

Authorized Delegate

Authorized Delegates are Kentucky Medicaid Partner Portal Application (KY MPPA) users who have obtained written permission from the Provider, Group, or Entity to submit information to DMS (Department for Medicaid Services) on their behalf. With this permission, the Provider, Officer, Owner, or Board Member is **not** required to create a KY MPPA account to review, e-Sign, and submit information to DMS. Any Partner Portal user who works on behalf of a Provider, Group, or Entity can be an Authorized Delegate.

To become an Authorized Delegate the user must have a Partner Portal account in their own name and with their own email address. They must also have an Authorized Delegate form signed by the Provider, Officer, Owner, or Board Member.

The Authorized Delegate must:

- Be linked to an existing Medicaid ID with the Credentialing Agent role.
 - To be linked to the Medicaid ID please call the Partner Portal Technical Support Staff.
- Start new enrollment applications by selecting “I am a Credentialing Agent” and only listing their email address in the Communication Email Address field on the 1.1 Basic Information screen.
- Choose the “Authorized Delegate” option on the 10.0 Submit screen when submitting any item to DMS.
- Upload a copy of the Authorized Delegate form on the 10.0 Submit screen.

The screenshot shows the 'Role Selection' screen in the Partner Portal TRAIN. The page title is 'Kentucky.gov Partner Portal TRAIN' and the user is logged in as 'Provider1 Train1'. The navigation menu includes 'Dashboard', 'Application', 'Maintenance', 'Correspondence', and 'Administration'. The 'Role Selection' section is circled in red and contains a red asterisk indicating a required field. Below the heading, there is a prompt: '* Select one of the three roles below'. Three radio button options are listed: 'I am a Provider enrolling as an Individual', 'I am an Owner, Officer or Board Member who is legally authorized to enroll a Group/Entity', and 'I am a Credentialing Agent'. The 'I am a Credentialing Agent' option is highlighted with a yellow box. At the bottom of the form, there are two buttons: 'Exit' and 'Save & Next'.

For further assistance with navigation, invitations, or account creation please contact the Partner Portal Technical Support Center at 877-838-5085. Select option 1 and option 1, again, to speak with a customer service representative.

Completing the Authorized Delegate form

**Provider, Group, Entity Officer
Owner or Board Member name**

**KY Department for Medicaid Services
Division of Program Integrity / Provider Licensing and Certification
KY Medicaid Partner Portal Application - Authorized Delegate Form**

**Provider, Group, Entity Officer
Owner or Board Member name**

**Credentialing Agent or
Credentialing Organization
Name**

I, _____, understand and acknowledge that I am legally responsible for my Kentucky Medicaid Provider Number and to be in compliance with all applicable Medicaid Rules and Regulations as outlined in 42 USC Section 1320a-7b, KRS 205, 907 KAR 1:671, or 907 KAR 1:672. It is my responsibility to review on a routine basis my Kentucky Medicaid Provider file for accuracy, which will require a Kentucky Medicaid Partner Portal Application (KY MPPA) account.

I, _____, hereby authorize _____ (individual, group, entity), or their duly appointed designee, when completing Kentucky Department for Medicaid Services (KY DMS) Provider Enrollment information (new, revalidation, and maintenance information to be updated) and electronically submitting to KY DMS:

- To act as a proxy agent for me in the preparation, signature, and submission of New Enrollment, Maintenance information, and Revalidations. This proxy includes creating a user account into the internet-based systems of the KY DMS, Kentucky Medicaid Partner Portal Application (KY MPPA).
- To release my signature electronically, or electronically sign, all KY MPPA applications and only KY MPPA applications necessary for enrollment and updates to required information for KY Medicaid Provider Licensing and Certification.

This proxy applies only to KY DMS Provider Licensing and Certification activities as outlined above.

Initial Submission: The initial submission of this form requires signature to be within 30 days of submission of a Maintenance, Revalidation or new Enrollment. The effective date of this delegation shall run until the next Revalidation date of my Kentucky Medicaid Provider information, on file with KY DMS Provider Licensing and Certification. This time period shall be no longer than 5 years from date of my enrollment, or until revoked by myself, the Provider, Owner, Officer or Board member, or at a time of a change of information that requires being updated with KY DMS, i.e., name change.

Revoking Delegation: To revoke this delegation, I acknowledge that I must go into (or create an account with) the Kentucky Online Gateway (KOG), and de-link the credentialing agent and/or Authorized Delegate, thereby prohibiting the credentialing agent and/or Authorized Delegate from performing updates to my KY Medicaid information.

Complete this side for Individual Provider Medicaid ID's only.

Individual Provider (Complete this column if submitting with an Individual Provider Enrollment, Revalidation or Maintenance)	Group or Entity (Complete this column if submitting with a Group or Entity Enrollment, Revalidation or Maintenance)
Provider Name <u>Printed</u> :	Owner/Officer or Board Member Name <u>Printed</u> :
Individual Provider NPI:	Group NPI:
Social Security Number:	Social Security Number: N/A to Group/Entity
Federal Tax Identification Number: N/A to an Individual Provider	Group Federal Tax Identification Number:
Individual Provider Signature:	Group Owner/Officer or Board Member Signature:
Date Signed:	Date Signed:

Complete this side for Group or Entity Medicaid ID's only.

Authorized Delegate Form October 2019, Version2.0

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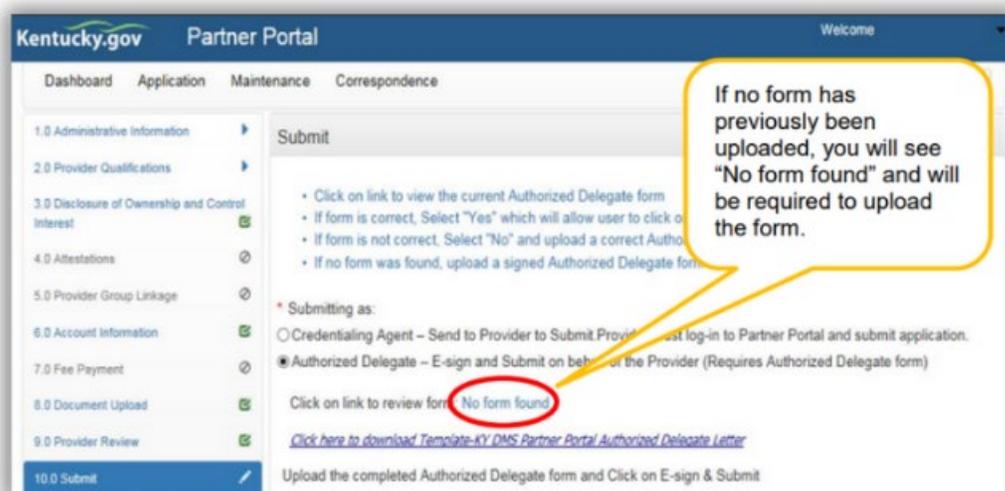
Form and Signature Requirements

The initial submission of the Authorized Delegate form requires the signature to be within 30 days of submission of a Maintenance, Revalidation, or New Enrollment.

The effective date of the delegation shall be no longer than five years from the date of the enrollment, or until revoked by the Authorized Delegate, the Provider, Owner, Officer, or Board Member, or at a time of a change of information requires being updated with Kentucky DMS (i.e. Provider or Authorized Delegate's name changes).

Submitting as an Authorized Delegate

- On the 10.0 Submit screen, select "Authorized Delegate".
- If this is the first time submitting an Authorized Delegate form, select "No Form Found".
- Browse files on your computer to locate the file and upload it to Partner Portal then complete the e-Signature page.



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