

ILLINOIS PROVIDER ENROLLMENT



Groups

- 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
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- **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:**
 - **Group:** An organization of individual providers that provide medical or dental services. A type 2 NPI is required and group licensing is not.
 - **New Enrollment:** A Group provider who needs to enroll in the IMPACT system.
 - **Billing Agent:** An agent who 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:** A health care provider who provides health care through a provider network. In addition, sister agencies will also be listed as an MCO plan. A sister agency is also known as a State Agency or a Waiver Provider.

NOTE: A Group must be enrolled in IMPACT in order for a provider to associate with them.

Application Process

Step 1: Provider Basic Information

Step 2: Add Locations

Step 3: Add Specialties

Step 4: Add Associate Billing Provider/Other Associations

Step 5: Mode of Claim Submission/EDI Exchange

Step 6: Associate Billing Agent

Step 7: Add Provider Controlling Interest/Ownership Details

Step 8: Add Taxonomy Details

Step 9: Associate MCO Plan

Step 10: 835/ERA Enrollment Form

Step 11: Complete Enrollment Checklist

Step 12: Submit Enrollment Application for Approval

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

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

Shortcut to Step:



Start New Application

Manage your account

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

Access your applications

- **IMPACT Provider Enrollment**

- After completing the 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:



Start New Application

 Provider Enrollment	
New Enrollment	Enroll As A New Provider
Track Application	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).

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

- 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:

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



Start New Application

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

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

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



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: *

NPI: *

Contact Email Address:

Email-1: * Email-2:

Email-3: Email-4:

Email-5: Email-6:

- 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: 20150520803272 Name: David Doe

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 the Basic Information screen.
- The system will generate an application ID after the successful completion of the Basic Information screen; the application ID is a 14-digit number that has the following components:
 - The system date in yyymmdd format
 - A 6-digit system generated random number
 - Example: 20150520803272
- 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 the application has been approved.
- After documenting the application ID, click **OK**.

Shortcut to Step:



Using the Business Process Wizard (BPW)

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

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	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 Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

- **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:



Completing the Application Using BPW

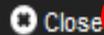
- Once you have documented your Application ID, you have completed Step 1: **Provider Basic Information**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- **Steps 1, 2** and **3** must be completed in sequential order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

Enroll Provider - Group		Business Process Wizard - Provider Enrollment (G)		
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	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 Mode of Claim Submission/EDI Exchange	Required			Incomplete
Step 6: Associate Billing Agent	Optional			Incomplete
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete
Step 8: Add Taxonomy Details	Required			Incomplete
Step 9: Associate MCO Plan	Optional			Incomplete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

Shortcut to Step:



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 ▲▼
No Records Found !			

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

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: Doeceedoe Anesthesia Buddies

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: 123 Samplesap Rd *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER

Country: UNITED STATES *

Zip Code: 11545 - 0069

- Complete all boxes marked with an asterisk *.
- Enter the street address and zip code, then click **Validate Address**.
- Scroll down the page to continue.

Shortcut to Step:



Step 2: Add Locations

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:	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	Thursday:	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *
Monday:	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	Friday:	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *
Tuesday:	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	Saturday:	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *
Wednesday:	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *	<input type="text"/> *	<input type="text"/> AM <input type="text"/> PM *					

Handicap Accessible:

835(reported at EIN/TIN level):

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

- When all the information has been entered, scroll down, click **OK** in the lower right corner.
- Note that the office hours section must be filled out completely to proceed.

Shortcut to Step:



Step 2: Add Locations

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

Locations List

Filter By

<input type="checkbox"/>	Doing Business As ▲▼	Location Type ▲▼	Location Details ▲▼	End Date ▲▼
<input type="checkbox"/>	Doeceedoe Anesthesia Buddi	Primary Practice Location	123 Samplesap Rd, Ste 300, MELVILLE, NEW YORK 11747	12/31/2999

View Page: Page Count : 1 Viewing Page: 1

- Click on **Primary Practice Location** to add each address for this Location.
- For the Primary Practice Location, a **Correspondence** and a **Pay To** address are required.

Shortcut to Step:



Step 2: Add Locations

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	02:00	AM PM
Monday:	Close	AM PM		AM PM	Friday:	Close	AM PM		AM PM
Tuesday:	08:00	AM PM	05:00	AM PM	Saturday:	Close	AM PM		AM PM
Wednesday:	08:00	AM PM	06:00	AM PM					

Handicap Accessible: No

Accept 835 (reported at EINTIN level): No

Language(s) Spoken: English
(For Multiple Selection, use Ctrl Key)

End Date: 12/31/2999

Address List

[Add Address](#)

Address Type	Address	End Date
<input type="checkbox"/> AT	AT	AT
<input type="checkbox"/> Location	4150 Woodland Ave, Springfield, ILLINOIS 62706	12/31/2999

- Click on **Add Address** to input the additional address information.

Shortcut to Step:



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

- When all the addresses have been entered for the Primary Practice Location, click **Close**.

Shortcut to Step:



Step 2: Add Locations

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

Locations List

Filter By

<input type="checkbox"/>	Doing Business As ▲▼	Location Type ▲▼	Location Details ▲▼	End Date ▲▼
<input type="checkbox"/>	Doeceedoe Anesthesia Buddi	Primary Practice Location	123 Samplesap Rd, Ste 300, MELVILLE, NEW YORK 11747	12/31/2999

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- To enter an Other Servicing Location, click on **Add** and repeat the previous steps. A Correspondence address will need to be entered for the Other Servicing Location.
- Once all address details have been entered, click on **Close**.

Shortcut to Step:



Business Process Wizard - Provider Enrollment (Group). Click				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required			Complete
Step 3: Add Specialties ←	Required	02/08/2019	02/08/2019	Incomplete
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete
Step 6: Associate Billing Agent	Optional			Incomplete
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete
Step 8: Add Taxonomy Details	Required			Incomplete
Step 9: Associate MCO Plan	Optional			Incomplete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 2.
- Click on Step 3: **Add Specialties** to continue with the application.



Step 3: Add Specialties

The screenshot shows a web interface for managing specialties. At the top left, there are two buttons: 'Close' and 'Add'. The 'Add' button is circled in red. Below the buttons is a header for 'Specialty/Subspecialty List'. Underneath the header is a filter section with a 'Filter By' dropdown, two input fields, a 'Go' button, a 'Save Filters' button, and a 'My Filters' dropdown. Below the filter section is a table with three columns: 'Specialty/Subspecialty', 'Provider Type', and 'End Date'. Each column has a dropdown arrow. Below the table, a red message reads 'No Records Found!'.

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

Shortcut to Step:



Step 3: Add Specialties

Add Specialty/Subspecialty

Location: 01- *

Provider Type: --SELECT-- * ←

Specialty: * ←

End Date:

Add Subspecialty

Available Subspecialties		Associated Subspecialties *
<input type="text"/>	<input type="button" value="»"/> <input type="button" value="«"/>	<input type="text"/>

- 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

Add Specialty/Subspecialty

Location: 01-Doeceedoe An *
Provider Type: GROUP *
Specialty: Clinic *
End Date: [Calendar Icon]

Add Subspecialty

Available Subspecialties | Associated Subspecialties *
[Empty Box] | [No Subspecialty]

»
«

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**

<input type="checkbox"/>	Specialty/Subspecialty ▲▼	Provider Type ▲▼	End Date ▲▼
<input type="checkbox"/>	Clinic/No Subspecialty	GROUP	12/31/2999

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

SaveToXLS

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

Shortcut to Step:



Business Process Wizard - Provider Enrollment (Group). Click on				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete
Step 6: Associate Billing Agent	Optional			Incomplete
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete
Step 8: Add Taxonomy Details	Required			Incomplete
Step 9: Associate MCO Plan	Optional			Complete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 3.
- Click on Step 4: **Associate Billing Provider/Other Associations** to continue with the application.



Step 4: Associate Billing Provider/Other Associations

Note: this is an optional step

Close Add

Billing Provider List

Filter By [] [] Go Save Filters My Filters

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

- Click **Add** to associate to a Billing Provider.

Shortcut to Step:



Step 4: Associate Billing Provider/Other Associations

Note: this is an optional step

Associate Billing Provider

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

Type: NPI *
ID: 1497875298 * → Provider Name: Cicero Health Center
Start Date: 05/01/2015 * End Date: 12/31/2999 *

- Once all information has been entered, click on **Confirm Provider** and verify the correct **Provider Name** is displayed .
- Click **OK** when you are finished.

Shortcut to Step:



Step 4: Associate Billing Provider/Other Associations

Note: this is an optional step

Billing Provider List

Filter By

<input type="checkbox"/>	Billing Provider NPID	Billing Provider Name	Start Date	End Date	Status
<input type="checkbox"/>	1497875298	cicero health center	05/27/2015	12/31/2999	Approved

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- Click **Add** and repeat the process as necessary.
- If there are no other Billing Providers to add, click on **Close** to return to the BPW.

Shortcut to Step:



Step 4: Associate Billing Provider/Other Associations

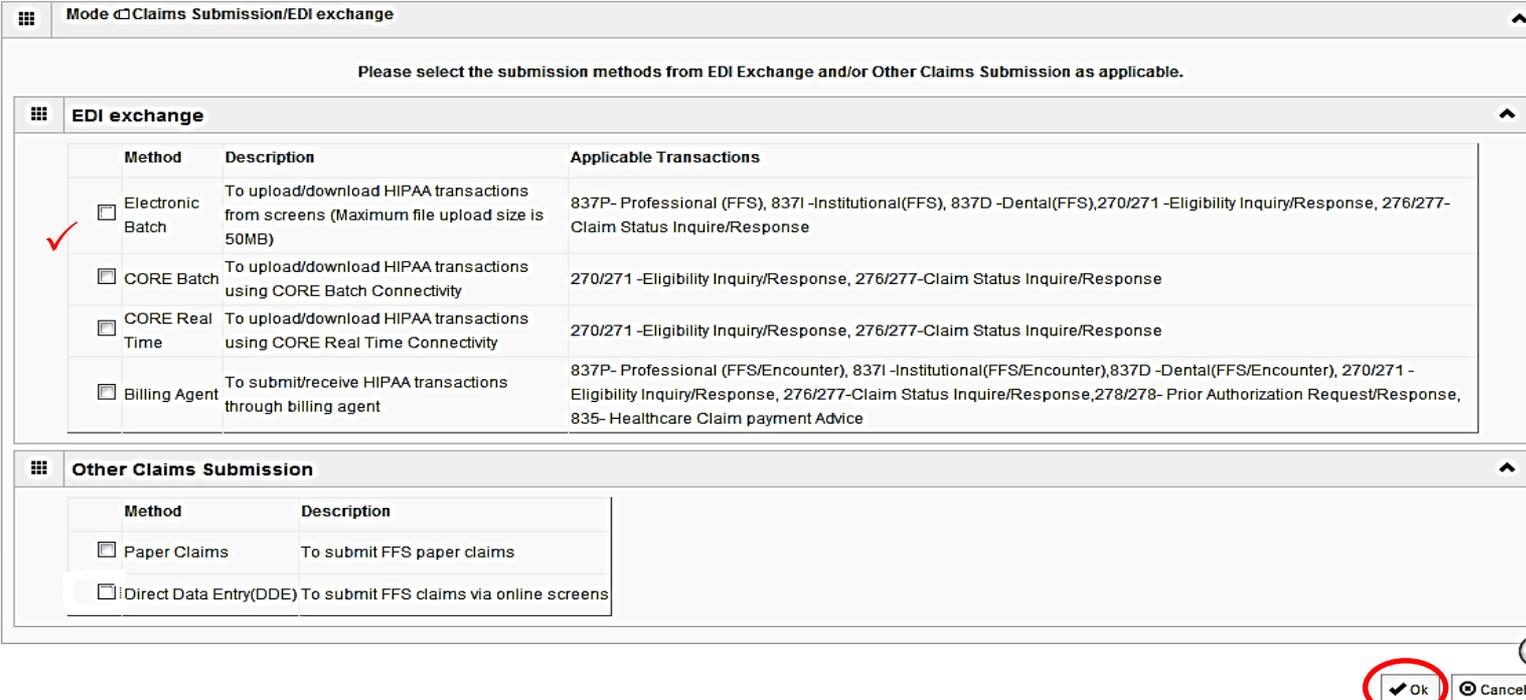
Enroll Provider - Group

Business Process Wizard - Provider Enrollment (Group). Click on the

Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete
Step 6: Associate Billing Agent	Optional			Incomplete
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete
Step 8: Add Taxonomy Details	Required			Incomplete
Step 9: Associate MCO Plan	Optional			Complete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- You have completed Step 4: **Associate Billing Provider/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 Mode of Claim Submission/EDI Exchange** to continue your application.

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.



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

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

Method	Description
<input 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:



Enroll Provider - Group				
Business Process Wizard - Provider Enrollment (Group). Clic				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	02/08/2019	02/08/2019	Complete
Step 6: Associate Billing Agent	Optional			Incomplete
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete
Step 8: Add Taxonomy Details	Required			Incomplete
Step 9: Associate MCO Plan	Optional			Complete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 5.
- Click on Step 6: **Associate Billing Agent** (if applicable) to continue with the application.



Step 6: Associate Billing Agent

Note: this is an optional step

Billing Agent List

Filter By

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

- If applicable, click **Add** to input a Billing Agent.

Shortcut to Step:



Step 6: Associate Billing Agent

Note: this is an optional step

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 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.

Shortcut to Step:



Step 6: Associate Billing Agent

Note: this is an optional step

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	fly by night billing	05/20/2015	12/31/2999

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- Use the **Filter By** drop down to chose an option and enter information to filter the list of available Billing Agents. (% is a wild card function).
- After locating the desired billing agent, mark the check box next to that option, then click **Select**.

Shortcut to Step:



Step 6: Associate Billing Agent

Note: this is an optional step

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: Test Billing Agent

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 selected billing agent information will populate. Verify it is correct, then click **OK**.

Shortcut to Step:



Step 6: Associate Billing Agent

Note: this is an optional step

Close **Add**

Billing Agent List

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

Billing Agent ID	Billing Agent Name	835 Authorization	Start Date	End Date
7125888	Availity	No	05/21/2015	12/31/2999

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

- Click **Add** to input additional Billing Agents.
- When all Billing Agents have been entered, click **Close** to return to the BPW.



Enroll Provider - Group				
Business Process Wizard - Provider Enrollment (Group). Cii				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	02/08/2019	02/08/2019	Complete
Step 6: Associate Billing Agent	Optional	02/08/2019	02/08/2019	Complete
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete
Step 8: Add Taxonomy Details	Required			Incomplete
Step 9: Associate MCO Plan	Optional			Complete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 6.
- Click on Step 7: **Add Provider Controlling Interests/Ownership Details** to continue with the application.



Step 7: Add Provider Controlling Interest/Ownership Details

Close Actions ⓘ

Pe Annual

Import Owner

Owners Relationships

PROVIDER CONTROL DISCLOSURES

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

Owners Adverse Action

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

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

Shortcut to Step:



Step 7: Add Provider Controlling Interest/Ownership Details

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

Provider Controlling Interest/Ownership

Type: <input type="text" value="--SELECT--"/> *	Percentage Owned: <input type="text"/> *
SSN: <input type="text"/> ←	or → EIN/TIN: <input type="text"/>
Legal Entity Name: <input type="text"/> (As shown on the Income Tax Return)	Entity Business Name: <input type="text"/> (Doing Business As)
First Name: <input type="text"/>	Last Name: <input type="text"/>
Suffix: <input type="text"/>	DOB: <input type="text"/>
Phone Number: <input type="text"/> * Extn: <input type="text"/>	Email: <input type="text"/>
Start Date: <input type="text"/> *	End Date: <input type="text"/>
Address Line 1: <input type="text"/> * (Enter Street Address or PO Box Only)	Address Line 2: <input type="text"/>
Address Line 3: <input type="text"/>	City/Town: <input type="text"/> OTHER <input type="text"/> *
State/Province: <input type="text"/> OTHER <input type="text"/> *	County: <input type="text"/> OTHER <input type="text"/>
Country: <input type="text"/> UNITED STATES <input type="text"/> *	Zip Code: <input type="text"/> - <input type="text"/> <input type="button" value="Validate Address"/>

- Either your **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 7: 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' button with a plus sign, which is circled in red. A dropdown menu is open from the 'Actions' button, showing 'Add Owner' and 'Import Owner' options, both with red arrows pointing to them. Below the menu, there is a section titled 'REQUIRED DISCLOSURE INFORMATION' with a list of requirements for providers. The requirements include: The name and address of any person (individual or corporation) with ownership or control interest; Date of birth and Social Security Number; Other Tax Identification Number; Whether the person is related to another person with ownership or control interest; The name of any other fiscal agent or managed care entity; and The name, address, date of birth and Social Security Number of any managing employee. Below this, there is a section titled 'REQUIRED OWNERS' with a list of ownership types: 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.

- 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 7: 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 a red circle highlights the 'Owners Relationships' option in the dropdown menu. The background content is a form titled 'PROVIDER OWNERSHIP DISCLOSURES'. It includes a section for 'REQUIRED DISCLOSURE INFORMATION' with a list of requirements for providers, and a section for 'REQUIRED OWNERS' with a list of ownership types.

REQUIRED DISCLOSURE INFORMATION

- 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 mailing home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).
- 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 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 - Non Charitable
 - Corporate - Publicly Traded
 - Corporate - Not Publicly Traded
 - Sub-contractor
 - Holding Company
 - Foreign, Nonresident Alien
 - Limited Liability Company
 - Indirect Owner

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

Shortcut to Step:



Step 7: Add Provider Controlling Interest/Ownership Details

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 Save Filters My Filters

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 Page Count Save To XLS 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 7: 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] [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, go to the bottom of the page and click on **Add Other Owned Entity**.

Shortcut to Step:



Step 7: Add Provider Controlling Interest/Ownership Details

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: - Validate Address

OK Cancel

- 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 7: Add Provider Controlling Interest/Ownership Details

 Close  Add

Owners List

Filter By

<input type="checkbox"/>	Owner SSN/EIN/TIN ▲▼	Owner Information ▲▼	Type ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/>	111111111	Doe, David	Managing Employee	06/02/2015	12/31/2999
<input type="checkbox"/>	222222222	Doe, Sam	Individual/Sole Proprietor	06/02/2015	12/31/2999

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

Filter By

<input type="checkbox"/>	Other Owner EIN/TIN ▲▼	Other Owner Information ▲▼	Address ▲▼
<input type="checkbox"/>	123456789	Department of Human Services	123 Anywhere Lane Chicago, IL 60601

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

Shortcut to Step:



Enroll Provider - Group				
Business Process Wizard - Provider Enrollment (Group). Click on t				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	02/08/2019	02/08/2019	Complete
Step 6: Associate Billing Agent	Optional	02/08/2019	02/08/2019	Complete
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/08/2019	02/08/2019	Complete
Step 8: Add Taxonomy Details ←	Required			Incomplete
Step 9: Associate MCO Plan	Optional			Complete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 7.
- Click on Step 8: **Add Taxonomy Details** to continue with the application.

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



Step 7: Add Taxonomy Details

Taxonomy List

Filter By

Taxonomy Code ▲▼	Description ▲▼	Start Date ▲▼	End Date ▲▼
No Records Found!			

- To enter Taxonomy Details click on **Add**.

Shortcut to Step:



Step 7: Add Taxonomy Details

Add Taxonomy

Taxonomy Code: *  (Click here for Taxonomy List)

Location: *

Description:

 Start Date: *

End Date: *

- If the Taxonomy Code is known, 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 7: Add Taxonomy Details

Add Taxonomy

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

Location: 01-Doeceedoe ▼ *

Description:

Start Date: 📅 *

End Date: 📅

Confirm Taxonomy Ok Cancel

- If 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 new web browser window.
- 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 7: Add Taxonomy Details

The screenshot shows the National Uniform Claim Committee (NUCC) website. At the top left is the NUCC logo. To the right is a search bar with the text 'SEARCH' and 'Search this site ...'. Below the logo is the title 'National Uniform Claim Committee'. A navigation menu contains links for 'Home', 'Announcements', 'NUCC Structure', 'Calendar', '1500 Claim Form', 'Code Sets', and 'Resources'. The main content area has a section titled 'Open All' with a red circle around the following list items: '+ Individual or Groups (of Individuals)' and '+ Non-individual'. To the right of this list is a text box explaining that clicking a definition link displays code value definitions and additional information. Below this text box are links for '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 7: 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 7: Add Taxonomy Details

NUCC
National Uniform Claim Committee

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 [\[definition\]](#)
 - [-] 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

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](#)

Copyright 2015 American Medical Association

- Make a note of the **Taxonomy Code** that is correct for your area of practice.
- Click on the **X** button in the upper right corner to close the National Uniform Claim Committee webpage.

Shortcut to Step:



Step 7: Add Taxonomy Details

Add Taxonomy

Taxonomy Code: *

(Click here for Taxonomy List)

Location: *

Description: ←

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 7: Add Taxonomy Details

Close **Add**

Taxonomy List

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

<input type="checkbox"/>	Taxonomy Code	Description	Start Date	End Date
<input type="checkbox"/>	193400000X	Single Specialty	05/20/2015	12/31/2999

Delete View Page: **Go** Page Count : 1 **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:



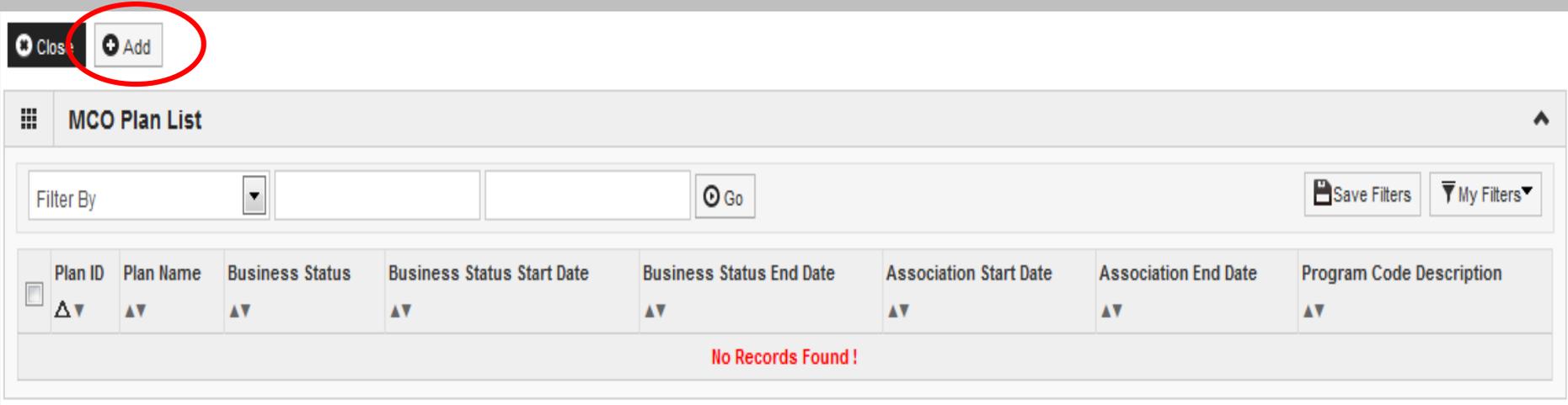
Enroll Provider - Group				
Business Process Wizard - Provider Enrollment (Group). Click				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	02/08/2019	02/08/2019	Complete
Step 6: Associate Billing Agent	Optional	02/08/2019	02/08/2019	Complete
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/08/2019	02/08/2019	Complete
Step 8: Add Taxonomy Details	Required	02/08/2019	02/08/2019	Complete
Step 9: Associate MCO Plan	Optional			Complete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 8.
- Click on Step 9: **Associate MCO Plan** to continue with the application.



Step 9: Associate MCO Plan

Note: this is an optional step



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.
- Sister Agencies will also be listed as an MCO Plan. A sister agency is also known as a State Agency or a Waiver provider.

Shortcut to Step:



Step 9: Associate MCO Plan

Note: this is an optional step

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** to confirm the plan ID or to search for the plan.
- Verify the **Plan Name** populated correctly, then click **OK**.
- If the MCO is not known, click on **Confirm/Search Plan** to search for a plan.

Shortcut to Step:



Step 9: Associate MCO Plan

Note: this is an optional step

Close
Select

☰ MCO Plan Search List
▲

→

Go

Save Filters
My Filters ▼

<input type="checkbox"/>	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

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◀ Prev
Next ▶
Last »

- Use the **Filter By** drop down and enter desired information to filter the available MCO plans.
- When the desired MCO plan is located, click on the checkbox next to the that line then, click **Select**.

Shortcut to Step:



Step 9: Associate MCO Plan

Note: this is an optional step

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: Blue Cross Blue Shield

Program Code Description: Family Health Plan

Association Start Date: * Association End Date: *

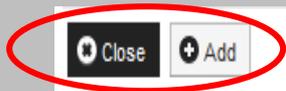
- The chosen MCO plan information will populate.
- Verify it is correct then, click **OK**.

Shortcut to Step:



Step 9: Associate MCO Plan

Note: this is an optional step



MCO Plan List

Filter By

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program Code Description
7126080	Blue Cross Blue Shield IL FHP	Active	01/01/2015	12/31/2999	05/21/2015	12/31/2999	Family Health Plan/Affordable Care Act

View Page:
 Page Count : 1
 Viewing Page: 1

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

Shortcut to Step:



Business Process Wizard



Enroll Provider - Group				
Business Process Wizard - Provider Enrollment (Group). Click on				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	02/08/2019	02/08/2019	Complete
Step 6: Associate Billing Agent	Optional	02/08/2019	02/08/2019	Complete
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/08/2019	02/08/2019	Complete
Step 8: Add Taxonomy Details	Required	02/08/2019	02/08/2019	Complete
Step 9: Associate MCO Plan	Optional	02/08/2019	02/08/2019	Complete
Step 10: 835/ERA Enrollment Form	Optional			Incomplete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 9.
- Click on Step 10: **835/ERA enrollment form** to continue with the application.

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



Step 10: 835/ERA Enrollment Form

Note: This step is optional. 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

ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name:
Doing Business As Name (DBA): Doeceedoe Anesthesia Buddies

Provider Address

Street: 123 Samplesap Rd STE 300 **State/Province:** NEW YORK
City: Melville **Zip Code/Postal Code:** 11747
Country Code: UNITED STATES

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): 454876995
National Provider Identifier (NPI): 1265847461

Other Identifier(s)

Assigning Authority: **Trading Partner ID:**

Provider License Details

Provider License No: **License Issuer:**
Provider Type: GROUP
Provider Taxonomy Code:

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

Shortcut to Step:



Step 10: 835/ERA Enrollment Form

Note: this is an optional step

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: *

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.

Shortcut to Step:



Step 10: 835/ERA Enrollment Form

Note: this is an optional step

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: 05/22/2015

Requested ERA Effective Date:

(Once approve the next paycycle date.)

- Mark the checkbox to authorize the creation of an 835/ERA account.
- The written signature portion should populate.
- Once all fields are complete, click **Submit** and **Close** at the top of the page.

Shortcut to Step:



Enroll Provider - Group				
Business Process Wizard - Provider Enrollment (Group). Click				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	02/08/2019	02/08/2019	Complete
Step 6: Associate Billing Agent	Optional	02/08/2019	02/08/2019	Complete
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/08/2019	02/08/2019	Complete
Step 8: Add Taxonomy Details	Required	02/08/2019	02/08/2019	Complete
Step 9: Associate MCO Plan	Optional	02/08/2019	02/08/2019	Complete
Step 10: 835/ERA Enrollment Form	Optional	02/08/2019	02/08/2019	Complete
Step 11: Complete Enrollment Checklist	Required			Incomplete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 10.
- Click on Step 11: **Complete Enrollment Checklist** to continue with the application.

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



Step 11: Complete Enrollment 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 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	
Is your org a health plan, LTC fac or other prov approved for an ABE provider portal acct to assist individuals with eligibility for medical benefits? If yes, enter effective date of participation.	Not Completed	
Do you carry professional liability insurance? If yes, please provide the name of your carrier and the policy coverage limit per occurrence and in aggregate.	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.

Shortcut to Step:



Enroll Provider - Group				
Business Process Wizard - Provider Enrollment (Group). Cl				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	02/08/2019	02/08/2019	Complete
Step 6: Associate Billing Agent	Optional	02/08/2019	02/08/2019	Complete
Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/08/2019	02/08/2019	Complete
Step 8: Add Taxonomy Details	Required	02/08/2019	02/08/2019	Complete
Step 9: Associate MCO Plan	Optional	02/08/2019	02/08/2019	Complete
Step 10: 835/ERA Enrollment Form	Optional	02/08/2019	02/08/2019	Complete
Step 11: Complete Enrollment Checklist	Required	02/08/2019	02/08/2019	Complete
Step 12: Submit Enrollment Application for Approval	Required			Incomplete

- The system will place the current date in the End Date field and will place **Complete** for Step 11.
- Click on Step 12: **Submit Enrollment Application for Approval** to continue with the application.



Step 12: Submit Enrollment Application for Approval

Final Submission

Application ID: 20150520803272 EnrollmentType: Group Practice (Corporation, Partnership, LLC, etc.)

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.



Step 12: 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.

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:



- 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 20181216516823 has been successfully submitted for State review. Return with this application number to track the status of your application. x  

Business Process Wizard - Provider Enrollment (Group). Click				
Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
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Step 7: Add Provider Controlling Interest/Ownership Details	Required	02/08/2019	02/08/2019	Complete
Step 8: Add Taxonomy Details	Required	02/08/2019	02/08/2019	Complete
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Step 10: 835/ERA Enrollment Form	Optional	02/08/2019	02/08/2019	Complete
Step 11: Complete Enrollment Checklist	Required	02/08/2019	02/08/2019	Complete
Step 12: Submit Enrollment Application for Approval	Required	02/08/2019	02/08/2019	Complete

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Business Process Wizard



Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	12/16/2018	12/16/2018	Complete
Step 2: Add Locations	Required	02/08/2019	02/08/2019	Complete
Step 3: Add Specialties	Required	02/08/2019	02/08/2019	Complete
Step 4: Associate Billing Provider/Other Associations	Optional	02/08/2019	02/08/2019	Complete
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Step 10: 835/ERA Enrollment Form	Optional	02/08/2019	02/08/2019	Complete
Step 11: Complete Enrollment Checklist	Required	02/08/2019	02/08/2019	Complete
Step 12: Submit Enrollment Application for Approval	Required	02/08/2019	02/08/2019	Complete

- The system will place the current date in the End Date field and will place **Complete** for Step 12.

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



- 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