



IDAHO DEPARTMENT OF  

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HEALTH & WELFARE

***New Provider Enrollment User Guide – Ordering  
Referring Prescribing Provider (ORP)***

***for***

***State of Idaho MMIS***



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## 1. Introduction

Thank you for your interest in participating in the Idaho Medicaid program. In order to begin the enrollment process, a Trading Partner Account will need to be established. Refer to the [Trading Partner Account \(TPA\) Provider Not Yet Enrolled Registration](#) User Guide for detailed instructions on how to register.

The *Provider Enrollment Guide – ORP* describes the enrollment process for a **non-billing** Ordering, Referring and Prescribing provider who does not and will not be submitting medical claims for direct payment. Most practitioners enroll in the Idaho Medicaid program to be reimbursed for the covered services they rendered to Medicaid participants. However, with the implementation of the Affordable Care Act, Medicaid permits certain practitioners to enroll in the Medicaid program for the sole purpose of ordering, referring, and prescribing for Medicaid participants. To determine if the provider type and specialty you are enrolling with is eligible to enroll as an ORP, refer to the [Provider Types and Specialties](#), Provider Handbook document.

In the following sections, you will find a list of the information you should have on hand before starting the enrollment process and a detailed description of how to complete the enrollment application.

If you are not an ORP provider, or you intend to bill Idaho Medicaid for services, refer to the appropriate user guide for instructions on how to complete your enrollment application. All User Guides can be found [here](#) on the Gainwell Technologies Provider Portal.

### 1.1. Glossary

Acronym	Definition
ORP	Any physician or other health care provider who writes orders, prescriptions or referrals for Medicaid participants for healthcare services or supplies.
NPI	National Provider Identification
SSN	Social Security Number

## 2. Necessary Information

The following information is necessary to complete the enrollment application:

- NPI
- Social Security Number (SSN)
- Legal name
- Email, physical and mailing address
- Date of birth
- Gender
- The provider type and specialty that represents the services provided by the rendering provider, as well as all licensing, certifications, and credentialing documents

## 3. System Requirements

To utilize all features of the provider enrollment application, ensure that your computer system meets the following minimum requirements:

- Internet browser 11
- Microsoft Edge 85.x

- Google Chrome 85.x
- Safari 5.1.7
- Mozilla Firefox 33 and 34
- Acrobat Reader DC
- Screen Resolution of 1024 x 768 or higher

## 4. User Interface and Navigation

### 4.1. My Enrollment Application Home Page

To access the provider enrollment application, a user must sign into the Idaho Gainwell Technologies Medicaid website at [www.idmedicaid.com](http://www.idmedicaid.com). Once signed in, hover over the **Account Maintenance** tab and select the **Provider Enrollment** link. The **My Enrollment Applications** table will display.

IDAHO DEPARTMENT OF HEALTH & WELFARE  
Medicaid Management Information System

Provider Enrollment Application      Back to Portal      Home      Sign Out      Toll Free: 1-866-686-4272

Enrollment Links to start new Enrollment  
> Provider Enrollment

To perform any type of Maintenance, please use the Action Button associated to the applicable enrollment in the grid below.

Case Number	Provider ID	Provider Name	Email Address	Enumeration Type	Enrollment Status	Enrollment Type	Actions
190000000	188888888	John Doe	Provider@acme.com	Type 2 - Organization	NEW	NEW	»

Note  
Provider ID = NPI or API

Help Links and Guidance

- Relevant Text Link 1
- Relevant Text Link 2
- Relevant Text Link 3
- Relevant Text Link 4
- Relevant Text Link 5
- Relevant Text Link 6
- Relevant Text Link 7
- Relevant Text Link 8
- Relevant Text Link 9
- Relevant Text Link 10

The **Application Banner** displayed on each page will allow a user to return to the portal, return to the Home page of Enrollment Applications, or sign out of the application. It also displays a contact number to reach a representative for assistance with questions M-F 7:00 AM to 7:00 PM MST.

Displayed in the right corner of each page is the **Accessibility** link. When this feature is enabled it allows the website to present information in a manner that is understandable for accessibility software, such as Job Access with Speech (JAWS). To enable the feature, simply select the Accessibility link or icon.

Next to the Accessibility link, there are four **A's**, which allow a user to increase or decrease text size on the screen. There is also a drop-down box which can be used to change the language.

The **My Enrollment Applications** table will display each enrollment application that has been initiated under this Trading Partner Account. If desired, the filter feature can be used to locate other existing applications that have been started, submitted, or approved under this Trading Partner Account. On this table you may also expand an application to see additional detail for the specific application.

My Enrollment Applications							
Case Number	Provider ID	Provider Name	Email Address	Enumeration Type	Enrollment Status	Enrollment Type	Actions
< [ ] >	< [ ] >	< [ ] >	< [ ] >	< [ ] >	< [ ] >	< [ ] >	
> 190000000	188888888	John Doe	Provider@acme.com	Type 2 - Organization	NEW	NEW	>>

The **Help Links and Guidance** table will provide quick access to additional resources, such as the Provider Handbooks and User Guides to assist a user with completing the application.

Help Links and Guidance					
<a href="#">Relevant Text Link 1</a>	<a href="#">Relevant Text Link 2</a>	<a href="#">Relevant Text Link 3</a>	<a href="#">Relevant Text Link 4</a>	<a href="#">Relevant Text Link 5</a>	
<a href="#">Relevant Text Link 6</a>	<a href="#">Relevant Text Link 7</a>	<a href="#">Relevant Text Link 8</a>	<a href="#">Relevant Text Link 9</a>	<a href="#">Relevant Text Link 10</a>	

A red asterisk (\*) is used throughout the application to indicate required fields on each screen. An alert will display if you attempt to move to another screen without entering information into the required fields. It is recommended that all fields are filled in, regardless of the red asterisk. The information provided on the application is used in a variety of ways, one of which being the provider directory on [www.idmedicaid.com](http://www.idmedicaid.com).

## 4.2. Standard Buttons

A set of standard buttons will be located below the fields on each screen, and this will enable the user to perform certain actions. The actions available will depend on the purpose of the screen. Most screens include the following:

### BACK

If selected, the application will go to the previous screen.

### RESET

If selected, the application will reset all fields displayed on the current screen.

### SAVE

If selected, the application will save all fields displayed on the screen.

### SAVE AND CONTINUE

If selected, the application will save and advance to the next screen.

### CLOSE

If selected, the application will save and close. The application will be available for completion for a period of 14 days.

**EDIT**

Select to edit any existing information that is already displayed.

**DELETE**

Select to delete any existing information that is already saved.

**ADD**

Select to add new information.

<b>BACK</b>	<b>RESET</b>	<b>SAVE</b>	<b>SAVE AND CONTINUE</b>	<b>CLOSE</b>
-------------	--------------	-------------	--------------------------	--------------

**Note:**

- It is recommended to use the save and continue button to advance to the next portion of the application, rather than independently navigating the application to ensure all necessary information is captured.
- While navigating through the application, **do not use** the **Back** button from the browser. This will take the user out of the application, and the application will need to be resumed.

### 4.3. User Guide Navigation

When completing the application, it is recommended to use the user guide, based on your enrollment type. All user guides are presented in a similar manner. First, text and questions that are displayed on the screen will be presented, along with special notes, and then a visual representation of the screen will be displayed.

## 5. Start Enrollment

To start an application, select the blue **Provider Enrollment** hyperlink.

My Enrollment Applications							
Case Number	Provider ID	Provider Name	Email Address	Enumeration Type	Enrollment Status	Enrollment Type	Actions
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you've already initiated an application, and need to resume the existing application, see the [Resuming an Existing Enrollment Application](#) section in this user guide.

Once the Provider Enrollment link has been selected, the user will be prompted to provide information on the Start Enrollment screen. Provide the following information:

The information provided on the Start Enrollment screen is the foundation for the New Enrollment application, and once the information has been input changes cannot be made.

If information was entered incorrectly, the user can **Delete** the application on the Business Information screen and begin the application process again.

### NPI Number\*

Enter the NPI number for the ORP provider. The information associated to the NPI number from the NPPES registry will display on future screens. Please contact NPPES to update the record with them, if the information that was auto-populated was incorrect.

### Business Enumeration Type\*

From the drop-down, select **ORP** to begin an ORP application.

### Business Enrollment Type\*

From the drop-down, select **ORP**.

### Tax ID Type\*

When enrolling as an ORP, the **Tax ID Type** will default to SSN.

### Enter Tax ID and Re-Enter Tax ID\*

Enter the social security number that is associated with the ORP's NPI number.

Select the **SAVE AND CONTINUE** button once all required fields are completed to advance to the **Business Info** screen.

**Note:** After the application has been started, the selections made on this screen cannot be changed.

Provider Enrollment Application
Back to Portal
Home
Sign Out
Toll Free: 1-866-686-4272

Welcome to Idaho Medicaid Provider Enrollment. Please review the user guides for complete instructions before you begin. For assistance with the enrollment process, contact a provider representative at 1-866-686-4272 or email [jdproviderenrollment@molinahealthcare.com](mailto:jdproviderenrollment@molinahealthcare.com).

**Start Enrollment**

NPI Number\* :

Business Enumeration Type\* :

Business Enrollment Type\* :

Tax ID Type\* :  SSN

Enter Tax ID\* :

Re-Enter Tax ID\* :

**Help Links and Guidance**

<a href="#">▶ Relevant Text Link 1</a>	<a href="#">▶ Relevant Text Link 2</a>	<a href="#">▶ Relevant Text Link 3</a>	<a href="#">▶ Relevant Text Link 4</a>	<a href="#">▶ Relevant Text Link 5</a>
<a href="#">▶ Relevant Text Link 6</a>	<a href="#">▶ Relevant Text Link 7</a>	<a href="#">▶ Relevant Text Link 8</a>	<a href="#">▶ Relevant Text Link 9</a>	<a href="#">▶ Relevant Text Link 10</a>

On each of the following screens the user will find a table displaying the following information:

### Billing Provider ID

The ORP provider's NPI number entered on the initial screen.

**Enrollment Case Number**

A unique ID assigned to this enrollment application. This case number should be referenced when discussing your enrollment application with Gainwell Technologies.

**Status**

The status of NEW-NEW will be reflected, as this is a new enrollment application.

Billing Provider ID: 1234567890	Enrollment Case Number: 191140004	Status: <b>NEW - NEW</b>
---------------------------------	-----------------------------------	--------------------------

## 6. Ordering/Referring Providers Tab

The **Ordering/Referring Providers** tab will include questions related to the ORP Provider, including their legal name, contact information, and address information.

### 6.1. Ordering/Referring Provider Tab

The Ordering/Referring Provider tab, located in the sub-menu on the Ordering/Referring tab, includes the following:

#### 6.1.1. Ordering Provider NPI Section

**Provider ID(NPI)\***

Auto-populated based on the entry from the Start Enrollment screen.

#### 6.1.2. Ordering Provider Section

**First Name\***

Enter the legal first name of the individual ORP provider enrolling.

**Middle Name**

Enter the legal middle name of the individual ORP enrolling.

**Last Name\***

Enter the legal last name of the individual ORP enrolling.

**Suffix**

Enter the suffix of the individual's legal name, if applicable.

**Email and Re-Type Email\***

Enter the contact email address. Re-Type the email address for confirmation. An email containing the Enrollment Case Number will be sent to the email address provided.

**Note:** The email provided in this portion of the application will be used for any future correspondence related to this provider record, and any other necessary email communications.

**Date of Birth\***

Enter the individual's Date of Birth using MM/DD/YYYY format.

**Gender\***

Enter the individual's gender.



### 6.1.3. Mailing Address Section

**Address Line 1\***

Enter the first line of the mailing address for the Billing Provider. The address provided is where all payment correspondence will be mailed.

**Address Line 2**

Enter the second line of the mailing address, if applicable.

**Zip Code\***

Enter the zip code associated to the mailing address

**Zip Code Extension\***

In the drop-down, select the zip code extension. This will default to "0000" if one is not entered.

**City\*, County\*, State\*, and Country\***

These fields will be auto-populated based on the zip code entered.

### 6.1.4. Practice Physical Address Section

**Same as Mailing Address**

If the practice physical address is the same as the mailing address entered in the previous section, select this box. This action will auto-populate the physical address fields.

**Address Line 1\***

Enter or update the physical street address where the ORP provider practices.

**Note:** The address information will be auto-populated based on information contained in the NPPES NPI Registry System. If the information displayed is incorrect, update the information. Please contact NPPES to update the record with them, if the information that was auto-populated was incorrect.

**Address Line 2**

Enter the second line of the physical street address where the ORP provider practices.

**Zip Code\***

Enter the zip code associated to the physical street address.

**Zip Code Extn\***

In the drop-down, select the zip code extension. This will default to "0000" if one is not entered.

**City, County, State, and Country\***

These fields will be auto-populated based on the zip code entered.

### 6.1.5. Ordering Provider Conviction

**Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing Medicare or Idaho Medicaid Program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program?\***

**Yes** or **No**. If **Yes** is chosen, check all that apply\* and provide an explanation in the free form text box.

- Sanctioned
- Excluded
- Convicted

**Note:** An explanation is required related to the sanction, exclusion, or conviction.

Once all information has been reported, select the **SAVE AND CONTINUE** button. The application will advance to the next screen.

Ordering/Referring Providers
Documents
Signature

Ordering/Referring Provider | Provider Type/Specialty |

### Ordering/Referring Provider

Billing Provider ID: 
Enrollment Case Number: 201840002
Status: NEW - NEW

**Ordering Provider NPI**

Enter the Ordering/Referring Provider NPI. The application will check the current providers and the CMS NPI registry and return this provider Provider(ID) NPI\*

Provider ID(NPI)\* :

**Ordering Provider**

Status : NEW

First Name* : <input type="text" value="JANE"/>	Middle Name : <input type="text"/>
Last Name* : <input type="text" value="DOE"/>	Suffix : <input type="text" value="--Please Select--"/>
Email* : <input type="text" value="PROVIDER@OFFICE.CC"/>	Primary Phone* : <input type="text" value="(208)-555-5555"/>
Emergency Phone : <input type="text" value="( )- - - -"/>	Fax : <input type="text" value="( )- - - -"/>
Date of Birth* : <input type="text" value="1/1/1985"/>	Gender* : <input type="text" value="Female"/>
SSN* : <input type="text" value="*****6789"/>	

**Mailing Address**

Address Line 1* : <input type="text" value="123 W PROVIDER ST"/>	Address Line 2 : <input type="text"/>
Zip Code* : <input type="text" value="83704"/>	Zip Code Extn* : <input type="text" value="0000"/>
City* : <input type="text" value="BOISE"/>	County* : <input type="text" value="ADA"/>
State* : <input type="text" value="ID"/>	Country* : <input type="text" value="USA"/>

**Practice Physical Address**

Same as Mailing Address

Address Line 1* : <input type="text" value="123 W PROVIDER ST"/>	Address Line 2 : <input type="text"/>
Zip Code* : <input type="text" value="83704"/>	Zip Code Extn* : <input type="text" value="0000"/>
City* : <input type="text" value="BOISE"/>	County* : <input type="text" value="ADA"/>
State* : <input type="text" value="ID"/>	Country* : <input type="text" value="USA"/>

**Ordering Provider Conviction**

Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing Medicare or Idaho Medicaid Program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program?\*

Please check all that apply\* :  Sanctioned  Excluded  Convicted

Explanation\* :

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## 6.2. Provider Type/Specialty Tab

### Provider Type\*

From the drop-down, choose the individual's provider type. The following options are displayed:

- Allopathic and Osteopathic Physician
- Eye and Vision Services Provider
- Other Service Providers
- Physician Assistants & Advances Practice Nursing Providers
- Podiatric Medicine and Surgery Service Providers
- Speech, Language and Hearing Service Providers

### Begin Date\*

Enter date that this provider type/specialty began.

### Specialty\*

From the drop-down, choose the specialty; for a complete list of the valid ORP provider specialties, refer to the [Provider Types and Specialties](#), Provider Handbook document.

### Term Date

Enter a term date for the provider type/specialty, if applicable.

### 6.2.1. Provider Type and Specialty Details Section

Depending on the provider type and specialty, the questions that display in this section of the application are dynamic, based on set requirements. Enter all required details.

Once all information has been reported, select the **SAVE AND CONTINUE** button. The application will advance to the next screen.

Ordering/Referring Providers
Documents
Signature

Ordering/Referring Provider | 
 Provider Type/Specialty |

Billing Provider ID: 
 Enrollment Case Number: 201840002
 Status: NEW - NEW

**Ordering Provider Details**

Ordering Provider NPI :  - JANE, DOE City, State : BOISE, ID

Specialties: You must enter your PRIMARY specialty first.  
 To view or edit, highlight a Specialty.

Provider Type	Specialty	Begin Date	Term Date
No records to display.			

EDIT
DELETE
ADD

**Provider Type/Specialty**

Provider Type\* : 
 Begin Date\* :

Specialty\* : 
 Term Date :

**Provider Type and Specialty Details**

Do you have prescribing/dispensing privileges?\* :  Yes  No  
 Do you provide laboratory services in your office/facility?\* :  Yes  No

**License**

Enter your number *exactly* as it is shown on your License (including dashes, commas, and spaces).

Licensing Board	License#	Begin Date	Term Date
KENTUCKY	<input type="text"/>	6/1/2018	12/31/2022

EDIT
DELETE
ADD

**Additional Information**

Medicare Enrollment #\* : 
 Begin Date\* : 
 Term Date :

## 7. Documents

All required documentation for the enrollment application will be displayed on the Documents tab.

### 7.1. Supporting Docs

In the **Supporting Docs** tab, a list of required documents will be displayed. The enrollment application is not complete until all required documentation has been received. Failure to submit the required documentation will delay the approval of the application. Signing electronically, when designated, or uploading documentation to the application is encouraged to expedite the processing of your application.

For each document displayed you may use the **Method of Submission** drop-down box to determine how to submit the document. Options will include:

- **Upload**
- **Mail-In**
- **Fax-In**
- **Email-In**

The following documents are required for the ORP provider enrollment application:

**Medicaid Provider Agreement\***

Select the action how you would like to submit the document.

Ordering/Referring Providers
Documents
Signature

Ordering/Referring Provider Docs |

**Ordering/Referring Provider Supporting Documents**

Billing Provider ID:  Enrollment Case Number: 201840002 Status: NEW - NEW

Your Enrollment is not complete until all required documentation listed below has been received. Failure to submit supporting documentation will delay the approval of your application and result in non-payment of claims.

Uploading images of the required documents is highly encouraged to expedite the processing time of your application. Choose the Method of Submission from the dropdown for each document listed and submit to DXC Provider Enrollment.

Refer to the User Guides found at [www.IDMedicaid.com](http://www.IDMedicaid.com) for detailed instructions regarding uploading documents. Fax, email, and mailing address information can also be found at [www.IDMedicaid.com](http://www.IDMedicaid.com) by selecting the Contact Us link.

Document Name	NPI	Name	Method Of Submission	Actions	Submitted/Signed Documents
* Medicaid Provider Agreement	<input type="text"/>	DOE, JANE	Sign-Electronically <span style="font-size: small;">▼</span>	<a href="#">Download Document</a> <a href="#">Upload</a> <a href="#">View Uploaded</a>	<a href="#">Review before Signing</a>

## 8. Signature

The **Signature** tab is required in order for an application to be submitted; the following is presented and required to be attested to and signed:

Regarding this application:

- I certify that I am the provider, owner, or officer with the legal authority to sign this application and I certify that all of the information provided in this application is true, correct, and complete.
- Incorrect information may lead to the denial of the application or delay the approval process. Please verify that all information is true, correct, and complete, before submitting the application.
- If I become aware that any information in this application is not true, correct, or complete, I will notify the Department or designee of this fact immediately.
- I authorize the Department or designee to verify the information contained herein.

Ongoing maintenance requirements:

- Per your Provider agreement changes must be reported to the Department or designee as follows:
  - I understand that a change in the ownership of my organization or my status as an individual or group biller must be reported within 35 days of the change and may require a new application.
  - All other changes to the information contained in this enrollment must be reported within 30 days of the date of that change.
  - Either of these types of changes may require a new application.

## 8.1. Signature

### **I Attest\***

Select the checkmark box to indicate that, as the submitter, you attest to the information displayed on the screen.

### **Provider Name\***

Auto-populated based on prior screen entry.

### **Signatory Title\***

Enter the title of the signer.

**Note:** An owner, board member or managing employee must sign the application.

### **Signatory Name\***

Enter name of the of the signer.

### **Date\***

Auto-populated to the current date.

### **IP Address\***

Auto-populated based on computer IP address.

### **I confirm that all the information contained in the application is correct \***

Select the checkmark box to agree.

### **I Attest, All demographic information is up to date and correct \***

Select the checkmark box to agree.

### **Override Submission\***

Select the checkmark box to agree.

Select **Submit** to submit your application. Select **Save** to save your application until you are ready to submit.

**Note:** If you do not submit the application, you may resume the application for a period of 14 days. See the [Resuming an Existing Enrollment Application](#) section in this user guide for more information.

Ordering/Referring Providers
Documents
Signature

Signature | Summary

**Signature**

Billing Provider ID:  Enrollment Case Number: 201840002 Status: NEW - NEW

**Signature**

Regarding this application:

- I certify that I am the provider, owner, or officer with the legal authority to sign this application and I certify that all of the information provided in this application is true, correct, and complete.
- Incorrect information may lead to the denial of the application or delay the approval process. Please verify that all information is true, correct, and complete, before submitting the application.
- If I become aware that any information in this application is not true, correct, or complete, I will notify the Department or designee of this fact immediately.
- I authorize the Department or designee to verify the information contained herein.

Ongoing maintenance requirements:

- Per your Provider agreement changes must be reported to the Department or designee as follows:
  - I understand that a change in the ownership of my organization or my status as an individual or group biller must be reported within 35 days of the change and may require a new application.
  - All other changes to the information contained in this enrollment must be reported within 30 days of the date of that change.
  - Either of these types of changes may require a new application.

By my signature, I declare, under penalty of perjury, that I have the legal authority as a current Owner, Board Member or Managing Employee, to enter into this Agreement and hereby bind all entities and individuals that comprise the Provider.

I Attest \*

**Provider Application Enrollment Signature**

Provider Name\* :

Signatory Title\* :

Signatory Name\* :

Date\* :

IP Address\* :

I confirm that all the information contained in the application is correct \*

I Attest, All demographic information is up to date and correct. \*

Override Submission \*

**Signature Affiliation**
X

Your enrollment has been submitted and is currently being processed. An email will be sent with the current status. Please review the email to see if further action is required.

OK

## 9. Resuming an Existing Enrollment Application

To **Resume** an application, you will go to the **My Enrollment Application** table, select the **>>** icon in the Actions column for the application you would like to resume. Select **Resume Application**.

My Enrollment Applications							
Case Number	Provider ID	Provider Name	Email Address	Enumeration Type	Enrollment Status	Enrollment Type	Actions
>	190860001	John Doe	provider@acme.com	ORP	NEW	NEW	<div style="display: flex; align-items: center; justify-content: center;"> <span style="font-size: 8px;">Resume Enrollment</span> </div>

## Revision History

Version	Date	Author	Action/Summary of Changes
1.0	07/02/2020	Myranda Payne	Initial Document- ORP Guide
1.1	07/06/2020	Tara Humpherys/ State Team	Reviewed and added comments
1.2	10/02/2020	Myranda Payne	Formatted throughout.
1.3	10/13/2020	Tara Humpherys	Review. Informally approved with changes.
1.4	10/13/2020	Myranda Payne	Updates made based on informal review.
2.0	11/27/2020	TQD	Finalized per DHW approved via UB02337B.