ILLINOIS PROVIDER ENROLLMENT

Individual / Sole Proprietor

Agenda

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

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

Introduction and Key Terms

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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:**
  - Sole Proprietor: A provider who owns his or her own practice.
  - Billing Provider: A provider who submits claims and/or receives payments for an Individual Provider.
  - Billing Agent: Submits Medicaid HIPAA compliant Transactions or exchanges EPHI with Medicaid providers or other authorized parties. Also known as Clearing House, Software Vendor or Value Added Network (VAN).
  - MCO Plan: Health care plans that provide health care through a provider network. Sister Agencies will also be listed as an MCO. A sister agency is also known as a State Agency or a Waiver provider.
  - New Enrollment: A new provider who needs to enroll in the IMPACT system.
  - Revalidation: A provider who was previously enrolled in the MMIS system and whose information was transferred to IMPACT.
- **Enrollment Timeline:**
  - Individual Providers will need to enroll or revalidation with IMPACT starting in August 2015.

Application Process

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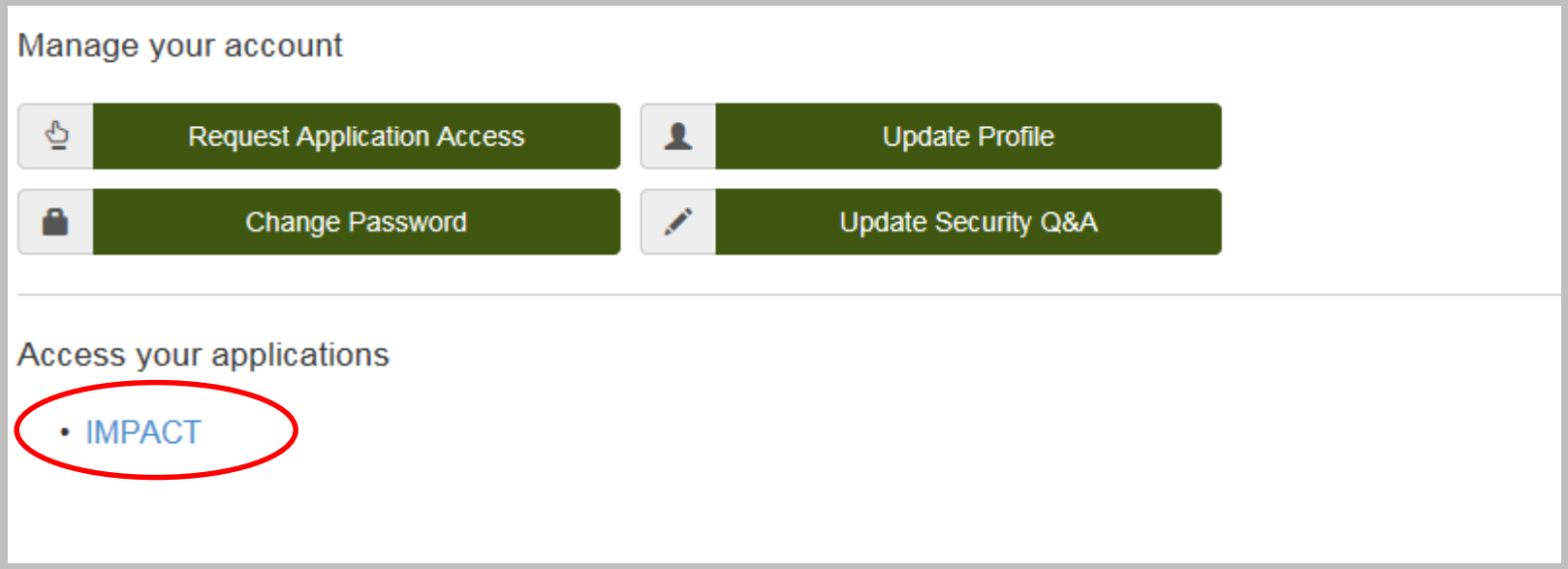
- Step 1: Provider Basic Information
- Step 2: Add Locations
- Step 3: Add Specialties
- Step 4: Associate Billing Provider
- Step 5: License/Certification
- Step 6: Mode of Claim Submission
- Step 7: Associate Billing Agent
- Step 8: Add Ownership Details
- Step 9: Add Taxonomy Details
- Step 10: Associate MCO Plan
- Step 11: 835/ERA Enrollment Form
- Step 12: Enrollment Checklist
- Step 13: Submit Application

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

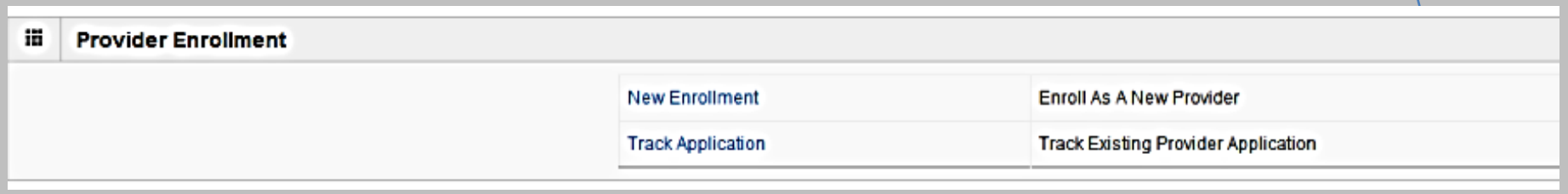
Pressing this button on any screen will bring you back to this menu.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Start New Application

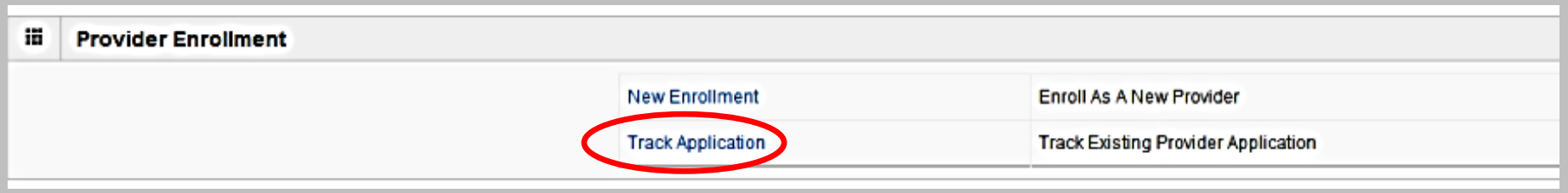


- After completing the sign-on, click on ***IMPACT***.

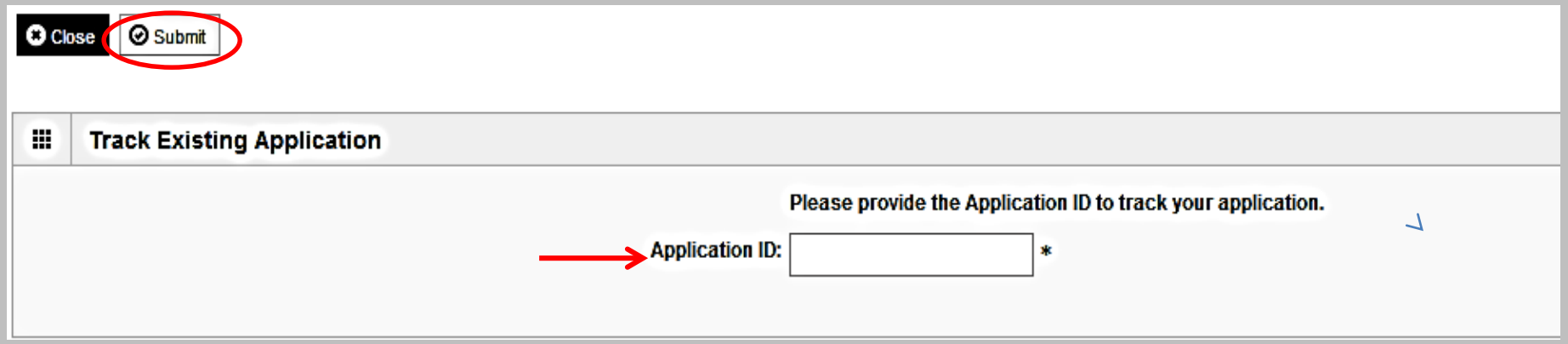


- In regards to completing an application, there are two options: New Enrollment or Resuming an application.

Start New 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).



- 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).

Start New Application

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Provider Enrollment

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

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

Enrollment Type

Select the Applicable Enrollment Type

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

Submit

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

Start New Application

Step 1:(Basic information)

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*Complete all fields especially required, which are marked with an *.*

Basic Information

EIN/TIN:

First Name: *

Middle Initial:

Last Name: *

Suffix:

Gender:

SSN: *

Date of Birth: *

Applicant Type: *

Contact Email Address:

NPI: *

Email-5: Email-6:

Email-7: Email-8:

Email-9: Email-10:

Home Address

Address Line 1: *

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County:

Country: *

Zip Code: -

Validate Address

Confirm | View Screening Result | Finish | Cancel

- ***Applicant Type*** will need to be selected from the drop down and it drives the rest of the application.
- Click ***Validate Address*** after street address and zip code have been entered.
- After all the information has been entered click ***Confirm*** then ***Finish***.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Start New Application

Step 1: (Basic Provider Information)

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Application ID: 20150521438762 Name: Doe, David

Basic Information

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

Your Application ID is: 20150521438762

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 yyyymmdd 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 has been marked approved.
- After documenting the ID number, click ***OK***.

Completing Application using BPW

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The BPW serves as the "Control Center" of the application.

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/21/2015	05/21/2015	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go 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***.
- **Remarks**: ***Remarks*** are systematically generated throughout the enrollment process.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Completing the Application Using BPW

Illinois Medicaid Program Advanced Cloud Technology IMPACT

- 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 sequentially before attempting any of the later steps.
- Click on Step 2: ***Add Locations*** to continue completing your application.

Close

Enroll Provider - Individual

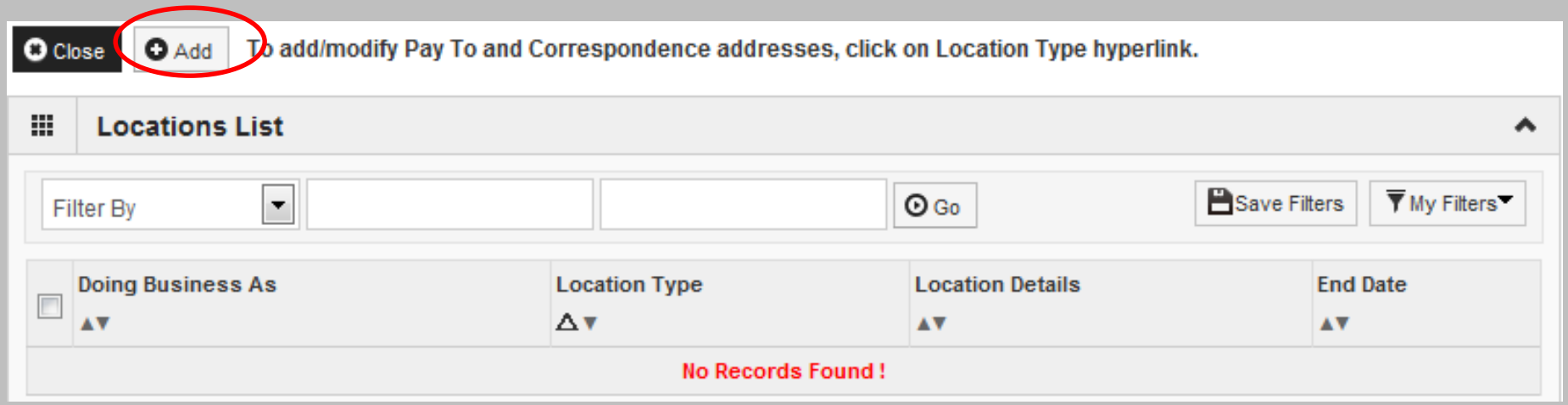
Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/21/2015	05/21/2015	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: 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: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 2: Add Locations



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

Step 2: Add Locations

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*Complete all fields especially required, which are marked with an *.*

For all locations, Correspondence address is required. For Primary Practice Location, Pay-To address is required.

Add Provider Location

Location Type: Primary Practice Location *

Doing Business As:

End Date:

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

Address Line 1: *
(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: - Validate Address

Phone Number: * Extn:

Fax Number:

Email Address:

Web Page:

Office Hours:

Communication Preference: Email

Accepting New Clients:

Maximum Clients:

Offers OB-Gyn Services:

Pediatric Services:

Handicap Accessible: No

FQHC:

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

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

OK Cancel

- After entering the address and zip code, click on ***Validate Address***.
- After all information has been entered, click on ***OK***.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 2: Add Locations

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

Locations List

Filter By | Go | Save Filters | My Filters

Doing Business As	Location Type	Location Details	End Date
Test Provider	Primary Practice Location	123 Anywhere Lane Chciago, IL 60601	12/31/2999

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

SaveToXLS

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

Step 2: Add Locations

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

Location Details

Doing Business As:
Phone Number: (863)123-4567 Ext:
Web Page:
Accepting New Clients:
Offers OB-Gyn Services:
Accept 835(reported at EIN/TIN level):
End Date: 12/31/2999

Location Code: 01
Fax Number:
Office Hours:
Maximum Clients:
Pediatric Services:
Language(s) Spoken: English, Arabic, Chinese
(For Multiple Selection, use Ctrl Key)

Location Type: Primary Practice Location
Email Address: ccc@ccc.com
Communication Preference: Email
Handicap Accessible: No
FQHC:

Address List

Add Address

Address Type	Address	End Date
Location	123 Anywhere Lane Chicago, IL 60601	12/31/2999

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

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

Step 2: Add Locations

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Add Provider Location Address

Type of Address: –SELECT–

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 Line 1: *
(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: - Validate Address

OK Cancel

- Choose type of address (Correspondence or Pay To).
- If the address you are entering is the same as the location address, then click the radio icon next to ***Copy This Location Address***.
- After entering the address and zip code information, click on ***Validate Address***.
- When all required fields and any optional fields are completed, click ***OK***.
- Repeat these steps for each additional address type.

Step 2: Add Locations

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

Locations List

Filter By | Go | Save Filters | My Filters

Doing Business As	Location Type	Location Details	End Date
Test Provider	Primary Practice Location	123 Anywhere Lane Chciago, IL 60601	12/31/2999

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

SaveToXLS

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

Business Process Wizard

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

Close

Enroll Provider - Individual

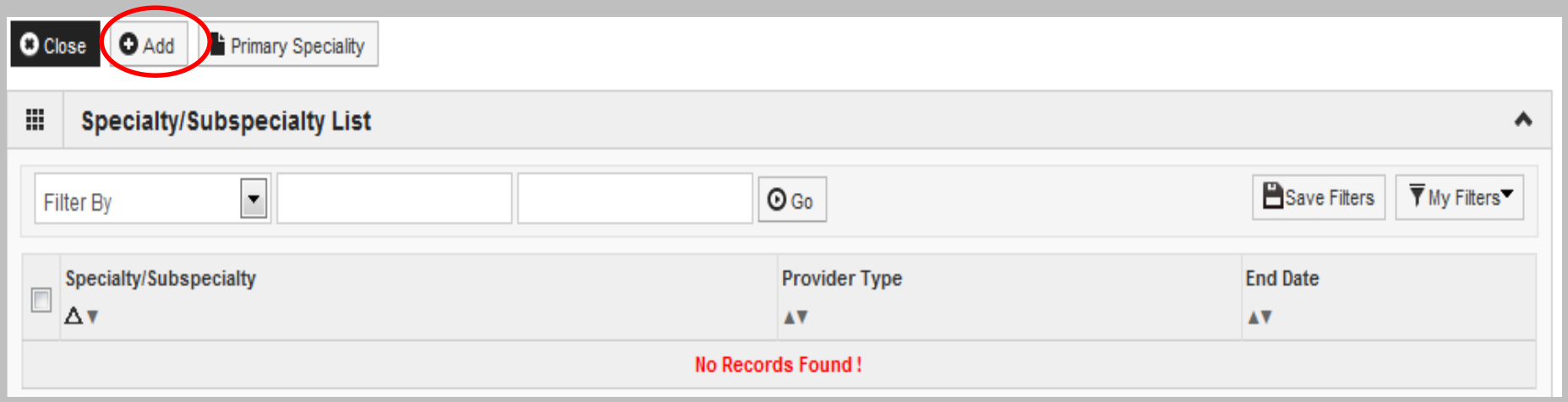
Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/21/2015	05/21/2015	Complete	
Step 2: Add Locations	Required	05/21/2015	05/21/2015	Complete	
Step 3: Add Specialties	Required	05/21/2015	05/21/2015	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: 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: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 3: Add Specialties



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

Step 3: Add Specialties

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Add Specialty/Subspecialty

Location: 01- *

Provider Type: ---SELECT--- *

Specialty: *

End Date:

Add Subspecialty

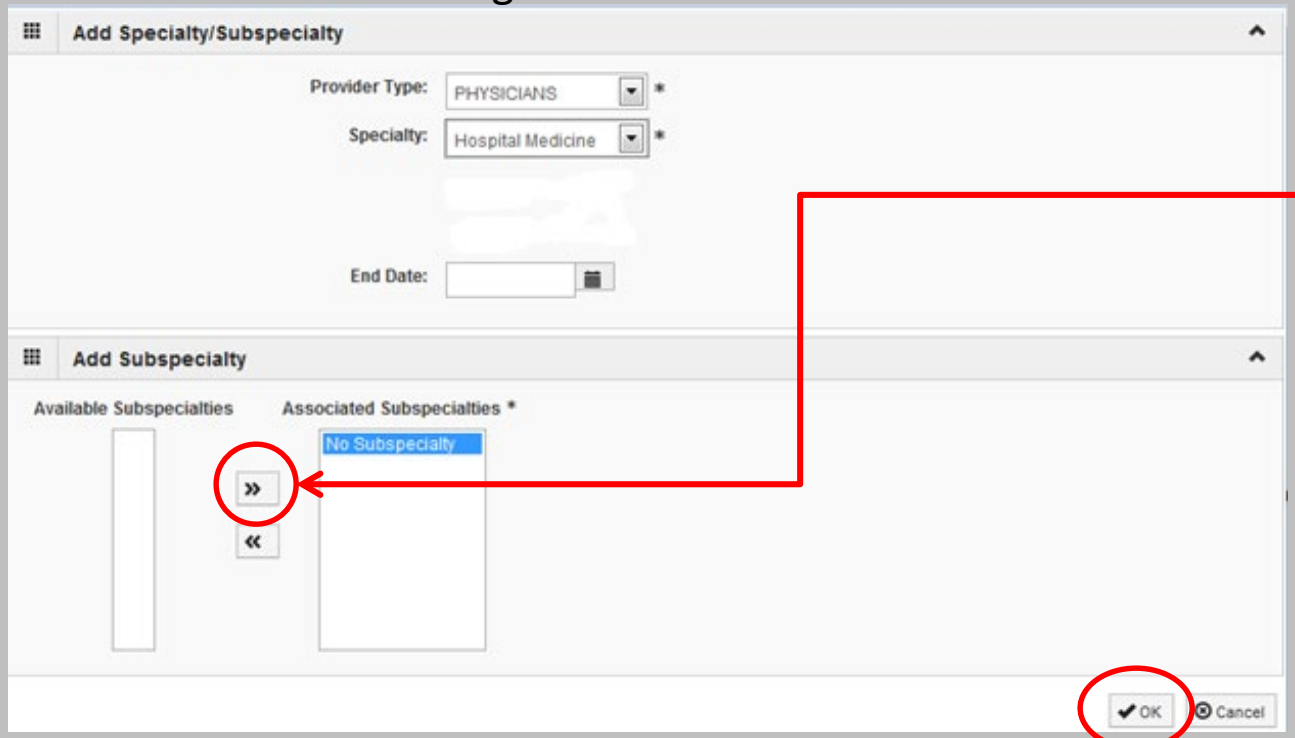
Available Subspecialties | Associated Subspecialties *

OK | Cancel

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

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



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

Step 3: Add Specialties

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Close | Add | Primary Speciality

Specialty/Subspecialty List

Filter By | Go | Save Filters | My Filters

	Specialty/Subspecialty	Provider Type	End Date
☐	Pediatrics/No Subspecialty	PHYSICIANS	12/31/2999

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

SaveToXLS

- If you have another Specialty/Subspecialty to enter click the ***Add*** button in the top left corner and repeat the previous steps.
- When all the specialties/subspecialties have been entered, click ***Primary Specialty*** to designate one of the listed Specialties as Primary.

Step 3: Add Specialties

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Close Save

Primary Specialty For Enrollment

Primary Speciality: PHYSICIANS/Hospital Medicine *

Your designation and attestation of a primary specialty will be utilized to identify and evaluate your eligibility for the Primary Care Rate Increase.

Start Date: 05/21/2015 *

End Date:

- Choose the ***Primary Specialty*** for this enrollment from the drop down menu.
- Choose the appropriate radio icon to select board certified or not.
- Complete the ***Start Date*** field. Leave ***End Date*** blank.
- When all information has been entered, click on ***Save*** then ***Close***.

Step 3: Add Specialties

Close | Add | Primary Speciality

Specialty/Subspecialty List

Filter By | Go | Save Filters | My Filters

	Specialty/Subspecialty	Provider Type	End Date
	Pediatrics/No Subspecialty	PHYSICIANS	12/31/2999

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

SaveToXLS

- When all the Specialty information has been entered, click on ***Close*** to return to the BPW.

Business Process Wizard

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/21/2015	05/21/2015	Complete	
Step 2: Add Locations	Required	05/21/2015	05/21/2015	Complete	
Step 3: Add Specialties	Required	05/21/2015	05/21/2015	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

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

Step 4: Associate Billing Provider

Illinois Medicaid Program Advanced Cloud Technology
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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.

Step 4: Associate Billing Provider

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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

Confirm Provider | Ok | Cancel

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

Step 4: Associate Billing Provider

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Close | Add

Billing Provider List

Filter By | Go | Save Filters | My Filters

Billing Provider NPI/ID	Billing Provider Name	Start Date	End Date	Status
1497875298	cicero health center	05/27/2015	12/31/2999	Approved

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

- To associate to an additional Billing Provider, click ***Add*** and repeat the previous steps.
- If there are no other Billing Providers to add, click on ***Close*** to return to the BPW.

Business Process Wizard

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

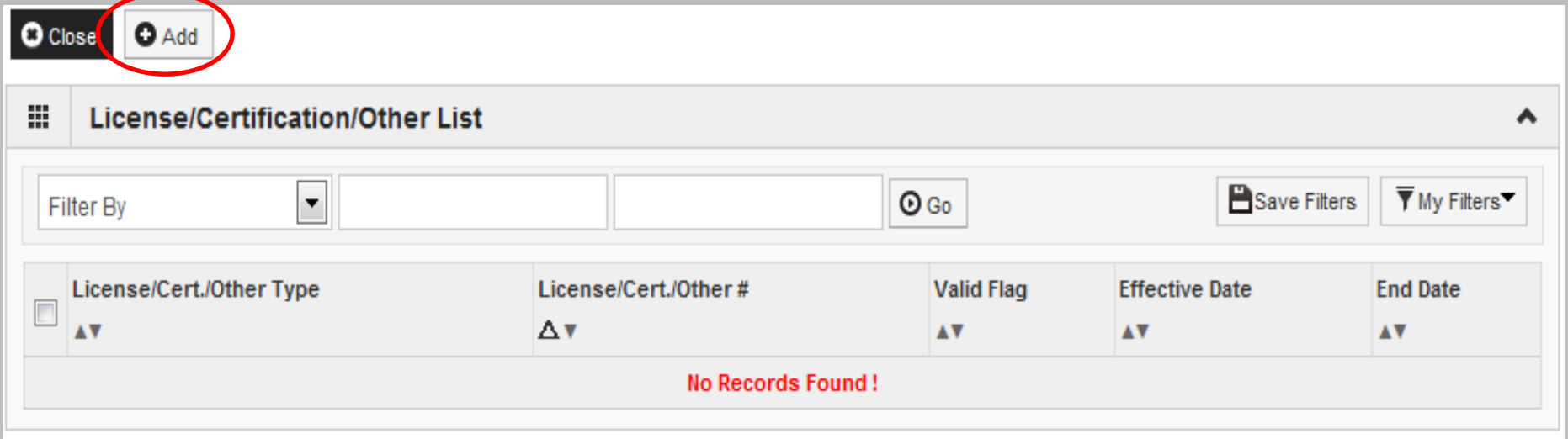
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/21/2015	05/21/2015	Complete	
Step 2: Add Locations	Required	05/21/2015	05/21/2015	Complete	
Step 3: Add Specialties	Required	05/21/2015	05/21/2015	Complete	
Step 4: Associate Billing Provider	Optional	05/21/2015	05/21/2015	Complete	
Step 5: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

- You have completed Step 4: ***Associate Billing Provider.*** 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 Licensing/Certification/Other*** to continue your application.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 5: Add Licenses/Certifications/Other



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

Step 5: Add Licenses/Certifications/Other

Add License/Certification/Other

Location: 01- *

License/Certification/Other Type: *

License/Certification/Other #: *

Valid Flag:

Effective Date: *

End Date:

Confirm License/Certification/Other | OK | Cancel

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

Step 5: Add Licenses/Certifications/Other

Close | Add

License/Certification/Other List

Filter By | Go | Save Filters | My Filters

License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Date
State Professional License	123-456789	No	05/27/2015	12/31/2999
Clinical Lab Improvement Amend. Cert.	987-654321	No	05/27/2015	12/31/2999

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

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

Business Process Wizard

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/21/2015	05/21/2015	Complete	
Step 2: Add Locations	Required	05/21/2015	05/22/2015	Complete	
Step 3: Add Specialties	Required	05/21/2015	05/22/2015	Complete	
Step 4: Associate Billing Provider	Optional	05/21/2015	05/21/2015	Complete	
Step 5: Add License/Certification/Other	Required	05/22/2015	05/22/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

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

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 6: Mode of Claim Submission

EDI Exchange

Illinois Medicaid Program Advanced Cloud Technology IMPACT

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

Mode Claims Submission/EDI exchange

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

EDI exchange

	Method	Description	Applicable Transactions
☑	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
☐	CORE Batch	To upload/download HIPAA transactions using CORE Batch Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
☐	CORE Real Time	To upload/download HIPAA transactions using CORE Real Time Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
☐	Billing Agent	To submit/receive HIPAA transactions through billing agent	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter),837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response,278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice

Other Claims Submission

	Method	Description
☑	Paper Claims	To submit FFS paper claims
☐	Direct Data Entry(DDE)	To submit FFS claims via online screens

Ok Cancel

- 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***.

Business Process Wizard

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

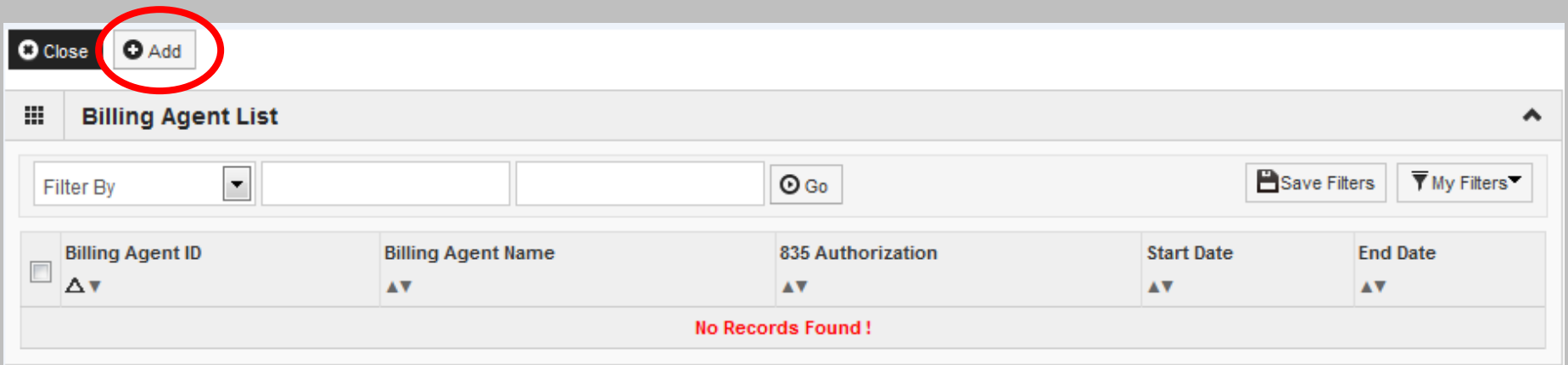
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/02/2015	06/02/2015	Complete	
Step 2: Add Locations	Required	06/02/2015	06/02/2015	Complete	
Step 3: Add Specialties	Required	06/02/2015	06/02/2015	Complete	
Step 4: Associate Billing Provider	Optional	06/02/2015	06/02/2015	Complete	
Step 5: Add License/Certification/Other	Required	06/02/2015	06/02/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	06/02/2015	06/02/2015	Complete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

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

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 7: Associate Billing Agent



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

Step 7: Associate Billing Agent

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

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	☐		

Confirm/Search Billing Agent | OK | Cancel

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

Step 7: Associate Billing Agent

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Close Select

Billing Agent List

Filter By Go Save Filters My Filters

Billing Agent ID	Billing Agent Name	Start Date	End Date
7125716	AJAX Billing Agency	05/04/2015	12/31/2999
7125725	Memorial Hospital	05/04/2015	12/31/2999
7125879	NEBO	05/05/2015	12/31/2999
7125888	Availity	05/04/2015	12/31/2999
7126704	Weil Foot And Ankle Services	05/21/2015	12/31/2999

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

- Use the ***Filter By*** drop down and enter information to filter the list of the available Billing Agents. (% can be used as a wild card)
- After locating the desired Billing Agent, mark the check box next to that line, then click ***Select***.

Step 7: Associate Billing Agent

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

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: 123456789 *

Billing Agent Name: Test Billing Agent

Association Start Date: 06/01/2015 *

Association End Date: 12/31/2999

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	☐		

Confirm/Search Billing Agent | OK | Cancel

- Confirm the Billing Agent information populated correctly.
- Click ***OK*** to return to the billing agent list.

Step 7: Associate Billing Agent

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

- To associate to additional Billing Agents not listed, click ***Add*** and repeat the previous steps.
- When all billing agents have been entered, click ***Close*** to return to the BPW.

Business Process Wizard

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/02/2015	06/02/2015	Complete	
Step 2: Add Locations	Required	06/02/2015	06/02/2015	Complete	
Step 3: Add Specialties	Required	06/02/2015	06/02/2015	Complete	
Step 4: Associate Billing Provider	Optional	06/02/2015	06/02/2015	Complete	
Step 5: Add License/Certification/Other	Required	06/02/2015	06/02/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	06/02/2015	06/02/2015	Complete	
Step 7: Associate Billing Agent	Required	06/02/2015	06/02/2015	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

- You have completed Step 7: ***Associate Billing Agent.*** The system will place the current date in the ***End Date*** field and will place ***Complete*** in the corresponding ***Status*** field.
- Click on Step 8: ***Add Provider Controlling Interest/Ownership Details*** to continue your application.

Step 8: Controlling Interest/Ownership

Close | Add

Owners List

Filter By | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
123456789	Test Provider	Individual/Sole Proprietor	05/21/2015	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 reimbursible by Medicaid and/or Medicare.

Filter By | Go | Save Filters | My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

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

Step 8: Controlling Interest/Ownership

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Provider Controlling Interest/Ownership

Type: —SELECT— *

SSN:

or

Percentage Owned: *

EIN/TIN:

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

Entity Business Name:
(Doing Business As)

First Name:

Last Name:

Suffix:

DOB:

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 *

State/Province: OTHER *

County: OTHER

Country: UNITED STATES *

Zip Code: -

Validate Address

OK Cancel

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

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 8: Controlling Interest/Ownership

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Close | Add

Owners List

Filter By | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
123456789	David Doe	Managing Employee	05/21/2015	12/31/2999
987654321	Sally Doe	Individual/Sole Proprietor	05/21/2015	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 reimbursible by Medicaid and/or Medicare.

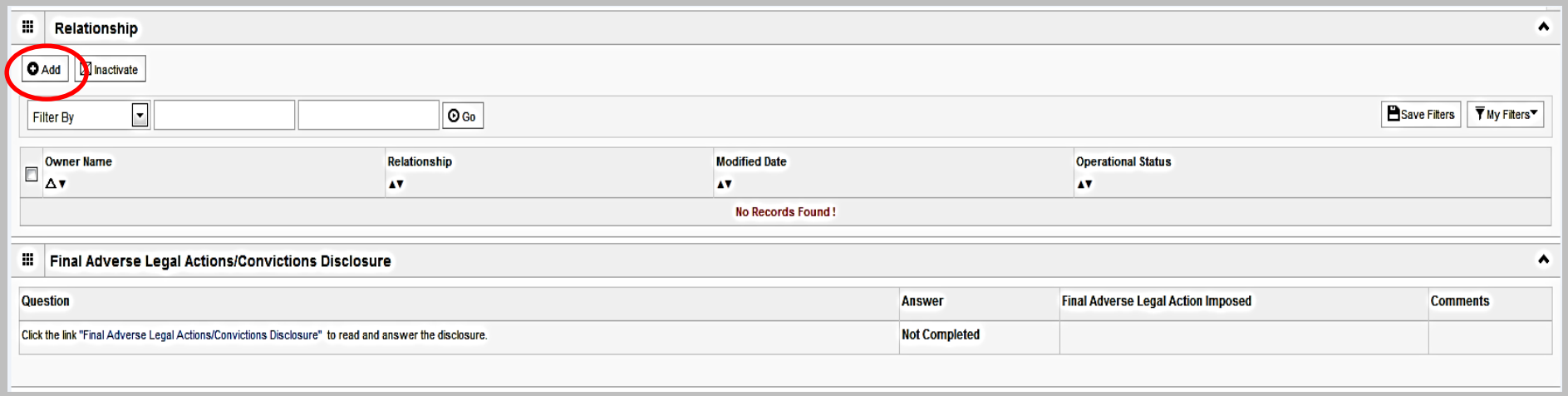
Filter By | Go | Save Filters | My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

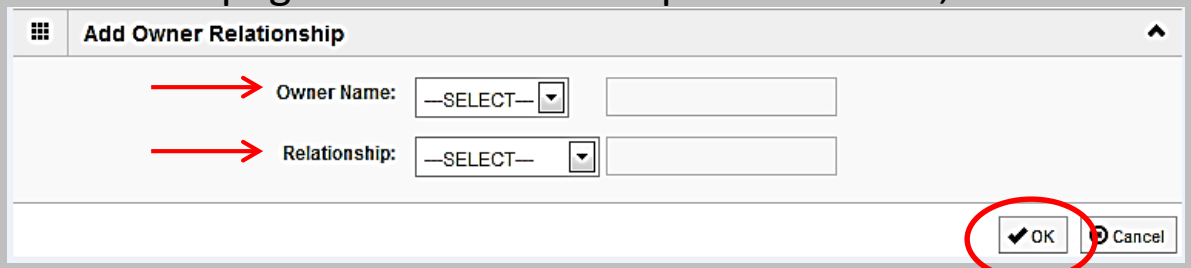
- To list additional owners, click ***Add*** and repeat the previous steps.
- After all ownerships have been listed, click the hyperlink for each Owner listed to specify the relationship between each owner and to complete the Legal Disclosure.

Step 8: Controlling Interest/Ownership

Illinois Medicaid Program Advanced Cloud Technology
IMPACT



- Scroll down the page to the relationship section then, click ***Add***.



- From the first drop down list of ***Owner Name***, choose an owner name.
- From the second drop down list of ***Relationships***, choose how the chosen owner is related to the listed owner.
- Repeat this step until the relationship has been set for each listed owner.
- When completed, click ***OK*** to return to the ownership listing.

Step 8: Controlling Interest/Ownership

Relationship

Add | Inactivate

Filter By | Go | Save Filters | My Filters

Owner Name	Relationship	Modified Date	Operational Status
No Records Found !			

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

- Scroll down to the Final Adverse Legal Action/Conviction History section.
- Click on the hyperlink ***Final Adverse Legal Action/Conviction History***.

Step 8: Controlling Interest/Ownership

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

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

CONVICTIONS

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

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

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? ○ Yes ◉ No

Comments (optional):

Ok | Cancel

- With regards to the chosen ownership, answer the listed question and enter comments if desired.
- Click ***OK*** when completed.
- Repeat for each listed ownership.

Step 8: Controlling Interest/Ownership

Close | Add

Owners List

Filter By | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
123456789	Doe, David	Managing Employee	05/21/2015	12/31/2999
987654321	Doe, Sally	Individual/Sole Proprietor	05/21/2015	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 reimbursible by Medicaid and/or Medicare.

Filter By | Go | Save Filters | My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

- 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***.

Step 8: Controlling Interest/Ownership

Illinois Medicaid Program Advanced Cloud Technology IMPACT

*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 *

State/Province: OTHER *

County: 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.

Step 8: Controlling Interest/Ownership

Close Add

Owners List

Filter By Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
222222221	Doe,David	Fiscal Agent	05/26/2015	12/31/2999
222222222	Doe,Alberta	Managing Employee	05/26/2015	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 reimbursible by Medicaid and/or Medicare.**

Filter By Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address
362518901	The Thresholds	550 W 43RD ST, CHICAGO, ILLINOIS 60609

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***.

Business Process Wizard

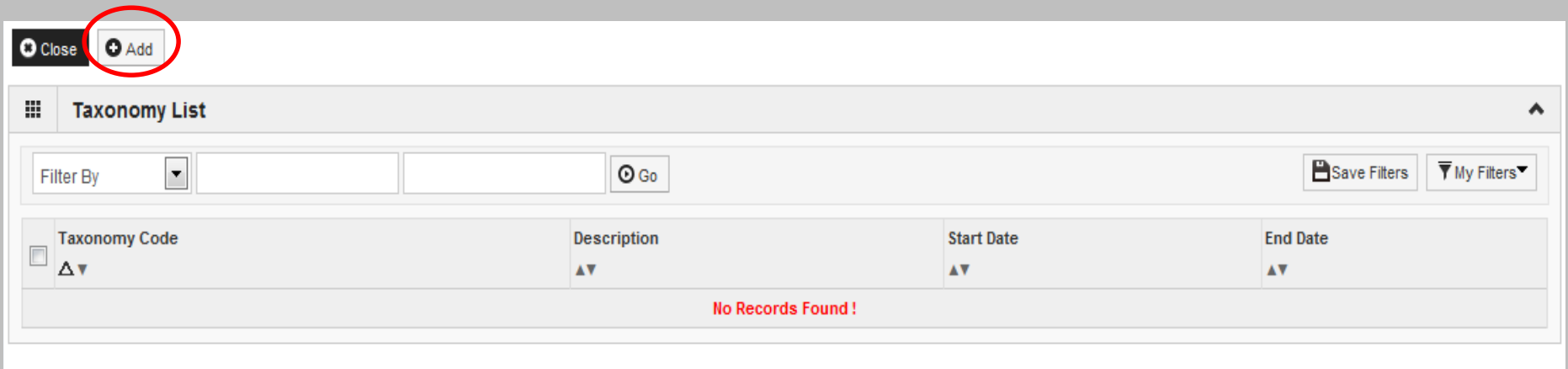
Business Process Wizard - Provider Enrollment (Atypical Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/02/2015	06/02/2015	Complete	
Step 2: Add Locations	Required	06/02/2015	06/02/2015	Complete	
Step 3: Add Specialties	Required	06/02/2015	06/02/2015	Complete	
Step 4: Associate Billing Provider	Optional	06/02/2015	06/02/2015	Complete	
Step 5: Add License/Certification/Other	Required	06/02/2015	06/02/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	06/02/2015	06/02/2015	Complete	
Step 7: Associate Billing Agent	Required	06/02/2015	06/02/2015	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	06/02/2015	06/02/2015	Complete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

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

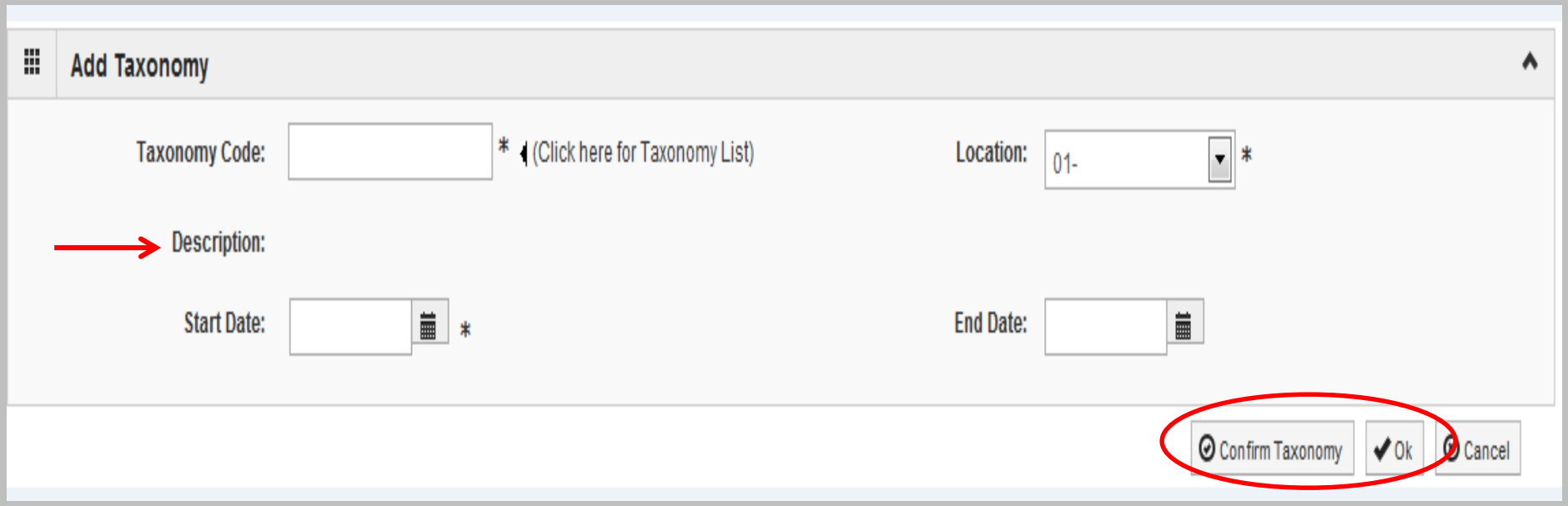
Step 9: Add Taxonomy Details



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

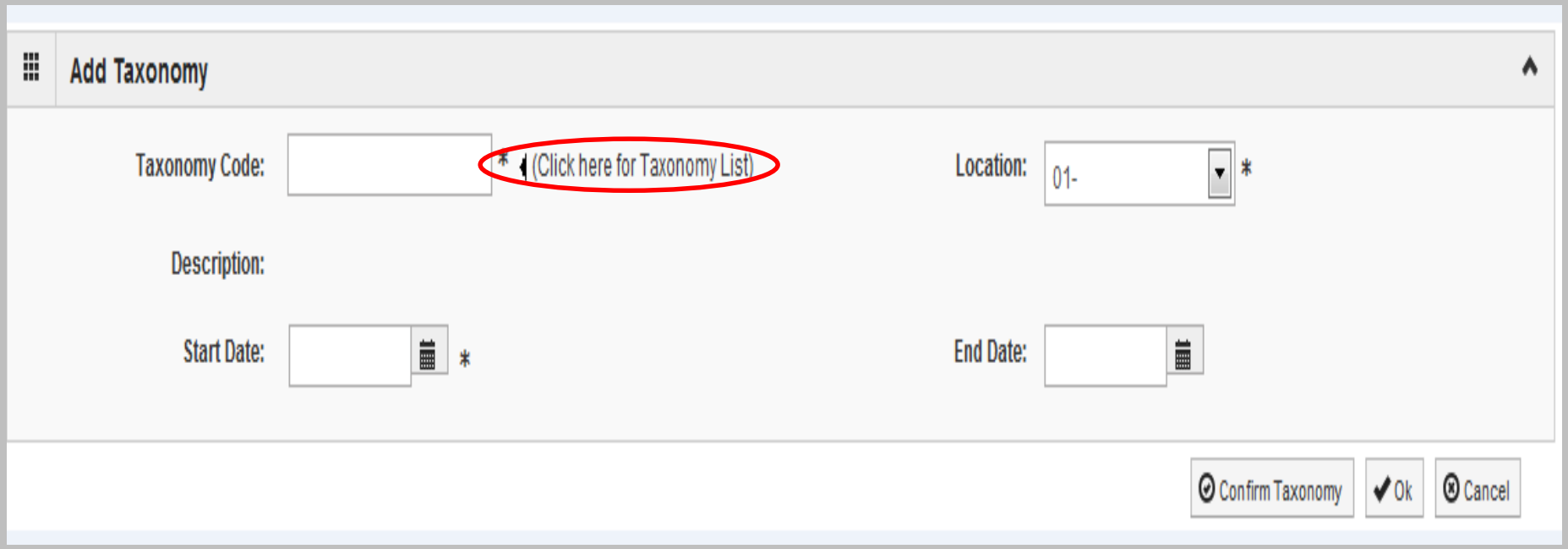
Step 9: Add Taxonomy Details

Illinois Medicaid Program Advanced Cloud Technology
IMPACT



- To add new Taxonomy Details, enter the ***Taxonomy Code*** and the ***Start Date***.
- Leave the ***End Date*** field blank.
- Click on ***Confirm Taxonomy*** and verify ***Description*** is populated correctly.
- Click on ***OK*** to finalize the submission.

Step 9: Add Taxonomy Details



- 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 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).

Step 9: Add Taxonomy Details

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

SEARCH

Search this site ...

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)
⊞ Non-individual

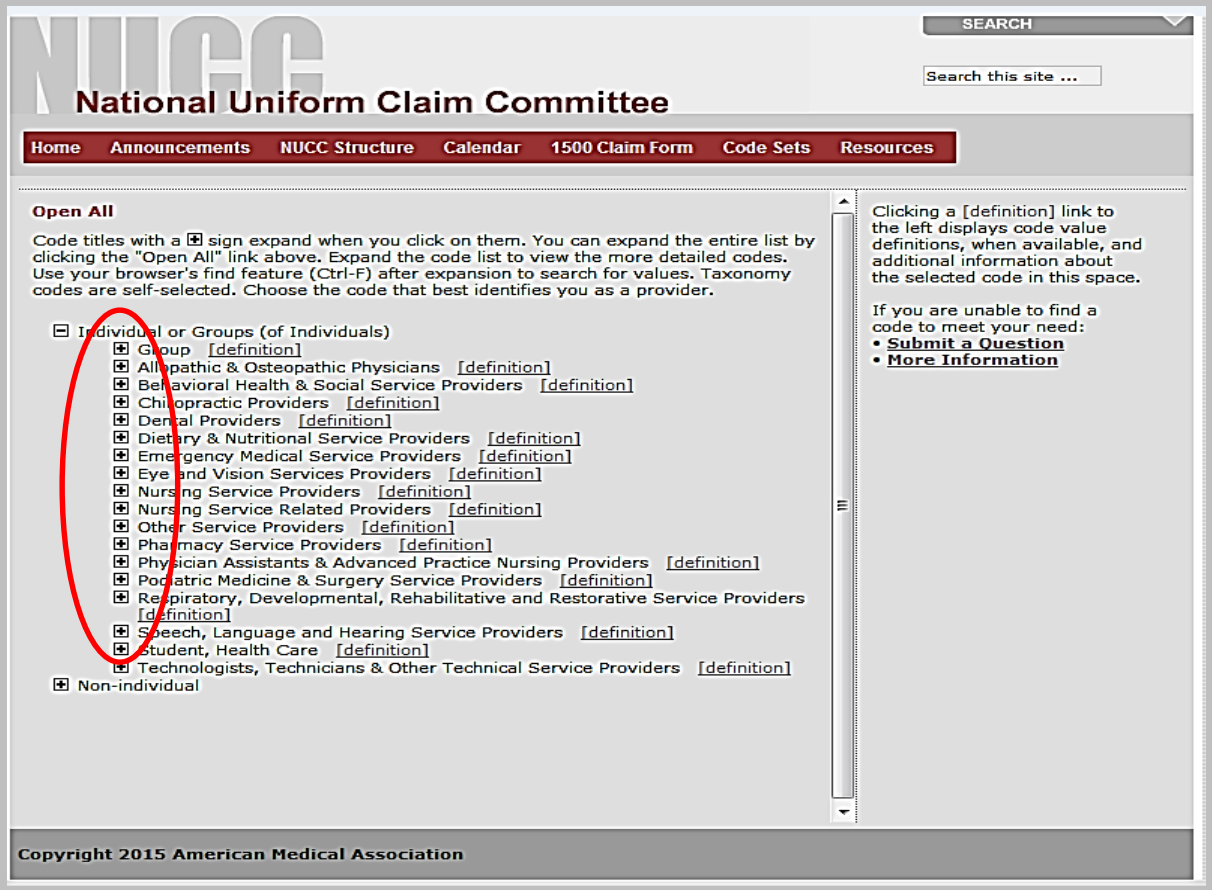
Clicking a [definition] link to the left displays code value definitions, when available, and additional information about the selected code in this space.

If you are unable to find a code to meet your need:
- Submit a Question
- More Information

Copyright 2015 American Medical Association

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

Step 9: Add Taxonomy Details



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

Step 9: Add Taxonomy Details

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

National Uniform Claim Committee

Home | Announcements | NUCC Structure | Calendar | 1500 Claim Form | Code Sets

Open All

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

- ⊟ Individual or Groups (of Individuals)
  - ⊞ Group [definition]
  - ⊞ 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]
    - Licensed Practical Nurse - **164W00000X** [definition]
    - Licensed Psychiatric Technician - **167G00000X** [definition]
    - Licensed Vocational Nurse - **164X00000X** [definition]
    - ⊞ Registered Nurse - **163W00000X** [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

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

Step 9: Add Taxonomy Details

Add Taxonomy

Taxonomy Code: 193400000X *

(Click here for Taxonomy List)

Location: 01-Doeceedoe *

Description: Single Speciality

Start Date: 06/01/2015 *

End Date: 12/31/2999

Confirm Taxonomy | Ok | Cancel

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

Step 9: Add Taxonomy Details

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Close Add

Taxonomy List

Filter By Go Save Filters My Filters

	Taxonomy Code	Description	Start Date	End Date
	193400000X	Single Specialty	05/20/2015	12/31/2999

Delete View Page: 1 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.

Business Process Wizard

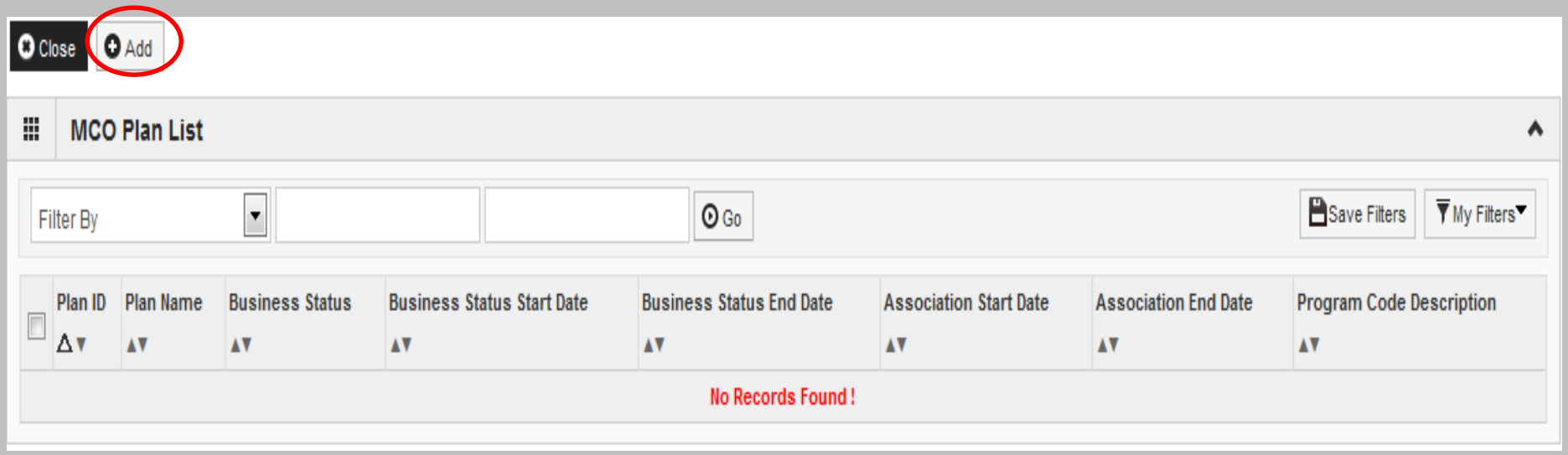
Business Process Wizard - Provider Enrollment (Atypical Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/02/2015	06/02/2015	Complete	
Step 2: Add Locations	Required	06/02/2015	06/02/2015	Complete	
Step 3: Add Specialties	Required	06/02/2015	06/02/2015	Complete	
Step 4: Associate Billing Provider	Optional	06/02/2015	06/02/2015	Complete	
Step 5: Add License/Certification/Other	Required	06/02/2015	06/02/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	06/02/2015	06/02/2015	Complete	
Step 7: Associate Billing Agent	Required	06/02/2015	06/02/2015	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	06/02/2015	06/02/2015	Complete	
Step 9: Add Taxonomy Details	Optional	06/02/2015	06/02/2015	Complete	
Step 10: Associate MCO Plan	Optional			Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

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

Step 10: Associate MCO Plan



- 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.

Step 10: Associate MCO Plan

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

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:

Confirm/Search Plan | Ok | Cancel

- Enter a ***Plan ID*** and ***Association Start Date.***
- Leave the ***End Date*** field blank.
- Click ***Confirm/Search Plan***, verify the ***Plan Name*** is correct then, click ***OK***.
- If the MCO plan ID is not known, click on ***Confirm/Search Plan***.

Step 10: Associate MCO Plan

Close | Select

MCO Plan Search List

Filter By | Go | Save Filters | My Filters

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Program Code Description
7126080	Blue Cross Blue Shield IL FHP	Active	01/01/2015	12/31/2999	Family Health Plan/Affordable Care Act
7126393	Meridan Health Plan INC VMC	Active	05/14/2015	12/31/2999	Family Health Plan/Affordable Care Act
7126400	HARMONY HEALTH PLAN IL INC VMC	Active	05/14/2015	12/31/2999	Family Health Plan/Affordable Care Act

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

- Use the ***Filter By*** drop down and enter information to filter the list of available MCO plans.
- After locating the desired plan, click on the checkbox next to that line.
- Click ***Select*** to return to the MCO summary screen.

Step 10: Associate MCO Plan

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

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: 123456 *

Plan Name: Blue Cross Blue Shield

Program Code Description: Family Health Plan

Association Start Date: 06/01/15 *

Association End Date: 12/31/99

Confirm/Search Plan | Ok | Cancel

- Verify that the MCO plan information populated correctly then click ***OK***.

Step 10: Associate MCO Plan

Close Add

MCO Plan List

Filter By Go Save Filters My Filters

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program 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

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

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

Business Process Wizard

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/02/2015	06/02/2015	Complete	
Step 2: Add Locations	Required	06/02/2015	06/02/2015	Complete	
Step 3: Add Specialties	Required	06/02/2015	06/02/2015	Complete	
Step 4: Associate Billing Provider	Optional	06/02/2015	06/02/2015	Complete	
Step 5: Add License/Certification/Other	Required	06/02/2015	06/02/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	06/02/2015	06/02/2015	Complete	
Step 7: Associate Billing Agent	Required	06/02/2015	06/02/2015	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	06/02/2015	06/02/2015	Complete	
Step 9: Add Taxonomy Details	Optional	06/02/2015	06/02/2015	Complete	
Step 10: Associate MCO Plan	Optional	06/02/2015	06/02/2015	Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

- You have completed Step 10: ***Associate MCO Plan*** **.** The system will place the current date in the ***End Date*** field and will place ***Complete*** in the corresponding ***Status*** field.
- Click on Step 11: ***835/ERA Enrollment Form*** to continue your application.

Step 11: Complete 835/ERA

Illinois Medicaid Program Advanced Cloud Technology IMPACT

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: Min,Yu

Doing Business As Name (DBA):

Provider Address

Street: 1045 W STEPHENSON ST, PO Box 857

State/Province: ILLINOIS

City: FREEPORT

Zip Code/Postal Code: 61032

Country Code: UNITED STATES

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): 362181997

National Provider Identifier (NPI): 1053303743

Other Identifier(s)

Assigning Authority:

Trading Partner ID:

Provider License Details

Provider License No: 036137433

License Issuer: IL

Provider Type: PHYSICIANS

Provider Taxonomy Code:

PROVIDER CONTACT INFORMATION

Provider Contact Name

Contact: Yu,Min

Title: Managing Employee

Telephone Number: 8531234567

Telephone Number Extension:

- Scroll down the page and verify/update the listed information and complete any additional fields.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 11: Complete 835/ERA

Close | Submit | Print | Help

Payment Center ID:

NCPDP Provider ID Number:

Medicaid Provider Number:

ELECTRONIC REMITTANCE ADVICE INFORMATION

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

NPI TAX ID *

MI Medicaid enumerates by Tax ID only.

Method of Retrieval: CORE *

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Not applicable at this time)

ClearingHouse Name:

ClearingHouse Contact Name

ClearingHouse Contact Name: Telephone Number:

Email Address:

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Not applicable at this time)

Vendor Name:

Vendor Contact

Vendor Contact Name: Telephone Number:

Email Address:

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

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 11: Complete 835/ERA

Close | Submit | Print | Help

ELECTRONIC REMITTANCE ADVICE 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: Y

Printed Name of Person Submitting Enrollment:

Printed Title of Person Submitting Enrollment: guest

Submission Date: 05/22/2015

Requested ERA Effective Date:

(Once approve the next paycycle date.)

- Check the box next to the agreement statement and the signature portion will be populated.
- Once all fields are complete, click ***Submit***, then ***Close*** at the top of the page.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Business Process Wizard

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/02/2015	06/02/2015	Complete	
Step 2: Add Locations	Required	06/02/2015	06/02/2015	Complete	
Step 3: Add Specialties	Required	06/02/2015	06/02/2015	Complete	
Step 4: Associate Biling Provider	Optional	06/02/2015	06/02/2015	Complete	
Step 5: Add License/Certification/Other	Required	06/02/2015	06/02/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	06/02/2015	06/02/2015	Complete	
Step 7: Associate Biling Agent	Required	06/02/2015	06/02/2015	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	06/02/2015	06/02/2015	Complete	
Step 9: Add Taxonomy Details	Optional	06/02/2015	06/02/2015	Complete	
Step 10: Associate MCO Plan	Optional	06/02/2015	06/02/2015	Complete	
Step 11: 835/ERA Enrollment Form	Optional	06/02/2015	06/02/2015	Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

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

Step 12: Complete Enrollment Checklist

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Close Save

Provider Checklist

Question	Answer	Comments
Have you had any malpractice settlement, judgment, or agreement?If yes, dollar amount and dates are required.	Not Completed	
Do you need to request a Retroactive Enrollment Date? If Yes, enter the requested Retroactive Enrollment Date in the comment field to be considered.	Not Completed	
Do you wish to end date your enrollment or association? If yes, what date and to which association.	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 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	
Has fingerprinting been completed per state requirements? If yes, with what vendor and date?	Not Completed	
Are you accepting new patients?	Not Completed	
Have you signed an agreement authorizing you or your organization to participate as an All Kids Application Agent? If yes, enter the effective date of your participation.	Not Completed	
Are you planning to provide services reimbursable through Department on Aging (DoA). If yes, provide the effective participation date you are requesting.	Not Completed	
Are you planning to provide services reimbursable through DHS, Division of Alcohol and Substance Abuse (DASA)? If yes, provide the effective participation date you are requesting.	Not Completed	
Are you planning to provide services reimbursable through DHS, Division of Rehabilitation Services (DRS)? If yes, provide the effective participation date you are requesting.	Not Completed	
Are you planning to provide services reimbursable through DHS, Division of Mental Health (DMH)? If yes, provide the effective participation date you are requesting.	Not Completed	
Are you planning to provide services reimbursable through DHS, Bureau of Early Intervention (EI)? If yes, provide the effective participation date you are requesting.	Not Completed	
Are you planning to provide services reimbursable through DHS, Division of Developmental Disabilities (DDD)? If yes, provide the effective participation date you are requesting.	Not Completed	
Are you planning to provide services reimbursable through Department of Children and Family Services (DCFS)? If yes, provide the effective participation date you are requesting.	Not Completed	

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

Business Process Wizard

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/02/2015	06/02/2015	Complete	
Step 2: Add Locations	Required	06/02/2015	06/02/2015	Complete	
Step 3: Add Specialties	Required	06/02/2015	06/02/2015	Complete	
Step 4: Associate Billing Provider	Optional	06/02/2015	06/02/2015	Complete	
Step 5: Add License/Certification/Other	Required	06/02/2015	06/02/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	06/02/2015	06/02/2015	Complete	
Step 7: Associate Billing Agent	Required	06/02/2015	06/02/2015	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	06/02/2015	06/02/2015	Complete	
Step 9: Add Taxonomy Details	Optional	06/02/2015	06/02/2015	Complete	
Step 10: Associate MCO Plan	Optional	06/02/2015	06/02/2015	Complete	
Step 11: 835/ERA Enrollment Form	Optional	06/02/2015	06/02/2015	Complete	
Step 12: Complete Enrollment Checklist	Required	06/02/2015	06/02/2015	Complete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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- You have completed Step 12: ***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 Step13: ***Submit Enrollment Application*** to Submit your application.

Shortcut to Step: 1 2 3 4 5 6 7 8 9 10 11 12 13

Step 13: Submit Enrollment for Approval

Close | Next

Final Submission

Application ID: 20150521438762

EnrollmentType: Individual/Sole Proprietor

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 13: Submit Enrollment for Approval

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

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

Personal Assistant or Private Duty Certified Nurse Aide Providers

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

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

Telepsychiatry and Group Psychotherapy Providers

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

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

Alcohol and Substance Abuse Providers

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

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

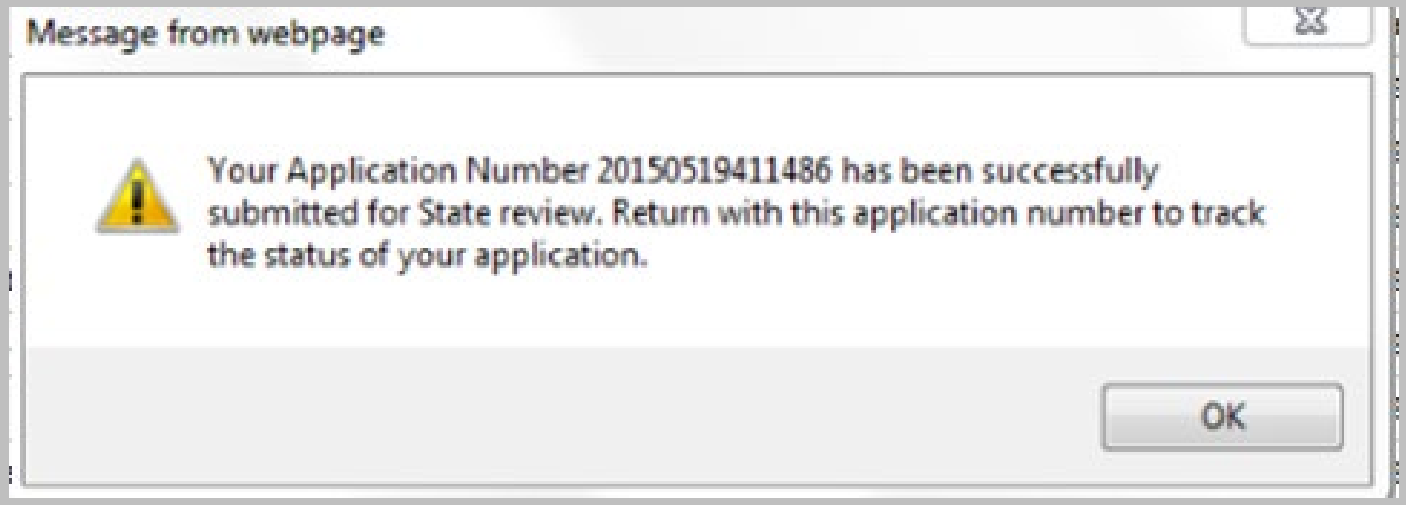
Community Mental Health Providers

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

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

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

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



- The message above will pop up and advise that the application has been submitted for review. Click on ***OK***.

Business Process Wizard

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/21/2015	05/21/2015	Complete	
Step 2: Add Locations	Required	05/21/2015	05/22/2015	Complete	
Step 3: Add Specialties	Required	05/21/2015	05/22/2015	Complete	
Step 4: Associate Billing Provider	Optional	05/21/2015	05/21/2015	Complete	
Step 5: Add License/Certification/Other	Required	05/22/2015	05/22/2015	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	05/22/2015	05/22/2015	Complete	
Step 7: Associate Billing Agent	Optional	05/22/2015		Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	05/22/2015	05/22/2015	Complete	
Step 9: Add Taxonomy Details	Required	05/22/2015	05/22/2015	Complete	
Step 10: Associate MCO Plan	Optional	05/22/2015	05/22/2015	Complete	
Step 11: 835/ERA Enrollment Form	Optional	05/22/2015	05/22/2015	Complete	
Step 12: Complete Enrollment Checklist	Required	05/22/2015	05/22/2015	Complete	
Step 13: Submit Enrollment Application for Approval	Required	05/22/2015	05/22/2015	Complete	

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- You have completed Step 13: ***Submit Enrollment Application for Approval***.

Resources

Illinois Medicaid Program Advanced Cloud Technology
IMPACT

- 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

Questions and Answers

- 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