



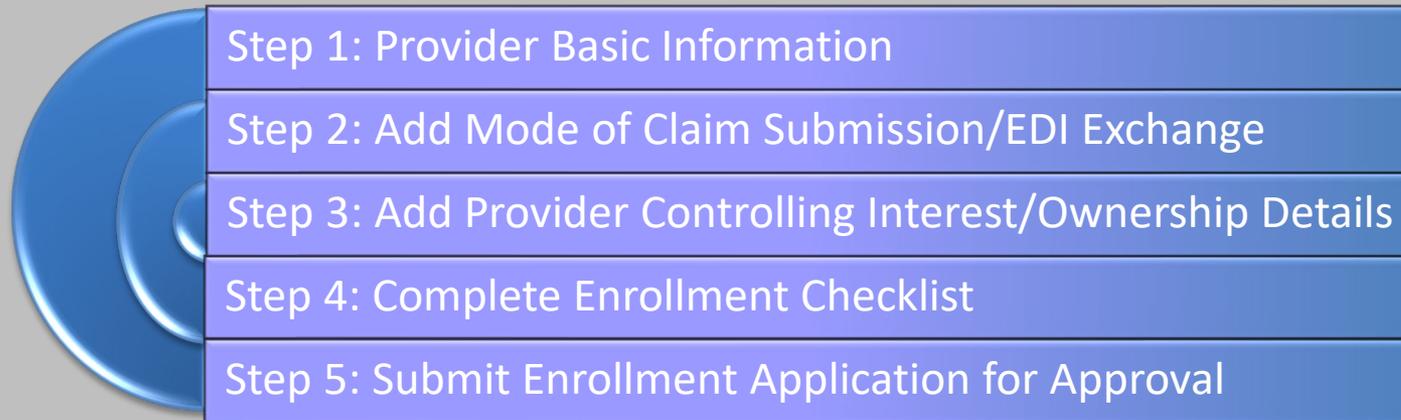
ILLINOIS PROVIDER ENROLLMENT



Billing Agent

- Introduction to IMPACT and Key Terms
- Application Process
- Starting an Application
- The Business Process Wizard (BPW)
- Completing the Application using the 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:**
 - **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).
 - **New Enrollment:** A billing agent who needs to enroll in the IMPACT system.
 - **NOTE:** A Billing Agent must be enrolled in IMPACT in order for a provider to associate with that Billing Agent.



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:



Start Application

Manage your account

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

Access your applications

• [IMPACT Provider Enrollment](#)

- After you have completed the single sign-on, click on **IMPACT Provider Enrollment**.

 Provider Enrollment	
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:



 Provider Enrollment 
New Enrollment Enroll As A New Provider
Track Application Track Existing Provider Application

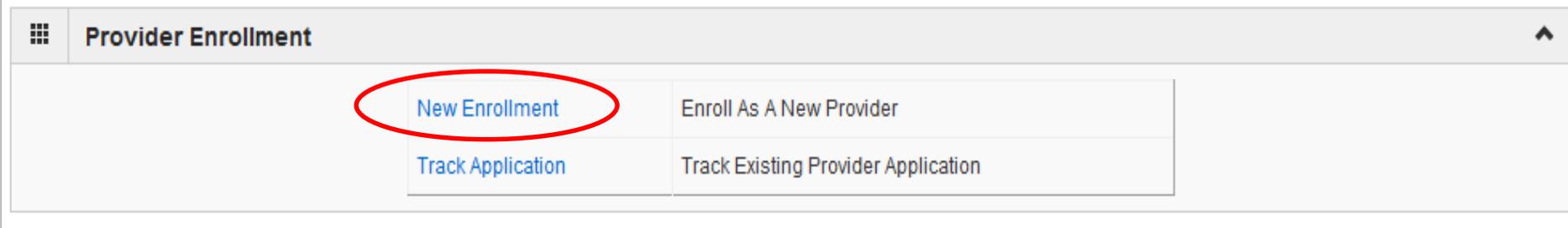
- To access a previously started application, click on **Track Application**.
- The application ID was sent to the email in the single sign-on account.

 Close	 Submit
 Track Existing Application	
Please provide the Application ID to track your application.	
	Application ID: <input type="text"/> *

- Enter the **Application ID** then, click **Submit**.
- You will be taken directly to the Business Process Wizard.

Shortcut to Step: 1 2 3 4 5

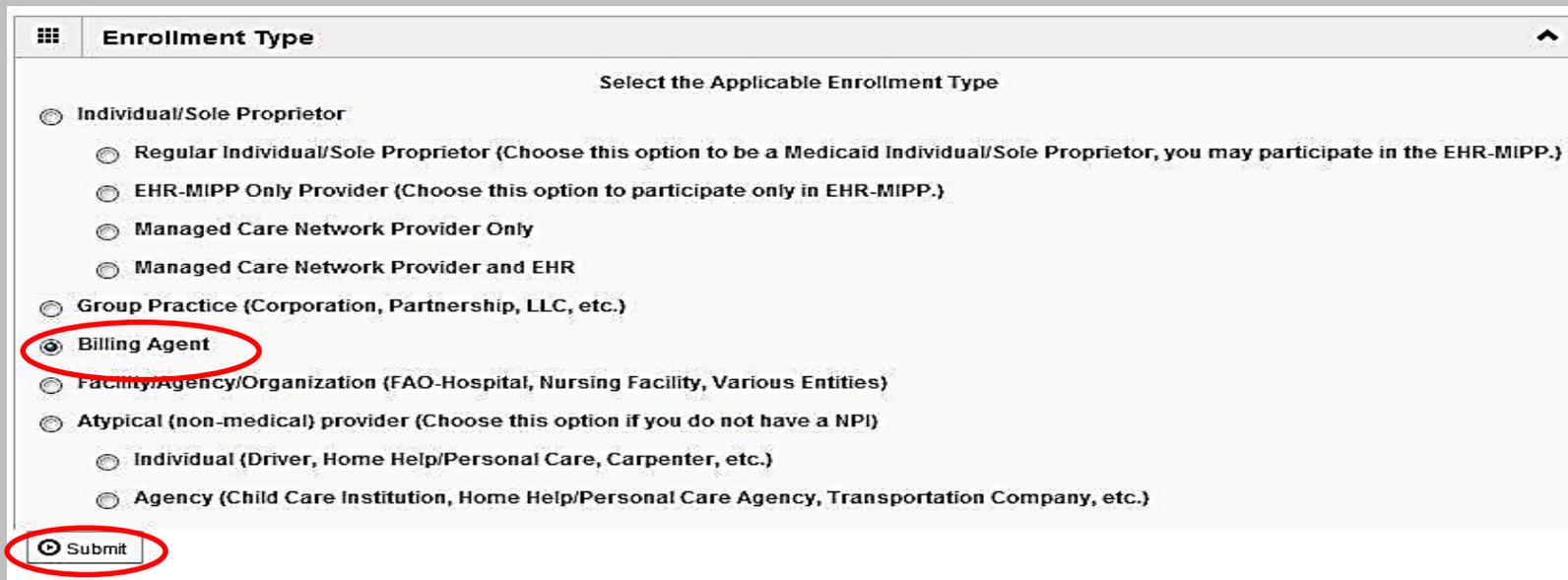




The screenshot shows a web interface with a header bar containing a grid icon and the text "Provider Enrollment". Below the header is a table with two rows and two columns. The first row has "New Enrollment" in the left column and "Enroll As A New Provider" in the right column. The second row has "Track Application" in the left column and "Track Existing Provider Application" in the right column. The "New Enrollment" text is circled in red.

New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

- To begin a new application, click on **New Enrollment**.
- Use the radio buttons to select your enrollment type (Billing Agent), then click on **Submit** in the lower left corner.



The screenshot shows a web interface with a header bar containing a grid icon and the text "Enrollment Type". Below the header is a form titled "Select the Applicable Enrollment Type". The form contains a list of radio button options. The "Billing Agent" option is circled in red. At the bottom left of the form, there is a "Submit" button, also circled in red.

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
 - Regular Individual/Sole Proprietor (Choose this option to be a Medicaid Individual/Sole Proprietor, you may participate in the EHR-MIPP.)
 - 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)
- 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, etc.)

Shortcut to Step:



Start Application

Step 1: Provider Basic Information

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

The screenshot shows a web form with three main sections: Basic Information, Support Contact, and Technical Contact. Each section has a scroll bar on the right. The Basic Information section includes fields for Entity Business Name (required), Claim Submission Type (Dental, Institutional, Professional), and a note to select at least one claim type. The Support Contact section includes fields for First Name (required), Last Name (required), Middle Initial, Phone Number (required), Extn., Fax Number, and six Email Address fields (Email-1 to Email-6, with Email-1 required). The Technical Contact section includes a checkbox labeled 'Same as Support Contact' which is circled in red, and identical fields for First Name (required), Last Name (required), Middle Initial, Phone Number (required), Extn., Fax Number, and six Email Address fields (Email-1 to Email-6, with Email-1 required).

- It is necessary to enter a Support Contact and a Technical Contact.
- If the Technical Contact is the same as the Support Contact, check the box next to **Same as Support Contact**.
- Use the scroll bar to move down the screen.



Start Application

Step 1: Basic Provider Information

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

Billing Agent Address Details

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 validation successful

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

Address Line 2:

Address Line 3:

State/Province: *

City/Town: *

Country: *

County: *

Zip Code: -

Entity Fax Number:

Entity Email Address: *

Entity Phone Number: *

- Complete all fields marked with an asterisk *.
- Click **Validate Address** after the street address and zip code have been entered.
- If the address is not validated, check to verify it is correct and update any incorrect information.
- When the address has been validated, click **Finish**.

Shortcut to Step:



Start Application

Step 1: Basic Provider Information

Application ID: 20150520803272 Name: Test Billing Agent

Basic Information

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

Your Application ID is: 20150520803272

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.

✓ Ok

- 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: 20130514412598
- 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.
- Click **OK** to continue with your application

Shortcut to Step:



Using the Business Process Wizard (BPW)

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

Application ID: 20150520803272 Name: Test Billing Agent

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/19/2015	05/19/2015	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 4: Complete Enrollment Checklist	Required			Incomplete	
Step 5: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Page Count: 1 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*.
- **Step Remark:** *Remarks* are systematically generated throughout the enrollment process.

Shortcut to Step:



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.
- **Step 1** must be completed before attempting any of the later steps.
- Click on Step 2: **Add Mode of Claim Submission/EDI Exchange** to continue completing your application.

Application ID: 20150520803272 Name: Test Billing Agent

[Close](#)

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/19/2015	05/19/2015	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 4: Complete Enrollment Checklist	Required			Incomplete	
Step 5: Submit Enrollment Application for Approval	Required			Incomplete	

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

Shortcut to Step:



Step 2: Add Mode of Claim Submission/EDI Exchange

A New Enrollment will need to complete the necessary external application at <http://www.myhfs.illinois.gov/>.

Mode of 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 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"/> Data Exchange Gateway (DEG)	To submit/receive HIPAA transactions via Data Exchange Gateway(DEG) using FTP/SFTP	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 NCPDP Post Adjudication

Ok Cancel

- Select any of the four options to indicate how you wish to process claims.
- After claim submission types have been selected click **OK**.

Shortcut to Step:



Business Process Wizard (BPW)

- You have completed Step 2: **Add Mode of Claim Submission/EDI Exchange**. 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 Provider Controlling Interest/Ownership Details** to continue your application.

Close

Enroll Billing Agent

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

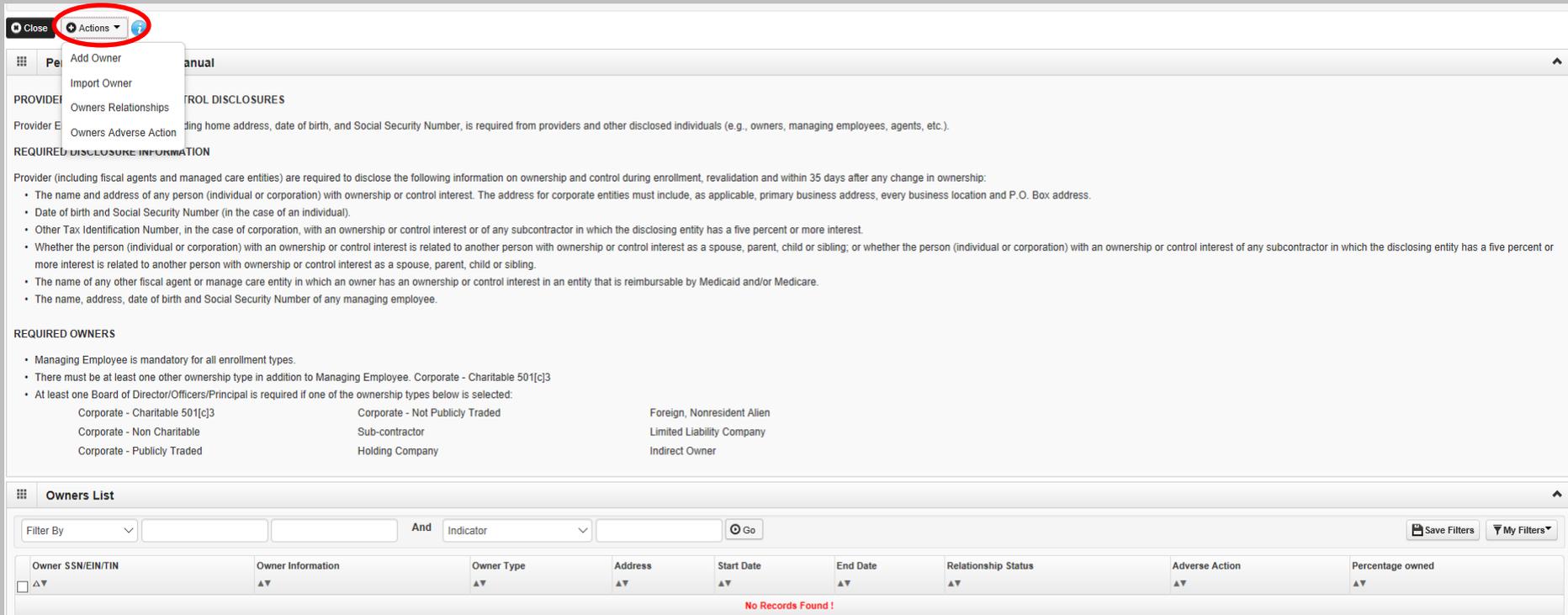
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/19/2015	05/19/2015	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	05/19/2015	05/19/2015	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 4: Complete Enrollment Checklist	Required			Incomplete	
Step 5: Submit Enrollment Application for Approval	Required			Incomplete	

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

Shortcut to Step:



Step 3: Add Provider Controlling Interest/Ownership Details



The screenshot shows the 'Actions' menu in the top left corner, with 'Add Owner' highlighted. Below the menu, there is a section for 'REQUIRED DISCLOSURE INFORMATION' and 'REQUIRED OWNERS'. The 'Owners List' table is currently empty, displaying 'No Records Found!'.

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 manage 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.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501[c]3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited Liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

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
No Records Found !								

- Ownership entries must include at least one Managing Employee and one other Ownership type.
- To add Ownership listings, click on the **Actions** box and select **Add Owner**.

Shortcut to Step:



Step 3: Add Provider Controlling Interest/Ownership Details

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

Provider Controlling Interest/Ownership

Type: * ⓘ

SSN: ←

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

First Name:

Suffix:

Phone Number: * Extn:

Start Date: ⓘ *

Percentage Owned: * ←

EIN/TIN: →

Entity Business Name:
(Doing Business As)

Last Name:

DOB: ⓘ

Email:

End Date: ⓘ

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

Address Line 2:

Address Line 3:

City/Town: OTHER *

County: OTHER

State/Province: OTHER *

Country: UNITED STATES *

Zip Code: - ⓘ **Validate Address**

- Complete all fields marked with an asterisk *.
- Either the **SSN** or **EIN/TIN** must be entered (as prompted by the system).
- 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 3: Add Provider Controlling Interest/Ownership Details

The screenshot shows a web application interface with a top navigation bar containing a 'Close' button, an 'Actions' dropdown menu, and an information icon. The 'Actions' dropdown menu is open, showing three options: 'Add Owner', 'Import Owner', and 'Owners Relationships'. Red arrows point to the 'Add Owner' and 'Import Owner' options. Below the menu, the main content area displays text related to provider ownership and disclosure requirements. The text includes sections for 'REQUIRED DISCLOSURE INFORMATION' and 'REQUIRED OWNERS'. The 'REQUIRED OWNERS' section lists various ownership types and their requirements.

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 owners

- 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
- 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 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.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited Liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

- Click **Add** and repeat the previous steps to list additional owners
- If one of the owners is listed on another enrollment, **Import Owner** can be selected from the **Action** box at the top of the page.
- This selection will allow the user to import owner information from another enrollment by using the **NPI or Provider ID**, the **Zip Code** of the Owner, and the **Owner Type**.

Shortcut to Step:



Step 3: Add Provider Controlling Interest/Ownership Details

The screenshot shows a web application interface. At the top left, there is a 'Close' button and an 'Actions' dropdown menu. A red arrow points to the 'Actions' dropdown, and another red circle highlights the 'Owners Relationships' option in the dropdown menu. The background shows a form titled 'PROVIDER OWNERSHIP DISCLOSURES' with sections for 'REQUIRED DISCLOSURE INFORMATION' and 'REQUIRED OWNERS'. The 'REQUIRED DISCLOSURE INFORMATION' section contains a list of items that providers must disclose, including names and addresses of owners, dates of birth, Social Security Numbers, and tax identification numbers. The 'REQUIRED OWNERS' section lists various ownership types such as 'Managing Employee', 'Corporate - Charitable 501[c]3', 'Corporate - Non Charitable', 'Corporate - Publicly Traded', 'Corporate - Not Publicly Traded', 'Sub-contractor', 'Holding Company', 'Foreign, Nonresident Alien', 'Limited Liability Company', and 'Indirect Owner'.

- Now complete the Owners Relationship information by selecting **Actions**, **Owners Relationships**.

Shortcut to Step:



Step 3: Add Provider Controlling Interest/Ownership Details

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: Nese Meyer, Jon	SSN/EIN/TIN: 351588635	Status: Not Completed		
Assoc. Owner	SSN/EIN/TIN	Type	Relation to Nese Meyer, Jon	Relation to Assoc. Owner
Johnson, MICHAEL	100001196	Managing Employee	<input type="text" value=""/>	<input type="text" value=""/>

View Page: 1 Viewing Page: 1

Selected Owner: Johnson, MICHAEL SSN/EIN/TIN: 100001196 Status: Not Completed

- Select **All** next to **Show Owners**, and choose the relationship next to each drop down menu.
- Choose **Save** to complete the screen.

Shortcut to Step:



Step 3: Add Provider Controlling Interest/Ownership Details

Close Actions ?

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, 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 manage 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.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited Liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

- Select **Close**.

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

Filter By [dropdown] [input] [Go]

Save Filters My Filters

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

- 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 3: Add Provider Controlling Interest/Ownership Details

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

Provider Controlling Interest/Ownership in Other Medicaid/Medicare Entities

Type: Other Medicaid/Medicare Entity

Percentage Owned: *

EIN/TIN: *

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

Entity Business Name: *
(Doing Business As)

Phone Number: * Extn:

Email:

Start Date: *

End Date:

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

Address Line 2:

Address Line 3:

City/Town: OTHER *

County: OTHER

State/Province: OTHER *

Country: UNITED STATES *

Zip Code: -

- After entering the street address and zip code, click **Validate Address**.
- When all information is complete, click **OK**.
- Repeat these steps to add ownership in another Medicaid/Medicare Entity.

Shortcut to Step:



Step 3: Add Provider Controlling Interest/Ownership Details

Close **Add**

Owners List

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

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
111111111	Doe, David	Managing Employee	06/02/2015	12/31/2999
222222222	Doe, Sam	Individual/Sole Proprietor	06/02/2015	12/31/2999

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

Add Other Owned Entity

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

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

Other Owner EIN/TIN	Other Owner Information	Address
123456789	Department of Human Services	123 Anywhere Lane Chicago, IL 60601

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

- When all ownerships for this location and ownership information in other entities is complete, click **Close**.

Shortcut to Step:



Business Process Wizard (BPW)

- You have completed Step 3: **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 4: **Complete Enrollment Checklist** to continue your application.

Application ID: 20150520803272 Name: Test Billing Agent

[Close](#)

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/19/2015	05/19/2015	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	05/19/2015	05/19/2015	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	05/19/2015	05/19/2015	Complete	
Step 4: Complete Enrollment Checklist ←	Required			Incomplete	
Step 5: Submit Enrollment Application for Approval	Required			Incomplete	

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

Shortcut to Step:



Step 4: Complete Enrollment Checklist

The screenshot shows a web-based form titled "Provider Checklist". At the top left, there are two buttons: "Close" and "Save", both of which are circled in red. The form contains four questions, each with a dropdown menu for the answer and a text box for comments. Red arrows point to the "Answer" and "Comments" columns. The questions and their current answers are:

Question	Answer	Comments
Are you able to produce HIPAA-Compliant transactions?	Not Completed	
Have you reviewed the HFS Handbook - Chapter 300, Electronic Processing and Federal Implementation Guides?	Not Completed	
Would you be willing to submit HIPAA-Compliant transactions for new providers?	Not Completed	
Do you wish to end date your enrollment? If yes, what date?	Not Completed	

At the bottom of the form, there are navigation controls: "View Page: 1", "Go", "Page Count", "SaveToXLS", "Viewing Page: 1", "First", and "Prev".

- 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 the **Save** button in the upper left corner followed by clicking on the **Close** button.

Shortcut to Step:



Business Process Wizard (BPW)

- You have completed Step 4: **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 5: **Submit Enrollment Application for Approval** to continue your application.

Application ID: 20150520803272 Name: Test Billing Agent

[Close](#)

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/19/2015	05/19/2015	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	05/19/2015	05/19/2015	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	05/19/2015	05/19/2015	Complete	
Step 4: Complete Enrollment Checklist	Required	05/19/2015	05/19/2015	Complete	
Step 5: Submit Enrollment Application for Approval	Required			Incomplete	

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

Shortcut to Step:



Step 5: Submit Enrollment Application for Approval

Application ID: 20150520803272 Name: Test Billing Agent

Final Submission

Application ID: 20150520803272 EnrollmentType: Billing Agent

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 5: Submit Enrollment Application for Approval

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

Billing Agent Terms and Conditions

I, the Billing Agent, agree to and certify as follows:

1. I will participate within the Business-to-Business (B2B) Testing process. I understand that I must meet required criteria before I will be able to submit claims in production.
2. Before billing for any medical services, I will fully comply with the HFS Manuals and all other materials required for billing purposes.
3. All production invoice information I submit to HFS on behalf of the Medical Assistance providers are true and a correct report of the information received.
4. I understand that I may be prosecuted under applicable federal and state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data systems input, other acts of misrepresentation, or conspiracy to engage therein.
5. I will maintain production claims data for six years from the date of the service and be able to reproduce production claims for resubmission or audit upon request from HFS or any other State or Federal law enforcement agency.
6. I will allow, upon request, and at a reasonable time and place, authorized federal or state government agents to inspect, copy, and/or take any records I maintain on the services provided and billed on behalf of my client.

Subpart A--Medical Assistance Agency Fraud Detection and Investigation Program

42 CFR 455.18 Provider's statements on claims forms.

(a) Except as provided in Sec. 455.19, the agency must provide that all provider claims forms be imprinted in boldface type with the following statements, or with alternate wording that is approved by the Regional CMS Administrator:

- (1) "This is to certify that the foregoing information is true, accurate, and complete."
- (2) "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

(b) The statements may be printed above the claimant's signature or, if they are printed on the reverse of the form, a reference to the statements must appear immediately preceding the claimant's signature.

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 click **Submit Application**.

Shortcut to Step:



Business Process Wizard (BPW)



- The message below 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.
- Click *Close*.

Your Application Number 20150727082646 has been successfully submitted for State review. Return with this application number to track the status of your application. x

Enroll Billing Agent

Business Process Wizard - Provider Enrollment (Billing Agent). Click on t

Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	07/27/2015	07/27/2015	Complete
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	02/07/2019	02/07/2019	Complete
Step 3: Add Provider Controlling Interest/Ownership Details	Required	02/07/2019	02/07/2019	Complete
Step 4: Complete Enrollment Checklist	Required	02/07/2019	02/07/2019	Complete
Step 5: Submit Enrollment Application for Approval	Required	02/07/2019	02/07/2019	Complete

Shortcut to Step:



Business Process Wizard (BPW)



- You have completed Step 5: **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: 20150520803272 Name: Test Billing Agent

[Close](#)

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/19/2015	05/19/2015	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	05/19/2015	05/19/2015	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	05/19/2015	05/19/2015	Complete	
Step 4: Complete Enrollment Checklist	Required	05/19/2015	05/19/2015	Complete	
Step 5: Submit Enrollment Application for Approval	Required	05/19/2015	05/21/2015	Complete	

View Page: [Go](#) Page Count: 1 [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
 - Phone: 1-877-782-5565
 - Choose option 1 for IMPACT Help