

# ILLINOIS PROVIDER ENROLLMENT

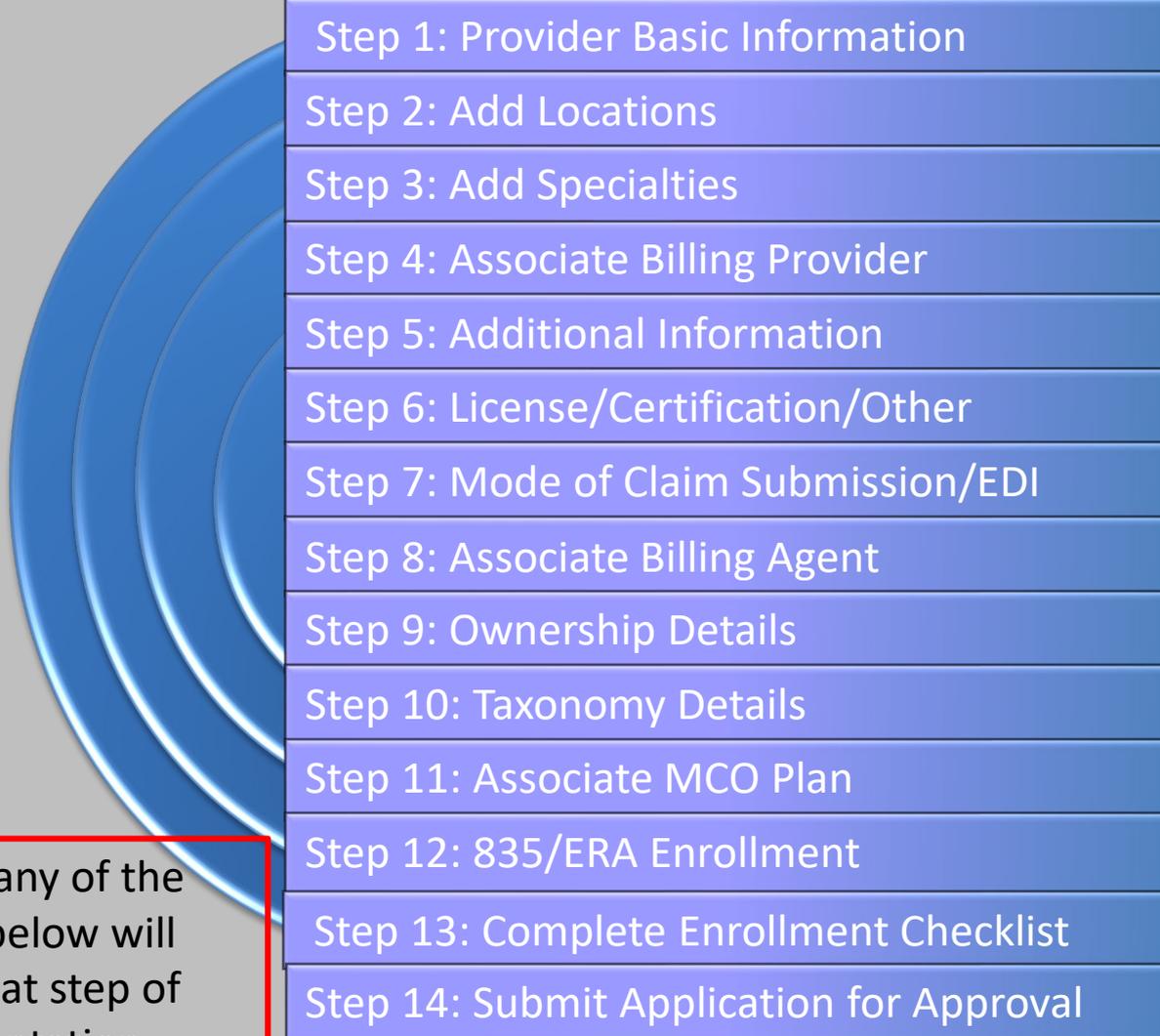


*Facilities, Agencies, Organizations*

- Introduction to IMPACT and Key Terms
- Application Process
- Resuming an Application
- Starting a New Application
- The Business Process Wizard (BPW)
- Completing the Application using BPW
- Reviewing Submitted Application
- Resources
- Questions & Answers

- **IMPACT** is a multi-agency effort to replace Illinois' 30-year-old Medicaid Management Information System (MMIS) with a web-based system that meets federal requirements, is more convenient for providers and increases efficiency by automating and expediting state agency processes.
- **Key Terms:**
  - Facility, Agency, Organization (FAO): An entity that provides health care services such as, hospitals, nursing facilities and laboratories. A type 2 NPI and licensing is required.
  - Revalidation: An FAO provider who was enrolled in the MMIS system and whose information was transferred to IMPACT.
  - Billing Agent: Submits Medicaid HIPAA compliant transactions or exchanges EPHI with Medicaid providers or other authorized parties. Also known as Clearing House, Software Vendor or Value Added Network (VAN).
  - MCO Plan: Health care plans that provide health care through a provider network. Sister Agencies will also be listed as an MCO. A sister agency is also known as a State Agency or a Waiver provider.

# Application Process



Pressing any of the buttons below will skip to that step of the presentation

Pressing this button on any screen will bring you back to this menu.

Shortcut to Step:

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12



# Application Process

## Manage your account

 Request Application Access	 Update Profile
 Change Password	 Update Security Q&A

## Access your applications

- **IMPACT**

- After completing the sign-on, click on **IMPACT**.

 <b>Provider Enrollment</b>	
New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

- In regards to completing an application, there are two options: New Enrollment or Resuming an application.

Shortcut to Step:



# Resume an Application

Provider Enrollment	
New Enrollment	Enroll As A New Provider
<b>Track Application</b>	Track Existing Provider Application

- To resume (or revalidate) an application, click on **Track Application**.
- The application number was either mailed out on a yellow card (revalidation) or sent to the listed email address (In-process application).

Close Submit

---

**Track Existing Application**

Please provide the Application ID to track your application.

Application ID:  \*

- Enter the Application ID for the application you want to access.
- After entering the ID number, click **Submit**.
- This process will then go directly to the Business Process Wizard (BPW).

Shortcut to Step:



# Start New Application

 <b>Provider Enrollment</b>	
<b>New Enrollment</b>	Enroll As A New Provider
Track Application	Track Existing Provider Application

- If completing a new application, click on **New Enrollment**.

**Enrollment Type**

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
  - Regular Individual/Sole Proprietor or Rendering/Service Provider
  - EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP.)
  - Managed Care Network Provider Only
  - Managed Care Network Provider and EHR
- Group Practice (Corporation, Partnership, LLC, etc.)
- Billing Agent
- Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- Contractor/MCO
- Atypical (non-medical) provider (Choose this option if you do not have a NPI)
  - Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
  - Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)

- Use the radio buttons to select your enrollment type, then click on **Submit** in the lower left corner.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12



# Start New Application (Step 1: Basic Provider Information)

*Please complete all fields. At a minimum, all fields with an \* are required.*

Basic Information: Enter required fields and click Confirm button.

**Basic Information**

Legal Entity Name:  (As shown on the Income Tax Return)  LLC (Disregarded Entity)

Entity Business Name:  \* (Doing Business As) EIN/TIN:  \*

Organization/Business Type:  \*

NPI:

Contact Email Address:

Email-1:	<input type="text" value="son@waiverservices.com"/> *	Email-2:	<input type="text"/>
Email-3:	<input type="text"/>	Email-4:	<input type="text"/>
Email-5:	<input type="text"/>	Email-6:	<input type="text"/>

Please note that all providers are subject to a criminal background screening that could affect your ability to be paid through the Home Help program.

- After all the information has been entered click **Confirm**.
- Click **Finish** in the bottom right corner to complete this step.

Shortcut to Step:



# Start New Application

## (Step 1: Basic Provider Information)

Application ID: 20191007736159      Name: Anderson Waiver Services

**Basic Information**

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: 20191007736159

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

- Application ID: systematically generated.
- Name: should reflect name from Basic Information.
- The system will generate an application ID after the successful completion of the Basic Information screen; the application number is a 14-digit number that has the following components:
  - The system date in yyyyymmdd format
  - A 6-digit system generated random number
  - Example: 20191007736159
- Application IDs are valid for 30 calendar days; applications must be completed and submitted to the state for review during this 30 day period or the application will be DELETED.
- The application ID will be used to access the application before submission to the state for review and will be used to track the status of your submitted application until it is marked approved.
- After documenting the ID number, click **OK**.

Shortcut to Step:



# Using the Business Process Wizard (BPW)



The BPW serves as the “Control Center” of the application.

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	10/07/2019	10/07/2019	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add Additional Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: 835/ERA Enrollment Form	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    << First    < Prev    > Next    >> Last

- **Required:** Steps listed as *Optional* may change to *Required* based upon previous steps.
- **Dates:** Entered by the system; *Start Date* is the date each step is opened, the *End Date* is the date each step is completed.
- **Status:** When a step is completed the *Status* will be updated to *Complete*; answering some checklist questions may change a prior step’s status back to *Incomplete*.
- **Remarks:** *Remarks* are systematically generated throughout the enrollment process.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12



# Completing the Application Using BPW

- Once you have documented your Application ID, you have completed Step 1: **Provider Basic Information**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Steps **1, 2** and **3** must be completed in sequential order before attempting any of the later steps.
- Click on Step 2: **Add Locations** to continue completing your application.

**Enroll Provider - Atypical Agency**

**Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.**

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add Additional Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: 835/ERA Enrollment Form	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    << First    < Prev    > Next    >> Last

Shortcut to Step:



# Step 2: Add Locations

Application ID: 20191001183382      Name: FAO Enrollment

To add/modify Pay To and Correspondence addresses, click on Location Type hyperlink.

**Locations List**

Filter By

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<b>No Records Found !</b>			

- Click **Add** to input the Primary Practice Location address details.

Shortcut to Step:



# Step 2: Add Locations

Please complete all fields. At a minimum, all fields with an \* are required.

**Add Provider Location**

Location Type: Primary Practice Location \*

Doing Business As:  End Date:

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1:  \* Address Line 2:   
(Enter Street Address or PO Box Only)

Address Line 3:  City/Town: OTHER \*

State/Province: OTHER \*  County: OTHER \*

Country: UNITED STATES \*  Zip Code:  \*

Phone Number:  \* Extn:  Fax Number:

Email Address:  Web Page:

Communication Preference: Email

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	Thursday:	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>
Monday:	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	Friday:	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>
Tuesday:	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	Saturday:	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>
Wednesday:	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>	<input type="text"/> *	AM <input type="text"/> * PM <input type="text"/>					

Handicap Accessible: No

Language(s) Spoken: English   
 Arabic   
 Chinese

(For Multiple Selection, use Ctrl Key)

Accept 835 (reported at EIN/TIN level): No

**Facility Details**

State Facility ID:  Fiscal Year End Date:  \*  
(mm/dd)

- Enter the street address and zip code, then click **Validate Address**.
- When all information has been entered, click **OK** at the lower right corner.

Shortcut to Step:



# Step 2: Add Locations

Close Add To add/modify Pay To and Correspondence addresses, click on Location Type hyperlink.

### Locations List

Filter By   Go Save Filters My Filters

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> Anderson Waiver Services	<a href="#">Primary Practice Location</a>	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

Delete View Page:  Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- Click on the **Primary Practice Location** hyperlink to add each address for this location.
- The **Primary Practice Location** address requires a **Correspondence** and a **Pay To** address.

Shortcut to Step:



# Step 2: Add Locations

☰ **Location Details** ▲

Doing Business As:       Location Code: 1

Phone Number:  \* Extn:       Fax Number:

Web Page:

Location Type: Primary Practice Location  
 Email:   
 Address:   
 Communication Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close ▾ *	AM ▾ PM ▾ *	▾ *	AM ▾ PM ▾ *	Thursday:	08:00 ▾ *	AM ▾ PM ▾ *	06:00 ▾ *	AM ▾ PM ▾ *
Monday:	08:00 ▾ *	AM ▾ PM ▾ *	06:00 ▾ *	AM ▾ PM ▾ *	Friday:	08:00 ▾ *	AM ▾ PM ▾ *	06:00 ▾ *	AM ▾ PM ▾ *
Tuesday:	08:00 ▾ *	AM ▾ PM ▾ *	06:00 ▾ *	AM ▾ PM ▾ *	Saturday:	Close ▾ *	AM ▾ PM ▾ *	▾ *	AM ▾ PM ▾ *
Wednesday:	08:00 ▾ *	AM ▾ PM ▾ *	06:00 ▾ *	AM ▾ PM ▾ *					

Close Save To add additional addresses, click 'Add Address' button.

Handicap Accessible:  ▾  
 Accept 835 (reported at EIN/TIN level):  ▾  
 End Date:

Language(s) Spoken:  ▾  
 (For Multiple Selection, use Ctrl Key) Arabic Chinese ▾

☰ **Facility Details** ▲

State Facility ID:

Fiscal Year End Date:  \*

(mm/dd)

☰ **Address List** ▲

➤ Add Address

Address Type	Address	End Date
<input type="checkbox"/> Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

- Click on **Add Address** to input the additional addresses for the Primary Practice Location.



# Step 2: Add Locations

**Add Provider Location Address**

Type of Address:   ←

End Date:  

Location Address:  Copy This Location Address

If a department or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address validation successful

Address Line 1:  \*  
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town:   \*

State/Province:   \*

County:  

Country:   \*

Zip Code:  -

- Choose type of address from the drop down menu.
- If the address you are entering is the same as the Location Address, then click the radio icon next to **Copy This Location Address**.
- If the address is not the same, enter the street address and zip code then click on **Validate address**.
- When all the information has been entered, click **OK**.
- Repeat these steps for each additional address type.

Shortcut to Step:



# Step 2: Add Locations

  To add additional addresses, click 'Add Address' button.

### Location Details

Doing Business As:  Location Code: 1

Phone Number:  \* Extn:  Fax Number:

Web Page:

Location Type: Primary Practice Location  
 Email:   
 Address:   
 Communication Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day	Open At	AM/PM	Close At	AM/PM	Day	Open At	AM/PM	Close At	AM/PM
Sunday	Close	AM/PM		AM/PM	Thursday	08:00	AM/PM	06:00	AM/PM
Monday	08:00	AM/PM	06:00	AM/PM	Friday	08:00	AM/PM	06:00	AM/PM
Tuesday	08:00	AM/PM	06:00	AM/PM	Saturday	Close	AM/PM		AM/PM
Wednesday	08:00	AM/PM	06:00	AM/PM					

### Address List

Address Type	Address	End Date
<input type="checkbox"/> Correspondence	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
<input type="checkbox"/> Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
<input type="checkbox"/> Pay To	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

• After all addresses have been entered click on **Save and the Close**.



# Step 2: Add Locations

To add/modify Pay To and Correspondence addresses, click on Location Type hyperlink.

### Locations List

Filter By

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> Anderson Waiver Services	<a href="#">Primary Practice Location</a>	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

View Page:     Viewing Page: 1

- To list an Other Servicing Location address, click on **Add** and enter the address information for that location.
- For Other Servicing Location, in addition to the location address itself, a **Correspondence** address is also required.
- Once all location addresses have been entered, click on **Close**.

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 2: **Add Locations**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 3: **Add Specialties** to continue your application.

Application ID: 20191007736159      Name: Anderson Waiver Services

**Enroll Provider - Atypical Agency**

**Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.**

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add Additional Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: 835/ERA Enrollment Form	Required			Incomplete	Please complete ERA form.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1                Viewing Page: 1               

Shortcut to Step:

1 2 3 4 5 6 7 8 9 10 11 12



# Step 3: Add Specialties

Close Add

### Specialty/Subspecialty List

Filter By [ ] [ ] Go Save Filters My Filters

Specialty/Subspecialty	Provider Type	End Date
No Records Found !		

- Click on the **Add** button in the upper left corner.

Shortcut to Step:



# Step 3: Add Specialties

Application ID: 20191007736159      Name: Anderson Waiver Services

**Add Specialty/Subspecialty**

Location: 01-Anderson Waiver \*  
Provider Type: SOCIAL SERVICES - AA \*  
Specialty: Case Management - AA \*  
End Date:

**Add Subspecialty**

Available Subspecialties: Individual Service Coordination, No Subspecialty, Training for Unpaid Caregiver  
Associated Subspecialties \*

OK    Cancel



- Select your **Provider Type** from the drop down.
- Select your **Specialty** from the drop down.

Shortcut to Step:



# Step 3: Add Specialties

- Once the Provider Type and the Specialty are selected, the Subspecialties will populate at the bottom of the screen in the **Available Subspecialties** box.
- The Provider must choose at least one Available Subspecialty (or No Subspecialty) if multiple selections are available.
- If only one choice is available, the system will preselect that selection.
- Once all desired selections are moved to the **Associated Subspecialties** box, click **OK** in the bottom right corner

Application ID: 20191007736159      Name: Anderson Waiver Services

**Add Specialty/Subspecialty**

Location: 01-Anderson Waiver \*  
Provider Type: SOCIAL SERVICES - AA \*  
Specialty: Case Management - AA \*  
End Date: [Calendar Icon]

**Add Subspecialty**

Available Subspecialties: No Subspecialty  
Associated Subspecialties \*: Individual Service Coordination, Training for Unpaid Caregiver

OK Cancel

Click on the Subspecialties then click on the **double arrows** to move the Subspecialties over to the **Associated Subspecialties** box.

Shortcut to Step:



# Step 3: Add Specialties

Close Add

### Specialty/Subspecialty List

Filter By   Go Save Filters My Filters

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> <input type="checkbox"/> Case Management - AA/Individual Service Coordination	SOCIAL SERVICES - AA	12/31/2999
<input type="checkbox"/> Case Management - AA/Training for Unpaid Caregiver	SOCIAL SERVICES - AA	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

- If you have another Specialty to enter click the **Add** button in the top left corner and repeat the steps as needed.
- When all the Specialty information has been entered, click on **Close** to return to the BPW.

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 3: **Add Specialties**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 4: **Associate Billing Provider/Other Associations** to continue your application.

Application ID: 20191007736159      Name: Anderson Waiver Services

Close

### Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional			Incomplete	
<a href="#">Step 5: Add Additional Information</a>	Optional			Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional			Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required			Incomplete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional			Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required			Incomplete	Please complete ERA form.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    << First    < Prev    > Next    >> Last

Shortcut to Step:



# Step 4: Associate Billing Provider/Other Associations List

Noted: This Step is Optional for this Enrollment Type.

Application ID: 20191007736159      Name: Anderson Waiver Services

### Billing Provider/Other Associations List

Filter By

NPI/Provider ID	Provider Name	Enrollment Type	Start Date	End Date	Status
No Records Found !					

- Click **Add** to input a Associated Billing Provider.

Shortcut to Step:



# Step 4: Associate Billing Provider/Other Associations

Application ID: 20191007736159      Name: Anderson Waiver Services

**Associate Billing Provider/Other Associations**

Enter NPI/Provider ID of Billing Provider/Other Associations and click "Confirm Provider."

Type:  \*  
ID:  \*

Provider Name:   
Enrollment Type:   
Applicant Type:

Start Date:  \*      End Date:

- Complete the Billing Provider information then click **Confirm Provider** and verify that the **Billing Provider Name is correct**.
- Click **OK** to return to the billing agent list.

Shortcut to Step:



# Business Process Wizard (BPW)

- You have completed Step 4: **Associate Billing Providers/Other Associations**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 5: **Add License/Certification/Other** to continue your application.

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional			Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional			Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required			Incomplete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional			Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required			Incomplete	Please complete ERA form.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    << First    < Prev    > Next    >> Last

Shortcut to Step:



# Step 5: Add Additional Information

Noted: This Step is Optional for this Enrollment Type.

Application ID: 20191007736159      Name: Anderson Waiver Services

### Contact List

Filter By

Contact Type	First Name	Last Name	Address	Location Name	Start Date	End Date
No Records Found !						

### Identifier List

Filter By

Identifier Type	Identifier Value	Location Name	Start Date	End Date
No Records Found !				

### Bed Information

Filter By

Bed Type	Bed(s)/Unit(s)	Location Name	Start Date	End Date
No Records Found !				

- This step is currently **OPTIONAL** but may become a required element when IMPACT is fully operational.

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 5: Add Additional Information. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 6: **Add License/Certification/Other** to continue your application.

Application ID: 20191007736159      Name: Anderson Waiver Services

Close

### Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional			Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required			Incomplete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional			Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required			Incomplete	Please complete ERA form.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1    Go    Page Count    Viewing Page: 1    << First    < Prev    Next >    >> Last

Shortcut to Step:



# Step 6: Add Licenses/Certifications/Other

Noted: This Step is Optional for this Enrollment Type.

**License/Certification/Other List**

Filter By

<input type="checkbox"/>	License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date
No Records Found !						

- Click on the **Add** button to begin adding Licenses and Certifications.

Shortcut to Step:



# Step 6: Add Licenses/Certifications/Other

**Add License/Certification/Other**

Location: 01- \*  
License/Certification/Other Type: \* License/Certification/Other #: \*  
Valid Flag: \*  
Effective Date: \* End Date: \*

Confirm License/Certification/Other

- Click the drop down menu next to **License/Certification Type** to select your License/Certification, then enter the **License/Certification Number** and **Effective Date** in the appropriate fields. Leave the **End Date** field blank.
- After all information is entered, click on **Confirm License/Certification**.
- Clicking this button will result in the License/Certification being validated and update the **Valid Flag** to **Yes** if it is verified to be authentic.
- Click **Ok**.

Shortcut to Step:



# Step 6: Add Licenses/Certifications/Other

**Close** **Add**

### License/Certification/Other List

Filter By [ ] And Filter By [ ] And Operational Status [ ]  
Active [ ] Go [ ] Save Filters [ ] My Filters [ ]

<input type="checkbox"/>	License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/>	STATE PROFESSIONAL LICENSE	123456789	01-NPI Default Base Location	Yes	06/16/2015	07/31/2017	APPROVED	Active	

View Page: 1 Go Page Count: 1 SaveToXLS Viewing Page: 1 First Prev Next Last

- If any additional Licenses/Certifications, click on the **Add** button in the top left corner and repeat the steps.
- Click **Close** once all Licenses/Certifications have been entered to return to the BPW.

Shortcut to Step:



# Business Process Wizard (BPW)

- You have completed Step 6: **Add Licenses/Certifications/Other**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 7: **Add Mode of Claim Submission** to continue your application.

Close

**Enroll Provider - Atypical Agency**

**Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.**

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required			Incomplete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional			Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required			Incomplete	Please complete ERA form.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1    Go    Page Count    Viewing Page: 1    << First    < Prev    > Next    >> Last

Shortcut to Step:



# Step 7: Mode of Claim Submission

## EDI Exchange

A New Enrollment will need to complete the necessary external application at <http://www.myhfs.illinois.gov/> unless using a Billing Agent or submitting Paper Claims.

Mode ☐ Claims Submission/EDI exchange

Please select the submission methods from EDI Exchange and/or Other Claims Submission as applicable.

**EDI exchange**

Method	Description	Applicable Transactions
<input checked="" type="checkbox"/> Electronic Batch	To upload/download HIPAA transactions from screens (Maximum file upload size is 50MB)	837P- Professional (FFS), 837I -Institutional(FFS), 837D -Dental(FFS),270/271 -Eligibility Inquiry/Response, 276/277- Claim Status Inquire/Response
<input type="checkbox"/> CORE Batch	To upload/download HIPAA transactions using CORE Batch Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> CORE Real Time	To upload/download HIPAA transactions using CORE Real Time Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> Billing Agent	To submit/receive HIPAA transactions through billing agent	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter),837D -Dental(FFS/Encounter), 270/271 - Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response,278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice

**Other Claims Submission**

Method	Description
<input checked="" type="checkbox"/> Paper Claims	To submit FFS paper claims
<input type="checkbox"/> Direct Data Entry(DDE)	To submit FFS claims via online screens

- Select any of the six options to indicate how you wish to process claims.
- Must select at least one option or claims will not be processed.
- After claim submission types have been selected click **OK**.

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 7: **Add Mode of Claim Submission** The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 8: **Associate Billing Agent** to continue your application.

Close

**Enroll Provider - Atypical Agency**

**Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.**

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional			Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required			Incomplete	Please complete ERA form.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1    Go    Page Count    Viewing Page: 1    << First    < Prev    > Next    >> Last

Shortcut to Step:

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12



# Step 8: Associate Billing Agent

Noted: This Step is Optional for this Enrollment Type.

**Billing Agent List**

Filter By

Billing Agent ID	Billing Agent Name	835 Authorization	Start Date	End Date
No Records Found !				

- Click **Add** to input a Billing Agent.

Shortcut to Step:



# Step 8: Associate Billing Agent

### Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID:  \*      Billing Agent Name:  \*

Association Start Date:  \*      Association End Date:

### Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

- Complete the Billing Agent information then click **Confirm/Search Billing Agent** and verify that the **Billing Agent Name** field is auto-populated with the correct agent.
- Click **OK** to return to the billing agent list.
- If the Billing Agent info is not known, click on **Confirm/Search Billing Agent** to locate the desired Billing Agent from the list.

# Step 8: Associate Billing Agent

### Billing Agent List

Filter By

<input type="checkbox"/>	Billing Agent ID ▲▼	Billing Agent Name ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/>	7125716	AJAX Billing Agency	05/04/2015	12/31/2999
<input type="checkbox"/>	7125725	Memorial Hospital	05/04/2015	12/31/2999
<input type="checkbox"/>	7125879	NEBO	05/05/2015	12/31/2999
<input checked="" type="checkbox"/>	7125888	Availity	05/04/2015	12/31/2999
<input type="checkbox"/>	7126526	fty by night billing	05/20/2015	12/31/2999

View Page:   Page Count : 1  Viewing Page: 1

- Use the **Filter By** drop down and choose an option to filter the list of available billing agents. (% is the wild card function)
- After the desired Billing Agent is shown on the list, click the check box for that option, then click **Select**.

Shortcut to Step:



# Step 8: Associate Billing Agent

Application ID: 20191007736159

Name: Anderson Waiver Services

## Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID:  \*



Billing Agent Name: MECS Billing Services LLC

Association Start Date:  \*

Association End Date:

## Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

- The chosen billing agent information will be populated. Verify that the information is correct then, click **OK** to return to the Billing Agent list.

Shortcut to Step:



# Step 8: Associate Billing Agent

**Close** **Add**

### Billing Agent List

Filter By   **Go** **Save Filters** **My Filters**

<input type="checkbox"/>	Billing Agent ID ▲▼	Billing Agent Name ▲▼	835 Authorization ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/>	7125888	Availity	No	05/21/2015	12/31/2999

**Delete** **View Page:**  **Go** **Page Count : 1** **SaveToXLS** **Viewing Page: 1** **First** **Prev** **Next** **Last**

- To associate to an additional Billing Agent, click **Add** and repeat the steps.
- When all billing agents have been entered, click **Close** to return to the BPW.

Shortcut to Step:



# Business Process Wizard (BPW)

- You have completed Step 8: **Associate Billing Agent** The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 9: **Add Provider Controlling Interest/Ownership Details** to continue your application.

**Enroll Provider - Atypical Agency**

**Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.**

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/07/2019	10/07/2019	Incomplete	Please select Billing Agent as a Mode of claim submission.
<a href="#">Step 8: Associate Billing Agent</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional			Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required			Incomplete	Please complete ERA form.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    << First    < Prev    > Next    >> Last

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

Application ID: 20191007736159      Name: Anderson Waiver Services

Close    + Actions    ⓘ

Add Owner  
Import Owner  
Owners Relationships  
Owners Adverse Action

PROVIDER CONTROL DISCLOSURES

Provider Enrollment and Control Disclosures: Provider Enrollment and Control Disclosures, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc).

**REQUIRED DISCLOSURE INFORMATION**

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

- Ownership entries must include at least one Managing Employee and one other Ownership type.
- Click on **Actions** drop down box and select **Add Owner or Import Owner**.

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

Please complete all fields. At a minimum, all fields with an \* are required.

**Provider Controlling Interest/Ownership**

Type:  \* ⓘ

SSN:  ← or → EIN/TIN:  ←

Legal Entity Name:  Entity Business Name:   
(As shown on the Income Tax Return) (Doing Business As)

First Name:  Last Name:

Suffix:  DOB:  ⓘ

Phone Number:  \* Extn:  Email:

Start Date:  ⓘ \* End Date:  ⓘ

Address Line 1:  \* Address Line 2:   
(Enter Street Address or PO Box Only)

Address Line 3:

City/Town: OTHER  \*

State/Province: OTHER  \* County: OTHER

Country: UNITED STATES  \* Zip Code:  -   Validate Address

OK

- Either your **SSN** or **EIN/TIN** must be entered.
- Enter **Percentage Owned** as a whole number.
- Enter the street address and zip code information, then click **Validate Address**.
- When all details are entered, click **OK**.

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

Application ID: 20191007736159

Name: Anderson Waiver Services

Close Actions

Pe... annual

PROVIDER CONTROL DISCLOSURES

Provider E... ing home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc)

- Add Owner
- Import Owner
- Owners Relationships
- Owners Adverse Action

Owners List

Filter By [ ] And Indicator [ ] Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 100001028	Anderson, Teresa	Managing Employee	607 E Adams St	10/02/2019	12/31/2999	Not Completed	Not Completed	100
<input type="checkbox"/> 100001040	Anderson, Harry	Board of Directors/Officers/Principles	607 E Adams St	10/07/2019	12/31/2999	Not Completed	Not Completed	100
<input type="checkbox"/> 100021032	TEST	Corporate - Not Publicly Traded	607 E Adams St	10/07/2019	12/31/2999	Not Completed	Not Completed	100

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Add Other Owned Entity List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By [ ] Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>		

No Records Found !

- Click **Actions** and select **Add Owner** or **Import Owner** repeat the previous steps to list additional owners
- After all ownerships have been added, click the **Actions** drop down box and select **Owner Relationships** or **Owners Adverse Action** to complete the relationship and adverse legal disclosure.

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

**Import Owner from Other Enrollment**

NPI  Provider ID \*      Zip Code \*            SSN/EIN/TIN \*            Owner Type      Owner [includes Managing Emplo: \           

**Owners Available to Import**

Filter By                       

Owner SSN/EIN/TIN	Owner Name	Owner/Other Owned Entity	Owner Type	Existing Owner	Start Date	End Date
No Records Found !						

- To import an owner from another enrollment click **Actions** and select **Import Owner**.
- Complete all fields and click on **Search**.
- Select one or all providers that is available to import.
- Click on **Import All** then **OK**.
- After all ownerships have been added, click the **Actions** drop down box and select **Owner Relationships** or **Owners Adverse Action** to complete the relationship and adverse legal disclosure.

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

Application ID: 20191007736159

Name: Anderson Waiver Services

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

Yes  No (Click Save to update) ←

### Owner List

Show Owners

All

Go

Save Filters

My Filters

Selected Owner: TEST SSN/EIN/TIN:100021032 Status:Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to TEST	Relation to Assoc. Owner
Anderson, Teresa	100001028	Managing Employee	<input type="text"/>	<input type="text"/>
Anderson, Harry	100001040	Board of Directors/Officers/Principles	<input type="text"/>	<input type="text"/>

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Selected Owner: Anderson, Harry SSN/EIN/TIN:100001040 Status:Not Completed

Selected Owner: Anderson, Teresa SSN/EIN/TIN:100001028 Status:Not Completed

Save Close

- Answer question regarding listed Owners and relationship.
- If no is selected From the first drop down list of **Owner Name**, choose an owner name.
- From the second drop down list of **Relationships**, choose how the chosen owner is related to the listed owner.
- Repeat this step until the relationship is set for each owner.
- When completed, click **OK** to return to the ownership listing.

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

**Owner List**

Show Owners Completed Go Save Filters My Filters

Selected Owner: TEST    SSN/EIN/TIN:100021032    Status:Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to TEST	Relation to Assoc. Owner
Anderson, Teresa	100001028	Managing Employee	Spouse	Self
Anderson, Harry	100001040	Board of Directors/Officers/Principles	Self	Spouse

View Page: 1 Go Page Count SaveToXLS    Viewing Page: 1    First Prev Next Last

Selected Owner: Anderson, Harry    SSN/EIN/TIN:100001040    Status:Completed

Selected Owner: Anderson, Teresa    SSN/EIN/TIN:100001028    Status:Completed

Save Close

- After adding the relationship information click on **Save**.



# Step 9: Controlling Interest/Ownership

Application ID: 20191001183382

Name: FAO Enrollment

## Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?  Yes  No (Click Save to update)

## Owner List

Show Owners All

- > Selected Owner: Doe, Jane SSN/EIN/TIN: 636642713 Status: Completed
- > Selected Owner: Jones, Mike SSN/EIN/TIN: 330862670 Status: Completed
- > Selected Owner: FAO Enrollment SSN/EIN/TIN: 100021050 Status: Completed

- If question is answered **No** click on **Save**.

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

The screenshot shows a web application interface for managing ownership information. At the top, there is a navigation bar with a grid icon on the left and an upward arrow on the right. Below this, a header section contains the text "Add Other Owned Entity" (circled in red) and "Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare." Below the header is a filter section with a "Filter By" dropdown, two input fields, and a "Go" button. To the right of the filter section are "Save Filters" and "My Filters" buttons. Below the filter section is a table with three columns: "Other Owner EIN/TIN", "Other Owner Information", and "Address". Each column has a small upward arrow icon. The table is currently empty, and a red message "No Records Found!" is displayed at the bottom of the table area.

- It is required that ownership of 5% or more in any other Medicaid/Medicare entity be entered.
- To enter Ownership details in another Medicaid/Medicare Entity, click on ***Add Other Owned Entity.***

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

Application ID: 20191007736159      Name: Anderson Waiver Services

Close    Actions    i

- Add Owner
- Import Owner
- Owners Relationships
- Owners Adverse Action**

Filter By    Import Owner    And    Indicator    Go    Save Filters    My Filters

Owner	Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
-------	-------------	------------	---------	------------	----------	---------------------	----------------	------------------

**FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS**

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

**Convictions**

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries or recipients. Offenses include, but are not limited to: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any misdemeanor or felonies that may result in a mandatory or permissive exclusion under State or Federal law.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

**Exclusions, revocations, or Suspensions**

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

Ok    Cancel

- Click on **Actions** drop down box and select Owner Adverse Action.
- Read reporting requirements.

Shortcut to Step:



# Step 9: Controlling Interest/Ownership

## FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

### Owners with Adverse Action

Filter By  All

Owner Name ▲▼	SSN/EIN/TIN ▲▼	Response ▲▼	Comments ▲▼
TEST	100021032	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>
Anderson, Teresa	100001028	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>
Anderson, Harry	100001040	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>

View Page:     Viewing Page: 1

- A Yes or No response is required for each owner listed in the application.
- After responding for each provider listed click on **OK**.

Shortcut to Step:



# Business Process Wizard (BPW)

- You have completed Step 9: **Add Provider Controlling Interest/Ownership Details**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 10: **Add Taxonomy Details** to continue your application.

Close
Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional			Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required			Incomplete	Please complete ERA form.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 
Go
Page Count
SaveToXLS

Viewing Page: 1

<< First
< Prev
Next >
Last >>

Shortcut to Step:



# Step 10: Add Taxonomy Details

Noted: This Step is Optional for this Enrollment Type.

The screenshot shows the 'Taxonomy List' interface. At the top left, there are 'Close' and 'Add' buttons. The 'Add' button is circled in red. Below the buttons is a 'Filter By' section with two input fields and a 'Go' button. To the right of the filter section are 'Save Filters' and 'My Filters' buttons. Below the filter section is a table with the following columns: 'Taxonomy Code', 'Description', 'Start Date', and 'End Date'. The table is currently empty, and the text 'No Records Found!' is displayed in red at the bottom of the table area.

- Click **Add** to enter a Taxonomy Code.
- At least one of the Taxonomy Codes entered in IMPACT must be the Taxonomy Code registered with the National Plan and Provider Enumeration System (NPPES).

Shortcut to Step:



# Step 8: Add Taxonomy Details

Application ID: 20191001183382      Name: FAO Enrollment

**Add Taxonomy**

Taxonomy Code:  \* ◀ (Click here for Taxonomy List)

Description:

Start Date:  \*

Location: 01-FAO Enrollment ▾ \*

End Date:

- Enter the **Taxonomy Code** and the **Start Date**.
- Click on **Confirm Taxonomy** and verify **Description** is populated correctly.
- Click on **OK** to finalize the submission.
- If the code is not known, click on the ◀ to the right of the box to access The National Uniform Claim Committee Taxonomy Code list. This will open a web browser window.

Shortcut to Step:



# Step 10: Add Taxonomy Details

The screenshot shows the National Uniform Claim Committee (NUCC) website. At the top right, there is a search bar with the text "SEARCH" and "Search this site ...". Below the search bar is a navigation menu with the following items: Home, Announcements, NUCC Structure, Calendar, 1500 Claim Form, Code Sets, and Resources. The main content area is titled "Open All" and contains the following text: "Code titles with a + sign expand when you click on them. You can expand the entire list by clicking the 'Open All' link above. Expand the code list to view the more detailed codes. Use your browser's find feature (Ctrl-F) after expansion to search for values. Taxonomy codes are self-selected. Choose the code that best identifies you as a provider." Below this text, there are two options: "+ Individual or Groups (of Individuals)" and "+ Non-individual". These two options are circled in red. To the right of the main content area, there is a sidebar with the following text: "Clicking a [definition] link to the left displays code value definitions, when available, and additional information about the selected code in this space." Below this text, there are two links: "Submit a Question" and "More Information".

- In the web browser window that opens will be a list of provider types.
- Click + next to the appropriate provider type for your enrollment.

Shortcut to Step:



# Step 10: Add Taxonomy Details

Home Announcements NUCC Structure Calendar 1500 Claim Form Code Sets Resources

**Open All**

Code titles with a  sign expand when you click on them. You can expand the entire list by clicking the "Open All" link above. Expand the code list to view the more detailed codes. Use your browser's find feature (Ctrl-F) after expansion to search for values. Taxonomy codes are self-selected. Choose the code that best identifies you as a provider.

-  Individual or Groups (of Individuals)
  -  Group [\[definition\]](#)
  -  Allopathic & Osteopathic Physicians [\[definition\]](#)
  -  Behavioral Health & Social Service Providers [\[definition\]](#)
  -  Chiropractic Providers [\[definition\]](#)
  -  Dental Providers [\[definition\]](#)
  -  Dietary & Nutritional Service Providers [\[definition\]](#)
  -  Emergency Medical Service Providers [\[definition\]](#)
  -  Eye and Vision Services Providers [\[definition\]](#)
  -  Nursing Service Providers [\[definition\]](#)
  -  Nursing Service Related Providers [\[definition\]](#)
  -  Other Service Providers [\[definition\]](#)
  -  Pharmacy Service Providers [\[definition\]](#)
  -  Physician Assistants & Advanced Practice Nursing Providers [\[definition\]](#)
  -  Podiatric Medicine & Surgery Service Providers [\[definition\]](#)
  -  Respiratory, Developmental, Rehabilitative and Restorative Service Providers [\[definition\]](#)
  -  Speech, Language and Hearing Service Providers [\[definition\]](#)
  -  Student, Health Care [\[definition\]](#)
  -  Technologists, Technicians & Other Technical Service Providers [\[definition\]](#)
-  Non-individual

Clicking a [definition] link to the left displays code value definitions, when available, and additional information about the selected code in this space.

If you are unable to find a code to meet your need:

- [Submit a Question](#)
- [More Information](#)

- Click on the **+** next to the appropriate profession listed under the heading which you previously selected.

Shortcut to Step:



# Step 10: Add Taxonomy Details

**National Uniform Claim Committee**

Home Announcements NUCC Structure Calendar 1500 Claim Form Code Sets

**Open All**

Code titles with a  sign expand when you click on them. You can expand the entire list by clicking the "Open All" link above. Expand the code list to view the more detailed codes. Use your browser's find feature (Ctrl-F) after expansion to search for values. Taxonomy codes are self-selected. Choose the code that best identifies you as a provider.

- Individual or Groups (of Individuals)
  - Group [\[definition\]](#)
    - Multi-Specialty - **193200000X** [\[definition\]](#)
    - Single Specialty - **193400000X** [\[definition\]](#)
  - Allopathic & Osteopathic Physicians [\[definition\]](#)
  - Behavioral Health & Social Service Providers [\[definition\]](#)
  - Chiropractic Providers [\[definition\]](#)
  - Dental Providers [\[definition\]](#)
  - Dietary & Nutritional Service Providers [\[definition\]](#)
  - Emergency Medical Service Providers [\[definition\]](#)
  - Eye and Vision Services Providers [\[definition\]](#)
  - Nursing Service Providers [\[definition\]](#)
  - Nursing Service Related Providers [\[definition\]](#)
  - Other Service Providers [\[definition\]](#)
  - Pharmacy Service Providers [\[definition\]](#)
  - Physician Assistants & Advanced Practice Nursing Providers [\[definition\]](#)
  - Podiatric Medicine & Surgery Service Providers [\[definition\]](#)
  - Respiratory, Developmental, Rehabilitative and Restorative Service Providers [\[definition\]](#)
  - Speech, Language and Hearing Service Providers [\[definition\]](#)
  - Student, Health Care [\[definition\]](#)
  - Technologists, Technicians & Other Technical Service Providers [\[definition\]](#)
- Non-individual

- Choose and write down your **Taxonomy Code**, then click the **X** on the top right of the page.

Shortcut to Step:



# Step 10: Add Taxonomy Details

Application ID: 20191007736159

Name: Anderson Waiver Services



## Add Taxonomy

Taxonomy Code:  \*

(Click here for Taxonomy List)

Location:  \*

Description: Case Manager/Care Coordinator

Start Date:  \*

End Date:

- Enter the **Taxonomy Code** and the **Start Date**.
- Click on **Confirm Taxonomy** and verify **Description** is populated correctly.
- Click on **OK** to finalize the submission.

Shortcut to Step:



# Step 10: Add Taxonomy Details

**Close** **Add**

**Taxonomy List**

Filter By   **Go** **Save Filters** **My Filters**

Taxonomy Code	Description	Start Date	End Date
<input type="checkbox"/> <b>▲▼</b>	<b>▲▼</b>	<b>▲▼</b>	<b>▲▼</b>
<input type="checkbox"/> 171M00000X	Case Manager/Care Coordinator	10/07/2019	12/31/2999

**Delete** **View Page:**  **Go** **Page Count** **SaveToXLS** **Viewing Page: 1** **First** **Prev** **Next** **Last**

- Repeat the steps by clicking on the **Add** button for any additional Taxonomy Codes that need to be entered.
- Otherwise, click on the **Close** button in the upper left corner.

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 10: **Add Taxonomy Details**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 11: **Associate MCO Plan** to continue your application.

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	10/07/2019	10/07/2019	Complete	
Step 2: Add Locations	Required	10/07/2019	10/07/2019	Complete	
Step 3: Add Specialties	Required	10/07/2019	10/07/2019	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	10/07/2019	10/07/2019	Complete	
Step 5: Add Additional Information	Optional	10/07/2019	10/07/2019	Complete	
Step 6: Add License/Certification/Other	Optional	10/07/2019	10/07/2019	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	10/07/2019	10/07/2019	Complete	
Step 8: Associate Billing Agent	Required	10/07/2019	10/07/2019	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	10/07/2019	10/07/2019	Complete	
Step 10: Add Taxonomy Details	Optional	10/07/2019	10/07/2019	Complete	
Step 11: Associate MCO Plan	Optional			Complete	
Step 12: 835/ERA Enrollment Form	Required			Incomplete	Please complete ERA form.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

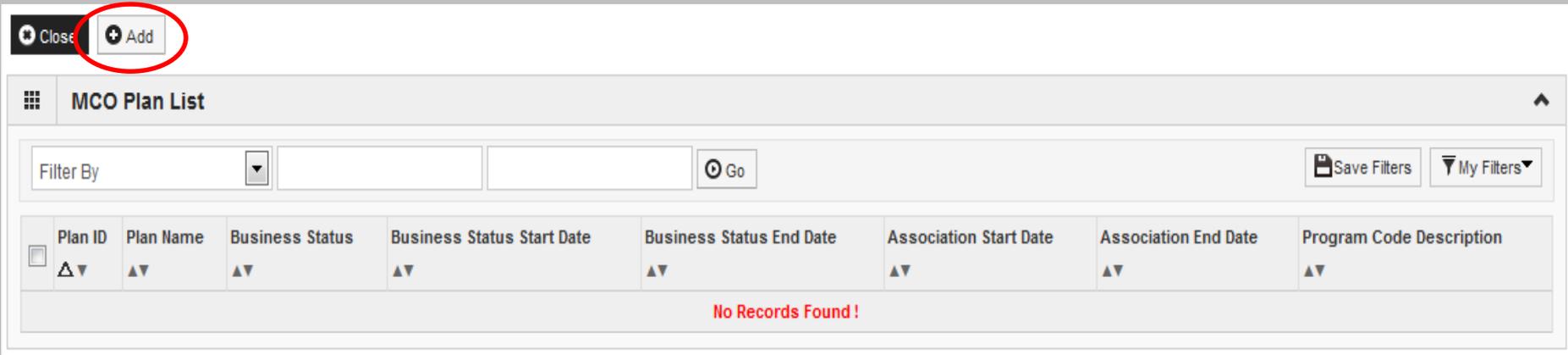
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Shortcut to Step:



# Step 11: Associate MCO Plan

Noted: This Step is Optional for this Enrollment Type.



Close Add

MCO Plan List

Filter By   Go Save Filters My Filters

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program Code Description
No Records Found!							

- Click **Add** to associate a MCO plan for which there is a current valid contract.
- Specific MCO plans can be added only once to the application.

Shortcut to Step:



# Step 11: Associate MCO Plan

### Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered  
Please associate only to plans with which you have a signed contract

Plan ID:  \* → Plan Name:

Program Code Description:

Association Start Date:  \* Association End Date:

- Enter a **Plan ID** and **Association Start Date** (or, the date of the application).
- **End Date**: Leave blank.
- Click **Confirm/Search Plan** and verify the **Plan Name** populated correctly then, click **OK**.
- If the MCO Plan information is not known, click on **Confirm/Search Plan**.

Shortcut to Step:



# Step 11: Associate MCO Plan

Close
Select

☰ MCO Plan Search List
▲

Filter By

Go

Save Filters

My Filters ▼

Plan ID ▲▼	Plan Name ▲▼	Business Status ▲▼	Business Status Start Date ▲▼	Business Status End Date ▲▼	Program Code Description ▲▼
<input checked="" type="checkbox"/> 7126080	Blue Cross Blue Shield IL FHP	Active	01/01/2015	12/31/2999	Family Health Plan/Affordable Care Act
<input type="checkbox"/> 7126393	Meridan Health Plan INC VMC	Active	05/14/2015	12/31/2999	Family Health Plan/Affordable Care Act
<input type="checkbox"/> 7126400	HARMONY HEALTH PLAN IL INC VMC	Active	05/14/2015	12/31/2999	Family Health Plan/Affordable Care Act

View Page: 1

Go

Page Count : 1

SaveToXLS

Viewing Page: 1

◀ First

◀ Prev

Next ▶

▶ Last

- Utilize the **Filter By** drop down and enter the desired information to filter the list of available MCO plans. (% is a wild card).
- Review the entries and click on the checkbox next to the line with the desired MCO information.
- Click **Select** to return to the MCO summary screen.

Shortcut to Step:



# Step 11: Associate MCO Plan

### Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered  
Please associate only to plans with which you have a signed contract

Plan ID:  \*

Plan Name:

Program Code Description:

Association Start Date:  \*

Association End Date:

- The chosen MCO plan information should be populated. Verify it is correct then click **OK**.

# Step 11: Associate MCO Plan

Close
 Add

MCO Plan List

Filter By Go

Save Filters
 My Filters

	Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program Description
<input type="checkbox"/>	3000003	DRS MCO	Active	01/01/1980	12/31/2999	10/07/2019	12/31/2999	DRS - Department of Human Services, Division of Rehabilitation Services

Delete
View Page: 
 Go
 Page Count
 SaveToXLS

Viewing Page: 1

First
 Prev
 Next
 Last

- Click **Add** to Associate to an additional MCO Plan.
- When all MCO Plans have been entered, click **Close** to return to the BPW.

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 11: **Associate MCO Plan** . The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 12: **835/ERA Enrollment Form** to continue your application.

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	10/07/2019	10/07/2019	Complete	
Step 2: Add Locations	Required	10/07/2019	10/07/2019	Complete	
Step 3: Add Specialties	Required	10/07/2019	10/07/2019	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	10/07/2019	10/07/2019	Complete	
Step 5: Add Additional Information	Optional	10/07/2019	10/07/2019	Complete	
Step 6: Add License/Certification/Other	Optional	10/07/2019	10/07/2019	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	10/07/2019	10/07/2019	Complete	
Step 8: Associate Billing Agent	Required	10/07/2019	10/07/2019	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	10/07/2019	10/07/2019	Complete	
Step 10: Add Taxonomy Details	Optional	10/07/2019	10/07/2019	Complete	
Step 11: Associate MCO Plan	Optional	10/07/2019	10/07/2019	Complete	
Step 12: 835/ERA Enrollment Form	Required			Incomplete	Please complete ERA form.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1   Go   Page Count   SaveToXLS   Viewing Page: 1   << First   < Prev   > Next   >> Last

Shortcut to Step:



# Step 12: Complete 835/ERA

Please complete this section once you have completed the enrollment steps found at <http://www.myhfs.illinois.gov/> if you wish to participate in 835/ERA, otherwise close this step.

Close Submit Print Help

**PROVIDER CONTACT INFORMATION**

Provider Contact Name

Contact: David Doe Title: Managing Employee

Telephone Number: 8631234567 Telephone Number Extension:

Email Address: abc@abc.com Fax Number:

**PROVIDER AGENT INFORMATION**

Provider Agent Name:

Agent Address

Street: State/Province:

City: Zip Code/Postal Code:

Country Code:

Provider Agent Contact Name

Provider Agent Contact Name: Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

**FEDERAL AGENCY INFORMATION (Not applicable at this time)**

Federal Program Agency Name: Federal Program Agency Identifier:

Federal Agency Location Code:

- Verify the generated information and complete information if needed.
- Use the scroll bar to move down the page.

Shortcut to Step:



# Step 12: Complete 835/ERA

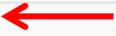
Close Submit Print Help

**ELECTRONIC REMITTANCE ADVISE INFORMATION**

Preference for Aggregation of Remittance Data(e.g., Account Number Linkage to Provider Identifier)

NPI  TAX ID \*

MI Medicaid enumerates by Tax ID only.

Method of Retrieval: CORE \* 

**ELECTRONIC REMITTANCE ADVISE CLEARINGHOUSE INFORMATION (Not applicable at this time)**

ClearingHouse Name:

ClearingHouse Contact Name

ClearingHouse Contact Name:  Telephone Number:

Email Address:

**ELECTRONIC REMITTANCE ADVISE VENDOR INFORMATION (Not applicable at this time)**

Vendor Name:

Vendor Contact

Vendor Contact Name:  Telephone Number:

Email Address:

**SUBMISSION INFORMATION**

Reason for Submission

Cancel Enrollment  Change Enrollment  New Enrollment \*

- Select your method of retrieval from the drop-down menu.
- Scroll down further.

Shortcut to Step:



# Step 12: Complete 835/ERA

**Close** **Submit** **Print** **Help**

**ELECTRONIC REMITTANCE ADVISE VENDOR INFORMATION (Not applicable at this time)**

Vendor Name:

**Vendor Contact**

Vendor Contact Name:  Telephone Number:

Email Address:

**SUBMISSION INFORMATION**

**Reason for Submission**

Cancel Enrollment  Change Enrollment  New Enrollment \*

**Authorized Signature**

**Electronic Signature of Person Submitting Enrollment:**

Authorization Agreement-By selecting the checkbox above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

**Authorization Agreement**

By signing this request, I am authorizing the Michigan Department of Community Health to establish an 835/ERA account for the Tax ID listed above and for 835/ERA files to be transmitted electronically to the designated entity.

**Written Signature of Person Submitting Enrollment:**

**Printed Name of Person Submitting Enrollment:**

**Printed Title of Person Submitting Enrollment:**

Submission Date: 06/22/2015

Requested ERA Effective Date:  
(Once approve the next paycycle date.)

- Checkbox to authorize the creation of an 835/ERA account then the signature portion will be populated.
- When complete, click **Submit** then **Close**.

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 12: **835/ERA Enrollment Form**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 13: **Complete Enrollment Checklist** to continue your application.

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	10/07/2019	10/07/2019	Complete	
Step 2: Add Locations	Required	10/07/2019	10/07/2019	Complete	
Step 3: Add Specialties	Required	10/07/2019	10/07/2019	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	10/07/2019	10/07/2019	Complete	
Step 5: Add Additional Information	Optional	10/07/2019	10/07/2019	Complete	
Step 6: Add License/Certification/Other	Optional	10/07/2019	10/07/2019	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	10/07/2019	10/07/2019	Complete	
Step 8: Associate Billing Agent	Required	10/07/2019	10/07/2019	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	10/07/2019	10/07/2019	Complete	
Step 10: Add Taxonomy Details	Optional	10/07/2019	10/07/2019	Complete	
Step 11: Associate MCO Plan	Optional	10/07/2019	10/07/2019	Complete	
Step 12: 835/ERA Enrollment Form	Required	10/07/2019	10/07/2019	Complete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    << First    < Prev    Next >    Last >>

Shortcut to Step:

1 2 3 4 5 6 7 8 9 10 11 12



# Step 13 Complete Enrollment Checklist

## Provider Checklist

Question	Answer	Comments
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested Date in the comment field to be considered.	Not Completed	
Do you wish to end date your enrollment? If yes, what date?	Not Completed	
Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	Not Completed	
Are you currently excluded from any federal program? If yes, provide the program and date.	Not Completed	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	Not Completed	
Have you ever had a judgment under any false claims act? If yes, list judgment and date	Not Completed	
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	Not Completed	
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	Not Completed	
Have you ever had a program exclusion/debarment? If yes, provide program and date	Not Completed	
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	Not Completed	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	Not Completed	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	Not Completed	
Are you a Home Health Agcy, DME, Medicar, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	Not Completed	
Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/DDD. If yes, complete "Associate MCO Plan" step in Business Process Wizard.	Not Completed	

- All questions must be answered either **Yes** or **No** and comments made if directed to do so, if a checklist item does not apply, select **No** as the answer.
- After all of the questions have been answered and comments made, click on the **Save** button in the upper left corner followed by clicking on the **Close** button.



# Business Process Wizard (BPW)



- You have completed Step 13: **Complete Enrollment Checklist**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 14 **Submit Enrollment Application for Approval** to continue your application.

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    << First    < Prev    > Next    >> Last

Shortcut to Step:

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12



# Step 14: Submit Enrollment for Approval

Application ID: 20191007736159      Name: Anderson Waiver Services

**Final Submission**

Application ID: 20191007736159      EnrollmentType: Atypical Agency Provider

The information submitted for enrollment shall be verified and reviewed by the State.  
During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).

**Application Document Checklist**

Forms/Documents	Special Instructions	Source	Required
△▽	△▽	△▽	△▽
No Records Found !			

- Click **Next** to confirm that all of the information that you have submitted as a part of the application is accurate.

Shortcut to Step:



# Step 14: Submit Enrollment for Approval

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

## Personal Assistant or Private Duty Certified Nurse Aide Providers

I, a Personal Assistant or Private Duty Certified Nurse Aide in the Medical Assistance Program agree, represent, and certify as follows:

1. I shall comply with all requirements set forth in the Home Services Customer/Provider Agreement (IL488-1947).
2. I shall not to discriminate in the provision of services based on the grounds of sex, race, color, national origin or disability.
3. I shall comply with the Personal Assistant requirements as set forth in 89 Ill. Adm. Code 686.10, or the Certified Nurse Aide requirements as set forth in 77 Ill. Adm. Code 395.
4. I shall voluntarily assign the responsibility for payment to me for the services I provide to customers of the Department of Human Services Division of Rehabilitation Services (DHS-DRS).
5. I shall accept payment from the State of Illinois for services provided, as payment in full.
6. I shall be accurate, complete and truthful in the completion of the HOME SERVICES TIME SHEET (L488-2251), and by signing the IL488-2251, I agree to be fully liable for the information the form contains (Any submission of false or fraudulent billing, or any concealment of information relevant to the payment of these bills may be prosecuted under applicable Federal and State laws).
7. I shall maintain a copy of the completed IL488-2251 and any other records related to the billing for services paid by the Division of Rehabilitation Services (These records must be maintained for at least three (3) years from the date the service was billed).
8. I shall notify DHS-DRS if there is an overpayment for any service provided and return any overpayment to the State of Illinois.
9. I agree that should the information provided be incomplete, inaccurate or falsified, it may be cause for my termination as a DHS-DRS provider under the Home Services Program.

## Telepsychiatry and Group Psychotherapy Providers

Telepsychiatry and group psychotherapy service providers in the Illinois Medical Assistance Program agree, represent, and certify as follows:

1. I have completed either a general psychiatric residency program or a child/adolescent psychiatric residency program. I agree to provide HFS with the name of the program and the date on which I completed the program. I further agree that my acceptance of these Terms and Conditions certifies, under penalties of perjury, that the information I have provided on my residency program is true, accurate and complete.

## Alcohol and Substance Abuse Providers

Alcohol and substance abuse providers in the Illinois Medical Assistance Program agree, represent, and certify as follows:

1. I shall notify Illinois Medical Assistance of any significant injury, suicide attempt or death at the facility, in order to allow Illinois Medical Assistance and the Department of Public Health to investigate the incident.
2. The Provider, if a substance abuse treatment and intervention provider per the definitions and requirements of 77 Ill. Admin. Code 2060 and 2090, agrees that it will maintain compliance with applicable parts of the then-effective Attachment C to the Department of Human Services Community Services Agreement (available via <http://www.dhs.state.il.us/page.aspx?item=29741>).

## Community Mental Health Providers

Community Mental Health providers in the Illinois Medical Assistance Program agree, represent, and certify as follows:

1. The Provider, if a community mental health provider per the definitions and requirements of 59 Ill. Admin. Code 132, agrees that it will maintain compliance with applicable parts of the then-effective Attachment B to the Department of Human Services Community Services Agreement (available via <http://www.dhs.state.il.us/page.aspx?item=29741>).

By checking this, I certify that I have read and that I agree and accept the enrollment conditions in the Trading Partner Agreement.

- Read through all of the terms and conditions.
- Check the box certifying that you agree to the terms and conditions.
- Then select **Submit Application**.

Shortcut to Step:



# Business Process Wizard (BPW)



- The below message will appear advising that the application has been submitted to the state for review. The application number can be used to check the status of the application by going through the track application option.

Application ID: 20191007736159      Name: Anderson Waiver Services

Your Application Number 20191007736159 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

[Close](#)

**Enroll Provider - Atypical Agency**

**Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.**

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required	10/07/2019	10/07/2019	Complete	

View Page:  [Go](#) [Page Count](#) [SaveToXLS](#)      Viewing Page: 1      [First](#) [Prev](#) [Next](#) [Last](#)

Shortcut to Step:



# Business Process Wizard (BPW)



- You have completed Step 14: **Submit Enrollment Application for Approval**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.

Application ID: 20191007736159      Name: Anderson Waiver Services

Your Application Number 20191007736159 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

**Enroll Provider - Atypical Agency**

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 2: Add Locations</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 5: Add Additional Information</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 6: Add License/Certification/Other</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 10: Add Taxonomy Details</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 11: Associate MCO Plan</a>	Optional	10/07/2019	10/07/2019	Complete	
<a href="#">Step 12: 835/ERA Enrollment Form</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	10/07/2019	10/07/2019	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required	10/07/2019	10/07/2019	Complete	

View Page: 1    Go    Page Count    SaveToXLS    Viewing Page: 1    First    Prev    Next    Last

Shortcut to Step:



- For more information regarding IMPACT, please visit <http://www.illinois.gov/hfs/impact/Pages/AboutIMPACT.aspx>
- Check out the definitions of common terms at <http://www.illinois.gov/hfs/impact/Pages/Glossary.aspx>

- FAQ's can be found at <http://www.illinois.gov/hfs/impact/Pages/faqs.aspx> to help resolve common questions and problems when submitting applications.
- General questions regarding IMPACT can be addressed to:
  - Email: [IMPACT.Help@Illinois.gov](mailto:IMPACT.Help@Illinois.gov)
  - Phone: 1-877-782-5565
    - Choose option 1 for IMPACT Help