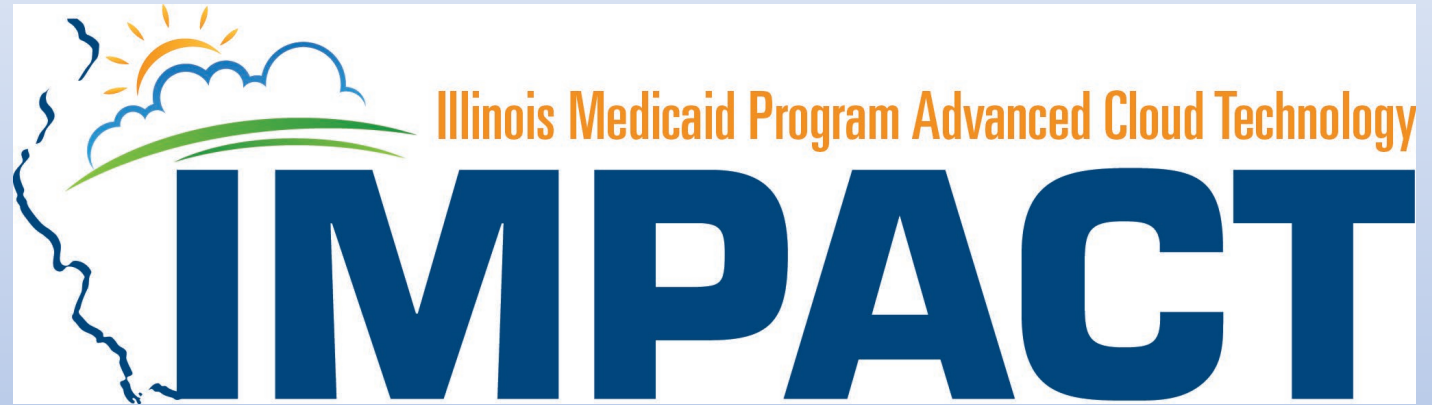
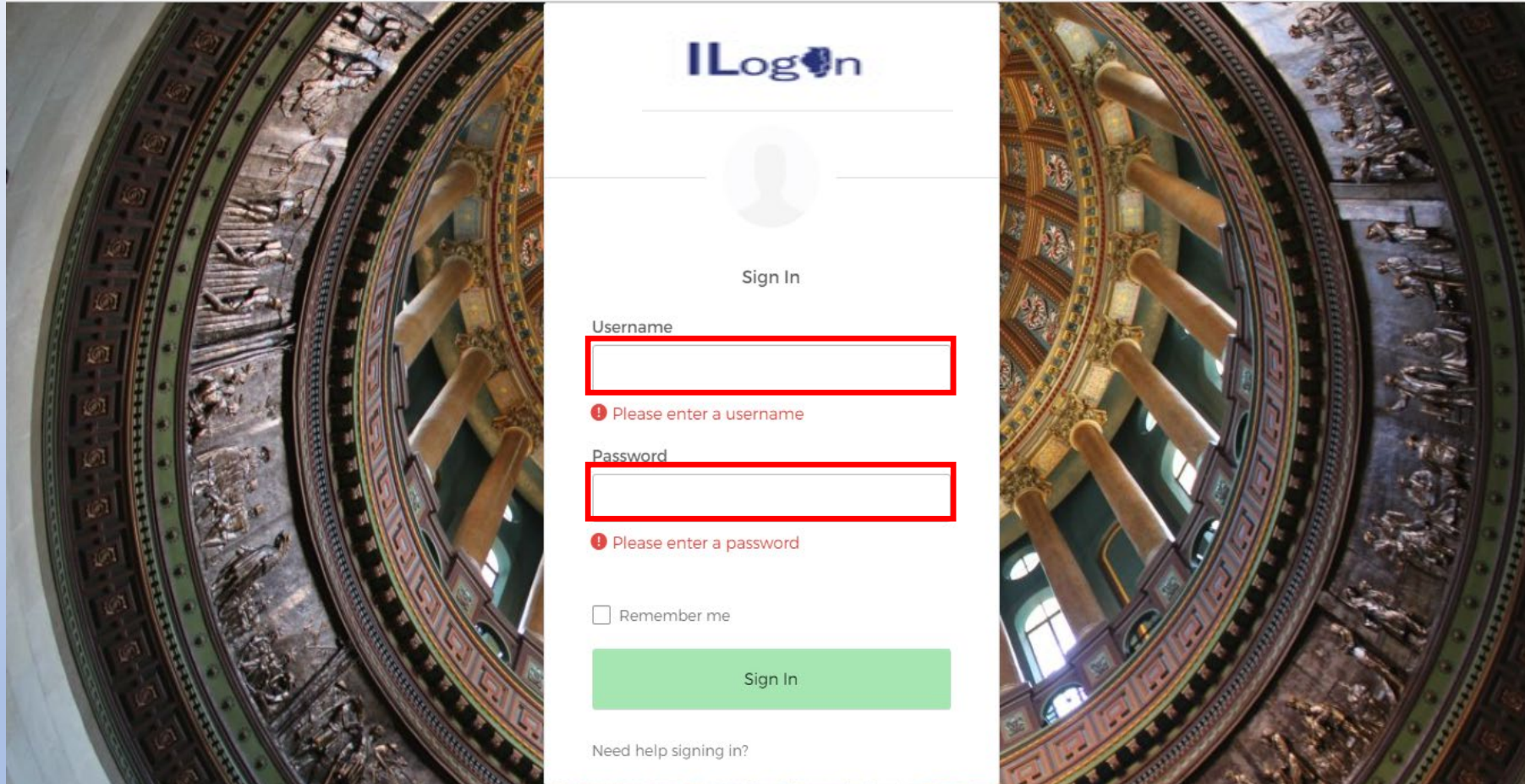




# ILLINOIS PROVIDER ENROLLMENT

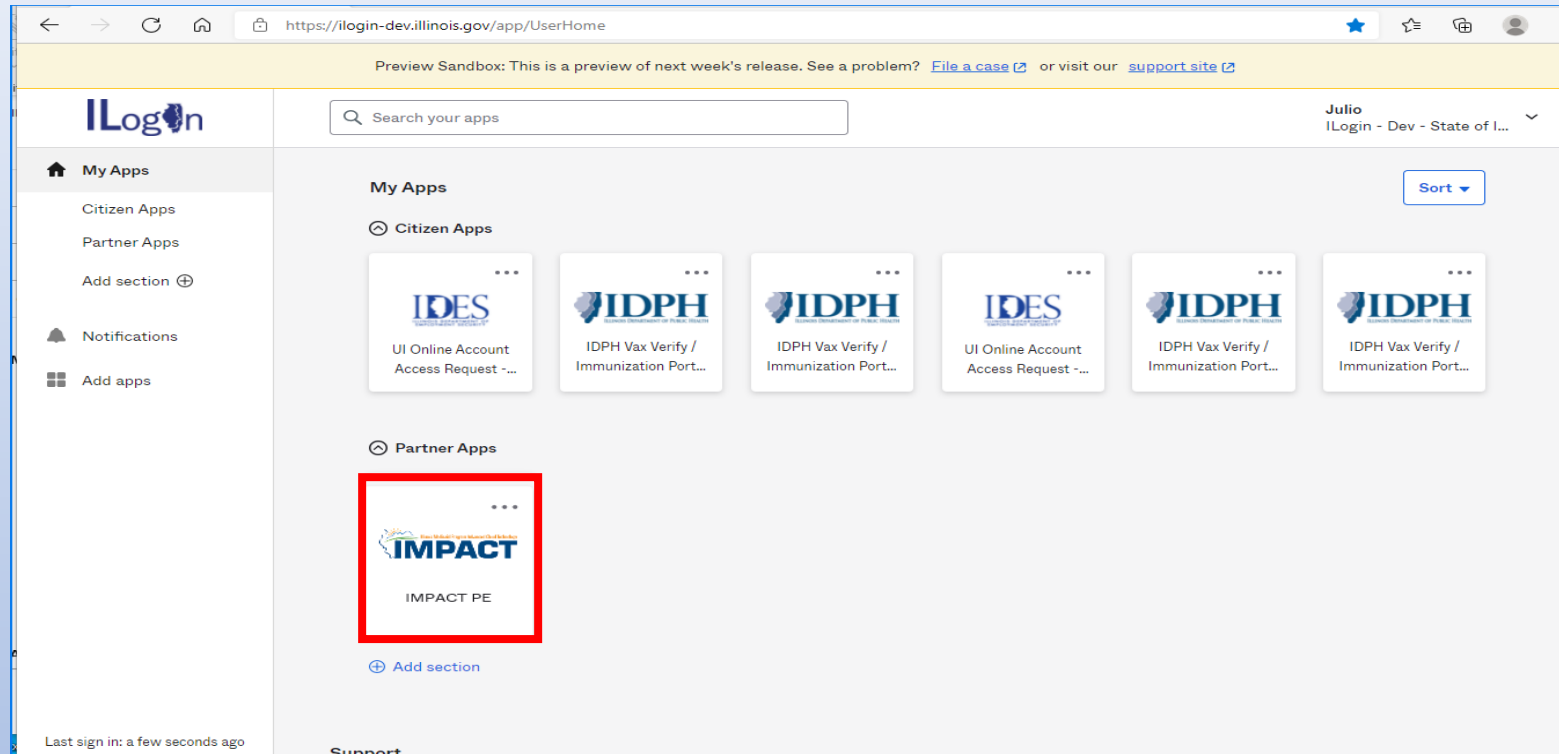


*Billing Agent*

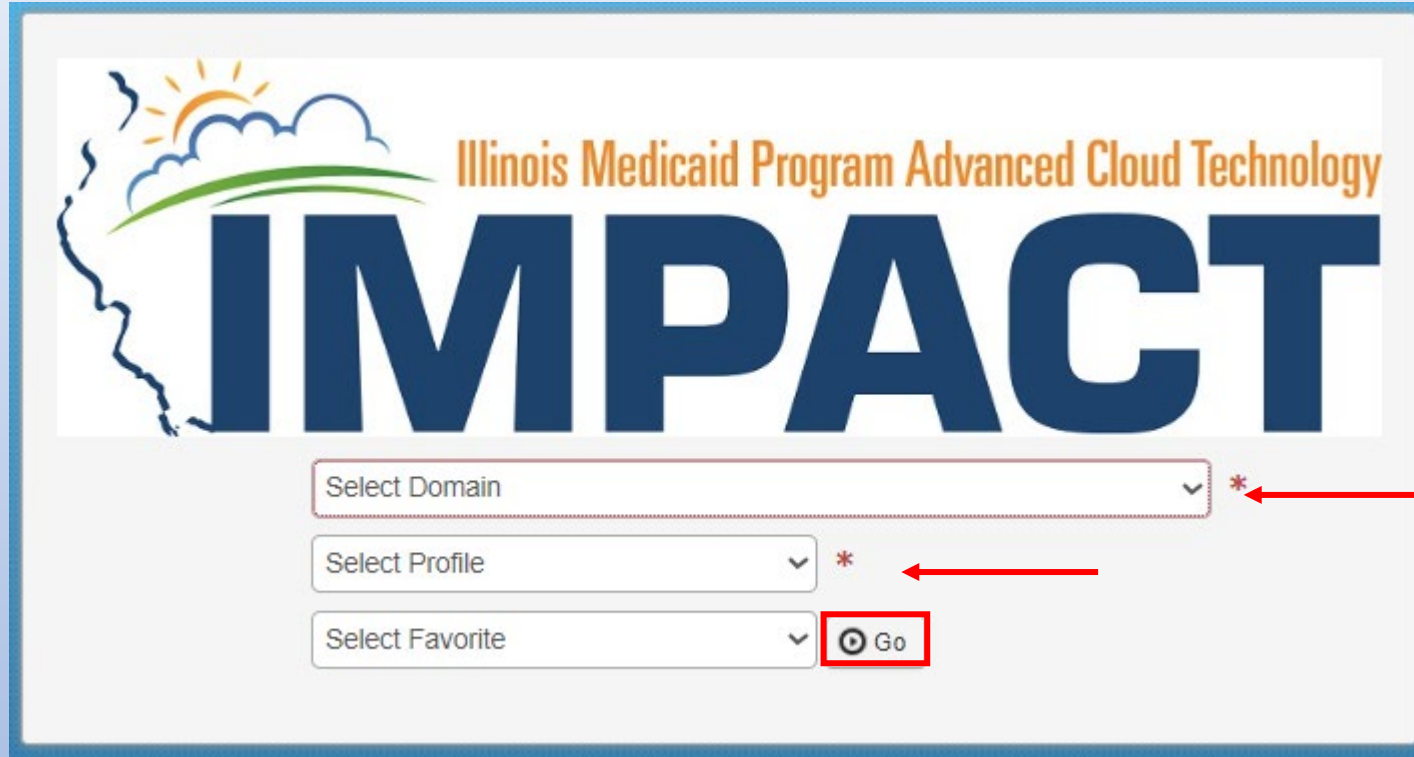


The screenshot shows the ILogon login interface. At the top, the "ILogon" logo is displayed. Below it is a "Sign In" button. The form contains two input fields: "Username" and "Password". Both fields are highlighted with red rectangular boxes. Below the "Username" field, there is a red error message: "Please enter a username". Below the "Password" field, there is a red error message: "Please enter a password". At the bottom of the form, there is a "Remember me" checkbox and a green "Sign In" button. Below the button, there is a link: "Need help signing in?". The background of the page is a photograph of the interior of a large, ornate dome with columns and intricate carvings.

- Input Username and Password created during the creation of the account.



- Click on the IMPACT PE Chicklet to access IMPACT



Illinois Medicaid Program Advanced Cloud Technology  
**IMPACT**

Select Domain  \*

Select Profile  \*

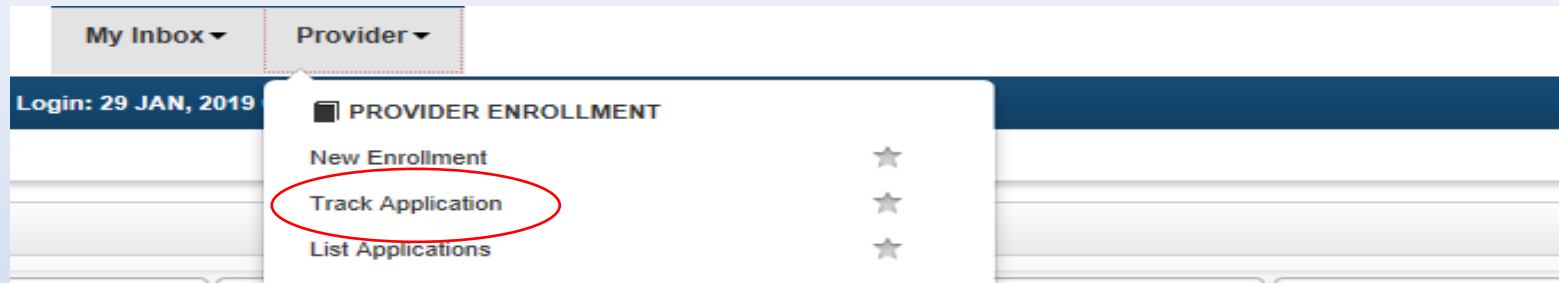
Select Favorite

- Select the Domain and Profile from the drop-down menus

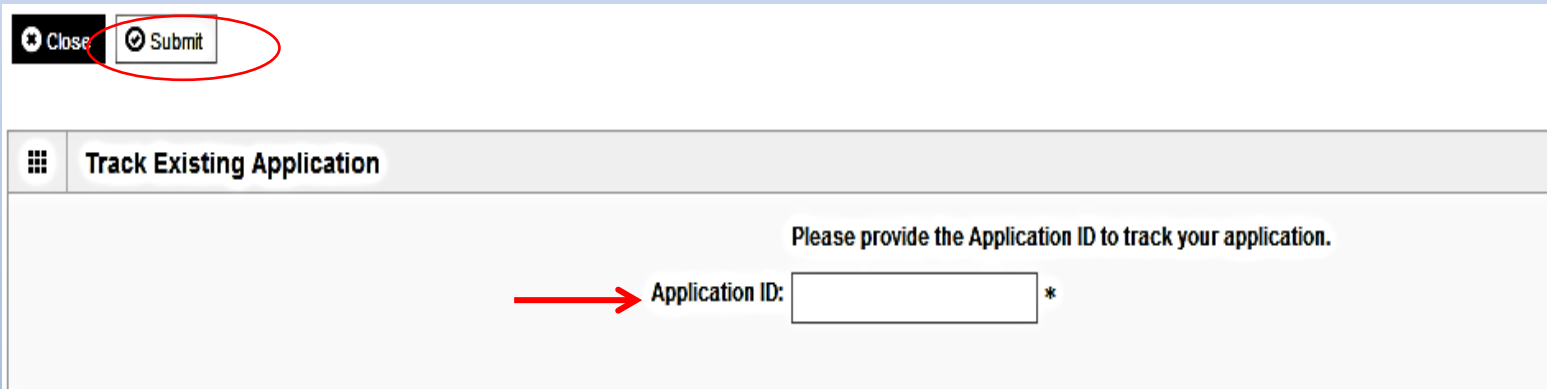
The screenshot shows the IMPACT web application interface. At the top, there is a navigation bar with the IMPACT logo, a back arrow, and two tabs: 'My Inbox' and 'Provider'. Below the navigation bar, the user's name 'Anderson, Teresa' is displayed. The main content area is divided into three sections: 'My Reminders', 'Notification', and a dropdown menu for the 'Provider' tab. The 'My Reminders' section has a 'Filter By' dropdown and a 'Read Status' dropdown with a 'Go' button. The 'Notification' section shows three messages from 'User1' sent yesterday. The 'Provider' dropdown menu is open, showing the following options:

- PROVIDER ENROLLMENT**
  - New Enrollment (indicated by an orange arrow and a star icon)
  - Track Application (star icon)
  - List Applications (indicated by an orange arrow and a star icon)
- MANAGE PROVIDER**
  - Provider List (star icon)
  - Provider Modification Request List (star icon)
- ALL PROVIDER LIST**
  - All Provider List (star icon)
- ADMINISTER**
  - Provider Types (star icon)
  - Provider Type/Specialty/Subspecialty Matrix (star icon)
  - Provider Specialty/Subspecialty (star icon)
  - License/Certification List (star icon)

- Regarding completing an application, there are two options: New Enrollment or Resuming an application.
- If starting a new application, go to slide 7 for step-by-step instructions.
- If resuming an application previously started go to slide 6 for step-by-step instructions.



- To resume an application, click on **Track Application**.



The screenshot shows a form titled 'Track Existing Application'. At the top left, there are two buttons: 'Close' and 'Submit'. The 'Submit' button is circled in red. Below the title, there is a text prompt: 'Please provide the Application ID to track your application.' Below this prompt, there is a text label 'Application ID:' followed by an input field and an asterisk. A red arrow points to the input field.

- 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).



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



MyInbox > New Enrollment

## Enrollment Type

### Select the Applicable Enrollment Type

- Regular Individual/Sole Proprietor or Rendering/Service Provider ?
- 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.) ?

Submit

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



# Start Application

(Step 1: Basic Provider Information)



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

**Basic Information**

Entity Business Name:  \* (Doing Business As)

Indicate Claim Submission Type:  Dental  Institutional  Professional \* (Must select at least one claim type)

---

**Support Contact**

First Name:  \* Middle Initial:

Last Name:  \*

Phone Number:  \* Extn:

Fax Number:

Contact Email Address:

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

---

**Technical Contact**

Same as Support Contact

First Name:  \* Middle Initial:

Last Name:  \*

Phone Number:  \* Extn:

Fax Number:

Contact Email Address:

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

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

# Start Application

(Step 1: Basic Provider Information)



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

**Billing Agent Address Details**

End Date:

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

Address validation successful

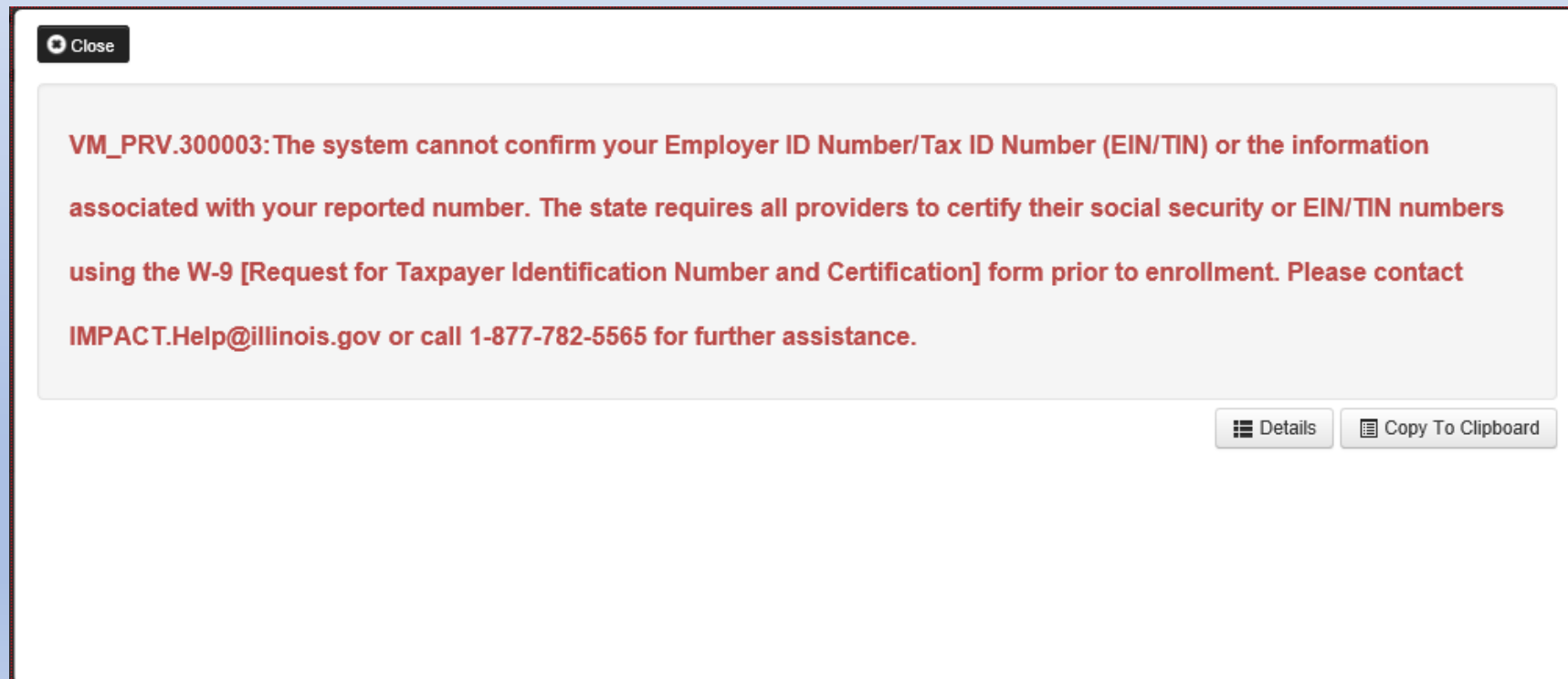
Address Line 1:	<input type="text" value="607 E Adams St"/> *	Address Line 2:	<input type="text"/>
	(Enter Street Address or PO Box Only)	City/Town:	<input type="text" value="Springfield"/> *
Address Line 3:	<input type="text"/>	County:	<input type="text" value="Sangamon"/>
State/Province:	<input type="text" value="ILLINOIS"/> *	Zip Code:	<input type="text" value="62701"/> * - <input type="text" value="1634"/> <input checked="" type="button" value="Validate Address"/>
Country:	<input type="text" value="UNITED STATES"/> *	Entity Phone Number:	<input type="text" value="(217) 555-0980"/> *
Entity Fax Number:	<input type="text"/>		
Entity Email Address:	<input type="text" value="xxx.xxx.xxx.com"/> *		

- Leave **End date** blank.
- Click **Validate Address** after the street address and zip code have been entered.
- If the address is not validated, check to verify it is correct and update any incorrect information.
- When the address has been validated, click **Finish**.

# Start New Application

## Step 1: Basic Provider Information

- If the following error message is received after entering the required basic information, your EIN/TIN or SSN has not been certified by the Illinois Comptroller.
- Upon receipt of this error message submit your **completed** W9 to [IMPACT.HELP@illinois.gov](mailto:IMPACT.HELP@illinois.gov)



The screenshot shows a modal dialog box with a dark border. In the top-left corner, there is a 'Close' button with a white circle icon. The main content area is a light gray box containing the following text in red: 'VM\_PRV.300003: The system cannot confirm your Employer ID Number/Tax ID Number (EIN/TIN) or the information associated with your reported number. The state requires all providers to certify their social security or EIN/TIN numbers using the W-9 [Request for Taxpayer Identification Number and Certification] form prior to enrollment. Please contact IMPACT.Help@illinois.gov or call 1-877-782-5565 for further assistance.' In the bottom-right corner of the dialog, there are two buttons: 'Details' with a list icon and 'Copy To Clipboard' with a document icon.

# Start Application

(Step 1: Basic Provider Information)

Application ID: 20230817522605      Name: Omni Billing Agency

**Basic Information**

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

Your Application ID is: **20230817522605**

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

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

Ok

- Application ID: systematically generated.
- Name: should reflect name from Basic Information.
- The system will generate an application ID after the successful completion of the Basic Information screen; the application number is a 14-digit number that has the following components:
  - The system date in yyyyymmdd format
  - A 6-digit system generated random number
  - Example: 20230817522605
- Application IDs are valid for 30 calendar days; applications must be completed and submitted to the state for review during this 30-day period or the application will be DELETED.
- The application ID will be used to access the application before submission to the state for review and will be used to track the status of your submitted application until it is marked approved.
- Click **OK** to continue with your application

# Using the Business Process Wizard (BPW)

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

Application ID: 20230817522605      Name: Omni Billing Agency

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/17/2023	08/17/2023	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 4: Upload Documents	Optional			Incomplete	
Step 5: Complete Enrollment Checklist	Required			Incomplete	
Step 6: Submit Enrollment Application for Approval	Required			Incomplete	

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

# Completing the Application Using BPW



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

Application ID: 20230817522605      Name: Omni Billing Agency

[Close](#)

### Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a> ←	Required			Incomplete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 4: Upload Documents</a>	Optional			Incomplete	
<a href="#">Step 5: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 6: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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# Step 2: Mode of Claim Submission

## EDI Exchange



A New Enrollment will need to complete the necessary external application at <http://www.myhfs.illinois.gov/>. In the future paper claims will not be an option for claims submission.

Application ID: 20230817522605      Name: Omni Billing Agency

Mode of Claims Submission/EDI exchange

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

EDI exchange

Method	Description	Applicable Transactions
<input 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, 835 Health Care Claim Payment/Advice
<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 checked="" type="checkbox"/> Data Exchange Gateway (DEG)	To submit/receive HIPAA Transactions via Data Exchange Gateway (DEG) using SFTP/SSLFTP/HTTPS	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter),837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 278/278-Prior Authorization Request/Response, 835- Healthcare Claim payment Advice NCPDP Post Adjudication

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



- You have completed Step 2: **Add Mode of Claim Submission/EDI Exchange**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 3: **Add Provider Controlling Interest/Ownership Details** to continue your application.

Application ID: 20230817522605      Name: Omni Billing Agency

[Close](#)

### Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a> ←	Required			Incomplete	
<a href="#">Step 4: Upload Documents</a>	Optional			Incomplete	
<a href="#">Step 5: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 6: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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# Step 3: Controlling Interest/Ownership

Application ID: 20230817522605

Name: Omni Billing Agency

Close Actions

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

During the enrollment process, every Provider (including fiscal agents and managed-care entities) is required to detail the ownership and controlling interests that individuals and corporate entities have in the Provider. For the purpose of this requirement, individuals or corporate entities with "ownership and controlling interest" in the provider include, but are not limited to, the following: (1) if the provider is a corporation or limited-liability company, any individual or corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the provider; (2) if the provider is a sole proprietorship, the owner of the provider; (3) if the provider is a partnership, each partner of the provider; (4) each individual who is a member of the provider's Board of Directors; and (5) each individual employed with the provider who has a significant responsibility. During enrollment and revalidation, the provider shall provide the following information:

- The name, home address date of birth, and Social Security Numbers of any individual or corporate entity with an ownership or controlling interest in the provider. The addresses for corporate entities must include as applicable, primary business address, the address of each business location, and the address of any PO Box used. For each of the provider's subcontractors, the Tax Identification Number of any corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the subcontractor.
- If any of the disclosed individuals with ownership or controlling interest are related disclose the nature of relation. In this context, "relation" means spouse, parent, child, or sibling.
- Where an individual with ownership or controlling interest in any of the provider's subcontractors is related to another individual who also has an ownership or controlling interest in the provider, the name of each related individual and his or her relation. In this context, "relation" means spouse, parent, child, or sibling.
- For each individual with ownership or controlling interest in the provider, the name of each fiscal agent or managed-care entity that is reimbursable by Medicaid and/or Medicare, in which that individual also has an ownership or controlling interest.

Note: The preceding information must also be provided within 35 days after any change in ownership.

## Owners List

Filter By  And Indicator  Go

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
-------------------	-------------------	------------	---------	------------	----------	---------------------	----------------	------------------

No Records Found !

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

# Step 3: Controlling Interest/Ownership

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

Application ID: 20230817522605      Name: Omni Billing Agency

**Provider Controlling Interest/Ownership**

Type: <input type="text" value="Managing Employee"/> *	Percentage Owned: <input type="text" value="0"/> *
SSN: <input type="text" value="100001002"/> *	EIN/TIN: <input type="text"/>
Legal Entity Name: <input type="text"/> <small>(As shown on the Income Tax Return)</small>	Entity Business Name: <input type="text"/> <small>(Doing Business As)</small>
Owner NPI: <input type="text" value="1000010029"/>	Middle Initial: <input type="text"/>
First Name: <input type="text" value="Sarah"/> *	DOB: <input type="text" value="07/22/1995"/> *
Last Name: <input type="text" value="Jones"/> *	Email: <input type="text" value="xxx.xxx.xxx.com"/>
Suffix: <input type="text"/>	End Date: <input type="text"/>
Phone Number: <input type="text"/> *    Extn: <input type="text"/>	
Start Date: <input type="text" value="10/01/2020"/> *	

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

Address Type: Home Address

Address validation successful

Address Line 1: <input type="text" value="355 E Madison St"/> *	Address Line 2: <input type="text"/>
<small>(Enter Street Address or PO Box Only)</small>	City/Town: <input type="text" value="Springfield"/> *
Address Line 3: <input type="text"/>	County: <input type="text" value="Sangamon"/>
State/Province: <input type="text" value="ILLINOIS"/> *	Zip Code: <input type="text" value="62701"/> * - <input type="text" value="1031"/>
Country: <input type="text" value="UNITED STATES"/> *	<input type="button" value="Validate Address"/>

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

# Step 3: Controlling Interest/Ownership

Application ID: 20230817522605      Name: Omni Billing Agency

Close   **Actions**   *i*

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

During the enrollment process, every Provider (including fiscal agents and managed-care entities) is required to detail the ownership and controlling interests that individuals and corporate entities have in the Provider. For the purpose of this requirement, individuals or corporate entities with "ownership and controlling interest" in the provider include, but are not limited to, the following: (1) if the provider is a corporation or limited-liability company, any individual or corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the provider; (2) if the provider is a sole proprietorship, the owner of the provider; (3) if the provider is a partnership, each partner of the provider; (4) each individual who is a member of the provider's Board of Directors; and (5) each individual employed with the provider who has a significant responsibility. During enrollment and revalidation, the provider shall provide the following information:

- The name, home address date of birth, and Social Security Numbers of any individual or corporate entity with an ownership or controlling interest in the provider. The addresses for corporate entities must include as applicable, primary business address, the address of each business location, and the address of any PO Box used. For each of the provider's subcontractors, the Tax Identification Number of any corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the subcontractor.
- If any of the disclosed individuals with ownership or controlling interest are related disclose the nature of relation. In this context, "relation" means spouse, parent, child, or sibling.
- Where an individual with ownership or controlling interest in any of the provider's subcontractors is related to another individual who also has an ownership or controlling interest in the provider, the name of each related individual and his or her relation. In this context, "relation" means spouse, parent, child, or sibling.
- For each individual with ownership or controlling interest in the provider, the name of each fiscal agent or managed-care entity that is reimbursable by Medicaid and/or Medicare, in which that individual also has an ownership or controlling interest.

Note: The preceding information must also be provided within 35 days after any change in ownership.

### Owners List

Filter By    And    Indicator    Go    Save Filters    My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 100001002	Jones, Sarah	Managing Employee	355 E Madison St	10/01/2020	12/31/2999	Completed	Not Completed	0

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- Click **Actions** and select **Add Owner** or **Import Owner** repeat the previous steps to list additional owners

# Step 3: Controlling Interest/Ownership

Application ID: 20230817522605      Name: Omni Billing Agency

Close    Actions

**Owners List**

Filter By    And    Indicator    Go    Save Filters    My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 100001002	Jones, Sarah	Managing Employee	355 E Madison St	10/01/2020	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/> 100001078	Smith, Marie	Board of Directors/Officers/Principles	120 Ruth Rd	10/01/2020	12/31/2999	Completed	Not Completed	85
<input type="checkbox"/> 100002830	Omni Billing Agency	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Completed	Not Completed	15

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- After all ownerships have been added, click the **Actions** drop down box and select **Owner Relationships**.

# Step 3: Controlling Interest/Ownership

Application ID: 20230817522605      Name: Omni Billing Agency

**Add Relationship**

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

**Owner List**

Show Owners: All

Selected Owner: Omni Billing Agency    SSN/EIN/TIN: 100002830    Status: Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Omni Billing Agency	Relation to Assoc. Owner
Jones, Sarah	100001002	Managing Employee	None	None
Smith, Marie	100001078	Board of Directors/Officers/Principles	None	None

View Page: 1         Viewing Page: 1

Selected Owner: Smith, Marie    SSN/EIN/TIN: 100001078    Status: Completed

Selected Owner: Jones, Sarah    SSN/EIN/TIN: 100001002    Status: Completed

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



# Step 3: Controlling Interest/Ownership

Application ID: 20230817522605

Name: Omni Billing Agency

Close Actions

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

During the enrollment process, every Provider (including fiscal agents and managed-care entities) is required to detail the ownership and controlling interests that individuals and corporate entities have in the Provider. For the purposes of this requirement, individuals or corporate entities with "ownership and controlling interest" in the provider include, but are not limited to, the following: (1) if the provider is a corporation or limited-liability company, any individual or corporate entity owning (directly or indirectly) 5% or more of the ownership in the provider; (2) if the provider is a sole proprietorship, the owner of the provider; (3) if the provider is a partnership, each partner of the provider; (4) each individual who is a member of the provider's Board of Directors; and (5) each individual employed with the provider who has a significant responsibility. During enrollment and revalidation, the provider shall provide the following information:

- The name, home address date of birth, and Social Security Numbers of any individual or corporate entity with an ownership or controlling interest in the provider. The addresses for corporate entities must include as applicable, primary business address, the address of each business location, and the address of any PO Box used. For each of the provider's subcontractors, the Tax Identification Number of any corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the subcontractor.
- If any of the disclosed individuals with ownership or controlling interest are related disclose the nature of relation. In this context, "relation" means spouse, parent, child, or sibling.
- Where an individual with ownership or controlling interest in any of the provider's subcontractors is related to another individual who also has an ownership or controlling interest in the provider, the name of each related individual and his or her relation. In this context, "relation" means spouse, parent, child, or sibling.
- For each individual with ownership or controlling interest in the provider, the name of each fiscal agent or managed-care entity that is reimbursable by Medicaid and/or Medicare, in which that individual also has an ownership or controlling interest.

Note: The preceding information must also be provided within 35 days after any change in ownership.

## Owners List

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

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 100001002	Jones, Sarah	Managing Employee	355 E Madison St	10/01/2020	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/> 100001078	Smith, Marie	Board of Directors/Officers/Principles	120 Ruth Rd	10/01/2020	12/31/2999	Completed	Not Completed	85
<input type="checkbox"/> 100002830	Omni Billing Agency	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Completed	Not Completed	15

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- After all relationships have been added, click the **Actions** drop down box and select **Owners Adverse Action**.



# Step 3: Controlling Interest/Ownership

Application ID: 20230817522605      Name: Omni Billing Agency

1. For the provider, any individual who has an ownership or controlling interest in the provider, and any of the provider's suppliers, each 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. § 1001.101 or 42 C.F.R. § 1001.201

2. For the provider, any individual who has an ownership or controlling interest in the provider, and any of the provider's suppliers, each 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**

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

**Owners with Adverse Action**

Filter By  All

Owner Name	SSN/EIN/TIN	Response	Comments
Jones,Sarah	100001002	<input type="radio"/> Yes <input checked="" type="radio"/> No ←	<input type="text"/>
Smith,Marie	100001078	<input type="radio"/> Yes <input checked="" type="radio"/> No ←	<input type="text"/>
Omni Billing Agency	100002830	<input type="radio"/> Yes <input checked="" type="radio"/> No ←	<input type="text"/>

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- With regards to the chosen Owner, read through the listed information and answer the question and enter comments, if desired.
- Click **OK** when completed.
- Repeat these steps for each listed Owner.

# Step 3: Controlling Interest/Ownership

Application ID: 20230817522605

Name: Omni Billing Agency

Close Actions

- address of any PO Box used. For each of the provider's subcontractors, the Tax Identification Number of any corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the subcontractor.
- If any of the disclosed individuals with ownership or controlling interest are related disclose the nature of relation. In this context, "relation" means spouse, parent, child, or sibling.
  - Where an individual with ownership or controlling interest in any of the provider's subcontractors is related to another individual who also has an ownership or controlling interest in the provider, the name of each related individual and his or her relation. In this context, "relation" means spouse, parent, child, or sibling.
  - For each individual with ownership or controlling interest in the provider, the name of each fiscal agent or managed-care entity that is reimbursable by Medicaid and/or Medicare, in which that individual also has an ownership or controlling interest.

Note: The preceding information must also be provided within 35 days after any change in ownership.

## Owners List

Filter By  And Indicator  Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 100001002	Jones, Sarah	Managing Employee	355 E Madison St	10/01/2020	12/31/2999	Completed	No	0
<input type="checkbox"/> 100001078	Smith, Marie	Board of Directors/Officers/Principles	120 Ruth Rd	10/01/2020	12/31/2999	Completed	No	85
<input type="checkbox"/> 100002830	Omni Billing Agency	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Completed	No	15

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

Filter By  Go Save Filters My Filters

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

- It is required that ownership of 5% or more in any other Medicaid/Medicare entity be entered.
- To enter Ownership details in another Medicaid/Medicare Entity, click on **Add Other Owned Entity**.
- If this step is not applicable proceed to slide 26.

# Step 3: Controlling Interest/Ownership



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

Application ID: 20230817522605      Name: Omni Billing Agency

**Provider Controlling Interest/Ownership in Other Medicaid/Medicare Entities**

Type: Other Medicaid/Medicare Entity

EIN/TIN:  \*

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

Owner NPI:

Phone Number:  \*    Extn:

Start Date:  \*

Percentage Owned:  \*

Entity Business Name:  \*  
(Doing Business As)

Email:

End Date:

Address Type: Business Address

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:  \* -

- 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 3: Controlling Interest/Ownership

Application ID: 20230817522605      Name: Omni Billing Agency

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address of any PO Box used. For each of the provider's subcontractors, the Tax Identification Number of any corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the subcontractor.

- If any of the disclosed individuals with ownership or controlling interest are related disclose the nature of relation. In this context, "relation" means spouse, parent, child, or sibling.
- Where an individual with ownership or controlling interest in any of the provider's subcontractors is related to another individual who also has an ownership or controlling interest in the provider, the name of each related individual and his or her relation. In this context, "relation" means spouse, parent, child, or sibling.
- For each individual with ownership or controlling interest in the provider, the name of each fiscal agent or managed-care entity that is reimbursable by Medicaid and/or Medicare, in which that individual also has an ownership or controlling interest.

Note: The preceding information must also be provided within 35 days after any change in ownership.

### Owners List

Filter By    **And**   Indicator    [Go](#)   [Save Filters](#)   [My Filters](#)

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> ▲▼ 100001002	▲▼ Jones,Sarah	▲▼ Managing Employee	▲▼ 355 E Madison St	▲▼ 10/01/2020	▲▼ 12/31/2999	▲▼ Completed	▲▼ No	▲▼ 0
<input type="checkbox"/> 100001078	Smith,Marie	Board of Directors/Officers/Principles	120 Ruth Rd	10/01/2020	12/31/2999	Completed	No	85
<input type="checkbox"/> 100002830	Omni Billing Agency	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Completed	No	15

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### Add Other Owned Entity

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

Filter By    [Go](#)   [Save Filters](#)   [My Filters](#)

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

No Records Found !

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

- You have completed Step 3: **Add Provider Controlling Interest/Ownership Details**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 4: **Upload Documents** to continue your application.

Application ID: 20230817522605 Name: Omni Billing Agency

[Close](#)

### Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required	08/17/2023	08/18/2023	Complete	
<a href="#">Step 4: Upload Documents</a> ←	Optional			Incomplete	
<a href="#">Step 5: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 6: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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# Step 4: Upload Documents

*Note: This Step is optional.*

Application ID: 20230817522605      Name: Omni Billing Agency

**Upload Documents**

Document Type *	Document Name *	File Name *	Remarks	Uploaded By	Uploaded Date
--Select--	--Select--	Choose File <input type="button" value="📎"/>	<input type="text"/>		

- If additional documentation:
  - From dropdown box labeled Document Type select the document being uploaded.
  - From Document Name drop down box select the name of the document being uploaded.
  - Click on paperclip icon to search for document being uploaded.
  - Once document is found click **Save** .

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

Application ID: 20230817522605      Name: Omni Billing Agency

**Enroll Billing Agent**

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required	08/17/2023	08/18/2023	Complete	
<a href="#">Step 4: Upload Documents</a>	Optional	08/18/2023	08/18/2023	Complete	
<a href="#">Step 5: Complete Enrollment Checklist</a> ←	Required			Incomplete	
<a href="#">Step 6: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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# Step 5: Complete Enrollment Checklist

Application ID: 20230817522605      Name: Omni Billing Agency

### Provider Checklist

Question	Answer	Comments
Are you able to produce HIPAA-Compliant transactions?	Yes	
Have you reviewed the HFS Handbook - Chapter 300, Electronic Processing and Federal Implementation Guides?	Yes	
Would you be willing to submit HIPAA-Compliant transactions for new providers?	Yes	
Do you wish to end date your enrollment? If yes, what date?	No	

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- All questions must be answered either **Yes** or **No** and comments made if directed to do so.
- After all the questions have been answered and comments made, click the **Save** button in the upper left corner followed by clicking on the **Close** button.

# Business Process Wizard (BPW)

- You have completed Step 5: **Complete Enrollment Checklist**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 6: **Submit Enrollment Application for Approval** to continue your application.

Application ID: 20230817522605      Name: Omni Billing Agency

[Close](#)

**Enroll Billing Agent**

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required	08/17/2023	08/18/2023	Complete	
<a href="#">Step 4: Upload Documents</a>	Optional	08/18/2023	08/18/2023	Complete	
<a href="#">Step 5: Complete Enrollment Checklist</a>	Required	08/18/2023	08/18/2023	Complete	
<a href="#">Step 6: Submit Enrollment Application for Approval</a> ←	Required			Incomplete	

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# Step 6: Submit Enrollment for Approval



Application ID: 20230817522605      Name: Omni Billing Agency

Close   **Next**

### Final Submission

Application ID: 20230817522605      EnrollmentType: Billing Agent

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

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

### Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
No Records Found !			

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

# Step 6: Submit Enrollment for Approval

Application ID: 20230817522605      Name: Omni Billing Agency

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

**Billing Agent Terms and Conditions**

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

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

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

**42 CFR 455.18 Provider's statements on claims forms.**

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

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

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

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

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

# Business Process Wizard (BPW)

- The below message will appear advising that the application has been submitted to the state for review. The application number can be used to check the status of the application by going through the track application option.
- You have completed Step 5: **Submit Enrollment Application**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click **Close** in the message box .

Application ID: 20230817522605      Name: Omni Billing Agency

**Your Application Number 20230817522605 has been successfully submitted for State review. Return with this application number to track the status of your application.** x

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	08/17/2023	08/17/2023	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required	08/17/2023	08/18/2023	Complete	
<a href="#">Step 4: Upload Documents</a>	Optional	08/18/2023	08/18/2023	Complete	
<a href="#">Step 5: Complete Enrollment Checklist</a>	Required	08/18/2023	08/18/2023	Complete	
<a href="#">Step 6: Submit Enrollment Application for Approval</a>	Required	08/22/2023	08/22/2023	Complete	

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- Check out the definitions of common terms at [Glossary | HFS \(illinois.gov\)](#)
- FAQ's can be found at [Frequently Asked Questions \(illinois.gov\)](#) to help resolve common questions and problems when submitting applications.
- General questions regarding IMPACT can be addressed to:
  - Email: [IMPACT.Help@Illinois.gov](mailto:IMPACT.Help@Illinois.gov)