KY Department for Medicaid Services
Division of Program Integrity / Provider Licensing and Certification

KY Medicaid Partner Portal Application - Authorized Delegate Form

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:

1. 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 KKY DMS, Kentucky Medicaid Partner Portal Application (KY MPPA).
2. 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.

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 Printed:	Owner/Officer or Board Member Name Printed:
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: