



Illinois Medicaid Program Advanced Cloud Technology

# IMPACT

Illinois Provider Enrollment

Facilities, Agencies, and Organizations

## Agenda

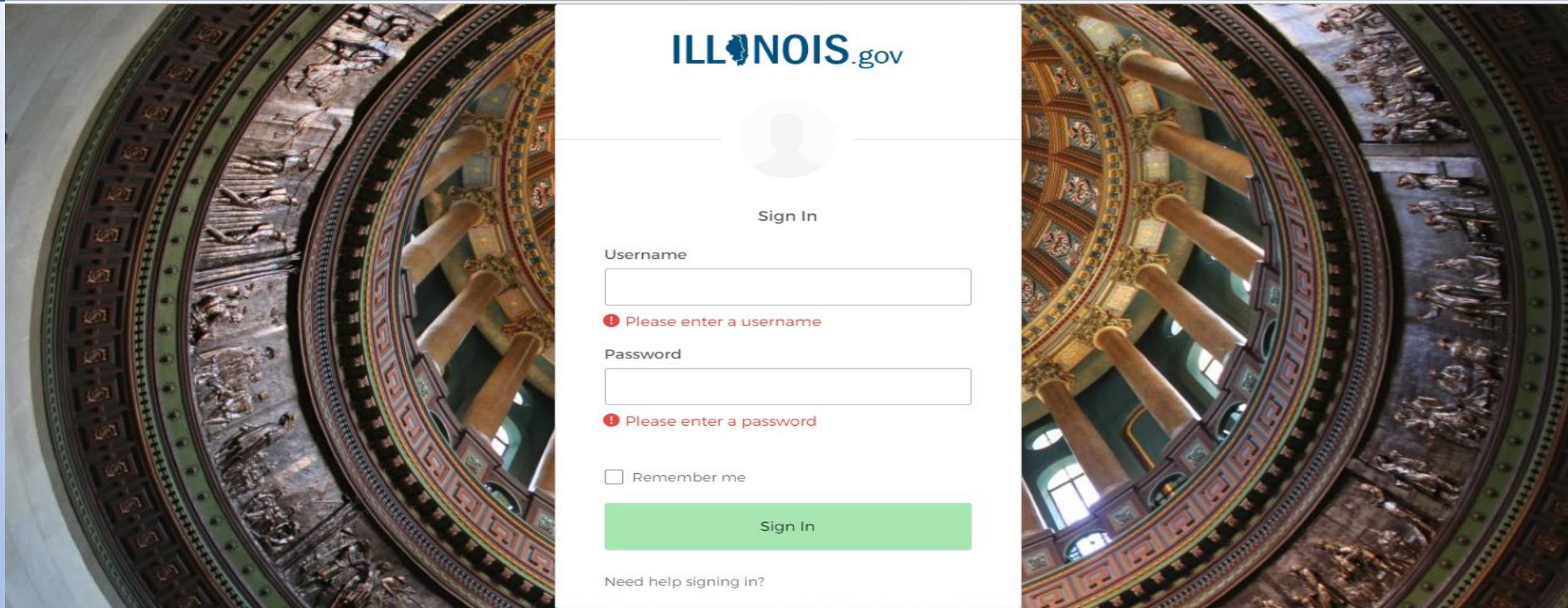
### Introduction to IMPACT

- Application Process
- Resuming an Application
- Starting a New Application
- The Business Process Wizard (BPW)
- Completing the Application using BPW
- Reviewing Submitted Application
- Resources
- Questions & Answers

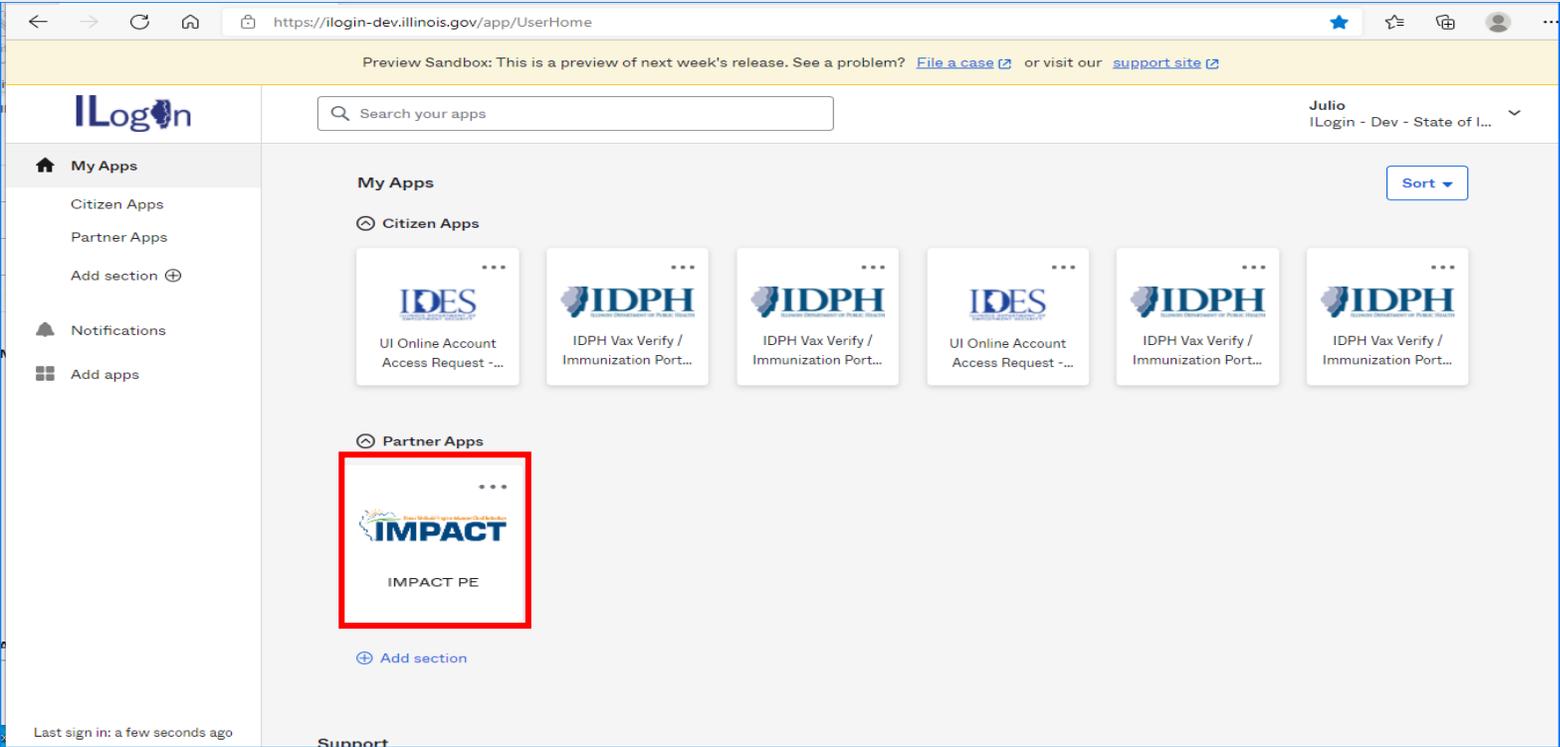
# Application Process

- Step 1: Provider Basic Information
- Step 2: Add Locations
- Step 3: Add Specialties
- Step 4: Associate Billing Provider/Other
- Step 5: Add Licenses/Certifications/Other
- Step 6: Add Additional Information
- Step 7: Add Mode of Claim Submission
- Step 8: Associate Billing Agent
- Step 9: Add Ownership Details
- Step 10: Add Taxonomy Details
- Step 11: Associate MCO Plan
- Step 12: 835/ERA Enrollment Form
- Step 13: Complete Enrollment Checklist
- Step 14: Submit Application for Approval

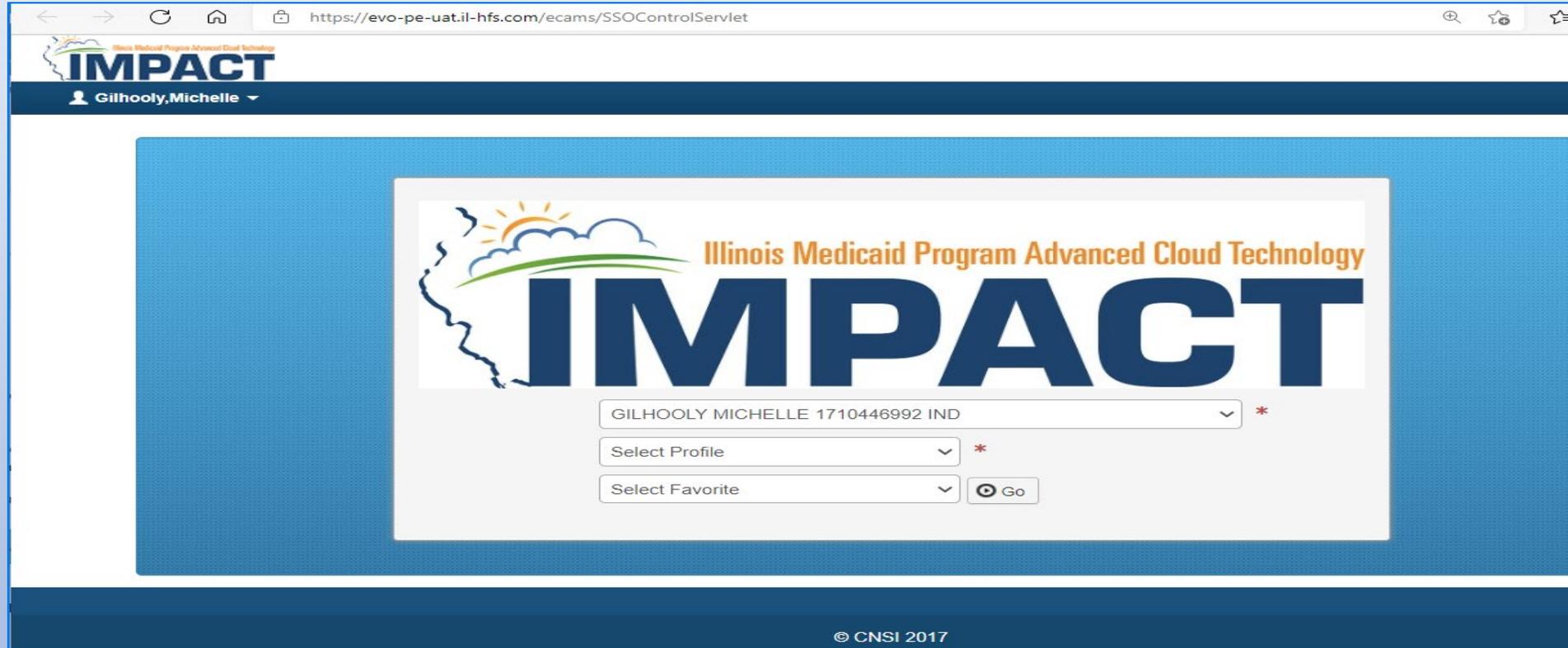
# OKTA LOGIN



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



Click on the IMPACT PE Chicklet to access IMPACT



Select the Domain and Profile from the drop-down menus

# Application Process

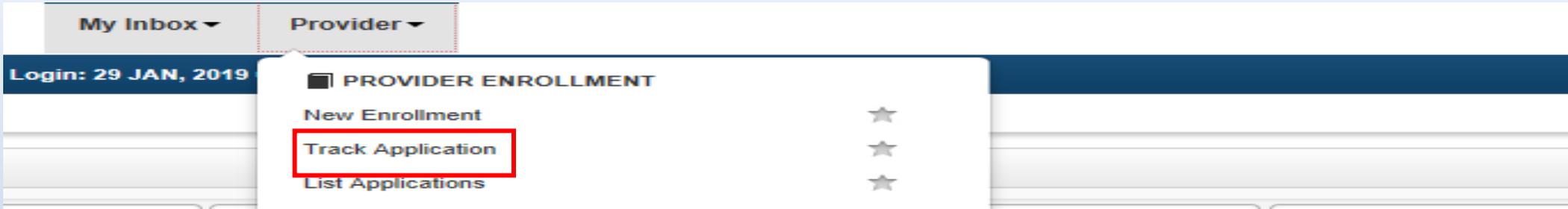
The screenshot displays the IMPACT web application interface. At the top, the user is logged in as 'Anderson, Teresa'. The main navigation bar includes 'My Inbox' and 'Provider'. A dropdown menu is open under the 'Provider' tab, listing several categories and their sub-items:

- PROVIDER ENROLLMENT**
  - New Enrollment (★)
  - Track Application (★)
  - List Applications (★)
- MANAGE PROVIDER**
  - Provider List (★)
  - Provider Modification Request List (★)
- ALL PROVIDER LIST**
  - All Provider List (★)
- ADMINISTER**
  - Provider Types (★)
  - Provider Type/Specialty/Subspecialty Matrix (★)
  - Provider Specialty/Subspecialty (★)
  - License/Certification List (★)

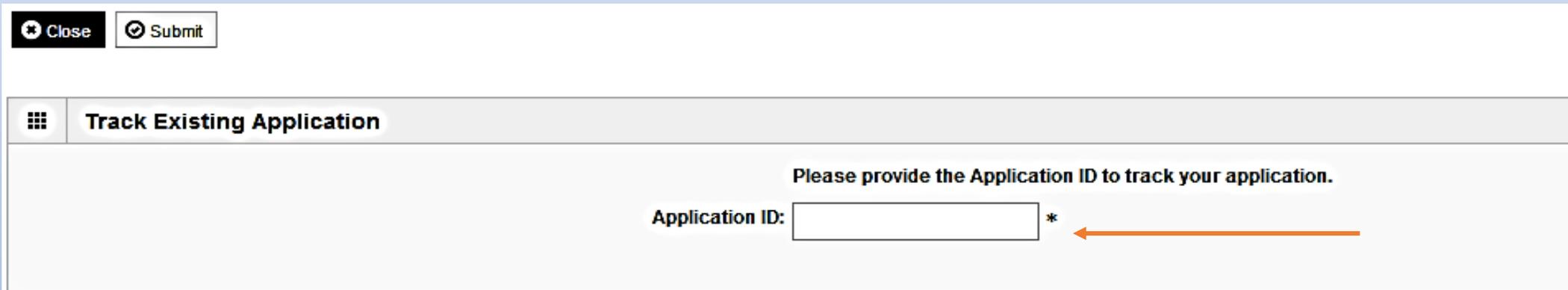
The background interface shows sections for 'My Reminders' with filter options and a table of alerts, and a 'Notification' section with a list of messages from 'User1'.

- There are two options for completing an application: New Enrollment or Resuming an application.
- If starting a new application, go to slide 9 for step-by-step instructions.
- If resuming an application previously started go to slide 8 for step-by-step instructions.

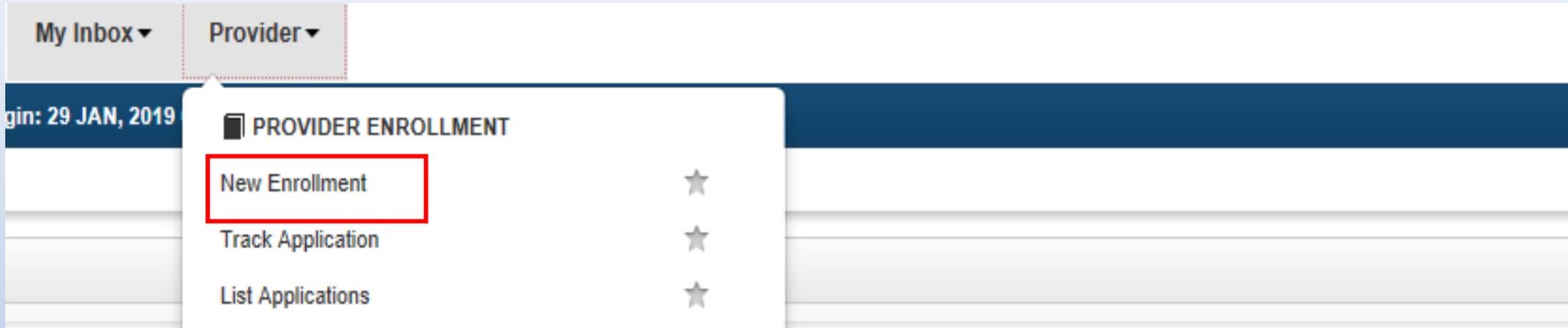
# Resuming an Application



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

A screenshot of the 'Track Existing Application' form. At the top left, there are two buttons: 'Close' and 'Submit'. Below the buttons is a header bar with a grid icon and the text 'Track Existing Application'. The main content area contains the text 'Please provide the Application ID to track your application.' followed by the label 'Application ID:' and an input field. An asterisk (\*) is placed to the right of the input field. An orange arrow points from the right side of the input field towards the left.

- 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***

# Starting a New Application

**Enrollment Type**

Select the Applicable Enrollment Type

Regular Individual/Sole Proprietor or Rendering/Serviceing 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.) ⓘ

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

# Start New Application (Step 1: Basic Provider Information)

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

Application ID: 20230517554064      Name: Anderson Help

**Basic Information:** Enter required fields and click Confirm button.

**Basic Information**

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

Entity Business Name:  \* (Doing Business As)      EIN/TIN:  \*

Organization/Business Type:  \*

NPI:

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"/>

- After all the information has been entered click **Confirm**.
- Click **Finish** in the bottom right corner to complete this step.
- Providers can only complete this step if the EIN/TIN has been certified by the Illinois Comptroller.
- In order to certify EIN/TIN completed and submitted a W9 to IMPACT.HELP
  - Place W9 in the subject line of the email.

# Start New Application (Step 1: Basic Provider Information)



Application ID: 20230718247195

Name: Anderson Help

## Basic Information

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

Your Application ID is: **20230718247195**

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.



- 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: 20230718247195
- 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.
- After documenting the ID number, click **OK**.

# Using the Business Process Wizard (BPW)



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

Application ID: 20230517245044      Name: Anderson Group

Close

Enroll Provider - FAO

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/17/2023	05/17/2023	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Bed Information	Optional			Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Fee Payment	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

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

# Completing the Application Using BPW



Step 1: **Provider Basic Information**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.

Steps **1**, **2** and **3** must be completed in sequential order before attempting any of the later steps.

Click on Step 2: **Add Locations** to continue completing your application.

Application ID: 20230517245044      Name: Anderson Group

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). 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	05/17/2023	05/17/2023	Complete	
<a href="#">Step 2: Add Locations</a> ←	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Bed Information	Optional			Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Fee Payment	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

# Step 2: Add Locations

Application ID: 20230718247195

Name: Anderson Help

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

**Locations List**

Filter By

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
No Records Found !			

- Click on **Add** tab to add Primary Practice address.

# Step 2: Add Locations

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

Application ID: 20230718247195      Name: Anderson Help

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

### Add Provider Location

Location Type: Primary Practice Location \*  
Doing Business As: Anderson Help      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: 607 E Adams St \*  
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: Springfield \*  
County: Sangamon

State/Province: ILLINOIS \*  
Country: UNITED STATES \*

Zip Code: 62701 \* - 1634  Validate Address

Phone Number: (217) 555-1212 \*      Extn:       Fax Number:

Email Address: xxx.xxx.xxx.com      Web Page:

- Enter the street address and zip code, then click **Validate Address**.

# Step 2: Add Locations

Application ID: 20230718247195      Name: Anderson Help      Communication Preference: Email

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close	AM/PM		AM/PM	Thursday:	06:00	AM/PM	06:00	AM/PM
Monday:	06:00	AM/PM	06:00	AM/PM	Friday:	06:00	AM/PM	06:00	AM/PM
Tuesday:	06:00	AM/PM	06:00	AM/PM	Saturday:	Close	AM/PM		AM/PM
Wednesday:	06:00	AM/PM	06:00	AM/PM					

Handicap Accessible: No      Language(s) Spoken: English, Arabic, Chinese (For Multiple Selection, use Ctrl Key)

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

---

**Facility Details**

State Facility ID:       Fiscal Year End Date: 12/23 (mm/dd)

- Input the office hours and Fiscal Year End Date.
- When all information has been entered, click **OK** at the lower right corner

## Step 2: Add Locations

Application ID: 20230718247195      Name: Anderson Help

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

### Locations List

Filter By

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> Anderson Help	<a href="#">Primary Practice Location</a>	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

View Page:          Viewing Page: 1     

- Clicked on Primary Practice Location to add required addresses.
- The **Primary Practice Location** address requires a **Correspondence** and a **Pay To** address.

# Step 2: Add Locations

Application ID: 20230718247195      Name: Anderson Help

To add additional addresses, click 'Add Address' button.

Handicap Accessible:    
Accept 835(reported at EIN/TIN level):    
End Date:

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

**Facility Details**

State Facility ID:   
Fiscal Year End Date:  \*  
(mm/dd)

**Address List**

Address Type	Address	End Date
<input type="checkbox"/> <input type="button" value="v"/>	<input type="button" value="v"/>	<input type="button" value="v"/>
<input type="checkbox"/> Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

View Page:     Viewing Page: 1

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

# Step 2: Add Locations

Application ID: 20230718247195      Name: Anderson Help

**Add Provider Location Address**

Type of Address:    
    
 Correspondence   
 Pay To   
 Remittance Advice

End Date:  

Location Address:  Copy This Location Address

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

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

Address Line 2:

Address Line 3:

City/Town:  \*

State/Province:  \*

County:

Country:  \*

Zip Code:  \* -   Validate Address

OK

- Choose type of address from the drop-down menu.
- If the address you are entering is the same as the Location Address, then click the radio icon next to **Copy This Location Address**.
- If the address is not the same, enter the street address and zip code then click on **Validate address**.
- When all the information has been entered, click **OK**.

# Step 2: Add Locations

Application ID: 20230718247195      Name: Anderson Help

To add additional addresses, click 'Add Address' button.

Handicap Accessible:       Accept 835 (reported at EIN/TIN level):       End Date:

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

**Facility Details**

State Facility ID:       Fiscal Year End Date:  \*   
 (mm/dd)

**Address List**

Address Type	Address	End Date
<input type="checkbox"/> <b>Correspondence</b>	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
<input type="checkbox"/> <b>Location</b>	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

   View Page:                 Viewing Page: 1               

- Click on **Add Address** to input the additional addresses for the Primary Practice Location.
- Repeat previous steps until all addresses have been added.

# Step 2: Add Locations

Application ID: 20230718247195      Name: Anderson Help

To add additional addresses, click 'Add Address' button.

Accept 835(reported at EIN/TIN level): 
 Language(s) Spoken: 
  
(For Multiple Selection, use Ctrl Key)

End Date:

---

**Facility Details**

State Facility ID: 
 Fiscal Year End Date:  \*
   
(mm/dd)

---

**Address List**

Address Type	Address	End Date
<input type="checkbox"/> Correspondence	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
<input type="checkbox"/> Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
<input type="checkbox"/> Pay To	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

View Page: 



 Viewing Page: 1

- After all addresses have been entered click on **Save then Close**

# Step 2: Add Locations

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20230718247195      Name: Anderson Help

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

**Locations List**

Filter By

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> Anderson Help	<a href="#">Primary Practice Location</a>	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

View Page:  


 Viewing Page: 1

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

# Business Process Wizard (BPW)

Application ID: 20230718247195      Name: Anderson Help

**Enroll Provider - FAO**

**Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a> ←	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Bed Information	Optional			Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Fee Payment	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:     Go    Page Count    Save to Excel      Viewing Page: 1      << First    < Prev    Next >    Last >>

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

# Step 3: Add Specialties/Taxonomy

MyInbox > New Enrollment > FAO Enrollment

Application ID: 20230718247195      Name: Anderson Help

### Specialty/Subspecialty List

Filter By

Specialty/Subspecialty	Provider Type	End Date
No Records Found !		

### Taxonomy List

Filter By

Taxonomy Code	Description	Start Date	End Date
No Records Found !			

- Click on Add button under Specialty/Subspecialty List.

# Step 3: Add Specialties/Taxonomy

Application ID: 20230718247195      Name: Anderson Help

**Add Specialty/Subspecialty**

Location: 01-Anderson Help \*  
Provider Type: HOME HEALTH \*  
Specialty: ---SELECT---  
End Date:

**Add Subspecialty**

- AMBULATORY SURGICAL TREATMENT CENTER
- BIRTHING CENTERS
- Behavioral Health Clinic
- CARE FACILITY
- CHILDRENS COMMUNITY BASED HEALTH CARE CENTER
- CLINIC
- COMMUNITY ADDICTION FACILITY
- COMMUNITY BASED RESIDENTIAL REHAB CENTER
- COMMUNITY HEALTH
- COMMUNITY MENTAL HEALTH CENTER
- CRISIS STABILIZATION UNIT
- DEVELOPMENTAL TRAINING PROVIDER - FAO
- DIALYSIS FACILITY
- DURABLE MEDICAL EQUIPMENT/SUPPLIES
- Diabetes Prevention Provider Organization
- Diabetes Self-Management Education and Support Org
- EDUCATION AGENCIES
- ELIGIBILITY APPLICATION AGENT - FAO
- HOME HEALTH

OK Cancel

- Selected Provider type from drop down box labeled Provider Type

# Step 3: Add Specialties/Taxonomy

Application ID: 20230718247195      Name: Anderson Help

---

**Add Specialty/Subspecialty**

Location: 01-Anderson Help \*  
Provider Type: HOME HEALTH \*  
Specialty: ---SELECT--- \*  
End Date: ---SELECT---  
                  Home Health Agency

---

**Add Subspecialty**

Available Subspecialties		Associated Subspecialties *
↑ ↓	>> <<	↑ ↓

OK    Cancel

- Selected Specialty from drop down box labeled Specialty

# Step 3: Add Specialties/Taxonomy

Application ID: 20230718247195      Name: Anderson Help

---

**Add Specialty/Subspecialty**

Location: 01-Anderson Help \*  
Provider Type: HOME HEALTH \*  
Specialty: Home Health Agency \*  
End Date: [Calendar Icon]

---

**Add Subspecialty**

Available Subspecialties	Associated Subspecialties *
Home Health Aide Services Occupational Therapy Physical Therapy Speech Therapy	Skilled Nursing Services

Navigation: >> <<

Buttons:  OK     Cancel

- Once the Provider Type and the Specialty are selected, the Subspecialties will populate at the bottom of the screen in the **Available Subspecialties** box.
- The Provider must choose at least one Available Subspecialty (or No Subspecialty) if multiple selections are available.
- If only one choice is available, the system will preselect that selection.
- Once all desired selections are moved to the **Associated Subspecialties** box, click **OK** in the bottom right corner

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

# Step 3: Add Specialties/Taxonomy

Application ID: 20230718247195      Name: Anderson Help

### Specialty/Subspecialty List

Filter By

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> <a href="#">Home Health Agency/Skilled Nursing Services</a>	HOME HEALTH	12/31/2999

View Page:     Viewing Page: 1

### Taxonomy List

Filter By

Taxonomy Code	Description	Start Date	End Date
No Records Found !			

- If you have another Specialty to enter, click the **Add** button in the top left corner and repeat the steps as needed.

# Step 3: Add Specialties/Taxonomy



Application ID: 20230718247195      Name: Anderson Help

[Close](#)

### Specialty/Subspecialty List

[+ Add](#)

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

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> <a href="#">Home Health Agency/Skilled Nursing Services</a>	HOME HEALTH	12/31/2999

[Delete](#)    View Page:  [Go](#)    [Page Count](#)    [Save to Excel](#)      Viewing Page: 1      [First](#) [Prev](#) [Next](#) [Last](#)

### Taxonomy List

[+ Add](#)

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

Taxonomy Code	Description	Start Date	End Date
No Records Found !			

- The Taxonomy Code should automatically populate but if it does not click on the **Add** tab under Taxonomy List.
- At least one of the Taxonomy Codes entered in IMPACT must be the Taxonomy Code registered with the National Plan and Provider Enumeration System (NPPES).
- If taxonomy code automatically populates proceed to slide 38.

# Step 3: Add Specialties/Taxonomy



Application ID: 20230718247195      Name: Anderson Help

**Add Taxonomy**

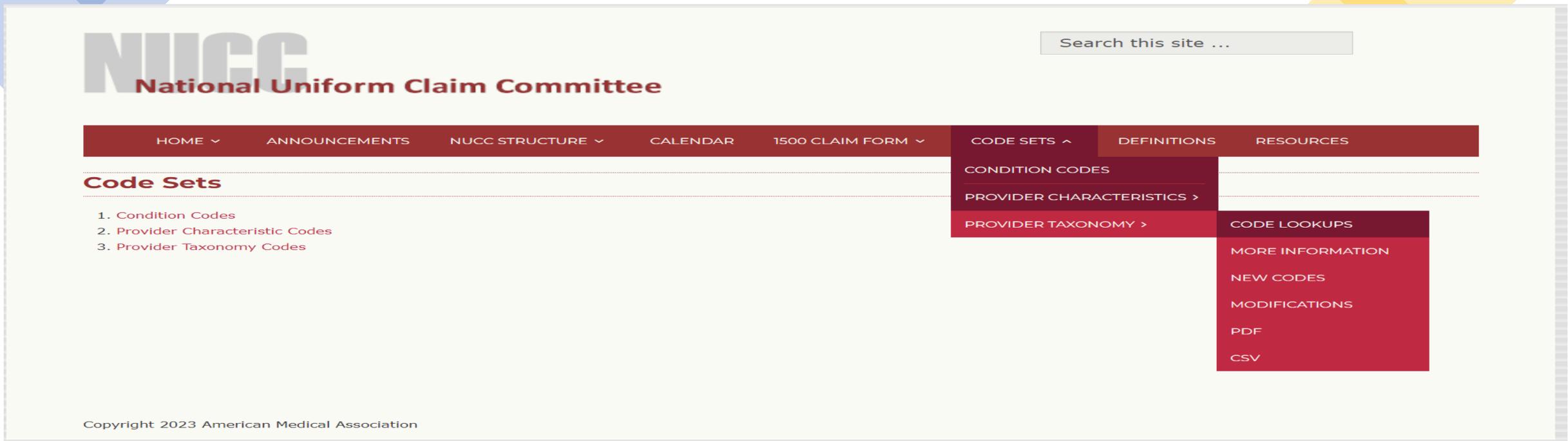
Taxonomy Code:  \* ◀ (Click here for Taxonomy List)      Location: 01-Anderson Help ▾ \*

Description: \_\_\_\_\_

Start Date:  \*      End Date:

- Enter the **Taxonomy Code** and the **Start Date**.
- Click on **Confirm Taxonomy** and verify **Description** is populated correctly.
- Click on **OK** to finalize the submission.
- If the code is not known, click on the ◀ to the right of the box to access The National Uniform Claim Committee Taxonomy Code list. This will open a web browser window.

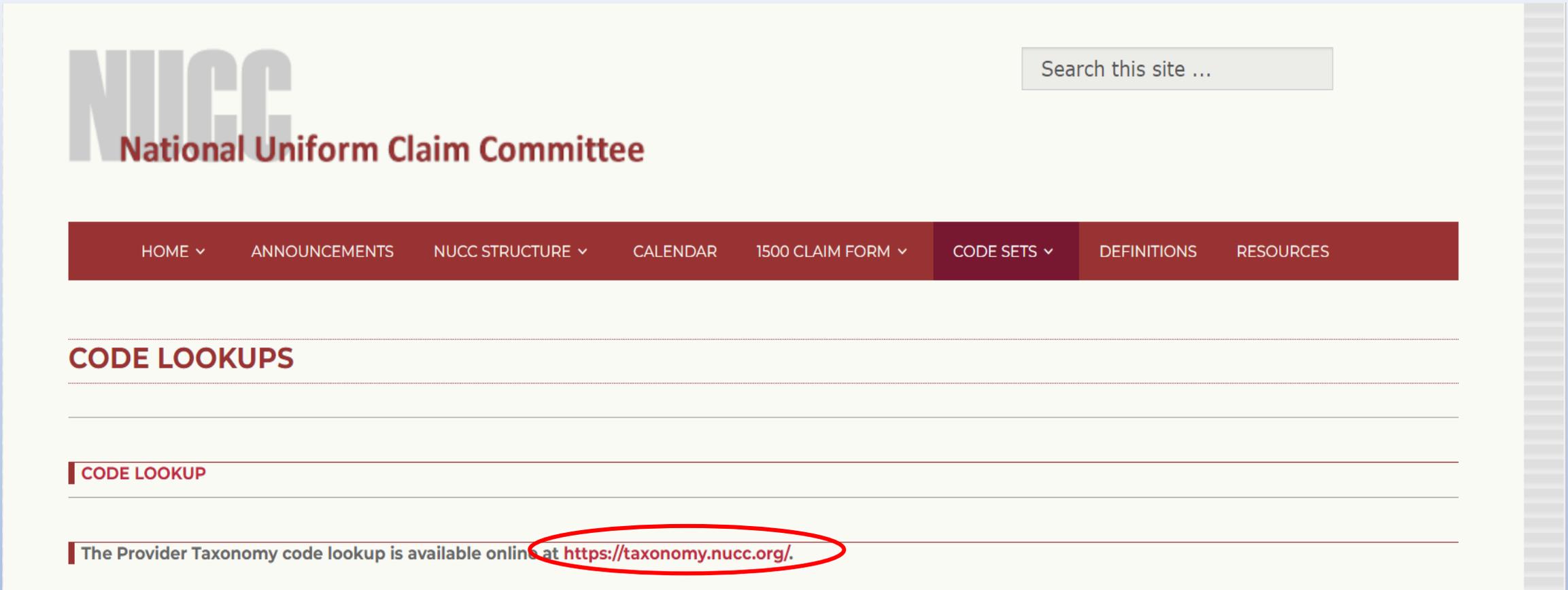
# Step 3: Add Specialties/Taxonomy



The screenshot shows the NUCC (National Uniform Claim Committee) website. At the top left is the NUCC logo. To the right is a search bar with the text "Search this site ...". Below the logo is a dark red navigation bar with the following items: HOME, ANNOUNCEMENTS, NUCC STRUCTURE, CALENDAR, 1500 CLAIM FORM, CODE SETS, DEFINITIONS, and RESOURCES. The CODE SETS menu is expanded, showing a sub-menu with: CONDITION CODES, PROVIDER CHARACTERISTICS, and PROVIDER TAXONOMY. The PROVIDER TAXONOMY item is further expanded to show: CODE LOOKUPS, MORE INFORMATION, NEW CODES, MODIFICATIONS, PDF, and CSV. On the left side of the page, under the heading "Code Sets", there is a numbered list: 1. Condition Codes, 2. Provider Characteristic Codes, and 3. Provider Taxonomy Codes. At the bottom left of the page, it says "Copyright 2023 American Medical Association".

- In the web browser window that opens click on Code Sets.
- Scroll down to Provider Taxonomy
- Click on Provider Taxonomy then scroll over to Code Lookups.

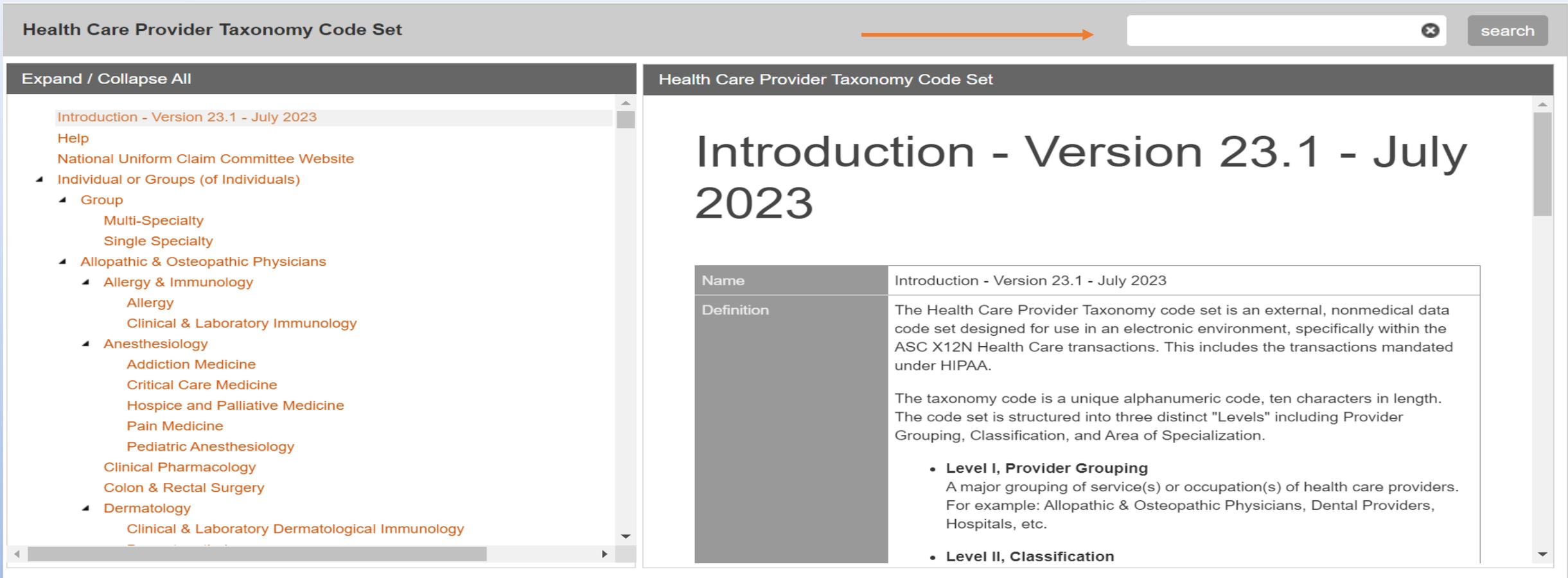
# Step 3: Add Specialties/Taxonomy



The screenshot shows the NUCC (National Uniform Claim Committee) website. At the top left is the NUCC logo and the text "National Uniform Claim Committee". To the right is a search bar labeled "Search this site ...". Below this is a dark red navigation bar with the following menu items: HOME, ANNOUNCEMENTS, NUCC STRUCTURE, CALENDAR, 1500 CLAIM FORM, CODE SETS, DEFINITIONS, and RESOURCES. The main content area is titled "CODE LOOKUPS" and contains a sub-section "CODE LOOKUP". A red circle highlights the text "The Provider Taxonomy code lookup is available online at <https://taxonomy.nucc.org/>."

- Click on the **red** hyperlink

# Step 3: Add Specialties/Taxonomy



Health Care Provider Taxonomy Code Set

Expand / Collapse All

- Introduction - Version 23.1 - July 2023
- Help
- National Uniform Claim Committee Website
- Individual or Groups (of Individuals)
  - Group
    - Multi-Specialty
    - Single Specialty
  - Allopathic & Osteopathic Physicians
    - Allergy & Immunology
      - Allergy
      - Clinical & Laboratory Immunology
    - Anesthesiology
      - Addiction Medicine
      - Critical Care Medicine
      - Hospice and Palliative Medicine
      - Pain Medicine
      - Pediatric Anesthesiology
    - Clinical Pharmacology
    - Colon & Rectal Surgery
    - Dermatology
      - Clinical & Laboratory Dermatological Immunology

Health Care Provider Taxonomy Code Set

## Introduction - Version 23.1 - July 2023

Name	Introduction - Version 23.1 - July 2023
Definition	<p>The Health Care Provider Taxonomy code set is an external, nonmedical data code set designed for use in an electronic environment, specifically within the ASC X12N Health Care transactions. This includes the transactions mandated under HIPAA.</p> <p>The taxonomy code is a unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Grouping, Classification, and Area of Specialization.</p> <ul style="list-style-type: none"><li><b>Level I, Provider Grouping</b> A major grouping of service(s) or occupation(s) of health care providers. For example: Allopathic &amp; Osteopathic Physicians, Dental Providers, Hospitals, etc.</li><li><b>Level II, Classification</b></li></ul>

- Scroll down Taxonomy Code list and choose and write down your **Taxonomy Code**.
- OR
- Type Specialty into search box and click on search and write down your **Taxonomy Code**.

# Step 3: Add Specialties/Taxonomy



Health Care Provider Taxonomy Code Set 251E00000X

---

Expand / Collapse All

- Non-individual
  - Agencies
    - Home Health

---

## Health Care Provider Taxonomy Code Set

# Home Health Agency

Code	251E00000X
Name	Home Health
Definition	A public agency or private organization, or a subdivision of such an agency or organization, that is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech-language pathology services, or occupational therapy, medical social services, and home health aide services. It has policies established by a professional group associated with the agency or organization (including at least one physician and one registered nurse) to govern the services and provides for supervision of such services by a physician or a registered nurse; maintains clinical records on all patients; is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards, where applicable; and meets other conditions found by the Secretary of Health and Human Services to be necessary for health and safety.
Notes	Source: CFR42 Chapter IV Part 484, <a href="http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html">http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html</a> [7/1/2007: definition added, source added]
Effective Date	4/1/2002

# Step 3: Add Specialties/Taxonomy

Application ID: 20230718247195      Name: Anderson Help

---

**Add Taxonomy**

Taxonomy Code:  \* [\(Click here for Taxonomy List\)](#)      Location:  \*

Description: Home Health

Start Date:  \*      End Date:  \*

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

# Step 3: Add Specialties/Taxonomy

Application ID: 20230718247195      Name: Anderson Help

**Close**

**Add**

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

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼
<input type="checkbox"/> Home Health Agency/Skilled Nursing Services	HOME HEALTH	12/31/2999

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

---

**Taxonomy List**

**Add**

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

Taxonomy Code	Description	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 251E00000X	Home Health	07/18/2023	12/31/2999

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

- Repeat the steps by clicking on the **Add** button for any additional Taxonomy Codes that need to be entered.
- Otherwise, click on the **Close** button in the upper left corner.

# Business Process Wizard (BPW)



Application ID: 20230718247195

Name: Anderson Help

## Enroll Provider - FAO

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

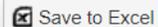
Step	Required	Start Date	End Date	Status	Step Remark
<a href="#">Step 1: Provider Basic Information</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional			Incomplete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required			Incomplete	Please add required License/Certification.
<a href="#">Step 6: Bed Information</a>	Optional			Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required			Incomplete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	



View Page: 1



Page Count



Viewing Page: 1



- You have completed Step 3: **Add Specialties/Taxonomy**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 4: **Associate Billing Provider/Other Associations** to continue your application if applicable.
- If not adding a billing provider proceed to Step 5 on slide 41.

# Step 4: Associate Billing Provider/Other Associations

*Note: This Step Is Optional.*

Application ID: 20230718247195      Name: Anderson Help

### Billing Provider/Other Associations List

Filter By

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

- Click **Add** to input an Associated Billing Provider

# Step 4: Associate Billing Provider/Other Associations

Application ID: 20230718247195      Name: Anderson Help

**Associate Billing Provider/Other Associations**

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

Type:  \*  
ID:  \*

Start Date:  \*      End Date:  \*

Provider Name:  
Enrollment Type:  
Applicant Type:

- Complete the Billing Provider information then click **Confirm Provider** and verify that the **Billing Provider Name is correct.**
- Click **OK** to return to the billing agent list.

# Business Process Wizard (BPW)

- You have completed Step 4: **Associate Billing Providers/Other Associations**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 5: **Add License/Certification/Other** to continue your application.

Application ID: 20230718247195      Name: Anderson Help

**Enroll Provider - FAO**

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/18/2023	07/18/2023	Complete	
Step 2: Add Locations	Required	07/18/2023	07/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	07/18/2023	07/18/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	07/21/2023	07/21/2023	Complete	
Step 5: Add License/Certification/Other ←	Required			Incomplete	Please add required License/Certification.
Step 6: Bed Information	Optional			Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Fee Payment	Optional			Complete	
Step 12: Upload Documents	Optional			Incomplete	Please upload required documents.
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

# Step 5: Add License/Certification/Other



Application ID: 20230718247195      Name: Anderson Help

**License/Certification/Other List**

Filter By

License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date
No Records Found !					

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

# Step 5: Add License/Certification/Other

Application ID: 20230718247195      Name: Anderson Help

---

**License Requirements Per Medicaid**

**REQUIRED LICENSES**

Below licenses are mandatory for the specialties associated to this provider:

- Public Health License-Certificate
- Medicare Certification

---

**Add License/Certification/Other**

Location: 01-Anderson Help \*

License/Certification/Other Type:  \*

Valid Flag:  \*

Effective Date:  \*

License/Certification/Other #:  \*

End Date:  \*

- Required license are listed for the provider type enrolling.
- Asterisk indicates the information is required and must be entered.

# Step 5: Add License/Certification/Other

Application ID: 20230718247195      Name: Anderson Help

---

**License Requirements Per Medicaid**

**REQUIRED LICENSES**

Below licenses are mandatory for the specialties associated to this provider:

- Public Health License-Certificate
- Medicare Certification

---

**Add License/Certification/Other**

Location: 01-Anderson Help \*

License/Certification/Other Type: Public Health License-Certificate\*      License/Certification/Other #: 1010286 \*

Valid Flag: Yes

Effective Date: 10/20/2018      End Date: 10/20/2024

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

# Step 5: Add License/Certification/Other

Application ID: 20230718247195

Name: Anderson Help

Close

**Add**

## License/Certification/Other List

Filter By

Go

Save Filters

My Filters

License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> Public Health License-Certificate	1010286	01-Anderson Help	Yes	10/20/2018	10/20/2024

Delete View Page: 1 Go Page Count Save to Excel Viewing Page: 1 << First < Prev > Next >> Last

- If any additional Licenses/Certifications, click on the **Add** button in the top left corner and repeat the steps.

# Step 5: Add License/Certification/Other

Application ID: 20230718247195      Name: Anderson Help

**License/Certification/Other List**

Filter By

<input type="checkbox"/> License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date
<input type="checkbox"/> Public Health License-Certificate	1010286	01-Anderson Help	Yes	10/20/2018	10/20/2024
<input type="checkbox"/> Medicare Certification	147783	01-Anderson Help	Yes	07/01/2020	07/31/2024

**View Page:**          **Viewing Page: 1**     

- Click **Close** once all Licenses/Certifications have been entered to return to the BPW.

# Business Process Wizard (BPW)

- You have completed Step 5: **Add Licenses/Certifications/Other**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 6: **Bed Information** to continue your application.
- This step only pertains to Long Term Care providers.

Application ID: 20230718247195      Name: Anderson Help

**Enroll Provider - FAO**

**Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a> ←	Optional			Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required			Incomplete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

# Step 6: Bed Information

*Note: Only Applicable to LTC Providers.*

Application ID: 20230718247195      Name: Anderson Help

**Bed Information**

Filter By

Bed Type	Bed(s)/Unit(s)	Location Name	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼
<b>No Records Found !</b>				

- This information is only applicable to Long Term Care Providers.

# Step 6: Bed Information

Application ID: 20230718247195      Name: Anderson Help

**Add Bed Information**

Location: 01-Anderson Help \*  
Bed Type: ---SELECT--- \*  
Start Date: ---SELECT--- \*  
Bed(s)/Unit(s):  \*  
End Date:

Acute Care Bed(s)  
Licensed LTC Unit(s)  
Licensed Medicaid Bed(s)  
Licensed Medicaid/Medicare Bed(s)  
Licensed Medicare Bed(s)  
Medicaid Surgery  
Obstetrics (OB/GYN)  
Pediatrics  
Psych Bed(s)  
Rehab Bed(s)  
Skilled Nursing Bed(s)  
Substance Abuse  
Swing Bed(s)  
Temporarily Non Available  
Ventilator Dependent Unit(s)

- From Bed Type drop down menu select the Bed Type.
- Input the number of Beds and Start and End Date.
- After all information has been entered Click **OK to return to BPW.**

# Business Process Wizard (BPW)

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

Application ID: 20230718247195      Name: Anderson Help

Close

**Enroll Provider - FAO**

**Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a> ←	Required			Incomplete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

# Step 7: Add Mode of Claims Submission/EDI Exchange

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

Application ID: 20230718247195      Name: Anderson Help

**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 type="checkbox"/> Billing Agent	To submit/receive HIPAA transactions through billing agent	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter), 837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice

**Other Claims Submission**

Method	Description
<input type="checkbox"/> Direct Data Entry(DDE)	To submit FFS claims via online screens

✓ Ok    ⌂ Cancel

- Select one of the options for claim submission. .
- Must select at least one option or claims will not be processed.
- After claim submission types have been selected click **OK**.

# Business Process Wizard (BPW)

Application ID: 20230718247195

Name: Anderson Help

Close

## Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a> ←	Optional			Incomplete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

- You have completed Step 7: **Add Mode of Claim Submission** The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 8: **Associate Billing Agent** to continue your application.
- If not adding a billing agent proceed to Step 9 on slide 58

# Step 8: Associate Billing Agent



Application ID: 20230718247195

Name: Anderson Help

**Billing Agent List**

Filter By

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

- This step is optional unless Billing Agent is selected as the Mode of Claims Submission then it becomes required.
- Click **Add** to input a Billing Agent

# Step 8: Associate Billing Agent

Application ID: 20230718247195      Name: Anderson Help

**Billing Agent List**

Filter By

Billing Agent ID	Billing Agent Name	Start Date	End Date
<input type="checkbox"/> 5022710	Trek World USA inc	09/22/2020	12/31/2999
<input type="checkbox"/> 5091127	Kristine Cain Counseling LCPC	10/29/2020	12/31/2999
<input type="checkbox"/> 5186473	Vinea Consulting INC.	11/20/2020	12/31/2999
<input type="checkbox"/> 5227001	Raise Em Therapy INC	04/27/2021	12/31/2999
<input type="checkbox"/> 5308923	Claimcare Inc.	05/19/2021	12/31/2999
<input type="checkbox"/> 5324757	Jung H Choi	06/25/2020	12/31/2999
<input type="checkbox"/> 5343092	Boost Billing Services Inc	10/05/2021	12/31/2999
<input type="checkbox"/> 5357293	Triune Counseling Services	06/26/2021	12/31/2999
<input type="checkbox"/> 5398401	Michaja Prendergast Johnson	11/15/2021	12/31/2999
<input type="checkbox"/> 5472446	MCJ Enterprises	05/05/2022	12/31/2999

View Page:          Viewing Page: 1     

- Use the **Filter By** drop down and choose an option to filter the list of available billing agents. (% is the wild card function)
- After the desired Billing Agent is shown on the list, click the check box for that option, then click **Select**

# Step 8: Associate Billing Agent

Application ID: 20230718247195      Name: Anderson Help

---

**Associate Billing Agent**

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID:  \*      Billing Agent Name:

Association Start Date:  \*      Association End Date:

---

**Authorized Transaction Responses**

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

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

# Step 8: Associate Billing Agent

Application ID: 20230718247195      Name: Anderson Help

**Associate Billing Provider/Other Associations**

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

Type:  \*

ID:  \*

Provider Name: Cook County Health at North Riverside Health

Enrollment Type: Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

Applicant Type:

Start Date:  \*      End Date:  \*

- The chosen billing agent information will be populated. Verify that the information is correct then, click **OK** to return to the Billing Agent list.

# Step 8: Associate Billing Agent

Application ID: 20230718247195      Name: Anderson Help

### Billing Provider/Other Associations List

Filter By

NPI/Provider ID	Provider Name	Enrollment Type	Start Date	End Date	Status
<input type="checkbox"/> 1497875298	Cook County Health at North Riverside Health	Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)	07/21/2023	12/31/2999	Approved

View Page:          Viewing Page: 1     

- To associate to an additional Billing Agent, click **Add** and repeat the steps.
- When all billing agents have been entered, click **Close** to return to the BPW.

# Business Process Wizard (BPW)

Application ID: 20230718247195      Name: Anderson Help

Enroll Provider - FAO

**Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a> ←	Required			Incomplete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

# Step 9: Add Provider Controlling Interest/Ownership Details

Total Ownership Percentage cannot equal more than 100%

Application ID: 20230718247195      Name: Anderson Help

Close    Actions    ?

**Add Owner** (circled in red)

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 who has management 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
No Records Found !								

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

Filter By    Go    Save Filters    My Filters

- 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 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

### Provider Controlling Interest/Ownership

Type:	---SELECT---	*	Percentage Owned:	<input type="text"/>	*
SSN:	---		EIN/TIN:	<input type="text"/>	
Legal Entity Name:	Board of Directors/Officers/Principles Corporate - Charitable 501[c]3 Corporate - Non Charitable Corporate - Not Publicly Traded Corporate - Publicly Traded		Entity Business Name:	<input type="text"/>	(Doing Business As)
Owner NPI:	Fiscal Agent Foreign, Nonresident Alien		Middle Initial:	<input type="text"/>	
First Name:	Government Holding Company		DOB:	<input type="text"/>	
Last Name:	Indirect Owner Individual/Sole Proprietor		Email:	<input type="text"/>	
Suffix:	Limited Liability Company Managing Employee		End Date:	<input type="text"/>	
Phone Number:	Partnership Sub-contractor				
Start Date:	<input type="text"/>	*			
Address Line 1:	<input type="text"/>	*	Address Line 2:	<input type="text"/>	
	(Enter Street Address or PO Box Only)		City/Town:	OTHER	*
Address Line 3:	<input type="text"/>			<input type="text"/>	
State/Province:	OTHER	*	County:	OTHER	*
	<input type="text"/>			<input type="text"/>	
Country:	UNITED STATES	*	Zip Code:	<input type="text"/>	* - <input type="text"/>
					<input type="button" value="Validate Address"/>

- Select type of Owner from drop down menu.

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

**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:

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

Address Line 2:

Address Line 3:

City/Town:  \*

State/Province:  \*

County:

Country:  \*

Zip Code:  \* -

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

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

Close    Actions

**Add Owner** (circled in red)

- 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 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 who has management 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
100002818	Anderson, Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Completed	Not Completed	0

Delete    View Page: 1    Go    Page Count    Save to Excel    Viewing Page: 1    First    Prev    Next    Last

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

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

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 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 who has management 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"/> 100002816	Smith, John	Board of Directors/Officers/Principles	350 E Madison St	10/01/2020	12/31/2999	Not Completed	Not Completed	90
<input type="checkbox"/> 100002818	Anderson, Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Not Completed	Not Completed	0
<input type="checkbox"/> 100002830	Anderson Help	Corporate - Non Charitable	607 E Adams St	10/01/2020	12/31/2999	Not Completed	Not Completed	10

Delete    View Page: 1    Go    Page Count    Save to Excel    Viewing Page: 1    First    Prev    Next    Last

- When all owners have been listed complete the Owners Relationship information by selecting **Actions, Owners Relationships**.

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

**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: Anderson Help   SSN/EIN/TIN: 100002830   Status: Not Completed
> Selected Owner: Anderson, Elizabeth   SSN/EIN/TIN: 100002818   Status: Not Completed
> Selected Owner: Smith, John   SSN/EIN/TIN: 100002816   Status: Not Completed

- Answer question regarding the relationship of any owners listed in application.
- If question is answered **No** click on **Save**.

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

**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

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Anderson Help	Relation to Assoc. Owner
Anderson, Elizabeth	100002818	Managing Employee	<input type="text"/>	<input type="text"/>
Smith, John	100002816	Board of Directors/Officers/Principles	<input type="text"/>	<input type="text"/>

View Page: 1  Page Count  Viewing Page: 1

Selected Owner: Anderson Help    SSN/EIN/TIN: 100002830    Status: Not Completed

Selected Owner: Anderson, Elizabeth    SSN/EIN/TIN: 100002818    Status: Not Completed

Selected Owner: Smith, John    SSN/EIN/TIN: 100002816    Status: Not 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 **OK** to return to the ownership listing.

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

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 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 who has management 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"/> 100002816	Smith, John	Board of Directors/Officers/Principles	350 E Madison St	10/01/2020	12/31/2999	Completed	Not Completed	90
<input type="checkbox"/> 100002818	Anderson, Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/> 100002830	Anderson Help	Corporate - Non Charitable	607 E Adams St	10/01/2020	12/31/2999	Completed	Not Completed	10

Delete    View Page: 1    Go    Page Count    Save to Excel    Viewing Page: 1    First    Prev    Next    Last

- Click on **Actions** drop down box and select Owner Adverse Action.

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195

Name: Anderson Help

## FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

In compliance with Federal law, as set forth in 42 C.F.R. § 424.502; 42 C.F.R. § 424.519, and 42 C.F.R. § 424.535, and State law, set forth in Ill. Admin. Code tit. 89 § 140.14 and Ill. Admin. Code tit. 89, § 140.16, the provider must disclose all final adverse legal actions taken against the provider, any individual who has an ownership or controlling interest in the provider, and any of the provider's suppliers. For the purpose of this section, the term "final adverse legal actions" captures information on final adverse legal actions, includes but is not limited to, criminal, convictions, administrative exclusions, administrative revocations, and administrative suspensions. A "final adverse legal action" also includes all legal actions, regardless of whether any records were expunged or for which there is an appeal pending.

### The provider must disclose the following:

If the provider, any individual who has an ownership or controlling interest in the provider, or any of the provider's suppliers, was within the last (10) years preceding enrollment or revalidation or 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, identify that offense. Offenses include, but are not limited to: (1) Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; (2) 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; (3) any felony that placed the Medicaid program or its beneficiaries at immediate risk and (4) any misdemeanor or felony that may result in a mandatory or permissive administrative exclusion under State or Federal law.

For the provider, any individual who has an ownership or controlling interest in the provider, or any other provider's suppliers, identify each misdemeanor conviction, under Federal or State law, related to: (1) the delivery of an item or service under Medicaid or a State health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service

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

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.

- Read the final adverse legal action statements

# Step 9: Add Provider Controlling Interest/Ownership Details

Owners with Adverse Action
▲

Filter By ▼  All ▼ Go Go
Save Filters ▼ My Filters

Owner Name ▲▼	SSN/EIN/TIN ▲▼	Response ▲▼	Comments ▲▼
Anderson, Elizabeth	100002818	<input type="radio"/> Yes <input checked="" type="radio"/> No <span style="color: orange; font-size: 1.2em; margin-left: 10px;">←</span>	<input type="text"/>
Smith, John	100002816	<input type="radio"/> Yes <input checked="" type="radio"/> No <span style="color: orange; font-size: 1.2em; margin-left: 10px;">←</span>	<input type="text"/>
Anderson Help	100002830	<input type="radio"/> Yes <input checked="" type="radio"/> No <span style="color: orange; font-size: 1.2em; margin-left: 10px;">←</span>	<input type="text"/>

View Page:  Go Page Count Save to Excel
Viewing Page: 1

First Prev Next Last

OK Cancel

- A Yes or No response is required for each owner listed in the application.
- A comment must be added to any Yes response.
- After responding for each provider listed click on **OK**.

# Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230718247195      Name: Anderson Help

Close    Actions    ?

- 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"/> 100002816	Smith, John	Board of Directors/Officers/Principles	350 E Madison St	10/01/2020	12/31/2999	Completed	No	90
<input type="checkbox"/> 100002818	Anderson, Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Completed	No	0
<input type="checkbox"/> 100002830	Anderson Help	Corporate - Non Charitable	607 E Adams St	10/01/2020	12/31/2999	Completed	No	10

Delete    View Page: 1    Go    Page Count    Save to Excel    Viewing Page: 1    First    Prev    Next    Last

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

Filter By    Go    Save Filters    My Filters

Other Owner EIN/TIN	Other Owner Information	Address
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**.

# Business Process Wizard (BPW)



Application ID: 20230718247195

Name: Anderson Help

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 10: 835/ERA Enrollment Form</a> ←	Optional			Incomplete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

- You have completed Step 9: **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 10: **835/ERA Enrollment Form** to continue your application.

# Step 10: 835/ERA Enrollment Form



Please complete this section once you have completed the enrollment steps found at <http://www.myhfs.illinois.gov/> if you wish to participate in 835/ERA, otherwise close this step.

Application ID: 20230718247195      Name: Anderson Help

Close   Submit   Print   Help

### ERA ENROLLMENT FORM

#### PROVIDER INFORMATION

**Provider Name:**  
**Doing Business As Name (DBA):** Anderson Help

**Provider Address**

<b>Street:</b> 607 E Adams St	<b>State/Province:</b> ILLINOIS
<b>City:</b> Springfield	<b>Zip Code/Postal Code:</b> 62701
<b>Country Code:</b> UNITED STATES	

#### PROVIDER IDENTIFIERS

**Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):** 100021108

**National Provider Identifier (NPI):** 1000210447

**Other Identifier(s)**

**Assigning Authority:**

**Trading Partner ID:**

**Provider License Details**

**Provider License No:**

**Provider Type:** HOME HEALTH

**Provider Taxonomy Code:**

**License Issuer:**

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

# Step 10: 835/ERA Enrollment Form



**SUBMISSION INFORMATION**

**Reason for Submission**

Cancel Enrollment  Change Enrollment  New Enrollment \*

**Authorized Signature**

**Electronic Signature of Person Submitting Enrollment:**

Authorization Agreement-By selecting the checkbox above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

**Authorization Agreement**

By signing this request, I am authorizing IL Medicaid to establish an 835/ERA account for the Tax ID listed above and for 835/ERA files to be transmitted electronically to the designated entity.

**Printed Name of Person Submitting Enrollment:**

**Printed Title of Person Submitting Enrollment:**

**Submission Date:** 07/21/2023

**Requested ERA Effective Date:**

(Once approve the next paycycle date.)

- Checkbox to authorize the creation of an 835/ERA account then the signature portion will be populated.
- When complete, click **Submit** then **Close**.

# Business Process Wizard (BPW)



Application ID: 20230718247195

Name: Anderson Help

Close

## Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 11: Fee Payment</a> ←	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

# Step 11: Fee Payment

*This step is currently not applicable. Fees for High and Moderate risk providers are not being accepted at this time. Close out of this step and move to Step 12 to complete application.*

MyInbox > Track Application > FAO Enrollment

Application ID: 20230718247195      Name: Anderson Help

Close   Add

**Fee Payment List**

Filter By   Go      Save Filters   My Filters

Payment Id	Payment Reason	Payment Amount	Fee Option	Payment Made To	Confirmation Number	Payment Date
No Records Found !						

# Business Process Wizard (BPW)



Application ID: 20230718247195

Name: Anderson Help

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 11: Fee Payment</a> ←	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	Please upload required documents.
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

- You have completed Step 11: **Fee Payment**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 12: **Upload Documents** to continue your application.

# Step 12: Upload Documents

*This step is optional except for Transportation, Home Health, and DME provides.*

Application ID: 20230718247195      Name: Anderson Help

### Upload Documents

<input type="checkbox"/> Document Type *	Document Name *	File Name * 	Remarks	Uploaded By	Uploaded Date
<input type="checkbox"/> --Select-- <ul style="list-style-type: none"><li>Agreement</li><li>Bills</li><li>Certification</li><li>Enrollment Verification</li><li>Fee Verification</li><li>Insurance</li><li>License</li><li>Organizational</li><li>Others</li><li>Proof of Fingerprinting</li><li>Records</li><li>Registration</li></ul>	--Select--	Choose File 	<input type="text"/>		

- From dropdown box labeled Document Type select the document being uploaded.

# Step 12: Upload Documents

Application ID: 20230718247195

Name: Anderson Help

Close

## Upload Documents

Save Delete

Document Type *	Document Name *	File Name * ⓘ	Remarks	Uploaded By	Uploaded Date
<input checked="" type="checkbox"/> License	--Select--	Choose File			

Document Name dropdown menu options:

- Select--
- State License
- IDPH licensure
- Driver License
- Vehicle Plate
- CLIA
- DEA

- From Document Name drop down box select the name of the document being uploaded.

# Step 12: Upload Documents

Application ID: 20230718247195      Name: Anderson Help

**Upload Documents**

<input type="checkbox"/> Document Type *	Document Name *	File Name * ⓘ	Remarks	Uploaded By	Uploaded Date
<input checked="" type="checkbox"/> License	IDPH licensure	Anderson Help IDPH License for UAT.docx	<input type="text" value=""/>		

- Click on paperclip icon to search for document being uploaded.
- Once document is found click **Save** .

# Step 12: Upload Documents

Application ID: 20230718247195      Name: Anderson Help

**Upload Documents**

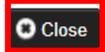
<input type="checkbox"/> Document Type *	Document Name *	File Name * 	Remarks	Uploaded By	Uploaded Date
<input type="checkbox"/> License	IDPH licensure	<a href="#">Anderson Help IDPH License for UAT.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/> --Select-- <input type="button" value="v"/>	--Select-- <input type="button" value="v"/>	Choose File <input type="button" value="Choose File"/> 	<input type="text"/>		

- Repeat the previous steps until all the required documents for the specific provider type have been uploaded.

# Step 12: Upload Documents

Application ID: 20230718247195

Name: Anderson Help

 Close

## Upload Documents

 Save  Delete

<input type="checkbox"/>	Document Type *	Document Name *	File Name * 	Remarks	Uploaded By	Uploaded Date
<input type="checkbox"/>	Insurance	Workers Compensation	<a href="#">Anderson Help UAT Workers Comp Insurance.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	Bills	Telephone Bill	<a href="#">Anderson Help UAT Telephone Bill.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	Insurance	Building Insurance	<a href="#">UAT Proof of Insurance.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	Proof of Fingerprinting	Proof of Fingerprinting	<a href="#">Anderson Help UAT Fingerprints.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	Agreement	Building Lease agreement	<a href="#">Anderson Help UAT Building Lease Agreement.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	Registration	SOS Registration	<a href="#">Anderson Help UAT Good Standing IL Secretary of State.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	Organizational	Business Ownership	<a href="#">Anderson Help UAT Organizational Chart.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	License	IDPH licensure	<a href="#">Anderson Help IDPH License for UAT.docx</a>		Teresa Anderson	07/24/2023
<input type="checkbox"/>	--Select-- 	--Select-- 	Choose File 	<input type="text"/>		

- Once all documents have been uploaded click on **Close** tab.

# Business Process Wizard (BPW)

- You have completed Step 12: **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 13: **Complete Enrollment Checklist** to continue your application.

Application ID: 20230718247195      Name: Anderson Help

[Close](#)

**Enroll Provider - FAO**

**Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Required	07/24/2023	07/24/2023	Complete	
<a href="#">Step 13: Complete Enrollment Checklist</a> ←	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

# Step 13: Complete Enrollment Checklist



Application ID: 20230718247195      Name: Anderson Help

### Provider Checklist

Question	Answer	Comments
If you are an out of state provider that provided emergent care to an Illinois Medicaid participant, you can request a retroactive enrollment back to the date the services were provided. If yes, enter the requested date to be considered in the comment field. Enrollment applications must be submitted within 45 days of the date of service to be considered for a retroactive enrollment date.	No	
Do you wish to end date your enrollment? If yes, what date?	No	
Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	No	
Are you currently excluded from any federal program? If yes, provide the program and date.	No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date	No	
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	Yes	12/21/2022
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	No	
Have you ever had a program exclusion/debarment? If yes, provide program and date	No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	No	
Are you a Home Health Agcy, DME, Medicar, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	No	
If this enrollment is for change of ownership (CHOW) with a new NPI, please enter the old NPI in the comment box	No	
Do you carry professional liability insurance? If yes, please provide the name of your carrier and the policy coverage limit per occurrence and in aggregate.	Yes	3 Million

View Page: 1                  Viewing Page: 1                 

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

# Business Process Wizard (BPW)

Application ID: 20230718247195      Name: Anderson Help

[Close](#)

**Enroll Provider - FAO**

Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	07/21/2023	07/24/2023	Complete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Required	07/24/2023	07/24/2023	Complete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	07/24/2023	07/24/2023	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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

- You have completed Step 13: **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 14 **Submit Enrollment Application for Approval** to continue your application.

# Step 14: Submit Enrollment Application for Approval



Application ID: 20230718247195      Name: Anderson Help

**Final Submission**

Application ID: 20230718247195      EnrollmentType: Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

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 14: Submit Enrollment Application for Approval



Application ID: 20230718247195

Name: Anderson Help

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

In applying for enrollment as a provider of goods and services in the Illinois Medical Assistance Program ("Program") administered by the Illinois Department of Healthcare and Family Services (hereinafter referred to as Illinois Medical Assistance), the provider applying for enrollment as a provider (hereinafter referred to as "the applicant") represents, agrees, and certifies as follows:

1. The undersigned has the legal authority to execute this Agreement on the applicant's behalf.
2. The applicant understands that enrollment in the Program does not guarantee participation in Illinois Medical Assistance managed care programs, nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished to Illinois Medical Assistance during the application process on any associated form is true, accurate, and complete.
4. The applicant has disclosed the name and address of each person with an ownership or control interest in the applicant or in any subcontractor in which the applicant has direct or indirect ownership of 5 percent (5%) or more.
5. The applicant agrees to submit, within 35 days of the date on a request by the Secretary or the Illinois Medical Assistance, full and complete information about the ownership of any subcontractor with whom the applicant has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the applicant and any wholly owned supplier, or between the applicant and any subcontractor, during the 5-month period ending on the date of the request.
6. The applicant will provide proper disclosure of all criminal convictions of any person associated with the applicant's business operations, including but not limited to owners, officers or principals, and persons with management responsibility.
7. When billing for any medical goods or services, the applicant will comply with all applicable terms, conditions, policies and procedures contained in the Illinois Medical Assistance Handbooks for Providers of Medical Services, the Illinois Administrative Code, statutes, provider bulletins, and program notifications.
8. The applicant will comply with the following provisions of federal law, which state the conditions and requirements under which participation in the Program is allowed: 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 431.107.
9. Upon request, the applicant will allow authorized state or federal government agents to inspect, copy, or electronically scan any records pertaining to the delivery of goods and services to, or on behalf of, a Program recipient. These records include, but are not limited to, medical records, financial records, business records and any service contract(s) the applicant has with any billing agent/service or service bureau, billing consultant, or other health care provider.
10. The applicant will include a clause in all subcontracts related to the provision of goods and services to Program recipients that requires all subcontractors to provide state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
11. The applicant is not currently, and has not been in the past, suspended, terminated, or excluded or barred from the Program by any state or by the U.S. Department of Health and Human Services, or from any state or federal healthcare program.
12. The applicant understands that disputed claims, including overpayments, may be adjudicated by Illinois Medical Assistance.
13. The applicant shall reimburse Illinois Medical Assistance for all overpayments, and the applicant acknowledges and accepts that the Program uses random sampling, which is a reliable and acceptable method for determining extrapolated overpayments.
14. The applicant shall accept all notifications of disputed claims, overpayments, and other administrative actions involving program payments and participation by electronic mail (email) at the address provided to Illinois Medical Assistance in the executed enrollment agreement, or by mail at the physical address of record.
15. The applicant agrees not to sell or provide their accounts receivable for the Program recipients to bill collection agencies, similar entities, or any other third party.
16. The applicant agrees that they may be required to refund, or have payment recouped by the Illinois Medical Assistance for both the state and federal share of any overpayments, including erroneous payments, erroneously claimed payments, payments made for non-compliant claims, payments in excess of the amount allowed, fraudulent claims or claims identified in accordance with the exclusion provisions of 42 CFR 1001.1901(b).
17. The applicant shall immediately notify Illinois Medical Assistance in writing of any change in the email address or physical address provided in the executed enrollment agreement.
18. Failure to provide Illinois Medical Assistance with changes to the email address or physical address provided in the executed enrollment agreement will constitute waiver of service of Illinois Medical Assistance notifications and documents.

- Scroll down to read through all the terms and conditions.

# Step 14: Submit Enrollment Application for Approval



Application ID: 20230718247195

Name: Anderson Help

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

10. The provider shall provide the Illinois Medical Assistance Program with a minimum of 30 days written notice in the instance that the provider determined a residential treatment service recipient is no longer appropriate to be served at the provider's facility.
11. The provider shall make follow-up services available to residential treatment service recipients following discharge from the provider's facility, consistent with the policies outlined in the Handbook for Providers of Residential Treatment Services.
12. Upon acceptance of these enrollment terms and conditions, the provider shall notify the Illinois Medical Assistance Program in writing of any legal relationship that exists between the provider and a hospital. The provider shall include a description of the following: how the hospital functions are separate from the residential treatment functions of the provider, how the governance of the residential treatment facility is separate from the hospital, a distinct organization/management separation between the residential treatment and the hospital part of the provider's structure, and how a conflict of interest will not occur between the residential treatment and the hospital parts of the provider's organization. The provider shall notify Illinois Medical Assistance within 30 days of any changes in the provider's legal relationship with a hospital.
13. The provider acknowledges it is solely responsible for reporting per diem rate changes, as issued by the Illinois Purchased Care Review Board for residential treatment services to the Department consistent with 89 Ill. Admin 139.305.
14. The provider shall submit claims for authorized residential treatment services to the Department consistent with the established policies and procedures pertaining to the authorized service. The provider shall accept its per diem residential rate as payment in full for services rendered to residential treatment service recipients and shall not seek additional reimbursement from the residential treatment service recipient or the recipient's family.
15. The provider shall perform background checks on all staff, including, but not limited to a check of the following in the state in which the provider operates: the child abuse and neglect tracking system, the sex offender registry, and a fingerprint check by the State Police and the Federal Bureau of Investigation.
16. The provider acknowledges the immediate reporting requirements outlined in the Handbook for Providers of Residential Treatment Services and the applicability of these reporting requirements upon the provider and its staff, including but not limited to the following: 1) significant events, changes in family circumstances, or unusual incidents; 2) suspected child abuse or neglect consistent with the provider's responsibilities as a Mandated Reporter under the Abused and Neglected Child Reporting Act; 3) suspected abuse or neglect consistent with the provider's responsibilities under 59 Ill. Admin Code 50; and 4) suspected financial fraud and abuse in the Medical Assistance Program or Child Support Enforcement Program.
17. The provider shall attend all regional and other required meetings when notified more than 14 days in advance by the Illinois Medical Assistance Program.
18. Residential Treatment Service Providers who are enrolled with a Subspecialty of Sub-Acute Psychiatric or Sub-Acute Substance Use Disorder shall also comply with the following:
  - Compliance with 42 CFR 483. Submit a completed HFS Form 2734A to the Department, attesting to the facility's compliance with federal requirements regarding the use of restraint and seclusion in each of the following instances: 1) Upon initial enrollment with Illinois Medical Assistance as a provider; 2) Annually on July 1 of each state fiscal year to be received by the Department by July 15th; and 3) In the event of a change in the facility director;
  - Notify the Department and the State's designated Protection and Advocacy System of any significant injury, suicide attempt, or death that occurs at the facility, consistent with the requirements established by the Department;
  - Comply with 42 CFR 440.10 and 42 CFR 441 Subpart D as defined and interpreted by the Department in the administration of the Illinois Medicaid Program; and
  - Comply with all State Survey activities performed by the Illinois Department of Public Health, or its agent(s).
19. Behavioral Health Residential Treatment Service Providers who are enrolled with a Subspecialty of Sub-Acute Substance Use Disorder shall establish licensure and remain in good standing with the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery (DHS-SUPR) as a provider of residential substance use disorder services.

#### Billing Certification

For each paper or electronic claim or invoice I submit for payment, remittance advice and voucher issued, as a condition of my enrollment, I certify and acknowledge that I am familiar with pertinent Healthcare and Family Services policies and procedures as set forth in the Illinois Medical Assistance Program Handbooks, rules and statutes. With that knowledge, I certify that the billing information on claims, invoices, remittances and vouchers, and billing information attached to, or reference in, those documents is true, accurate and complete; I certify that the services as described on the claims, invoices, vouchers or remittance advice were provided; I certify that I will keep and make available such records as are necessary to disclose fully the nature and extent of the services provided; and I certify that I understand payment is made from State and federal funds and any falsification or concealment of the material fact may be cause for prosecution or other appropriate sanctions and legal action.

By checking this, I certify that I have read and that I agree and accept all the enrollment terms and conditions in herein that are applicable to me.

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

# Business Process Wizard (BPW)



Application ID: 20230718247195      Name: Anderson Help

Your Application Number 20230718247195 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

### Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). 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	07/18/2023	07/18/2023	Complete	
<a href="#">Step 2: Add Locations</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 3: Add Specialties/Taxonomy</a>	Required	07/18/2023	07/18/2023	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 6: Bed Information</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 7: Add Mode of Claim Submission/EDI Exchange</a>	Required	07/21/2023	07/21/2023	Complete	
<a href="#">Step 8: Associate Billing Agent</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 9: Add Provider Controlling Interest/Ownership Details</a>	Required	07/21/2023	07/24/2023	Complete	
<a href="#">Step 10: 835/ERA Enrollment Form</a>	Optional	07/21/2023	07/21/2023	Complete	
<a href="#">Step 11: Fee Payment</a>	Optional			Complete	
<a href="#">Step 12: Upload Documents</a>	Optional	07/24/2023	07/24/2023	Complete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	07/24/2023	07/24/2023	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required	07/24/2023	07/24/2023	Complete	

View Page:  Go Page Count Save to Excel      Viewing Page: 1      First Prev Next Last

- You have completed Step 14: **Submit Enrollment Application for Approval**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- The above 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.

- 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