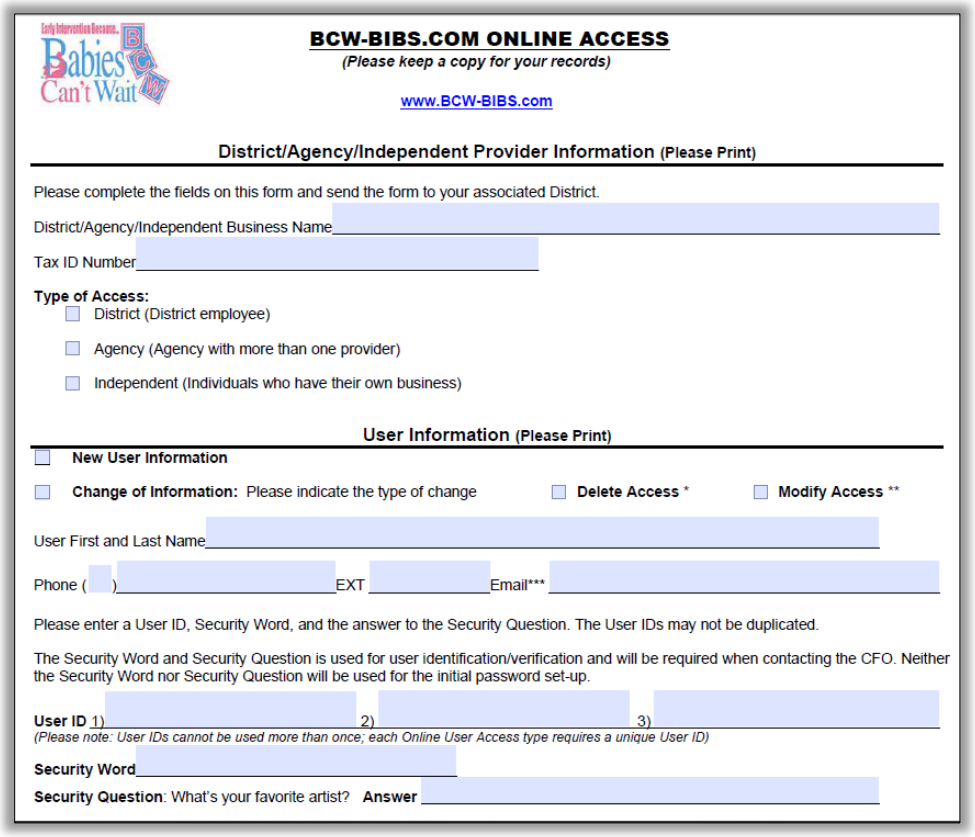
7.1.1.1 BCW-BIBS.COM Online Access Form

In the District/Agency/Independent Provider Information section complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access – click the checkbox *District (District employee)*

In the **User Information section** complete the following information:

- New User Information – click the checkbox to select
- User First and Last Name – the name of the EIC or Designee
- Phone, Ext, and Email for the EIC or Designee
- User ID – enter 3 IDs
- Security Word – enter one word to identify the EIC or Designee
- Security Question – answer the question 'What's your favorite artist?'



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

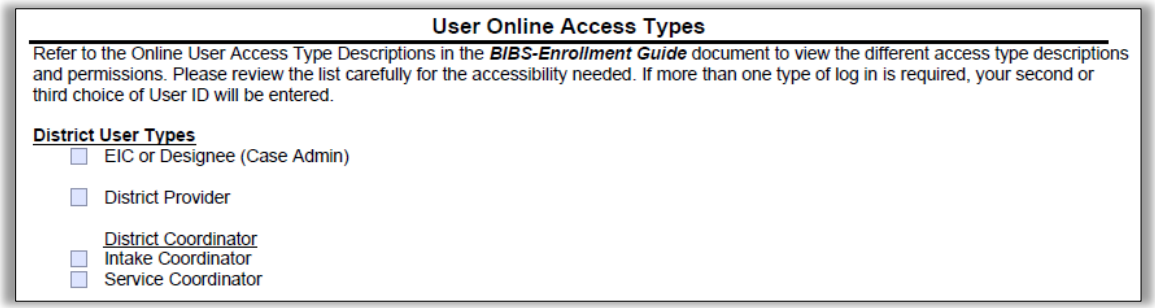
User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Online Access Types section**, select EIC or Designee (Case Admin) checkbox



User Online Access Types

Refer to the Online User Access Type Descriptions in the ***BIBS-Enrollment Guide*** document to view the different access type descriptions and permissions. Please review the list carefully for the accessibility needed. If more than one type of log in is required, your second or third choice of User ID will be entered.

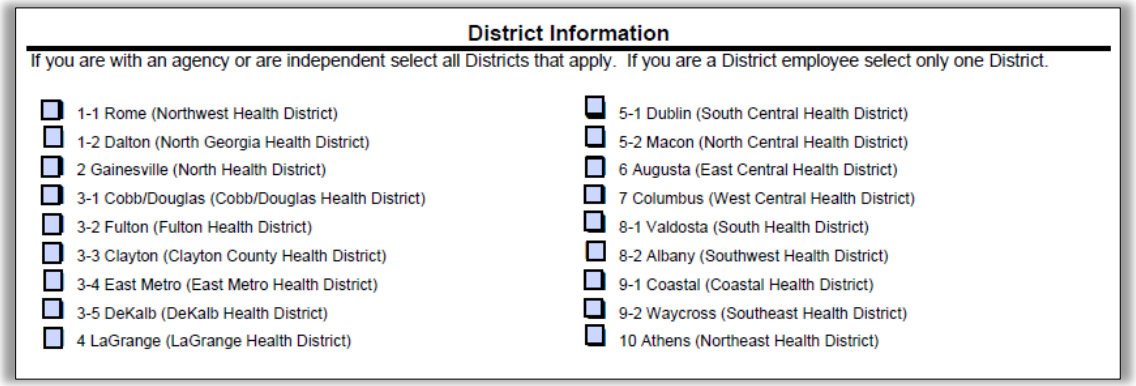
District User Types

- ☐ EIC or Designee (Case Admin)
- ☐ District Provider

District Coordinator

- ☐ Intake Coordinator
- ☐ Service Coordinator

In the **District Information section,** select the applicable District checkbox



At the bottom of the form complete the following information:

- First Name and Last Name, Phone, EXT, and email address
- User Signature – the signature of the EIC or Designee
- Date
- District EIC Signature – the signature of the District EIC
- Date

7.1.1.2 Certification For Online Claims and Electronic Signature Agreement

The **Certification for Online Claims and Electronic Signature Agreement** is required to enter claims/information on the BCW-BIBS.com website. Please read the document completely before signing the form.

7.1.2 New EIC/Designee Enrolling As A Provider And/or Intake/Service Coordinator

If the new EIC or Designee will also be enrolling as a provider and as an Intake and/or Service Coordination the following forms must be completed:

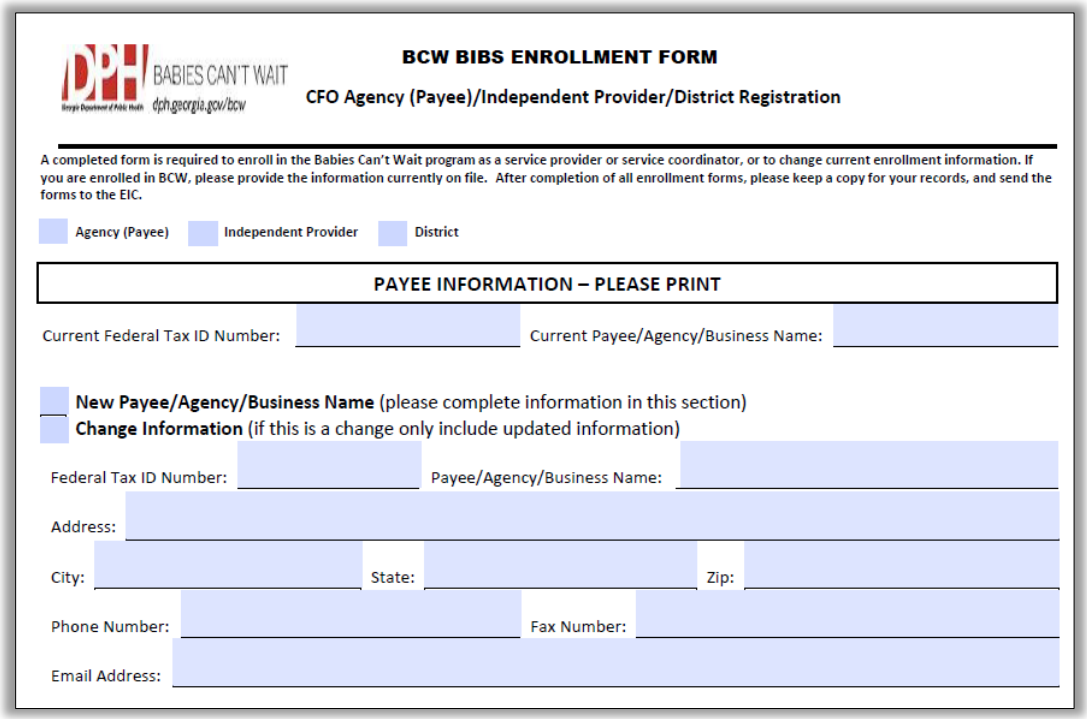
- **BCW BIBS Enrollment**
- **BCW-BIBS.COM Online Access**
- **Certification For Online Claims and Electronic Signature Agreement**
- **District Checklist**

7.1.2.1 BCW BIBS Enrollment Form

Click the **District checkbox** at the top of the form

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

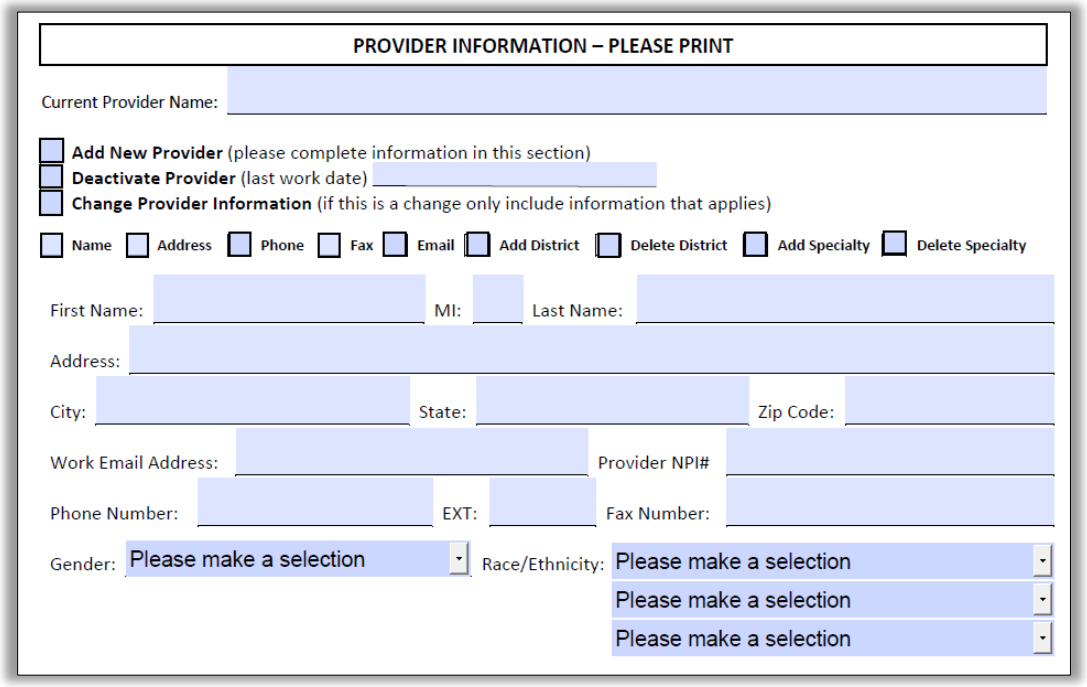
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Add New Provider - click in the checkbox to select
- Enter the (EIC/Designee) provider information
  - Gender - Select from the drop-down
  - Race/Ethnicity - Select from the drop-down(s)



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

Add New Provider (please complete information in this section)
Deactivate Provider (last work date)
Change Provider Information (if this is a change only include information that applies)

Name Address Phone Fax Email Add District Delete District Add Specialty Delete Specialty

First Name: MI: Last Name:

Address:

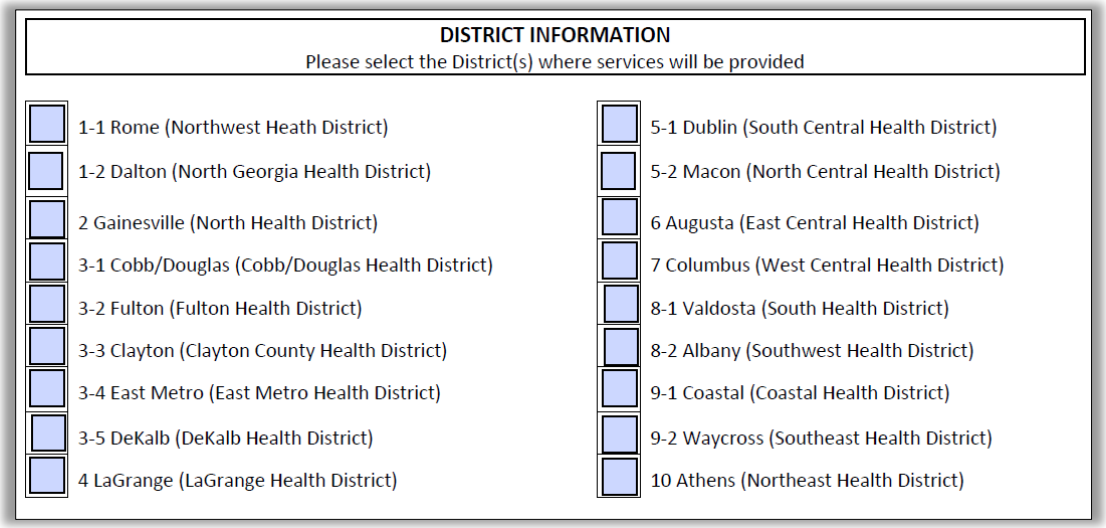
City: State: Zip Code:

Work Email Address: Provider NPI#

Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection
Please make a selection
Please make a selection

In the **District Information section**, select the district where services will be provided

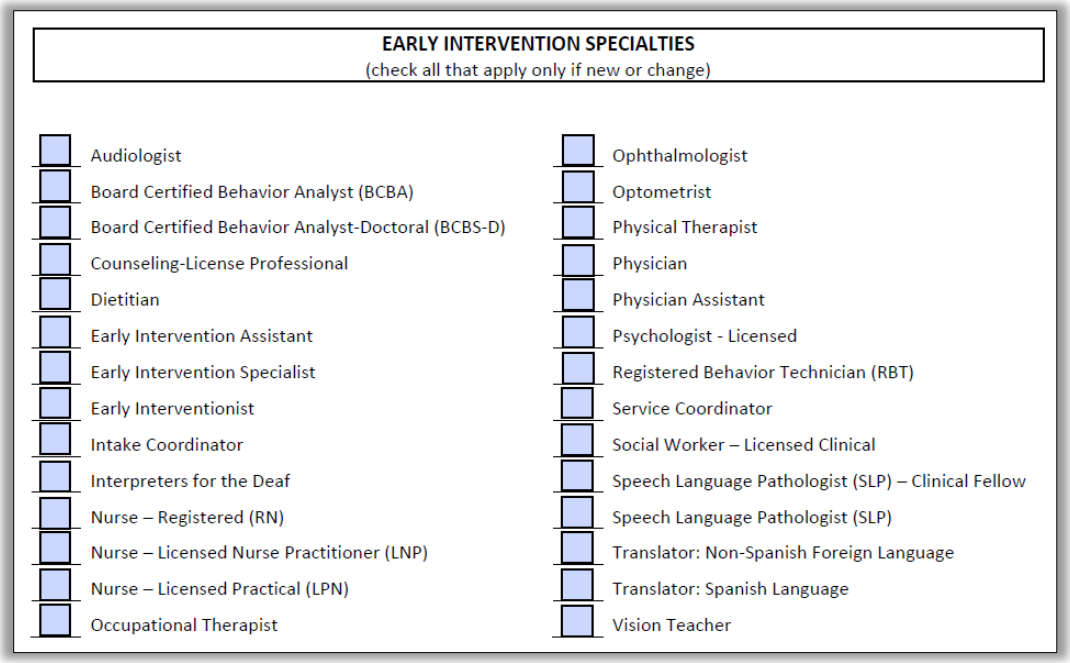


DISTRICT INFORMATION

Please select the District(s) where services will be provided

- ☐ 1-1 Rome (Northwest Heath District)
- ☐ 1-2 Dalton (North Georgia Health District)
- ☐ 2 Gainesville (North Health District)
- ☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
- ☐ 3-2 Fulton (Fulton Health District)
- ☐ 3-3 Clayton (Clayton County Health District)
- ☐ 3-4 East Metro (East Metro Health District)
- ☐ 3-5 DeKalb (DeKalb Health District)
- ☐ 4 LaGrange (LaGrange Health District)
- ☐ 5-1 Dublin (South Central Health District)
- ☐ 5-2 Macon (North Central Health District)
- ☐ 6 Augusta (East Central Health District)
- ☐ 7 Columbus (West Central Health District)
- ☐ 8-1 Valdosta (South Health District)
- ☐ 8-2 Albany (Southwest Health District)
- ☐ 9-1 Coastal (Coastal Health District)
- ☐ 9-2 Waycross (Southeast Health District)
- ☐ 10 Athens (Northeast Health District)

In the **Early Intervention Specialties section**, click on the checkboxes of all applicable specialties.

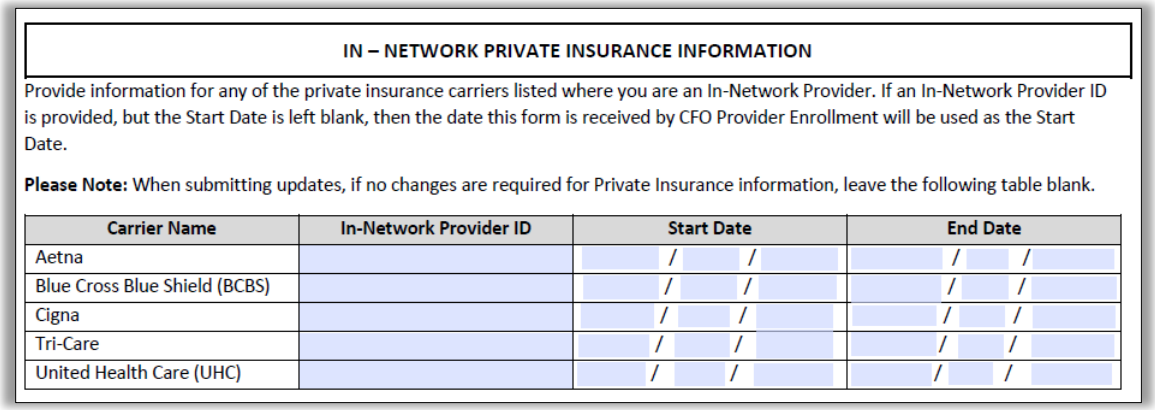


EARLY INTERVENTION SPECIALTIES

(check all that apply only if new or change)

- ☐ Audiologist
- ☐ Board Certified Behavior Analyst (BCBA)
- ☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)
- ☐ Counseling-License Professional
- ☐ Dietitian
- ☐ Early Intervention Assistant
- ☐ Early Intervention Specialist
- ☐ Early Interventionist
- ☐ Intake Coordinator
- ☐ Interpreters for the Deaf
- ☐ Nurse – Registered (RN)
- ☐ Nurse – Licensed Nurse Practitioner (LNP)
- ☐ Nurse – Licensed Practical (LPN)
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychologist - Licensed
- ☐ Registered Behavior Technician (RBT)
- ☐ Service Coordinator
- ☐ Social Worker – Licensed Clinical
- ☐ Speech Language Pathologist (SLP) – Clinical Fellow
- ☐ Speech Language Pathologist (SLP)
- ☐ Translator: Non-Spanish Foreign Language
- ☐ Translator: Spanish Language
- ☐ Vision Teacher

In the **In-Network Private Insurance Information section**, enter the information for any private insurance carriers listed where the EIC or Designee is an In-Network provider.



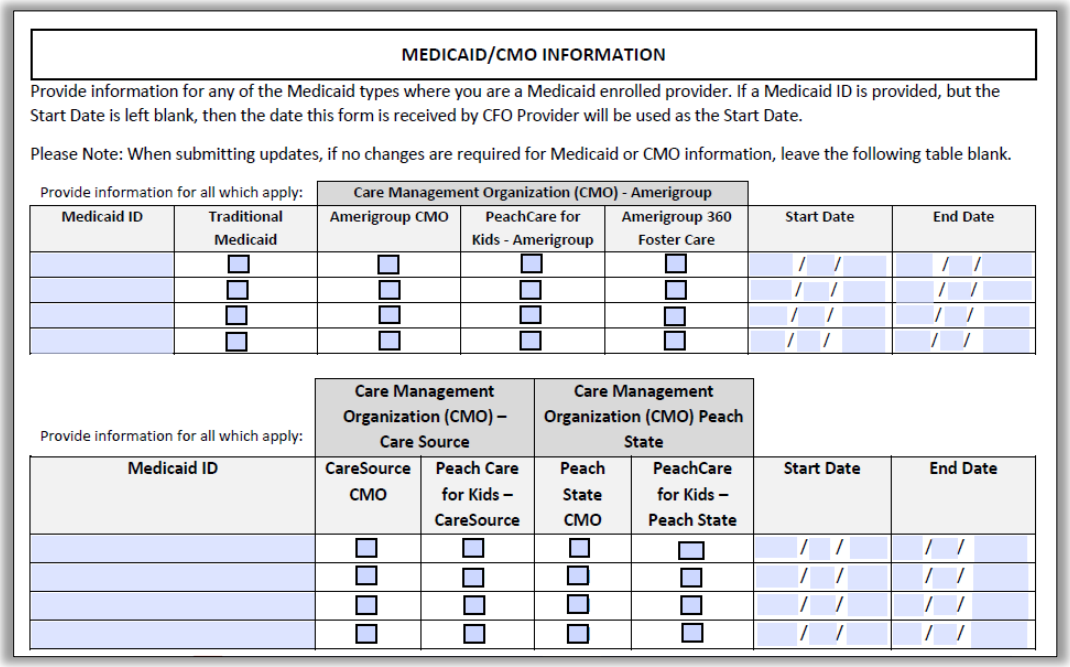
IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/CMO Information section**, enter the information for any Medicaid or CMOs the EIC or Designee is enrolled with.



MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

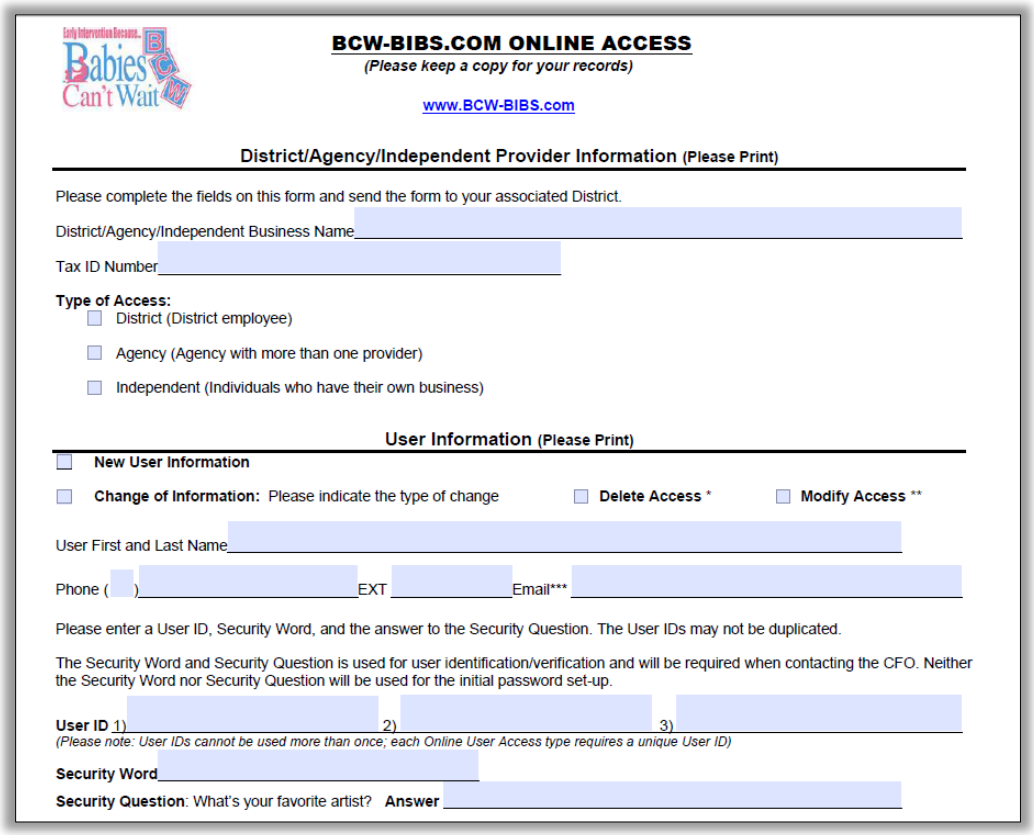
At the bottom of the form complete the following:

- Provider Signature - the signature of the EIC or Designee
- Date

7.1.2.2 BCW-BIBS.Com Online Access

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *District (District employee)*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

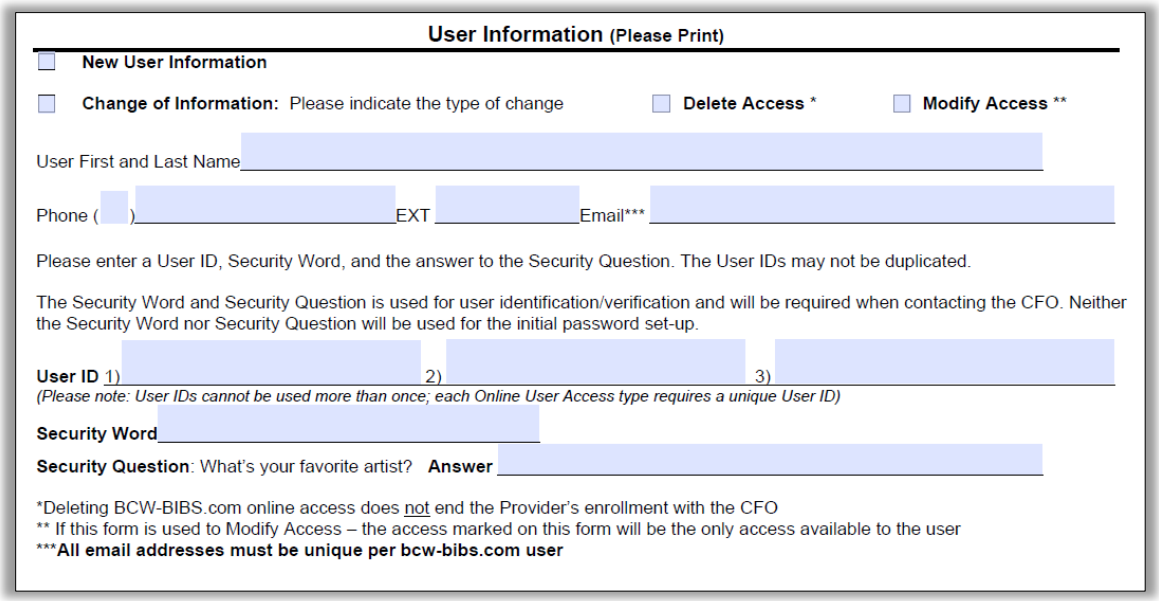
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- New User Information - click the checkbox to select
- First and Last Name, Phone, EXT, and Email of the person requesting access
- User ID - enter 3 User IDs
- Security Word - a single word to identify yourself
- Security Question - The answer to the question '*What's your favorite artist?*'



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

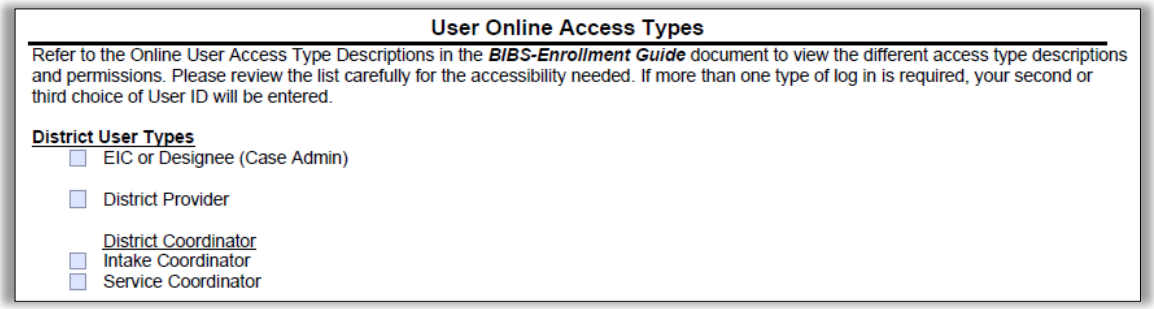
** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

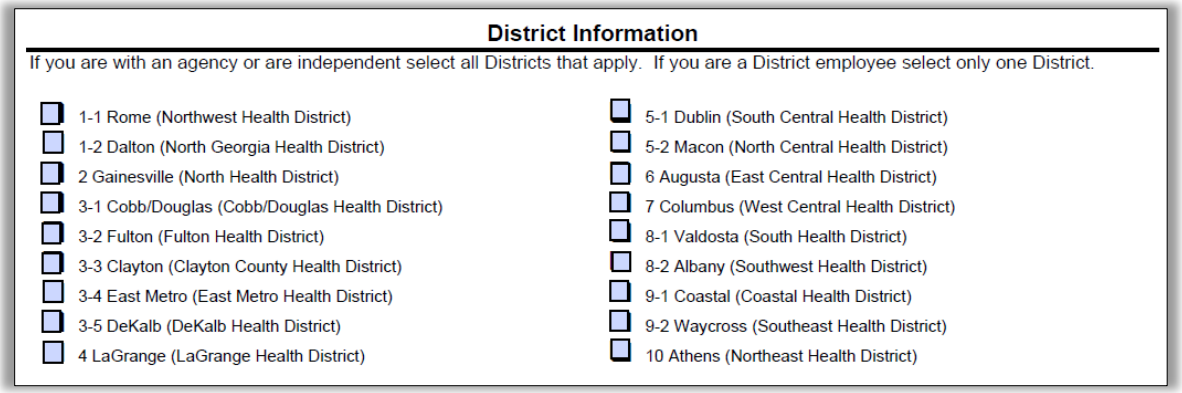
In the **User Online Access Types section,** the EIC or Designee requesting access would select the following checkboxes:

- If enrolling as an EIC/Designee and as a provider whose specialty is not Intake and/or Service Coordinator, select
  - EIC or Designee (Case Admin)
  - District Provider

- If enrolling as an EIC/Designee and as an Intake and/or Service Coordinator, select
  - EIC or Designee (Case Admin)
  - District Coordinator
    - Select either Intake or Service Coordinator
    - Can select both
- If enrolling as an EIC/Designee, provider, and Intake and/or Service Coordinator, select
  - EIC or Designee (Case Admin)
  - District Provider
  - District Coordinator
    - Select either Intake or Service Coordinator
    - Can select both



In the **District Information section**, select the checkbox of the district.



At the bottom of the form complete the following:

- Enter the First Name, Last Name, Phone, EXT, and Email
- User Signature - Signature of the EIC or Designee requesting access
- Date
- Agency Signature - Signature of the EIC
- Date

7.1.2.3 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims and Electronic Signature Agreement** is required to enter claims/information claims on the BCW-BIBS.com website. Please read the document completely before signing the form.

7.1.3 Removing An EIC or Designee

7.1.3.1 Removing EIC or Designee Access Only

To remove an EIC or Designee who is not enrolled as a provider and/or Intake/Service Coordinator complete the following form:

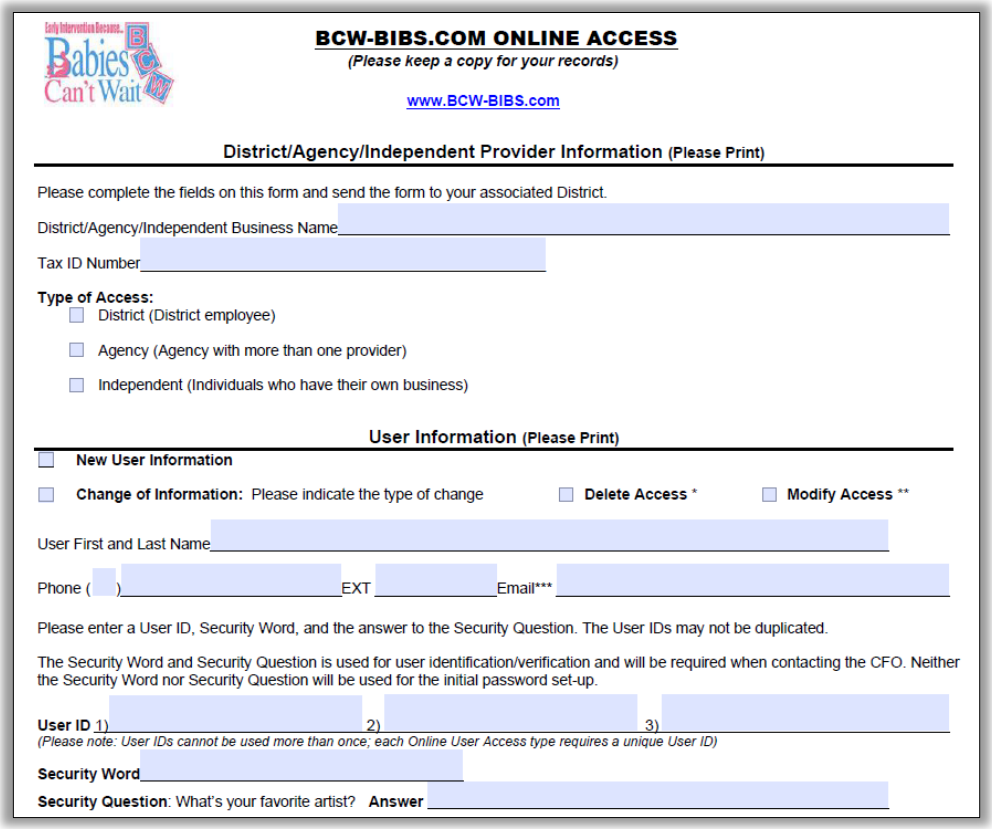
- **BCW-BIBS.COM Online Access**

In the **District/Agency/Independent Provider Information section,** complete the following:

- Agency Business Name
- Agency Tax ID number
- Type of Access - click the *District (district employee)* checkbox to select

In the **User Information section,** complete the following:

- Change of Information - click on the checkbox to select
- Delete Access - click on the checkbox to select
- User First and Last Name



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

- ☐ **New User Information**
- ☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

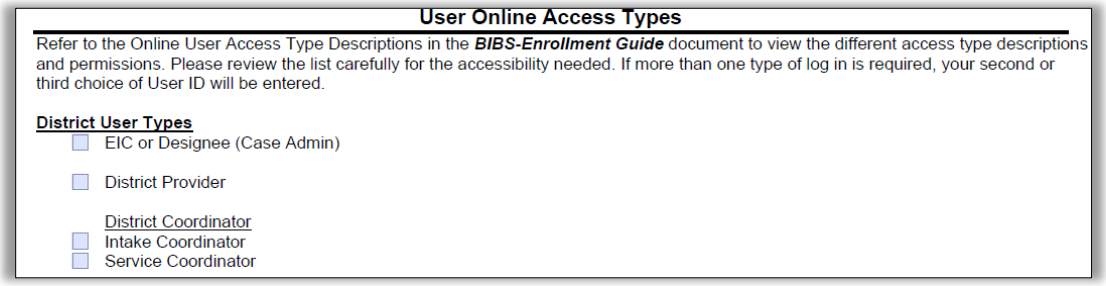
User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Online Access Types section**, click the checkbox in front of EIC or Designee (Case Admin) to select.



User Online Access Types

Refer to the Online User Access Type Descriptions in the ***BIBS-Enrollment Guide*** document to view the different access type descriptions and permissions. Please review the list carefully for the accessibility needed. If more than one type of log in is required, your second or third choice of User ID will be entered.

District User Types

- ☐ EIC or Designee (Case Admin)
- ☐ District Provider

District Coordinator

- ☐ Intake Coordinator
- ☐ Service Coordinator

At the bottom of the form complete the following:

- The First Name, Last Name, Phone, EXT, and Email
- User Signature and Date
- District EIC Signature and Date

7.1.3.2 Removing an EIC Who is a Provider/Coordinator

If an EIC or Designee is no longer contracted with a district the EIC/Designee access, provider specialty/specialties, and Intake and/or Service Coordinator specialty/specialties must be ended by completing the following forms:

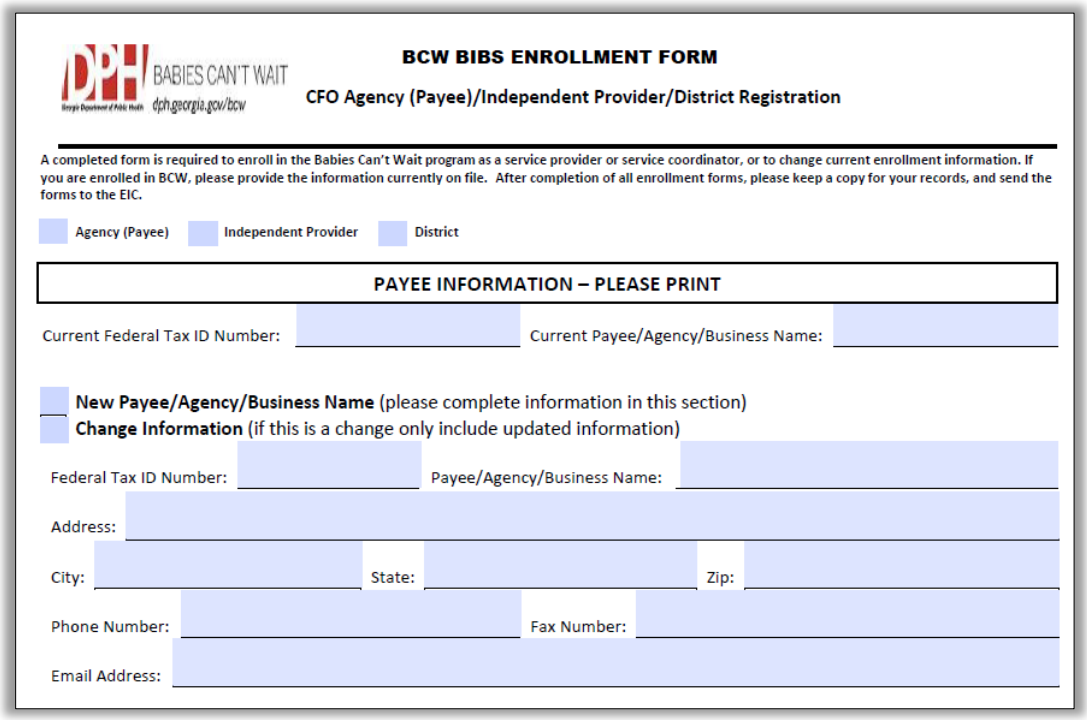
- **BCW BIBS Enrollment**
- **BCW-BIBS.COM Online Access**

7.1.3.2.1 BCW BIBS Enrollment Form

Click the **District checkbox** at the top of the form

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

☐ Agency (Payee) ☐ Independent Provider ☐ District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: _____ Current Payee/Agency/Business Name: _____

☐ **New Payee/Agency/Business Name** (please complete information in this section)
☐ **Change Information** (if this is a change only include updated information)

Federal Tax ID Number: _____ Payee/Agency/Business Name: _____

Address: _____

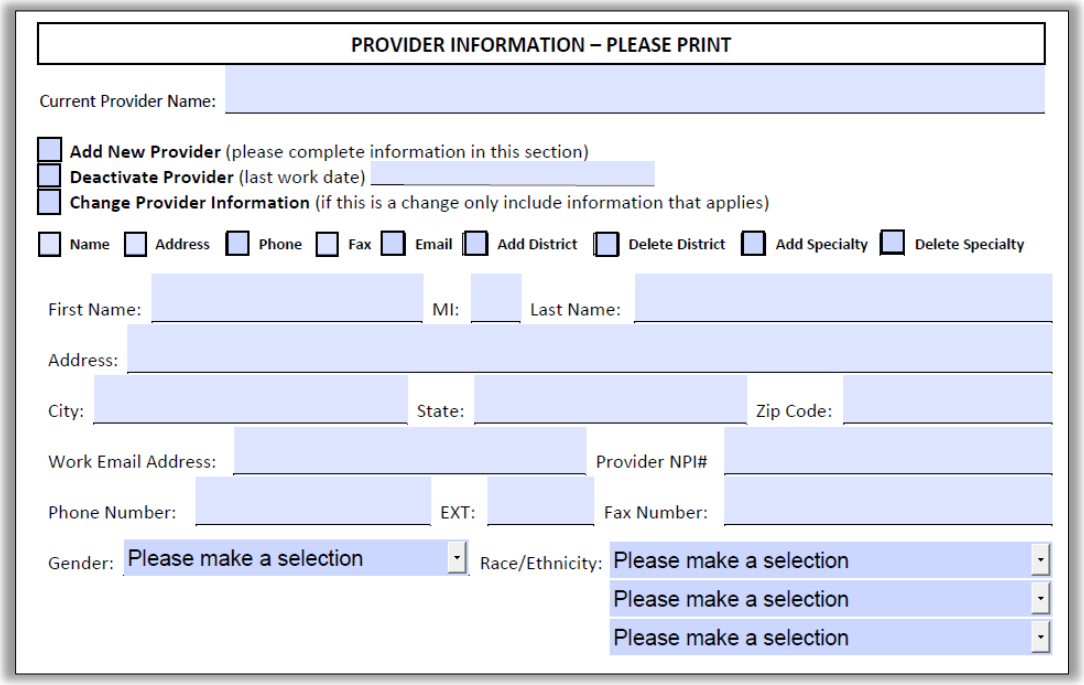
City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the **Provider Information section**, complete the following:

- Current Provider Name
- Deactivate Provider – click the checkbox to select
- (last work date) – enter the date the EIC will no longer be contracted with the district



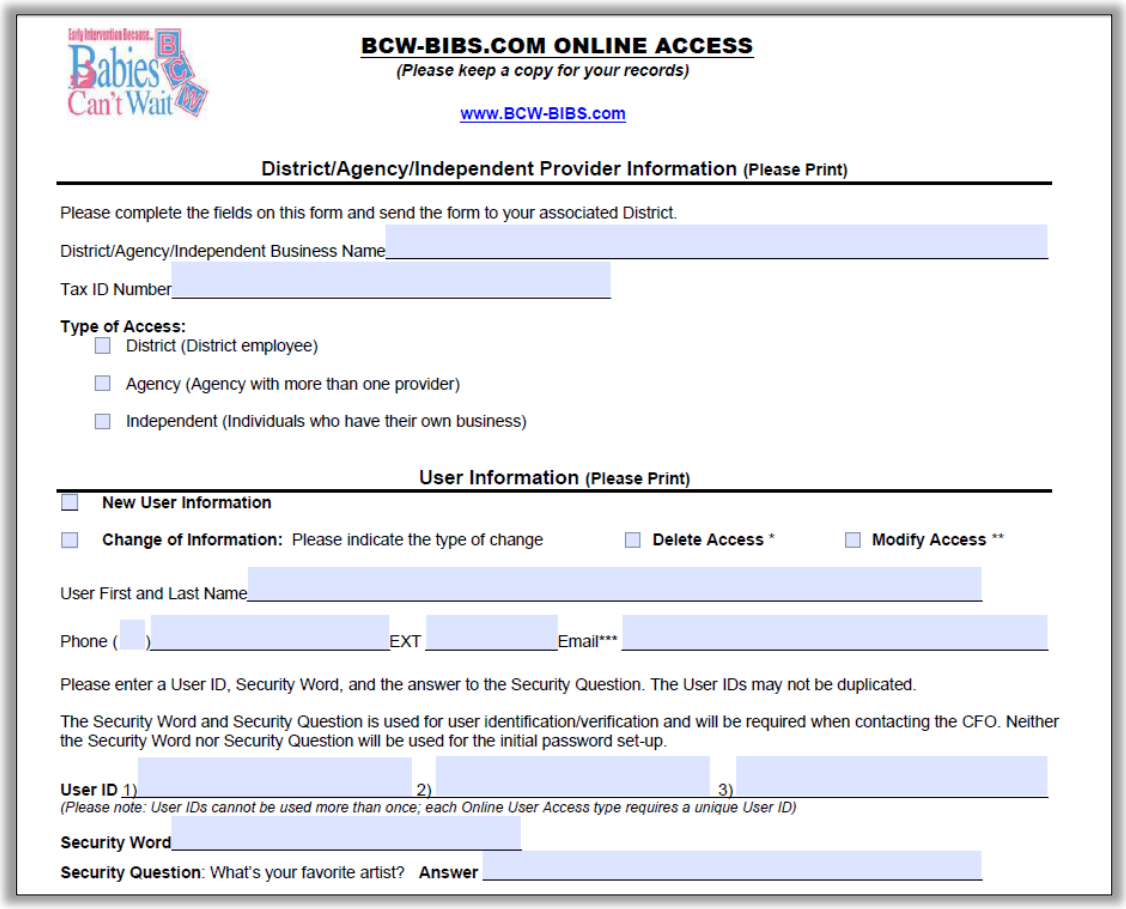
At the bottom of the form complete the following:

- First Name, Last Name, Phone, EXT, and email
- User Signature and Date
- District EIC Signature and Date

7.1.3.2.2 BCW-BIBS.Com Online Access

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *District (District employee)*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

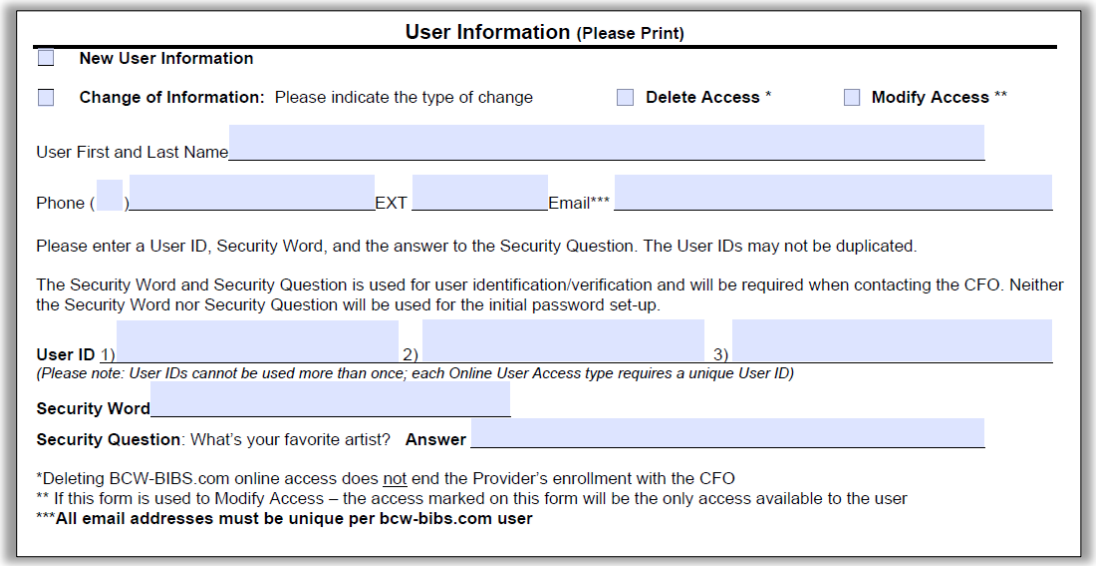
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- Change of Information - click the checkbox to select
- Delete Access – click the checkbox to select
- User First and Last Name



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

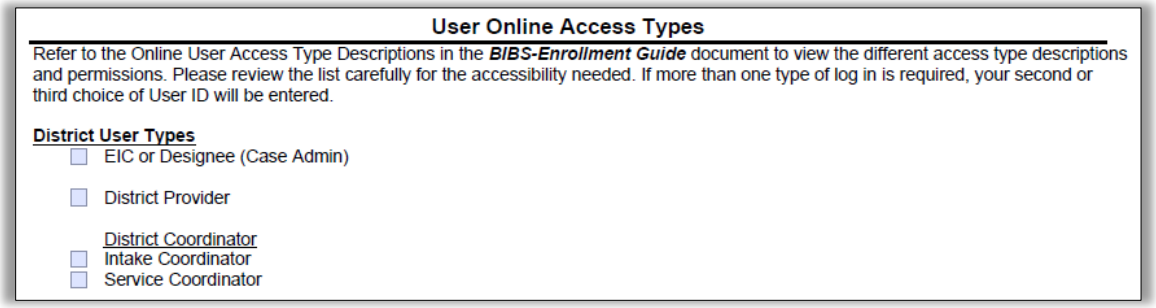
Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO

** If this form is used to Modify Access – the access marked on this form will be the only access available to the user

***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section,** select all the applicable user types associated with the EIC or Designee.



At the bottom of the form complete the following:

- Enter the First Name, Last Name, Phone, EXT, and Email of the provider
- User Signature - Signature of the EIC
- Date
- Agency Signature - Signature of the EIC
- Date

7.2 District Provider or Intake/Service Coordinator

7.2.1 New District Provider or Intake/Service Coordinator

To add a new district provider or district Intake/Service Coordinator the following forms must be completed:

- **BCW BIBS Enrollment**
- **BCW-BIBS.COM Online Access**
- **Certification For Online Claims and Electronic Signature Agreement**
- **District Checklist**

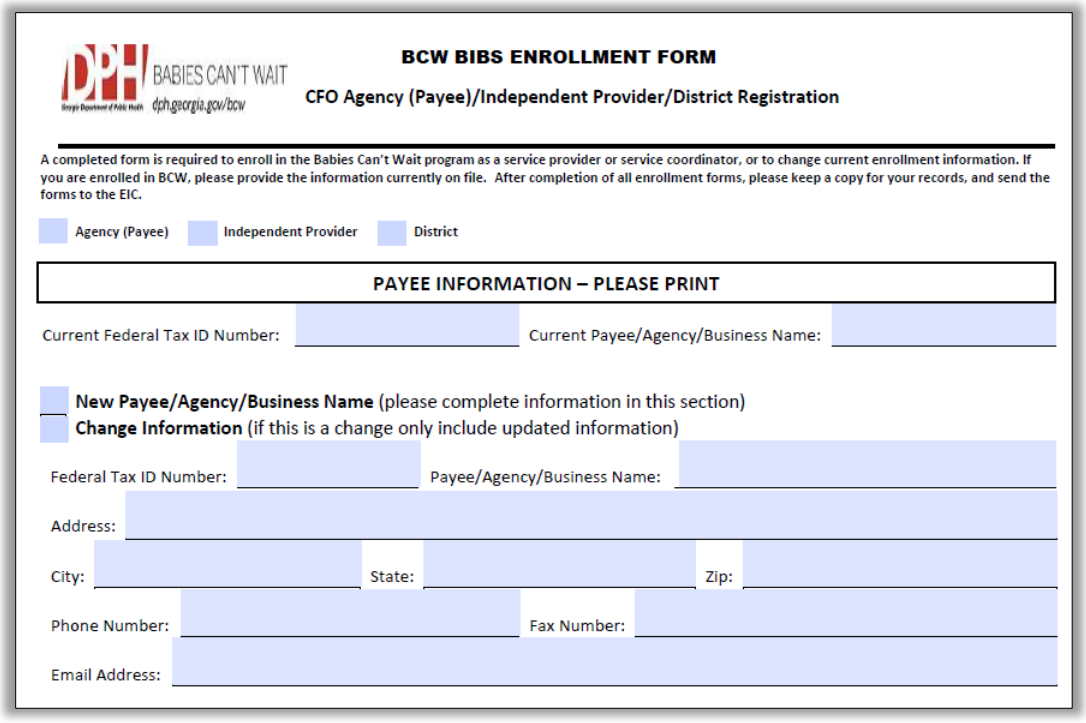
District Checklist			
✓	Form Name and Description	Original Signature Required?	District Approval Required?
	1. BCW BIBS Enrollment Form – *Required* - Complete this form to enroll as a Provider employed by the District	Yes	No
	2. BCW-BIBS.COM Online Access Form - *Required* - Complete this form to receive access to the BIBS system	Yes	Yes
	3. Certification for Online Claims Form and Electronic Signature Agreement Form – *Required* - Complete this form to perform direct data claim entry into the BIBS system and to certify authorization of your electronic signature for all actions within the BIBS system	Yes	Yes

7.2.1.1 BCW BIBS Enrollment

Click the **District checkbox** at the top of the form

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

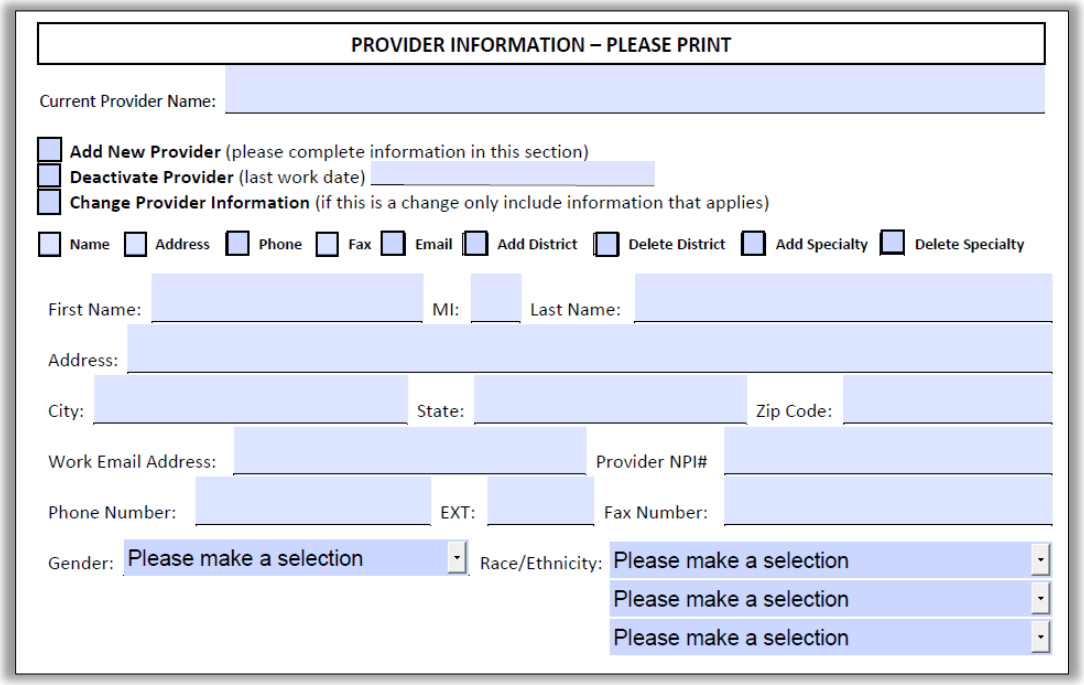
City: State: Zip:

Phone Number: Fax Number:

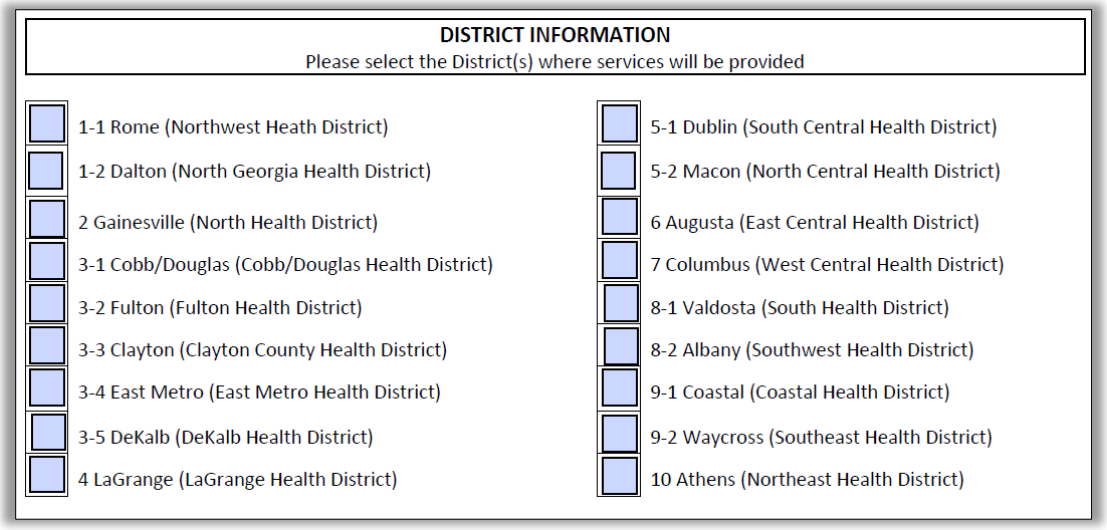
Email Address:

In the **Provider Information section**, complete the following:

- Add New Provider - Click in the checkbox to select
- Enter the provider's information
  - Gender - select from the drop-down
  - Race/Ethnicity - select from the drop-down(s)



In the **District Information section**, select the district.



In the **Early Intervention Specialties section**, click on the checkboxes of all applicable specialties.

EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

- ☐ Audiologist
- ☐ Board Certified Behavior Analyst (BCBA)
- ☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)
- ☐ Counseling-License Professional
- ☐ Dietitian
- ☐ Early Intervention Assistant
- ☐ Early Intervention Specialist
- ☐ Early Interventionist
- ☐ Intake Coordinator
- ☐ Interpreters for the Deaf
- ☐ Nurse – Registered (RN)
- ☐ Nurse – Licensed Nurse Practitioner (LNP)
- ☐ Nurse – Licensed Practical (LPN)
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychologist - Licensed
- ☐ Registered Behavior Technician (RBT)
- ☐ Service Coordinator
- ☐ Social Worker – Licensed Clinical
- ☐ Speech Language Pathologist (SLP) – Clinical Fellow
- ☐ Speech Language Pathologist (SLP)
- ☐ Translator: Non-Spanish Foreign Language
- ☐ Translator: Spanish Language
- ☐ Vision Teacher

In the **In-Network Private Insurance Information section**, enter the information for any private insurance carriers listed where the provider is an In-Network provider.

IN – NETWORK PRIVATE INSURANCE INFORMATION

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /

In the **Medicaid/CMO Information section**, enter the information for any Medicaid or CMOs the provider is enrolled with.

MEDICAID/CMO INFORMATION

Provide information for any of the Medicaid types where you are a Medicaid enrolled provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO) - Amerigroup				
Medicaid ID	Traditional Medicaid	Amerigroup CMO	PeachCare for Kids - Amerigroup	Amerigroup 360 Foster Care	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

Provide information for all which apply:	Care Management Organization (CMO) – Care Source		Care Management Organization (CMO) Peach State			
Medicaid ID	CareSource CMO	Peach Care for Kids – CareSource	Peach State CMO	PeachCare for Kids – Peach State	Start Date	End Date
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	/ /	/ /

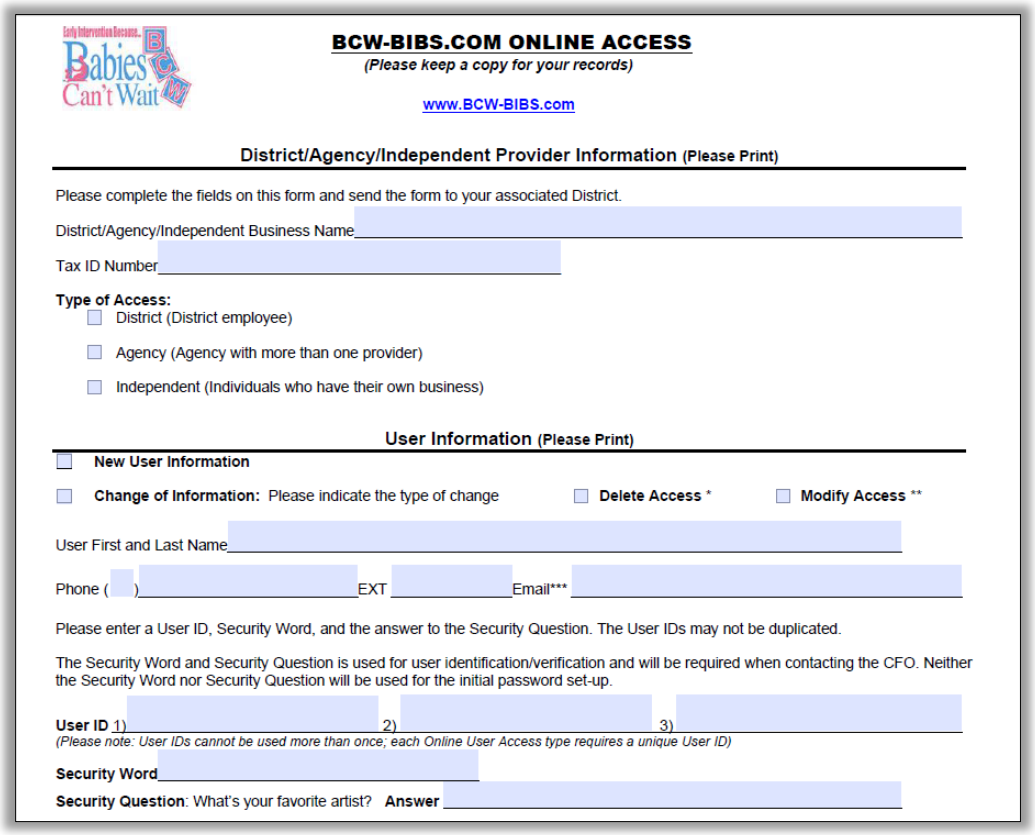
At the bottom of the form complete the following:

- Provider Signature - the signature of the provider
- Date – the date the form was signed

7.2.1.2 BCW-BIBS.Com Online Access

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - select *District (District employee)*



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

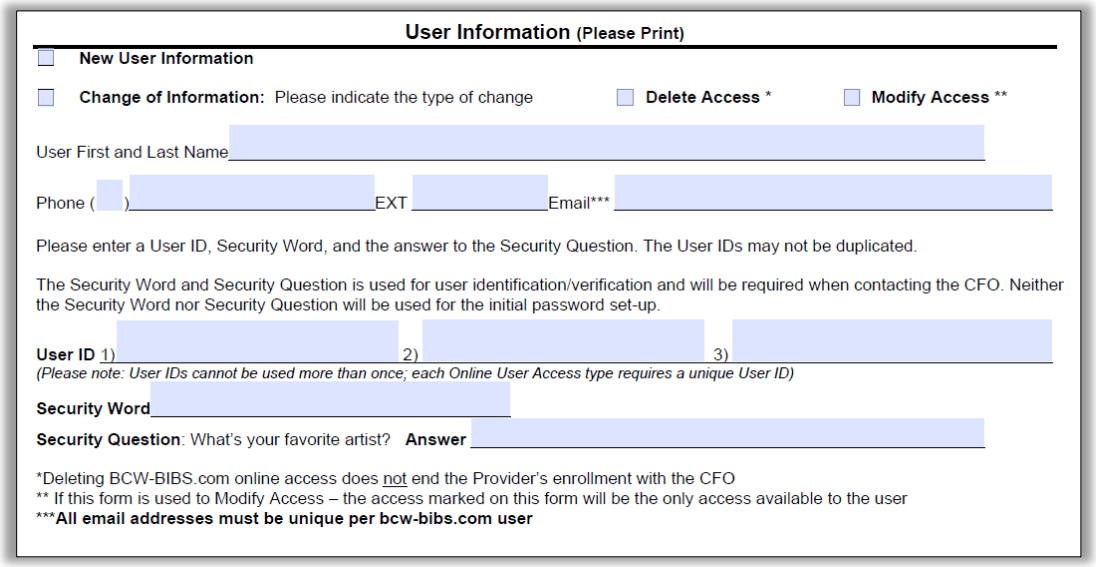
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Information section**, complete the following:

- New User Information - Click the checkbox to select
- Enter the First and Last Name, Phone, EXT, and Email of the provider/coordinator requesting access
- User ID - enter 3 User IDs
- Security Word - A single word to verify the provider/coordinator
- Security Question - The answer to the question '*What's your favorite artist?'*



User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

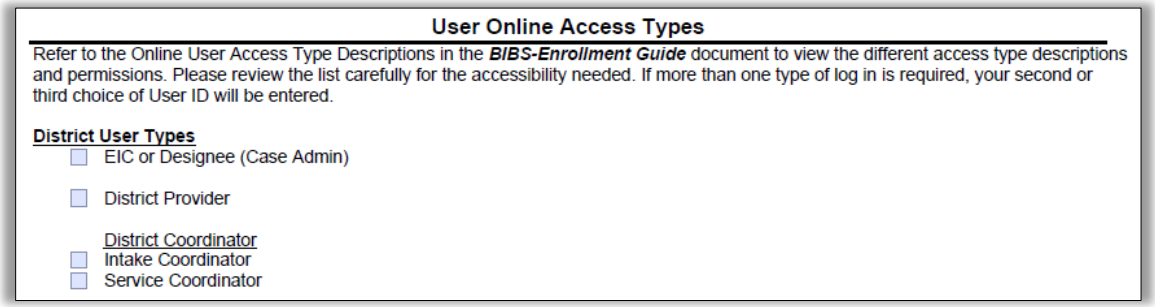
Security Word_____

Security Question: What's your favorite artist? **Answer** _____

*Deleting BCW-BIBS.com online access does not end the Provider's enrollment with the CFO
** If this form is used to Modify Access – the access marked on this form will be the only access available to the user
***All email addresses must be unique per bcw-bibs.com user

In the **User Online Access Types section,** the provider or Intake/Service requesting access would select the following checkboxes:

- If enrolling as a provider whose specialty is not Intake and/or Service Coordinator, select
  - District Provider
- If enrolling as an Intake and/or Service Coordinator, select
  - District Coordinator
    - Select either Intake or Service Coordinator
    - Can select both
- If enrolling as a provider, and as an Intake and/or Service Coordinator
  - District Provider
  - District Coordinator
    - Select either Intake or Service Coordinator
    - Can select both



User Online Access Types

Refer to the Online User Access Type Descriptions in the ***BIBS-Enrollment Guide*** document to view the different access type descriptions and permissions. Please review the list carefully for the accessibility needed. If more than one type of log in is required, your second or third choice of User ID will be entered.

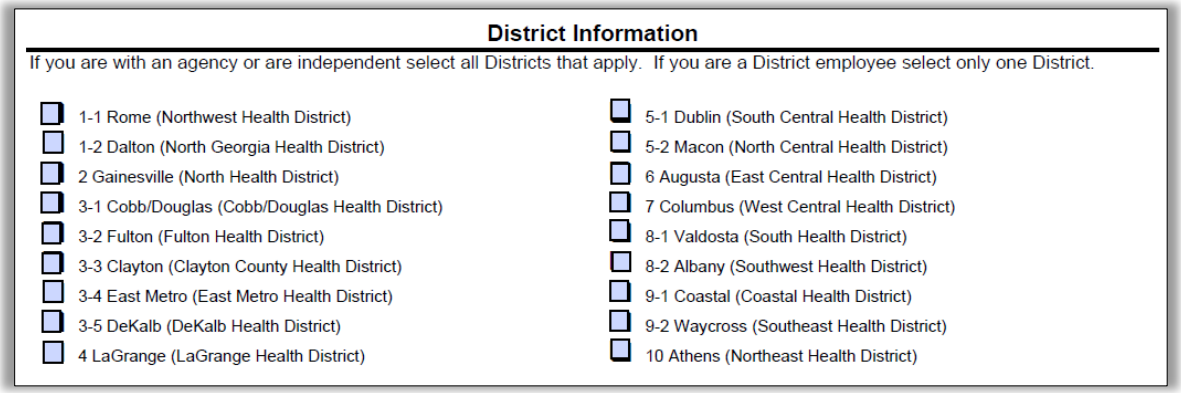
District User Types

☐ EIC or Designee (Case Admin)

☐ District Provider

District Coordinator
☐ Intake Coordinator
☐ Service Coordinator

In the **District Information section**, select the checkbox of the district.



District Information

If you are with an agency or are independent select all Districts that apply. If you are a District employee select only one District.

☐ 1-1 Rome (Northwest Health District)
☐ 1-2 Dalton (North Georgia Health District)
☐ 2 Gainesville (North Health District)
☐ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
☐ 3-2 Fulton (Fulton Health District)
☐ 3-3 Clayton (Clayton County Health District)
☐ 3-4 East Metro (East Metro Health District)
☐ 3-5 DeKalb (DeKalb Health District)
☐ 4 LaGrange (LaGrange Health District)
☐ 5-1 Dublin (South Central Health District)
☐ 5-2 Macon (North Central Health District)
☐ 6 Augusta (East Central Health District)
☐ 7 Columbus (West Central Health District)
☐ 8-1 Valdosta (South Health District)
☐ 8-2 Albany (Southwest Health District)
☐ 9-1 Coastal (Coastal Health District)
☐ 9-2 Waycross (Southeast Health District)
☐ 10 Athens (Northeast Health District)

At the bottom of the form complete the following:

- Enter the First Name, Last Name, Phone, EXT, and Email of the provider
- User Signature - Signature of the provider requesting access
- Date
- Agency Signature - Signature of the EIC
- Date

7.2.1.3 Certification for Online Claims and Electronic Signature Agreement

The **Certification for Online Claims and Electronic Signature Agreement** is required for the entry of claims/information and claims for services as a provider or Intake/Service Coordinator on the BCW-BIBS.com website. Please read the document completely before signing the form.

7.2.2 Existing District Provider or Intake/Service Coordinator

7.2.2.1 Add A Specialty

To add a specialty to a district provider or Intake/Service Coordinator the following forms must be completed:

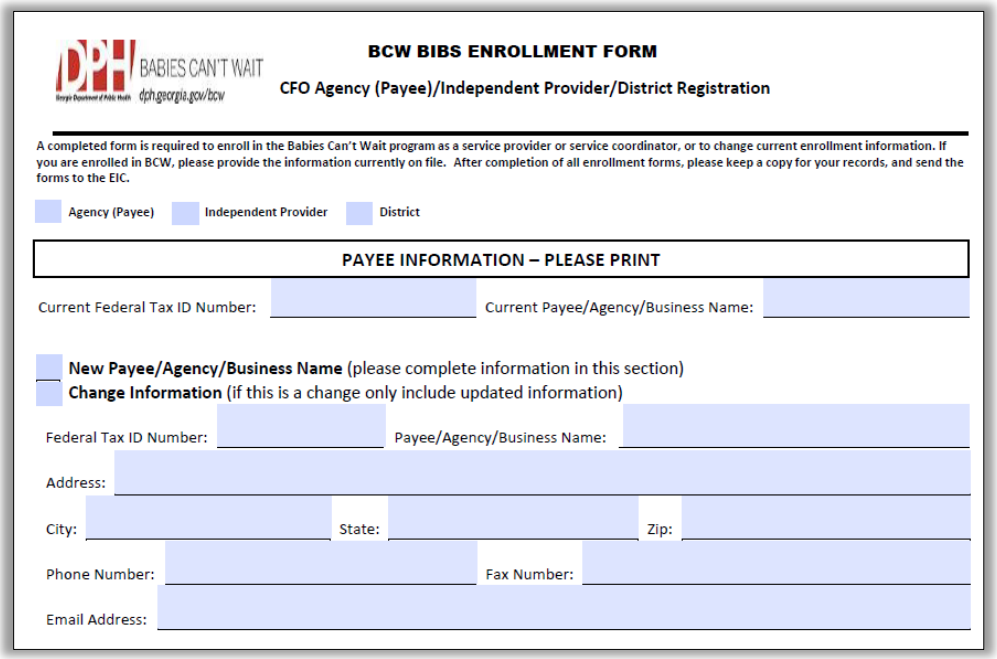
- **BCW BIBS Enrollment Form**
- **BCW-BIBS.COM Online Access**

7.2.2.1.1 BCW BIBS Enrollment

Click the **District checkbox** at the top of the form

In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name



BABIES CAN'T WAIT
dph.georgia.gov/bcw

BCW BIBS ENROLLMENT FORM

CFO Agency (Payee)/Independent Provider/District Registration

A completed form is required to enroll in the Babies Can't Wait program as a service provider or service coordinator, or to change current enrollment information. If you are enrolled in BCW, please provide the information currently on file. After completion of all enrollment forms, please keep a copy for your records, and send the forms to the EIC.

Agency (Payee) Independent Provider District

PAYEE INFORMATION – PLEASE PRINT

Current Federal Tax ID Number: Current Payee/Agency/Business Name:

New Payee/Agency/Business Name (please complete information in this section)
Change Information (if this is a change only include updated information)

Federal Tax ID Number: Payee/Agency/Business Name:

Address:

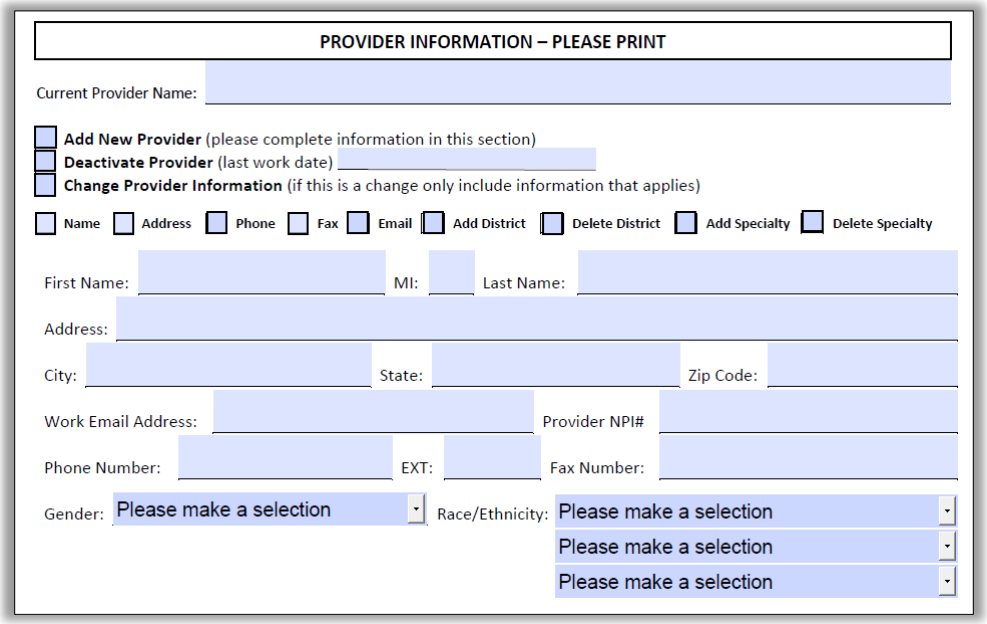
City: State: Zip:

Phone Number: Fax Number:

Email Address:

In the **Provider Information section**, complete the following:

- Current Provider Name – enter the first/last name of the provider
- Change Provider Information - click in the checkbox to select
- Add Specialty – click in the checkbox to select



PROVIDER INFORMATION – PLEASE PRINT

Current Provider Name:

☐ **Add New Provider** (please complete information in this section)
☐ **Deactivate Provider** (last work date)
☐ **Change Provider Information** (if this is a change only include information that applies)

☐ Name ☐ Address ☐ Phone ☐ Fax ☐ Email ☐ Add District ☐ Delete District ☐ Add Specialty ☐ Delete Specialty

First Name: MI: Last Name:

Address:

City: State: Zip Code:

Work Email Address: Provider NPI#

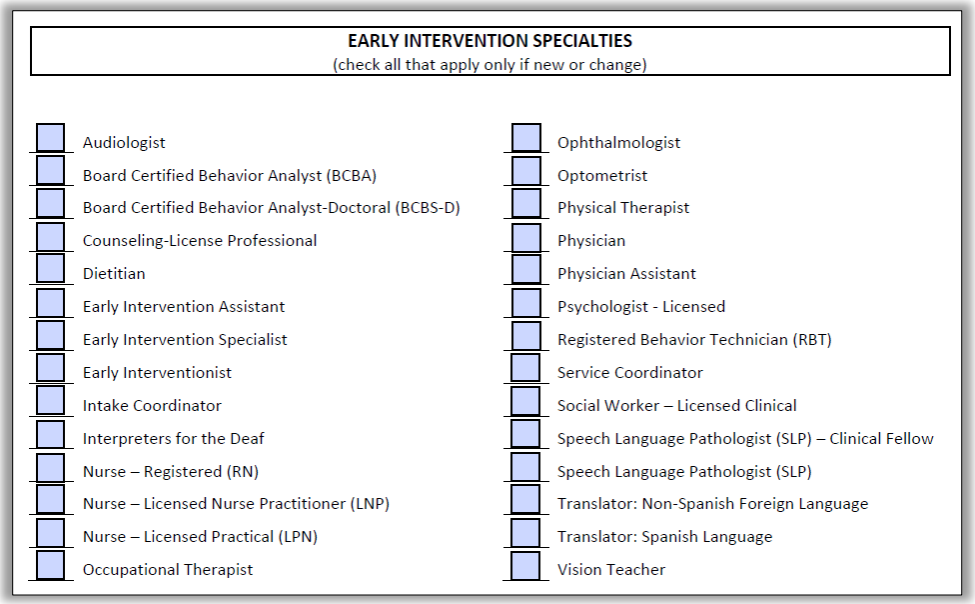
Phone Number: EXT: Fax Number:

Gender: Please make a selection Race/Ethnicity: Please make a selection

Please make a selection

Please make a selection

In the **Early Intervention Specialties section**, click on the checkboxes of all applicable specialties to be added.



EARLY INTERVENTION SPECIALTIES
(check all that apply only if new or change)

☐ Audiologist	☐ Ophthalmologist
☐ Board Certified Behavior Analyst (BCBA)	☐ Optometrist
☐ Board Certified Behavior Analyst-Doctoral (BCBS-D)	☐ Physical Therapist
☐ Counseling-License Professional	☐ Physician
☐ Dietitian	☐ Physician Assistant
☐ Early Intervention Assistant	☐ Psychologist - Licensed
☐ Early Intervention Specialist	☐ Registered Behavior Technician (RBT)
☐ Early Interventionist	☐ Service Coordinator
☐ Intake Coordinator	☐ Social Worker – Licensed Clinical
☐ Interpreters for the Deaf	☐ Speech Language Pathologist (SLP) – Clinical Fellow
☐ Nurse – Registered (RN)	☐ Speech Language Pathologist (SLP)
☐ Nurse – Licensed Nurse Practitioner (LNP)	☐ Translator: Non-Spanish Foreign Language
☐ Nurse – Licensed Practical (LPN)	☐ Translator: Spanish Language
☐ Occupational Therapist	☐ Vision Teacher

At the bottom of the form complete the following:

- Provider Signature - the signature of the provider
- Date

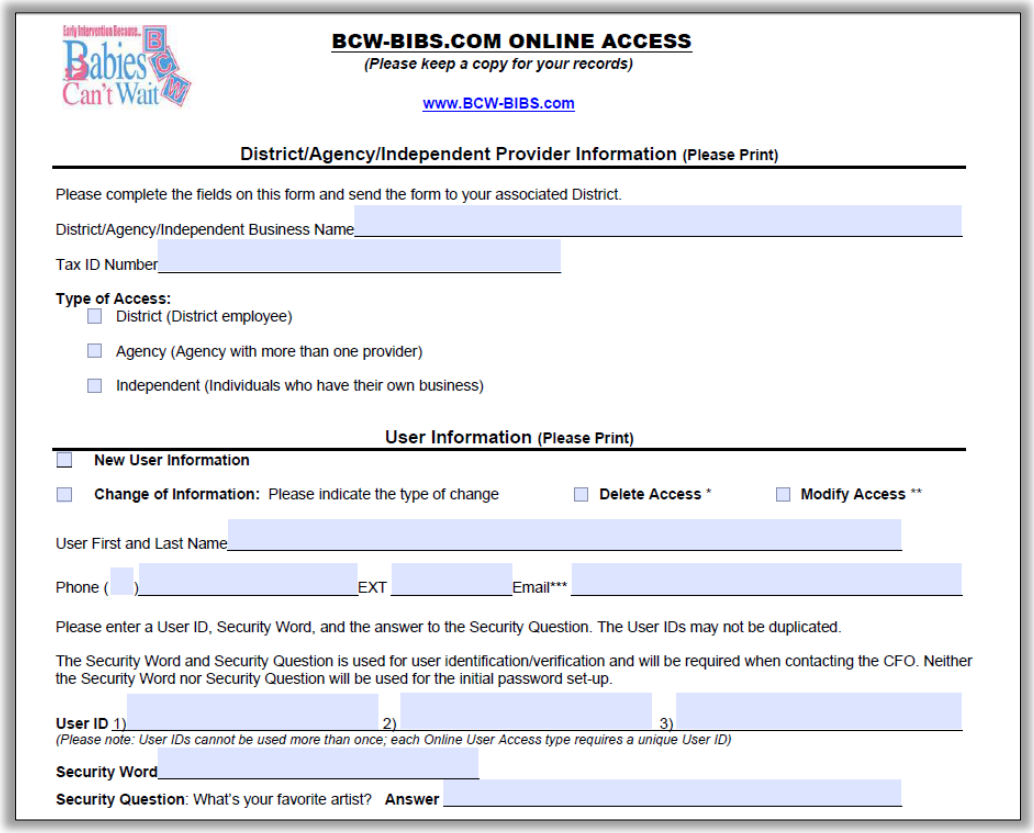
7.2.2.1.2 BCW-BIBS.Com Online Access

In the District/Agency/Independent Provider Information section, complete the following :

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *District (District employee)*

In the **User Information section**, complete the following:

- Change of Information - Click the checkbox to select
- Enter the First and Last Name of the provider/coordinator



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

- ☐ **New User Information**
- ☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

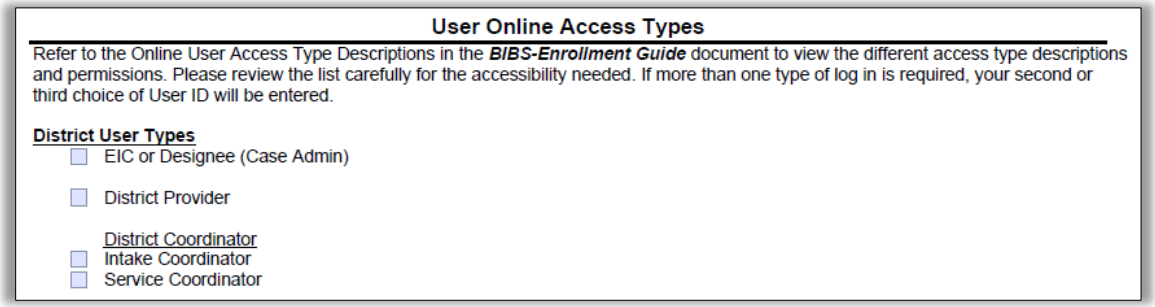
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the **User Online Access Types section,** the provider or Intake/Service requesting access would select the following checkboxes:

- If adding a specialty *that is not* Intake and/or Service Coordinator, select District Provider
- If adding a specialty of Intake and/or Service Coordinator**,** select District Coordinator
  - Select either Intake or Service Coordinator
  - Can select both if the provider has both specialties



User Online Access Types

Refer to the Online User Access Type Descriptions in the ***BIBS-Enrollment Guide*** document to view the different access type descriptions and permissions. Please review the list carefully for the accessibility needed. If more than one type of log in is required, your second or third choice of User ID will be entered.

District User Types

- ☐ EIC or Designee (Case Admin)
- ☐ District Provider

District Coordinator

- ☐ Intake Coordinator
- ☐ Service Coordinator

At the bottom of the form complete the following:

- Enter the First Name, Last Name, Phone, EXT, and Email of the provider
- User Signature - Signature of the provider
- Date
- Agency Signature - Signature of the EIC
- Date

7.2.2.2 Remove A Specialty

To remove a specialty to a district provider or Intake/Service Coordinator the following forms must be completed:

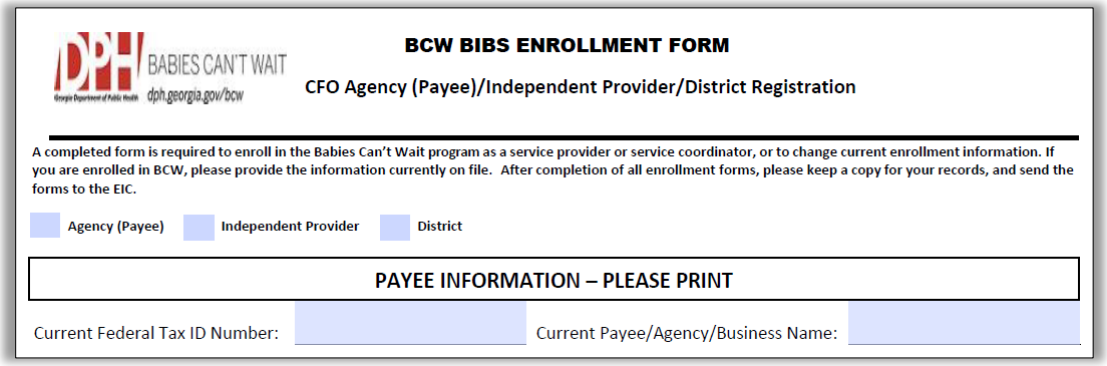
- **BCW BIBS Enrollment Form**
- **BCW-BIBS.COM Online Access**

7.2.2.2.1 BCW BIBS Enrollment

Click the **District checkbox** at the top of the form

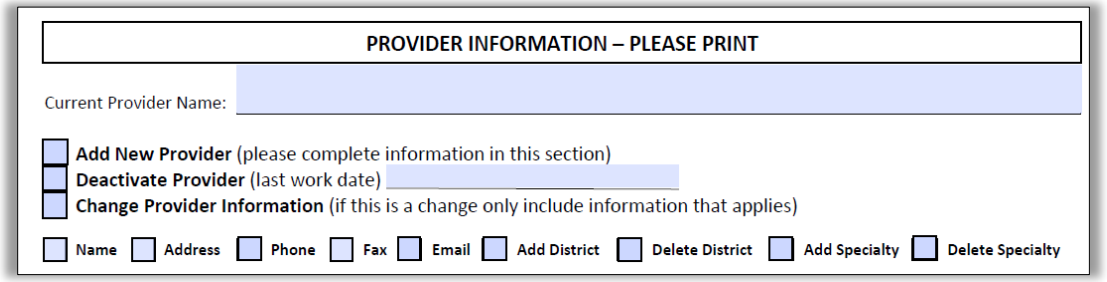
In the **Payee Information section**, complete the following:

- Current Federal Tax ID Number
- Current Payee/Agency/Business Name

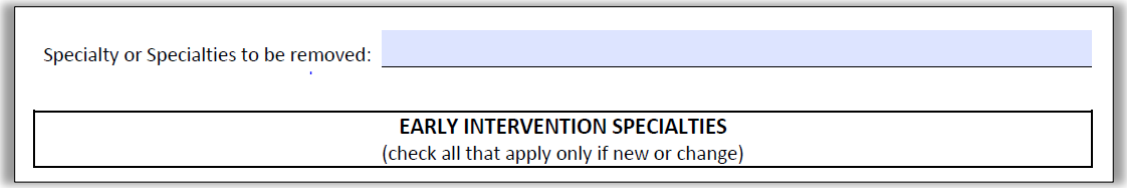


In the **Provider Information section**, complete the following:

- Current Provider Name – enter the first/last name of the provider
- Change Provider Information - click in the checkbox to select
- Delete Specialty – click in the checkbox to select



In the **Specialty or Specialties to be removed text field** enter the specialty/specialties to be removed. Please enter a comma between the specialties.



At the bottom of the form complete the following:

- Provider Signature - the signature of the provider
- Date

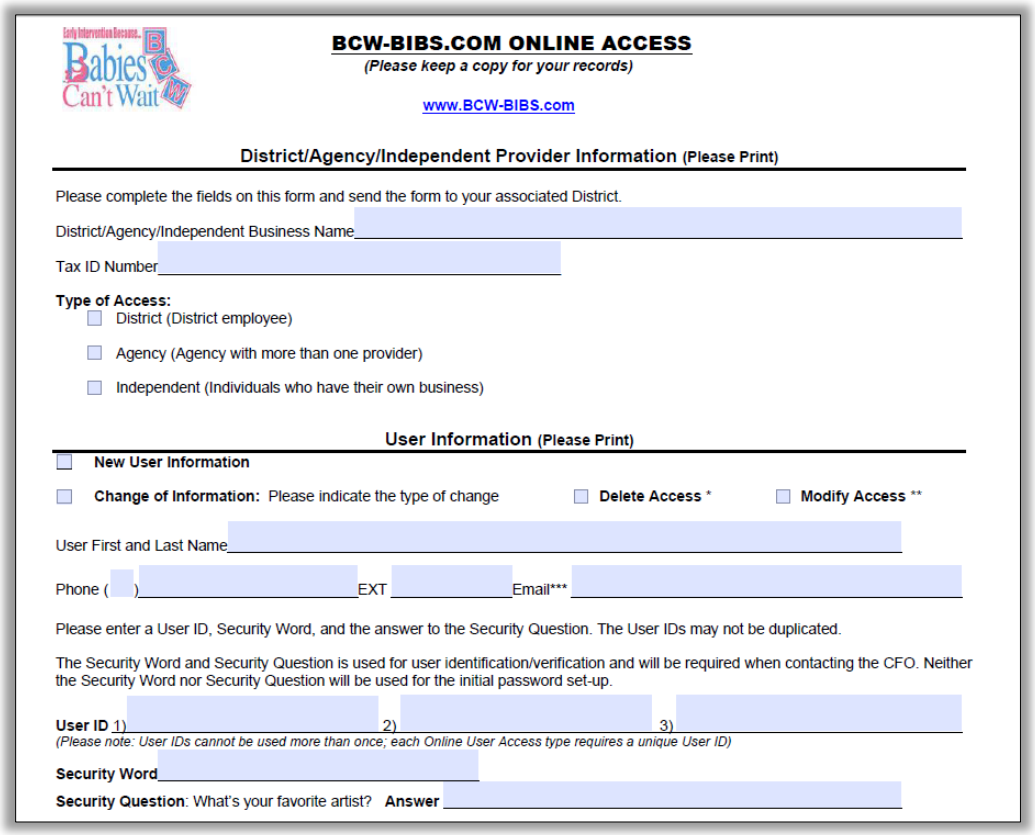
7.2.2.2.2 BCW-BIBS.Com Online Access

In the District/Agency/Independent Provider Information section, complete the following:

- District/Agency/Independent Business Name
- Tax ID Number
- Type of Access - Select *District (District employee)*

In the **User Information section**, complete the following:

- Change of Information - Click the checkbox to select
- Enter the First and Last Name of the provider/coordinator



BCW-BIBS.COM ONLINE ACCESS

(Please keep a copy for your records)

www.BCW-BIBS.com

District/Agency/Independent Provider Information (Please Print)

Please complete the fields on this form and send the form to your associated District.

District/Agency/Independent Business Name_____

Tax ID Number_____

Type of Access:

- ☐ District (District employee)
- ☐ Agency (Agency with more than one provider)
- ☐ Independent (Individuals who have their own business)

User Information (Please Print)

☐ **New User Information**

☐ **Change of Information:** Please indicate the type of change ☐ **Delete Access** * ☐ **Modify Access** **

User First and Last Name_____

Phone ( )_____EXT _____Email*** _____

Please enter a User ID, Security Word, and the answer to the Security Question. The User IDs may not be duplicated.

The Security Word and Security Question is used for user identification/verification and will be required when contacting the CFO. Neither the Security Word nor Security Question will be used for the initial password set-up.

User ID 1)_____ 2)_____ 3)_____

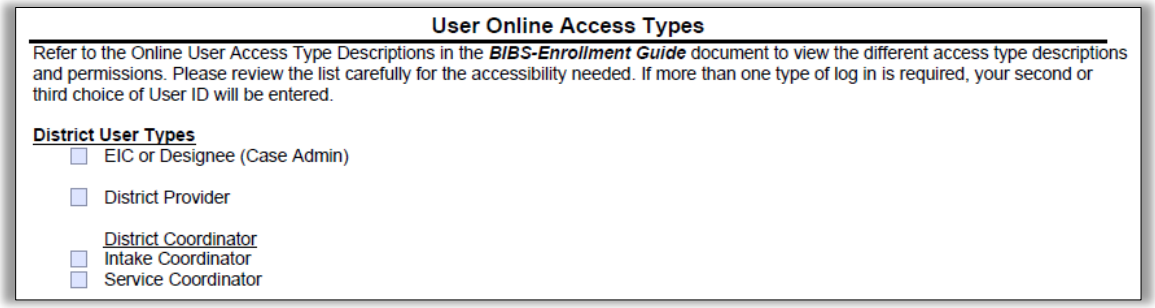
(Please note: User IDs cannot be used more than once; each Online User Access type requires a unique User ID)

Security Word_____

Security Question: What's your favorite artist? **Answer** _____

In the User Online Access Types section, select the following:

- If removing a specialty *<u>that is not</u>* Intake and/or Service Coordination, select
  - District Provider
- If removing a specialty of Intake and/or Service Coordination, select
  - Either Intake Coordinator or Service Coordinator
    - Can select both if applicable
- If removing all specialties including Intake and/or Service Coordinator
  - District Provider
  - District Coordinator
    - Select either Intake or Service Coordinator
    - Can select both if applicable



User Online Access Types

Refer to the Online User Access Type Descriptions in the ***BIBS-Enrollment Guide*** document to view the different access type descriptions and permissions. Please review the list carefully for the accessibility needed. If more than one type of log in is required, your second or third choice of User ID will be entered.

<u>District User Types</u>

- ☐ EIC or Designee (Case Admin)
- ☐ District Provider
- <u>District Coordinator</u>
- ☐ Intake Coordinator
- ☐ Service Coordinator

At the bottom of the form complete the following:

- Enter the First Name, Last Name of the provider/coordinator
- User Signature – the signature of the provider/coordinator
- Date
- Agency Signature – the signature of the EIC
- Date

8.0 User Types

8.1 Agency User Types

8.1.1 Agency Administrator

An Agency Administrator is the owner of an agency that has more than one BCW enrolled provider working at the agency.

The following briefly describes the permissions of this user type

- Home Page
  - Has monitoring capabilities available via the Home page lists
- Child Care Management
  - May view child records
  - May enter progress notes for their BCW enrolled providers who have an active authorization and/or is an active IFSP Team Member
  - May upload documents to the Child Library PSP Teams
- PSP Teams
  - Does not have access
- Provider Account Management (PAM)
  - May view and submit claims for their BCW enrolled providers
  - May view and print authorizations and authorization information for their enrolled providers
  - May view and modify certain elements of their information
  - May view payment/remittance information
  - May select email notification to receive

8.1.2 Agency Claims and Billing

An Agency Claims and Billing Agent is the billing person for an agency. This user is not enrolled as a provider.

The following briefly describes the permissions of this user type

- Home Page
  - Does not have access to Home page lists
- Child Care Management (CCM)
  - Cannot access to view child records
- PSP Team
  - Does not have access
- Provider Account Management (PAM)
  - May view and submit claims for the agency BCW enrolled providers
  - May view and print authorizations and authorization information for the agency-enrolled providers
  - May view - but not modify - certain elements of the agency information

8.1.3 Agency Provider (Billing)

An Agency Provider (Billing) is an enrolled provider enrolled who works for an agency that has more than one enrolled provider.

The following briefly describes the permissions of this user type

- Home Page
  - Has child access available via the Home page lists
- Message Center
  - May view messages sent to the provider from Child Care Management
  - May select the type of message to receive an email notification
- Child Care Management (CCM)
  - If the provider has an active authorization and/or is an active IFSP Team Member on a child record

        - May view child records
        - May enter progress notes
            - Cannot enter progress notes for other providers in the agency
        - May upload documents to the Child Library and complete Evaluation and Assessment Requests
- PSP Teams
    - Can view PSP Teams and PSP Meetings where the provider is an active PSP Team Member
- Provider Account Management (PAM)
    - May view and submit claims
        - Cannot enter claims for other providers in the agency
    - May view and print authorizations and authorization information where the provider is authorized
        - Cannot view or print authorizations for other providers in the agency
    - Cannot view payment information for the agency
    - May view and modify certain elements of their provider account

8.1.4 Agency Provider (Non-Billing)

An Agency Provider (Non-Billing) is an enrolled provider who works for an agency that has more than one enrolled provider.

The following briefly describes the permissions of this user type

- Home Page
    - Has child access available via the Home page lists
- Message Center
    - May view messages sent to the provider from Child Care Management
    - May select the type of message to receive an email notification
- Child Care Management (CCM)
    - If the provider has an active authorization and/or is an active IFSP Team Member on a child record
        - May view child records
        - May enter progress notes
            - Cannot enter progress notes for other providers in the agency
        - May upload documents to the Child Library
        - Complete Evaluation and Assessment Requests
- PSP Teams
    - Can view PSP Teams and PSP Meetings where the provider is on the PSP Team
- Provider Account Management (PAM)
    - May view their claims
        - Cannot enter claims for themselves or other providers in the agency
    - May view and print authorizations and authorization information where the provider is authorized
        - Cannot view or print authorizations for other providers in the agency
    - May view and modify certain elements of their provider account
    - Cannot view payment/remittance information for the agency

8.1.5 Agency Coordinator

8.1.5.1 Intake Coordinator

An Agency Intake Coordinator is a coordinator who performs intake activities when a child's status is Referral or Eligibility Determination. The coordinator must be enrolled with the specialty of Intake Coordination.

The following briefly describes the permissions of this user type

- Home Page
    - Has monitoring capabilities available via the Home page lists
- Message Center
    - May select email notifications to receive

- May view messages
- Child Care Management (CCM)
  - May update child records in Referral and Eligibility Determination status if assigned as the active Intake Coordinator on the child record
    - Once Eligibility has been determined the Intake Coordinator will lose access to a child's record
  - May enter Coordination Notes
- PSP Teams
  - Has access to PSP Teams or PSP Meetings where the Intake Coordinator is an active PSP Team Member
- Provider Account Management (PAM)
  - Has access to enter claims for their Intake services

8.1.5.2 Service Coordinator

A Service Coordinator is a coordinator who performs activities based on IFSP. The coordinator must be enrolled with the specialty of Service Coordination.

The following briefly describes the permissions of this user type

- Home Page
  - Has monitoring capabilities available via the Home page lists
- Message Center
  - May select email notifications to receive
  - May view messages
- Child Care Management (CCM)
  - May view child records in Referral and Eligibility Determination status if assigned as the active ongoing Service Coordinator
    - Cannot edit information
  - Once a child is in IFSP status the ongoing Service Coordinator will have edit access to child records
  - May enter Coordination Notes
  - Can review Progress Notes
  - Can upload documents to the Child Library
- PSP Teams
  - Has access to PSP Teams and PSP Meetings where the Service Coordinator is an active PSP Team Member
- Provider Account Management (PAM)
  - Has access to enter claims for their Service Coordination services

NOTE: If both Intake Coordinator and Service Coordinator are selected the Agency Coordinator can perform both Intake and Service Coordination activities.

- The provider must have the specialties of Intake Coordination and Service Coordination

8.2 Independent Provider/Self-Employed User Types

8.2.1 Independent Provider Admin

An Independent Provider/Administrator is an enrolled provider who is self-employed and is the only provider for the business.

The following briefly describes the permissions of this user type

- Home Page
  - • Has child access available via the Home page lists
- Message Center
  - • May select email notifications to receive
  - • May view messages

- Child Care Management (CCM)
  - • If the provider has an active authorization and/or is an active IFSP Team Member on a child record
    - May view child records
    - May enter progress notes
    - May complete Evaluation and Assessment Requests
    - May upload documents to the Child Library
- PSP Teams
  - • May view PSP Teams PSP Meetings where the provider is on a PSP Team
- Provider Account Management (PAM)
  - • May view and submit claims for themselves
  - • May view and print authorizations and authorization information
  - • May view and modify certain elements of their agency information
  - • May view and modify certain elements of their provider account
  - • May view payment information for their independent business

8.2.2 Independent Coordinator

8.2.2.1 Intake Coordinator

An Intake Coordinator is a coordinator who performs intake activities when a child's status is Referral or Eligibility Determination. The coordinator must be enrolled with the specialty of Intake Coordination.

The following briefly describes the permissions of this user type

- Home Page
  - Has monitoring capabilities available via the Home page lists
- Message Center
  - May select email notifications to receive
  - May view messages
- Child Care Management (CCM)
  - May update child records in Referral and Eligibility Determination status in Child Care Management (CCM) if assigned as the active Intake Coordinator
    - Once Eligibility has been determined the Intake Coordinator will lose access to a child's record
  - May enter Coordination Notes
- PSP Teams
  - Has access to PSP Teams or PSP Meetings where the Intake Coordinator is an active PSP Team Member
- Provider Account Management (PAM)
  - Has access to enter claims for their Intake services

8.2.2.2 Service Coordinator

A Service Coordinator is a coordinator who performs activities based on IFSP. The coordinator must be enrolled with the specialty of Service Coordination.

The following briefly describes the permissions of this user type

- Home Page
  - Has monitoring capabilities available via the Home page lists
- Message Center
  - May select email notifications to receive
  - May view messages
- Child Care Management (CCM)
  - May view child records in Referral and Eligibility Determination status if assigned as the active Service Coordinator
    - Cannot edit information
  - Once a child is in IFSP status the Service Coordinator will have edit access to child records

- May enter Coordination Notes
- Can review Progress Notes
- Can upload documents to the Child Library

- PSP Teams
  - Has access to PSP Teams and PSP Meetings where the Service Coordinator is an active PSP Team Member
- Provider Account Management (PAM)
  - Has access to enter claims for their Service Coordination services

NOTE: If both Intake Coordinator and Service Coordinator are selected the Independent Coordinator can perform both Intake and Service Coordination activities.

- The provider must have the specialties of Intake Coordination and Service Coordination

8.3 District User Types

8.3.1 EIC or EIC Designee

An EIC or EIC Designee is the District supervisor or a person who works in the office of the District. The EIC is responsible for the Service Coordination caseload for the District location.

The following briefly describes the permissions of this user type

- Home Page
  - • Has monitoring capabilities available via the Home page lists
- Message Center
  - May view messages and receive notifications when an IFSP Meeting is ready to be finalized if an email address exists
- Child Care Management (CCM)
  - Has access to all child records, active and inactive, assigned to the district location
    - May update child data including Date of Birth
    - May enter/delete Progress Notes
    - May enter/delete Coordination Notes
    - May finalize IFSP Meetings
    - May upload/delete documents to the Child Library
    - May delete/add a document to a completed Evaluation/Assessment request
    - May add/delete documents to the Child Library
- PSP Teams
  - Has access to PSP Teams in the District
    - May create a PSP Teams
    - Add PSP members
    - Create PSP Meetings
    - Enter PSP meeting attendance
- Provider Account Management (PAM)
  - Has access to limited options

NOTE: To enter or view claims for District employees an EIC will be required to have a user type of Agency Administrator with the District as the Agency.

- If a Designee will be entering the claims the Designee will be required to have a user type of Agency Claims and Billing.

8.3.2 District Agency Administrator

An Agency Administrator for the district is the EIC of the district who has coordinators and/or providers as district employees.

The following briefly describes the permissions of this user type

- Home Page
  - Has monitoring capabilities available via the Home page lists
- Child Care Management
  - May view child records
  - May enter progress notes for the district's enrolled providers
  - May upload documents to the Child Library
- PSP Teams
  - Does not have access
- Provider Account Management (PAM)
  - May view and submit claims for the district providers/coordinators
  - May view and print authorizations and authorization information for the district providers/coordinators
  - May select email notification to receive

8.3.3 District Provider

A District Provider is an enrolled provider who works for a district as an employee.

The following briefly describes the permissions of this user type

- Home Page
  - Has child access available via the Home page lists
- Message Center
  - May view messages sent to the provider from Child Care Management
  - May select the type of message to receive an email notification
- Child Care Management (CCM)
  - If the provider has an active authorization and/or is an active IFSP Team Member on a child record
    - May view child records
    - May enter progress notes
      - Cannot enter progress notes for other providers in the district
    - May upload documents to the Child Library
    - May Complete Evaluation and Assessment Requests
- PSP Teams
  - Can view PSP Teams and PSP Meetings where the provider is an active PSP Team Member
- Provider Account Management (PAM)
  - May view and submit claims
    - Cannot enter claims for other providers in the district
  - May view and print authorizations and authorization information where the provider is authorized
    - Cannot view or print authorizations for other providers in the district
  - Cannot view payment information for the agency
  - May view and modify certain elements of their provider account

8.3.4 District Coordinator

8.3.4.1 Intake Coordinator

A district Intake Coordinator is a district employee who performs intake activities when a child's status is Referral or Eligibility Determination. The coordinator must be enrolled with the specialty of Intake Coordination.

The following briefly describes the permissions of this user type

- Home Page

- Has monitoring capabilities available via the Home page lists
- Message Center
  - May select email notifications to receive
  - May view messages
- Child Care Management (CCM)
  - May update child records in Referral and Eligibility Determination status if assigned as the active Intake Coordinator
    - Once Eligibility has been determined the Intake Coordinator will lose access to a child's record
  - May enter Coordination Notes
- PSP Teams
  - Has access to PSP Teams or PSP Meetings where the Intake Coordinator is an active PSP Team Member
- Provider Account Management (PAM)
  - Has access to enter claims for their Intake services

8.3.4.2 Service Coordinator

A District Service Coordinator is a district employee who performs service coordination activities based on IFSP. The coordinator must be enrolled with the specialty of Service Coordination.

The following briefly describes the permissions of this user type

- Home Page
  - Has monitoring capabilities available via the Home page lists
- Message Center
  - May select email notifications to receive
  - May view messages
- Child Care Management (CCM)
  - May view child records in Referral and Eligibility Determination status if assigned as the active ongoing Service Coordinator
    - Cannot edit information
  - Once a child is in IFSP status the ongoing Service Coordinator will have edit access to child records
  - May enter Coordination Notes
  - Can review Progress Notes
  - Can upload documents to the Child Library
- PSP Teams
  - Has access to PSP Teams and PSP Meetings where the ongoing Service Coordinator is an active PSP Team Member
- Provider Account Management (PAM)
  - Has access to enter claims for their Service Coordination services

NOTE: If both Intake Coordinator and Service Coordinator are selected the District Coordinator can perform both Intake and Service Coordination activities.

- The provider must have the specialties of Intake Coordination and Service Coordination