

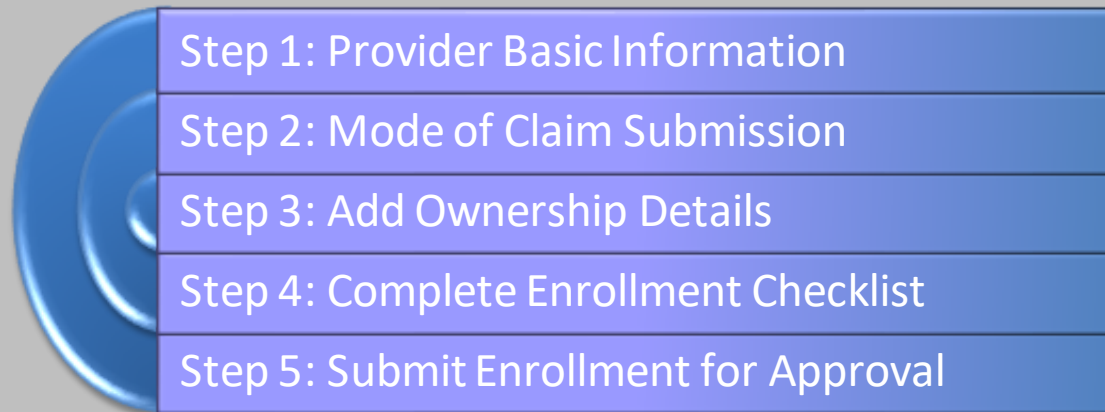
# ILLINOIS PROVIDER ENROLLMENT



***Billing Agent***





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

- **IMPACT** is a multi-agency effort to replace Illinois' 30-year-old Medicaid Management Information System (MMIS) with a web-based system that meets federal requirements, is more convenient for providers and increases efficiency by automating and expediting state agency processes.
- **Key Terms:**
  - Billing Agent: Submits Medicaid HIPAA compliant Transactions or exchanges EPHI with Medicaid providers or other authorized parties. Also known as Clearing House, Software Vendor or Value-Added Network (VAN).
  - New Enrollment: A billing agent who needs to enroll in the IMPACT system.
  - A Billing Agent must be enrolled in IMPACT for a provider to associate with that Billing Agent.




# Start Application

Manage your account



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

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Access your applications

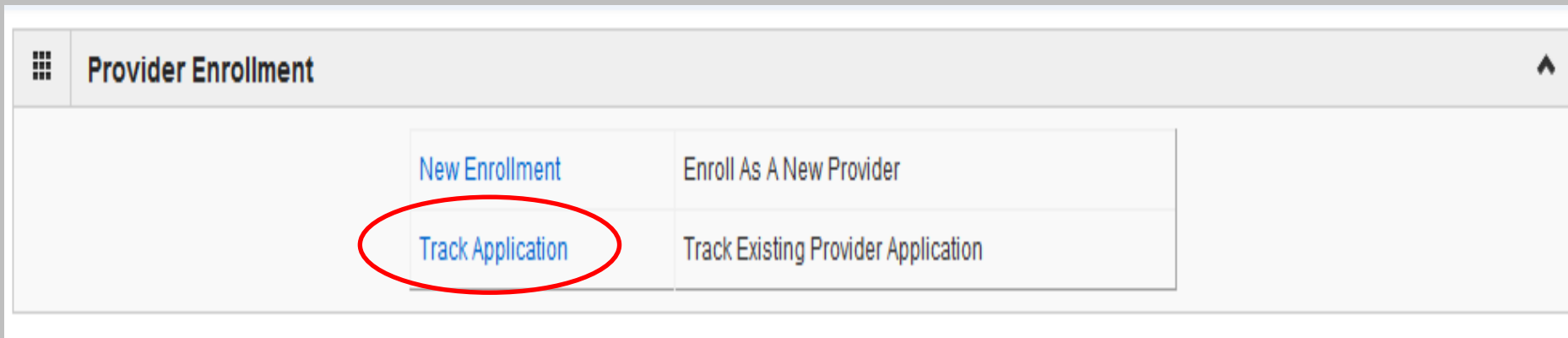
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- After you have completed the single sign-on, click on **IMPACT**.

	<b>Provider Enrollment</b>	
<a href="#">New Enrollment</a>		Enroll As A New Provider
<a href="#">Track Application</a>		Track Existing Provider Application

- 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.

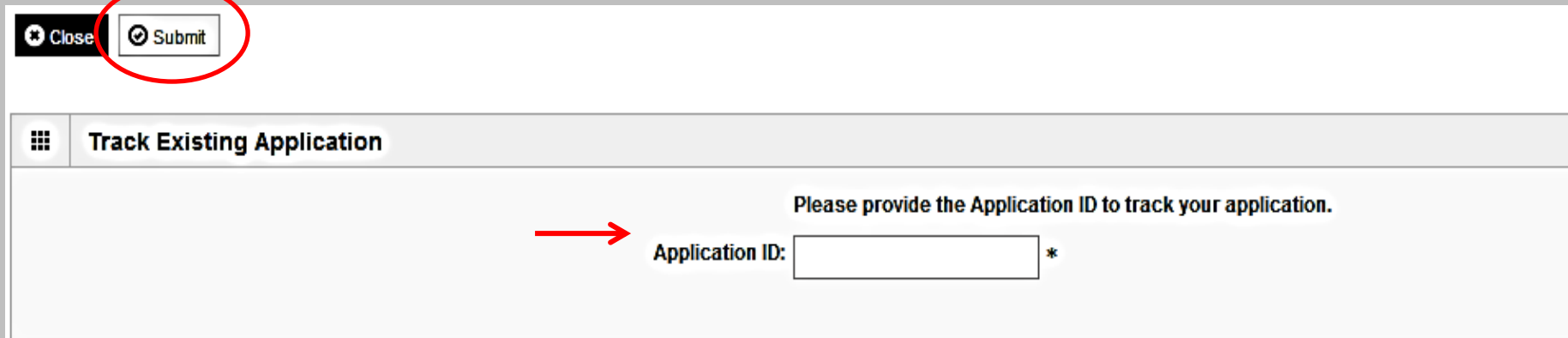
# Start Application



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

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

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



The screenshot shows a web interface with a header bar containing a grid icon and the text "Track Existing Application". Below this is a form with a "Close" button and a "Submit" button (both circled in red). The form contains the text "Please provide the Application ID to track your application." followed by a red arrow pointing to a text input field labeled "Application ID:" with an asterisk.

Close Submit

Please provide the Application ID to track your application.

Application ID:  \*

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

# Start Application

☰	<b>Provider Enrollment</b>	⬆
	<a href="#">New Enrollment</a>	Enroll As A New Provider
	<a href="#">Track Application</a>	Track Existing Provider Application

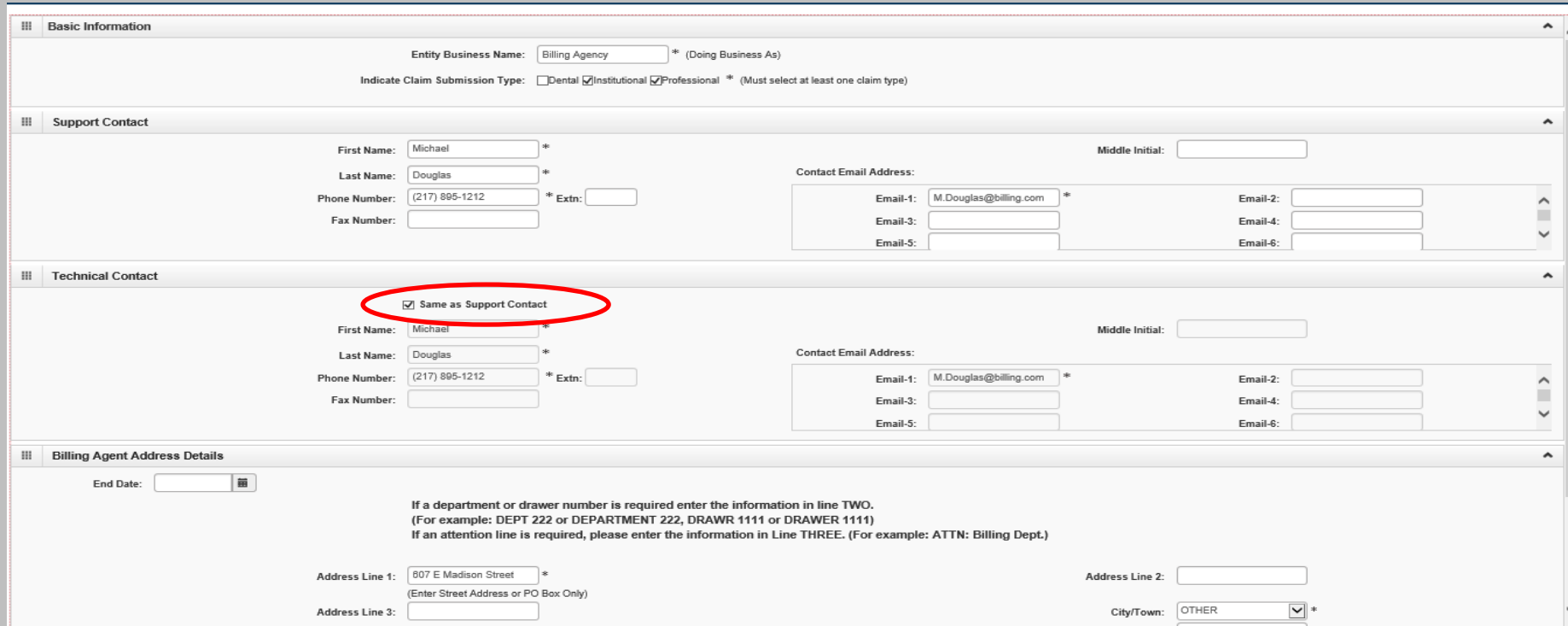
- To begin a new application, click on **New Enrollment**.
- Use the radio buttons to select your enrollment type (Billing Agent), then click on **Submit** in the lower left corner.

☰	<b>Enrollment Type</b>	⬆
Select the Applicable Enrollment Type		
<input type="radio"/> Individual/Sole Proprietor <ul style="list-style-type: none"><li><input type="radio"/> Regular Individual/Sole Proprietor or Rendering/Servicing Provider</li><li><input type="radio"/> EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP.)</li><li><input type="radio"/> Managed Care Network Provider Only</li><li><input type="radio"/> Managed Care Network Provider and EHR</li></ul>		
<input type="radio"/> Group Practice (Corporation, Partnership, LLC, etc.)		
<input checked="" type="radio"/> <b>Billing Agent</b>		
<input type="radio"/> Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)		
<input type="radio"/> Contractor/MCO		
<input type="radio"/> Atypical (non-medical) provider (Choose this option if you do not have a NPI) <ul style="list-style-type: none"><li><input type="radio"/> Individual (Driver, Home Help/Personal Care, Carpenter, etc.)</li><li><input type="radio"/> Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)</li></ul>		
<input checked="" type="radio"/> <b>Submit</b>		

# 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:  \* Email-2:

Email-3:  Email-4:

Email-5:  Email-6:

**Technical Contact**

☒ Same as Support Contact

First Name:  \* Middle Initial:

Last Name:  \*

Phone Number:  \* Extn:

Fax Number:


Contact Email Address:

Email-1:  \* Email-2:

Email-3:  Email-4:

Email-5:  Email-6:

**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, DRAWER 1111 or DRAWER 1111)  
If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1:  \* Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:  City/Town:  \*

- 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 Line 1:  \*

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

State/Province:  \*

Country:  \*

Entity Fax Number:

Entity Email Address:  \*

City/Town:  \*

County:  \*

Zip Code:  \* -

Entity Phone Number:  \*


Access - License: Database- C:\Share\License.accdb

- 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**.


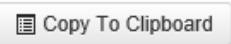
# Start New Application

## 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)

Close

**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](mailto:IMPACT.Help@illinois.gov) or call 1-877-782-5565 for further assistance.

Details Copy To Clipboard

# Start Application

## (Step 1: Basic Provider Information)

Application ID: 20201029004492      Name: Billing Agency

Basic Information

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

Your Application ID is: **20201029004492**

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: 20201029004492
- 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: 20201029004492      Name: 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	10/29/2020	10/29/2020	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: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 5: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page:

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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: 20201029004492      Name: 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	10/29/2020	10/29/2020	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: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 5: 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: 20201029004492 Name: 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 checked="" 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 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

Ok Cancel

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

# Business Process Wizard (BPW)



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

Application ID: 20201029004492Name: 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	10/29/2020	10/29/2020	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/29/2020	10/29/2020	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 4: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 5: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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# Step 3: Controlling Interest/Ownership

Application ID: 20201029004492 Name: Billing Agency

Close Actions 

**Add Owner** (circled in red)

Import Owner

PROVIDER OWNERSHIP DISCLOSURES

Provider Information: Provider Name, Address, Date of Birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

OWNERS ADVERSE ACTION

REQUIRED DISCLOSURE INFORMATION

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


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

REQUIRED OWNERS

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

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

Owners List

Filter By  And Indicator  Go  My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
No Records Found !								

- Ownership entries must include at least one Managing Employee and one other Ownership type.
- 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: 20201029004492      Name: Billing Agency

**Provider Controlling Interest/Ownership**

Type:  \*

SSN:  \*

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

Owner NPI:

First Name:  \*

Last Name:  \*

Suffix:

Phone Number:  \* Extn:

Start Date:  \*

Percentage Owned:  \*

EIN/TIN:

Entity Business Name:  (Doing Business As)

Middle Initial:

DOB:  \*

Email:

End Date:

or

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

Address Line 2:

Address Line 3:

City/Town:  \*

County:  \*

State/Province:  \*

Country:  \*

Zip Code:  \* -

- 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: 20201029004462
Name: Billing Agency

Close
Actions
Add Owner
Import Owner

PROVIDER CONTROL DISCLOSURES
Provider E
Owners Relationships
Owners Adverse Action

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

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

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

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

Owners List
Filter By
And
Indicator
Go
Save Filters
My Filters



Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
100001160	Douglas, Michael	Managing Employee	350 E Madison St	06/21/2011	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

**Import Owner from Other Enrollment**

☒ NPI ☐ Provider ID \*      Zip Code \*       SSN/EIN/TIN \*       Owner Type

                 Owner (includes Managing Employer) ☒       Search

**Owners Available to Import**

Filter By

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

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

# Step 3: Controlling Interest/Ownership

Application ID: 20201029004492 Name: Billing Agency

Close Actions

Add Owner  
Import Owner

**OWNERS RELATIONSHIPS**

Provider Information: Provider Name, Address, City, State, Zip, Phone, Fax, Email, Website, Tax ID, EIN, DUNS, Mailing home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

**REQUIRED DISCLOSURE INFORMATION**

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

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

**REQUIRED OWNERS**

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

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

**Owners List**

Filter By [v] [ ] And Indicator [v] [ ] 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"/> 100001160	Douglas, Michael	Managing Employee	350 E Madison St	06/21/2011	12/31/2999	Not Completed	Not Completed	0
<input type="checkbox"/> 100021048	Billing Agency	Corporate - Non Charitable	350 E Madison St	09/15/2000	12/31/2999	Not Completed	Not Completed	100

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

# Step 3: Controlling Interest/Ownership

Application ID: 20201029004492 Name: 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 Go Save Filters My Filters

Selected Owner: Billing Agency SSN/EIN/TIN: 100021048 Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Billing Agency	Relation to Assoc. Owner
Douglas, Michael	100001160	Managing Employee	<input type="text"/>	<input type="text"/>
Winters, Shelly	100001174	Board of Directors/Officers/Principles	<input type="text"/>	<input type="text"/>

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Selected Owner: Winters, Shelly SSN/EIN/TIN: 100001174 Status: Not Completed

Selected Owner: Douglas, Michael SSN/EIN/TIN: 100001160 Status: Not Completed

Save Close

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

# Step 3: Controlling Interest/Ownership

Application ID: 20201029004492 Name: Billing Agency

Close Actions ⓘ

Pe Add Owner  
Import Owner

PROVIDER OWNERS RELATIONSHIPS CONTROL DISCLOSURES

Provider F Owners Adverse Action ⓘ

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

**REQUIRED DISCLOSURE INFORMATION**

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

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

**REQUIRED OWNERS**

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

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

**Owners List**

Filter By [v] [ ] And Indicator [v] [ ] 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"/> 100001160	Douglas, Michael	Managing Employee	350 E Madison St	06/21/2011	12/31/2999	Not Completed	Not Completed	0
<input type="checkbox"/> 100021048	Billing Agency	Corporate - Non Charitable	350 E Madison St	09/15/2000	12/31/2999	Not Completed	Not Completed	100

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

# Step 3: Controlling Interest/Ownership

Application ID: 20201029004492 Name: Billing Agency

### FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

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

#### Convictions

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

#### Exclusions, revocations, or Suspensions

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

#### 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.

### 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  Go

Owner Name	SSN/EIN/TIN	Response	Comments
Douglas, Michael	100001160	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Billing Agency	100021048	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Winters, Shelly	100001174	<input checked="" type="radio"/> Yes <input 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

**Owners List**

Filter By

<input type="checkbox"/>	Owner SSN/EIN/TIN ▲▼	Owner Information ▲▼	Type ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/>	123456789	Doe, David	Managing Employee	05/21/2015	12/31/2999
<input type="checkbox"/>	987654321	Doe, Sally	Individual/Sole Proprietor	05/21/2015	12/31/2999

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

Filter By


<input type="checkbox"/>	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 3: Controlling Interest/Ownership

*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)


Phone Number:  \* Extn:

Start Date:   \*

Entity Business Name:  \*

(Doing Business As)

Email:


End Date:  


Address Line 1:  \*


(Enter Street Address or PO Box Only)


Address Line 2:

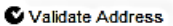
Address Line 3:


City/Town:  OTHER  \*


State/Province:  OTHER  \*

County:  OTHER 

Country:  UNITED STATES  \*

Zip Code:  -  

 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 3: 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
111111111	Doe,David	Managing Employee	06/02/2015	12/31/2999
222222222	Doe, Sam	Individual/Sole Proprietor	06/02/2015	12/31/2999

Delete

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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
123456789	Department of Human Services	123 Anywhere Lane Chicago, IL 60601

Delete

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
Last

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

# Business Process Wizard (BPW)

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




Application ID: 20201029004492      Name: 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	10/29/2020	10/29/2020	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/29/2020	10/29/2020	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required	10/29/2020	10/29/2020	Complete	
<a href="#">Step 4: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 5: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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  Last

# Step 4: Complete Enrollment Checklist

Application ID: 20251029004492 Name: Billing Agency

**Close** **Save**

### Provider Checklist

Question	Answer	Comments
Are you ONLY enrolling to provide services related to COVID-19 emergency response? Answering Yes to this question will create a temporary enrollment that will end within six months from the termination of the public health emergency. If you want to enroll to provide ongoing services to Illinois Medicaid participants, you should answer No to this question.	No	
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. If a checklist item does not apply, select **No** as the answer.
- 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 4: **Complete Enrollment Checklist**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 5: **Submit Enrollment Application for Approval** to continue your application.








Application ID: 20201029004492      Name: 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	10/29/2020	10/29/2020	Complete	
<a href="#">Step 2: Add Mode of Claim Submission/EDI Exchange</a>	Required	10/29/2020	10/29/2020	Complete	
<a href="#">Step 3: Add Provider Controlling Interest/Ownership Details</a>	Required	10/29/2020	10/29/2020	Complete	
<a href="#">Step 4: Complete Enrollment Checklist</a>	Required	10/29/2020	10/29/2020	Complete	
<a href="#">Step 5: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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# Step 5: Submit Enrollment for Approval

Application ID: 20201029004492 Name: Billing Agency

Close Next

Final Submission

Application ID: 20201029004492 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 5: Submit Enrollment for Approval

Application ID: 20201029004492      Name: 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: 20201029004492      Name: Billing Agency








Your Application Number 20201029004492 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

 Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	10/29/2020	10/29/2020	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	10/29/2020	10/29/2020	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	10/29/2020	10/29/2020	Complete	
Step 4: Complete Enrollment Checklist	Required	10/29/2020	10/29/2020	Complete	
Step 5: Submit Enrollment Application for Approval	Required	10/29/2020	10/29/2020	Complete	

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

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