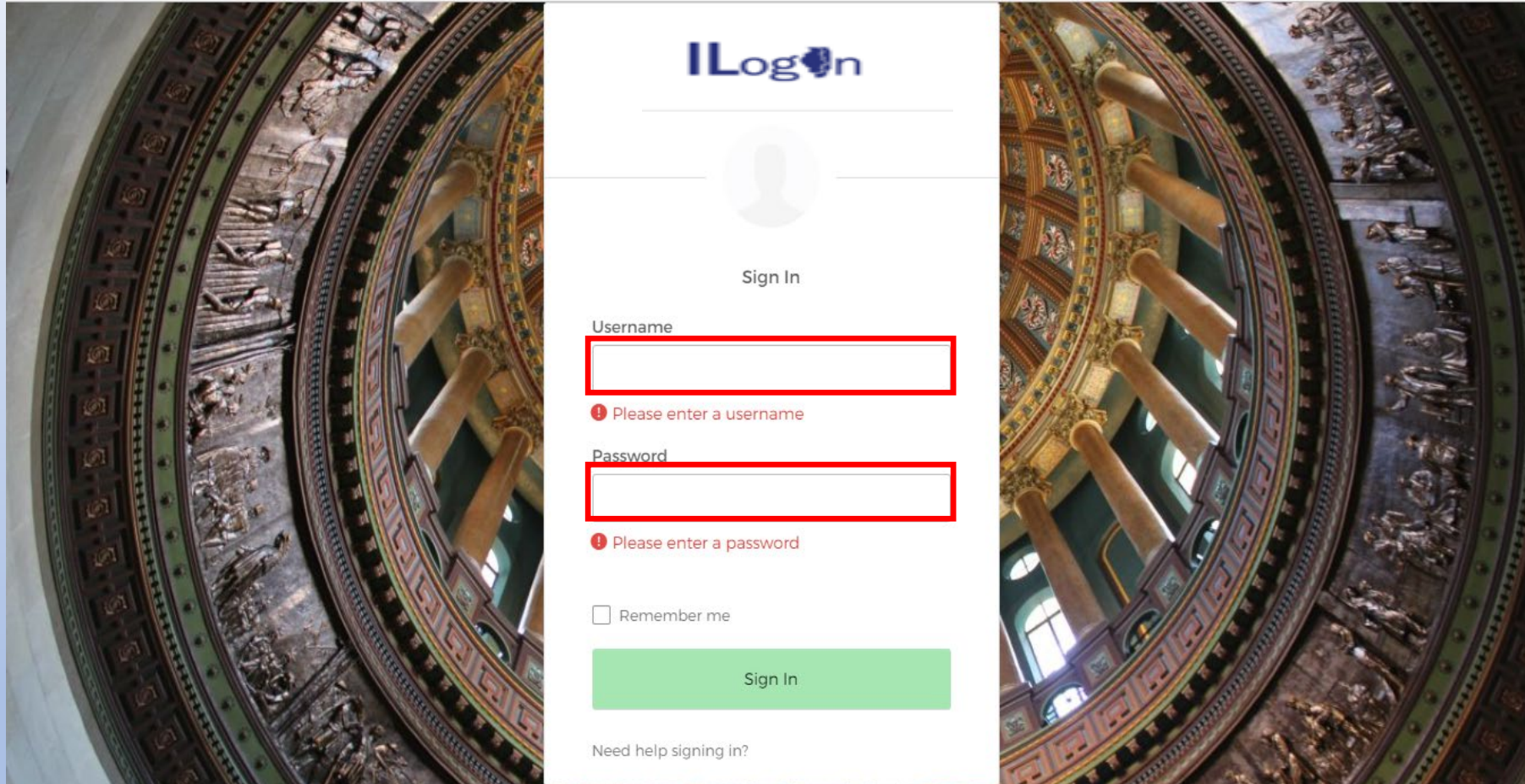


ILLINOIS PROVIDER ENROLLMENT

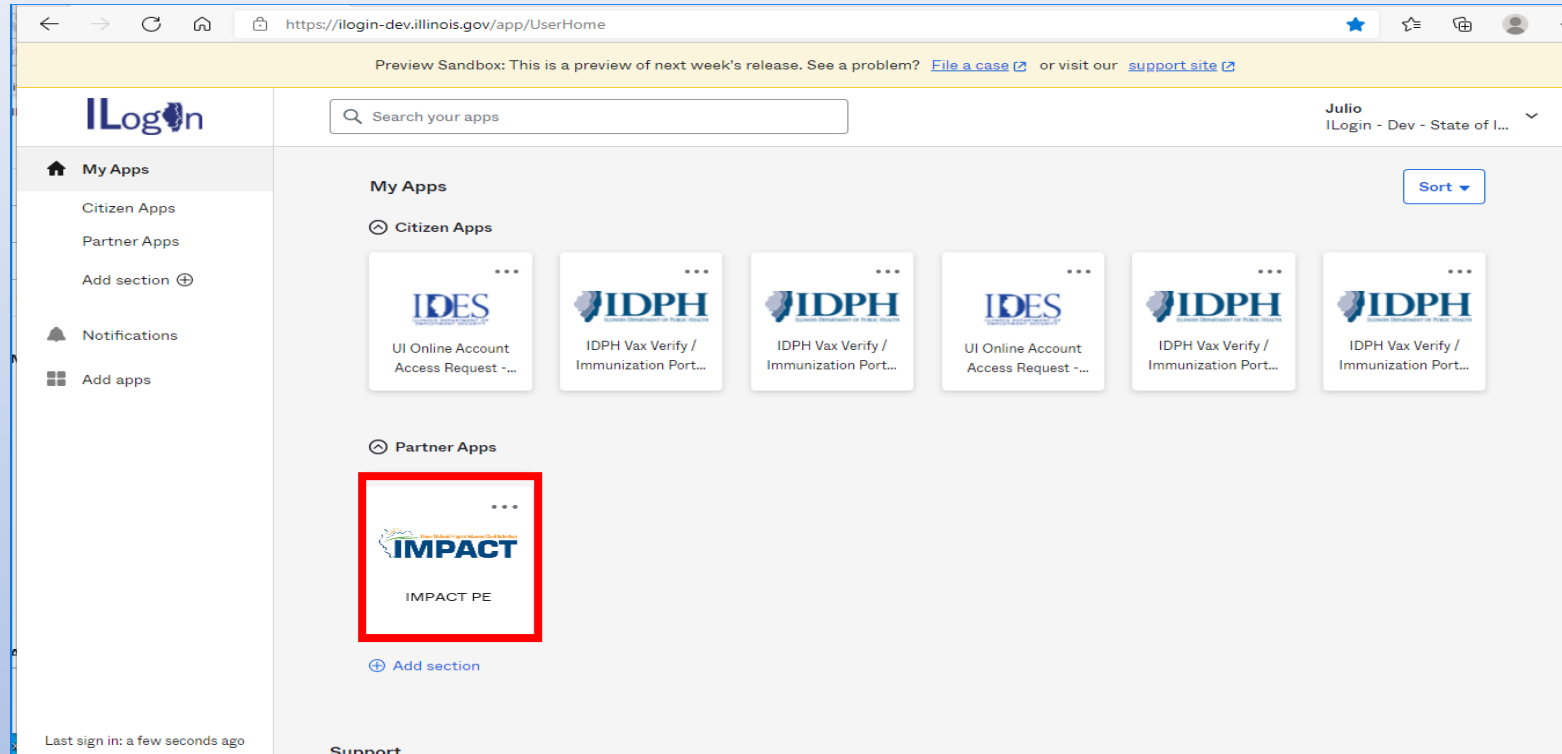


Individual / Sole Proprietor

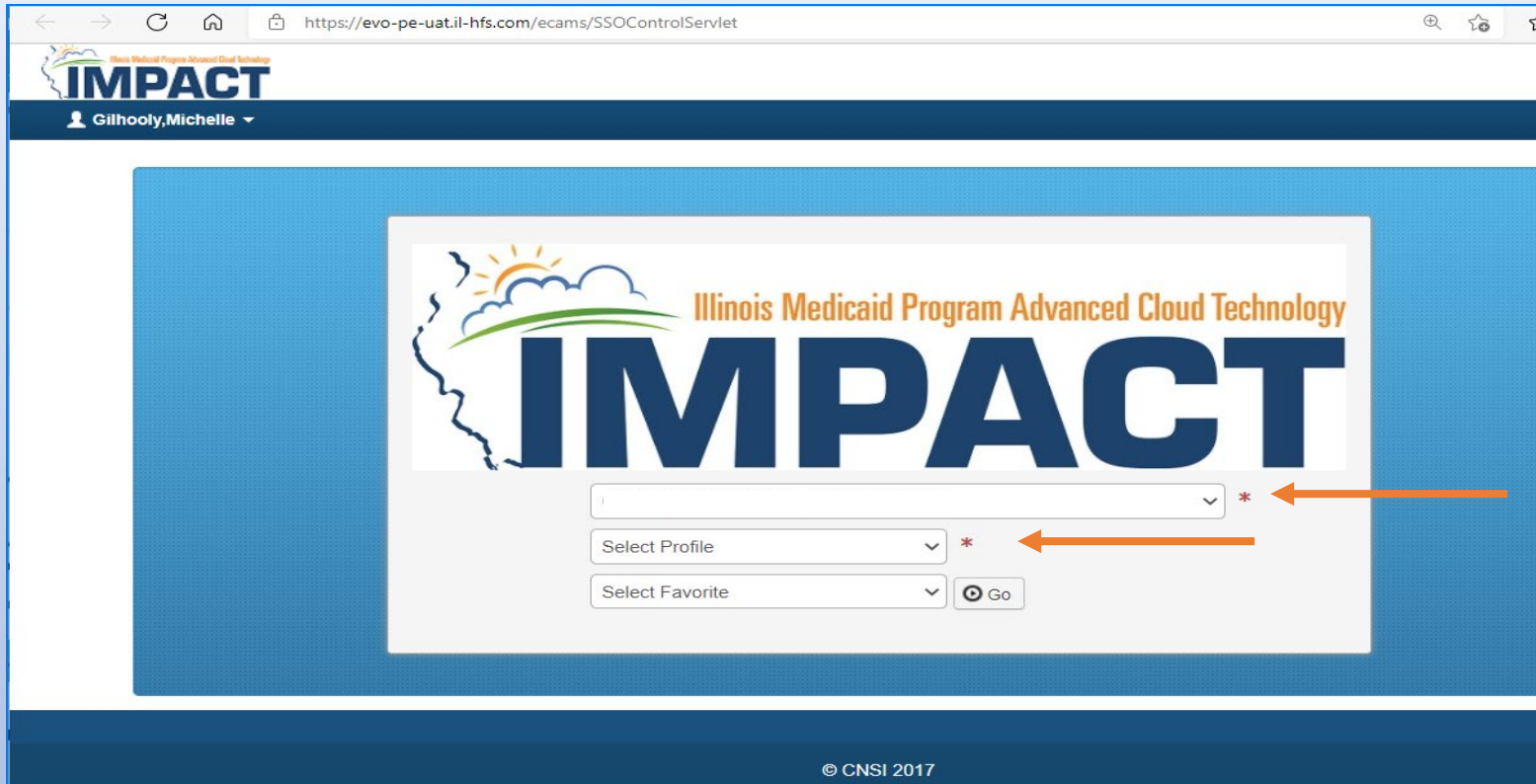


The screenshot shows the ILogon login interface. At the top is the 'ILogon' logo. Below it is a 'Sign In' button. The form contains two input fields: 'Username' and 'Password'. Both fields are highlighted with red boxes and have red error messages below them: 'Please enter a username' and 'Please enter a password'. There is also a 'Remember me' checkbox and a green 'Sign In' button at the bottom. The background of the page is a photograph of a large, ornate dome interior.

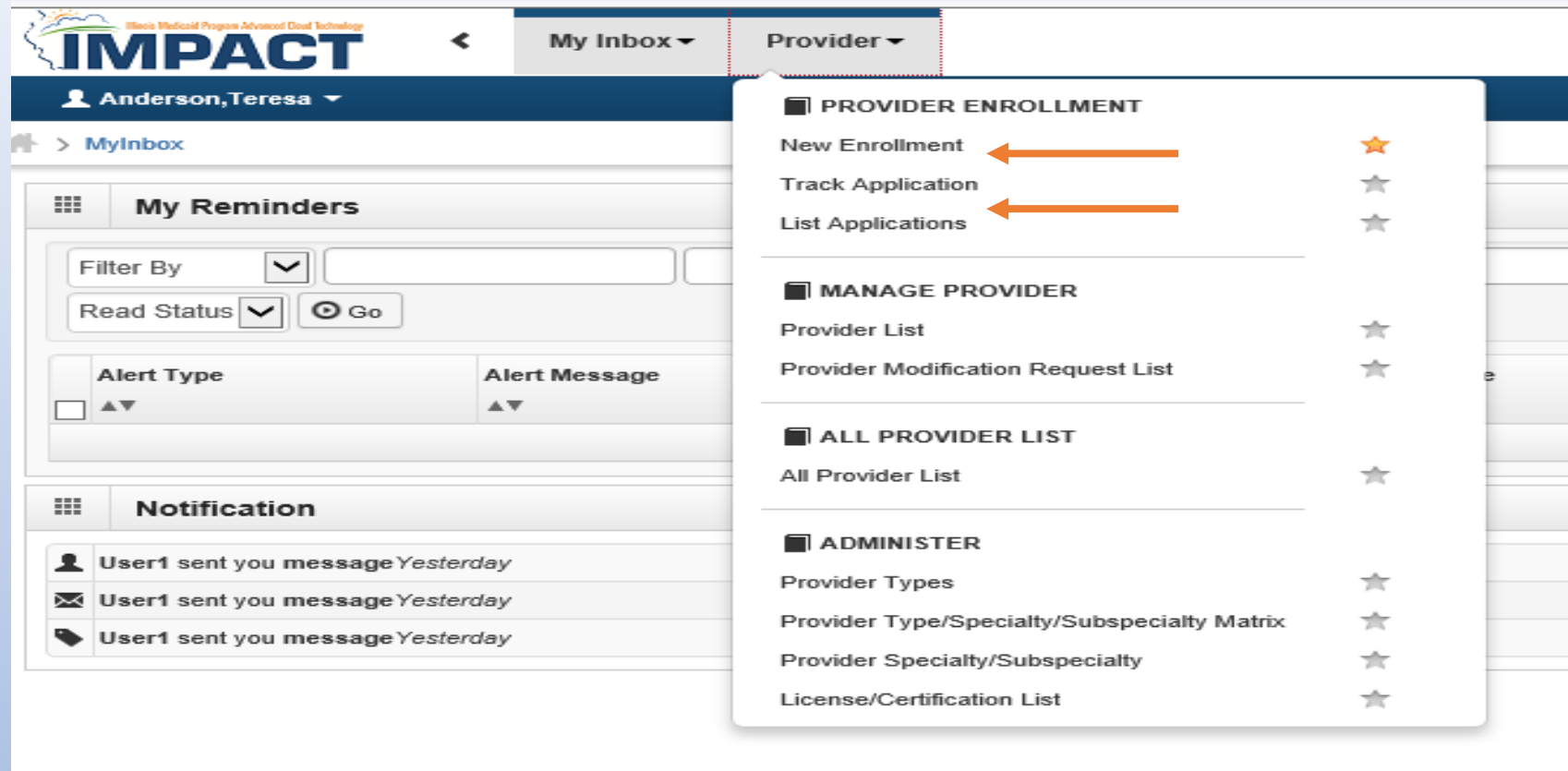
- Input Username and Password created during the creation of the account.



Click on the IMPACT PE Chicklet to access IMPACT

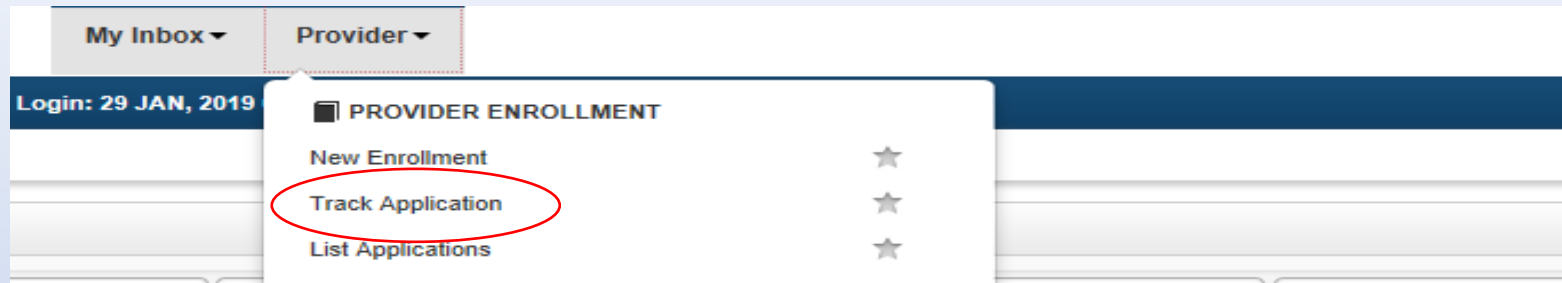


- Select the Domain and Profile from the drop-down menus

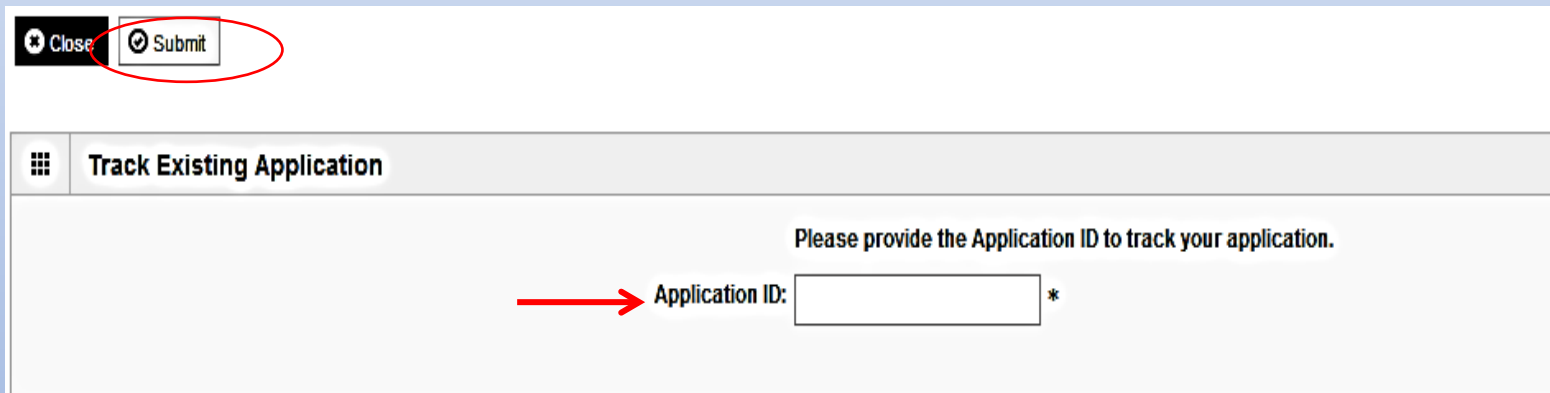


- Regarding completing an application, there are two options: New Enrollment or Resuming an application.
- If starting a new application, go to slide 7 for step-by-step instructions.
- If resuming an application previously started go to slide 6 for step-by-step instructions.

Resuming an Application

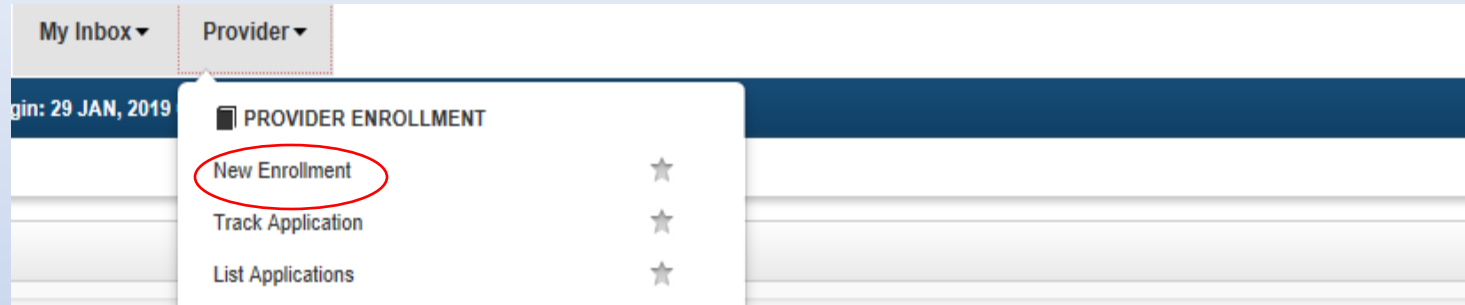


- To resume an application, click on **Track Application**.



The screenshot shows a form titled 'Track Existing Application'. At the top left, there are two buttons: 'Close' and 'Submit'. The 'Submit' button is circled in red. Below the title bar, there is a text prompt: 'Please provide the Application ID to track your application.' Below this prompt is a text input field labeled 'Application ID:'. A red arrow points to the input field. The input field has an asterisk (*) to its right, indicating it is a required field.

- Enter the Application ID for the application you want to access.
- After entering the ID number, click **Submit**.
- This process will then go directly to the Business Process Wizard (BPW).



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

☰ Enrollment Type ^

Select the Applicable Enrollment Type

Regular Individual/Sole Proprietor or Rendering/Servicing 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 information)

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

Basic Information: Enter required fields and click Confirm button.

Basic Information

EIN/TIN:

First Name: *

Last Name: *

Suffix:

SSN: *

Date of Birth: *

Middle Initial:

Gender:

Applicant Type: * ←

NPI: *

Contact Email Address:

Email-1: *

Email-2:

Email-3:

Home Address

Federal requirements mandate that a home address must be entered. Please ensure you are providing the correct home address and not a PO Box. Failure to do so may result in this application/modification being denied.

Address validation successful

Address Line 1: *

Address Line 2:

Address Line 3:

State/Province: *

City/Town: *

County:

Country: *

Zip Code: * -

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

Start New Application

Step 1: (Basic Provider Information)

Application ID: 20230918053765

Name: Knight, Mary Sue

Basic Information

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

Your Application ID is: **20230918053765**

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.



12/19/2023

- 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: 20230918053765
- Application IDs are valid for 30 calendar days; applications must be completed and submitted to the state for review during this 30-day period or the application will be DELETED.
- The application ID will be used to access the application before submission to the state for review and will be used to track the status of your submitted application until it has been marked approved.
- After documenting the ID number, click **OK**.

Completing Application using BPW



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

Application ID: 20230918053765 Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties/Taxonomy	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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

Completing the Application Using BPW

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

Application ID: 20230918053765 Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations ←	Required			Incomplete	
Step 3: Add Specialties/Taxonomy	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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

Step 2: Add Locations



Application ID: 20230918053765 Name: Knight, Mary Sue

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

Step 2: Add Locations

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

Application ID: 20230918053765

Name: Knight, Mary Sue

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

Add Provider Location

Location Type: Primary Practice Location *

Doing Business As:

End Date:

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

Address 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 *

State/Province: ILLINOIS *

County: Sangamon

Country: UNITED STATES *

Zip Code: 62701 * - 1634

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

Fax Number:

Email Address: xxx.xxx.xxx.com

Web Page:

Communication Preference: Email

Step 2: Add Locations

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

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:	Closed	AM PM		AM PM	Thursday:	08:00	AM PM	05:00	AM PM
Monday:	08:00	AM PM	05:30	AM PM	Friday:	08:00	AM PM	05:00	AM PM
Tuesday:	08:00	AM PM	05:30	AM PM	Saturday:	Closed	AM PM		AM PM
Wednesday:	08:00	AM PM	05:30	AM PM					

Accepting New Clients: Yes

Offers OB-Gyn Services:

Handicap Accessible: No

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

Maximum Clients:

Pediatric Services:

FQHC: No

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

- Enter office hours and answer questions.
- After all information has been entered, click on **OK**.

Step 2: Add Locations

Application ID: 20230918053765 Name: Knight, Mary Sue

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"/>	Primary Practice Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

View Page: Viewing Page: 1

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

Step 2: Add Locations

Application ID: 20230918053765

Name: Knight, Mary Sue

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

Sunday:	Closed	*	AM	*		*	AM	*	Thursday:	08:00	*	AM	*	05:00	*	AM	*
Monday:	08:00	*	AM	*	05:30	*	AM	*	Friday:	08:00	*	AM	*	05:00	*	AM	*
Tuesday:	08:00	*	AM	*	05:30	*	AM	*	Saturday:	Closed	*	AM	*		*	AM	*
Wednesday:	08:00	*	AM	*	05:30	*	AM	*									

Accepting New Clients: Yes

Maximum Clients:

Handicap Accessible: No

Offers OB-Gyn Services:

Pediatric Services:

FQHC: No

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

Language(s) Spoken: English, Arabic, Chinese

(For Multiple Selection, use Ctrl Key)

End Date: 12/31/2999

Address List

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

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

Step 2: Add Locations

Application ID: 20230918053765 Name: Knight, Mary Sue

Add Provider Location Address

Type of Address: ←

End Date: 

Location Address: Copy This Location Address ←

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

Address validation successful

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

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County:

Country: *

Zip Code: * -

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

Step 2: Add Locations

Application ID: 20230918053765 Name: Knight, Mary Sue

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

Monday:	08:00 * AM PM *	05:30 * AM PM *	Friday:	08:00 * AM PM *	05:00 * AM PM *
Tuesday:	08:00 * AM PM *	05:30 * AM PM *	Saturday:	Closed * AM PM *	AM PM *
Wednesday:	08:00 * AM PM *	05:30 * AM PM *			

Accepting New Clients: Yes
Offers OB-Gyn Services:
Accept 835(reported at EIN/TIN level): No
End Date: 12/31/2999

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

Handicap Accessible: No
FQHC: No

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

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

- 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/Taxonomy** to continue your application.

Application ID: 20230918053765 Name: Knight, Mary Sue

[Close](#)

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy ←	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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Step 3: Add Specialties/Taxonomy

Application ID: 20230918053765 Name: Knight, Mary Sue

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

Step 3: Add Specialties/Taxonomy

Application ID: 20230918053765

Name: Knight, Mary Sue

Add Specialty/Subspecialty

Location: 01- *
Provider Type: PHYSICIANS * ←
Specialty: Family Medicine * ←
End Date: 

Add Subspecialty

Available Subspecialties	Associated Subspecialties *
Adolescent Medicine	
Geriatric Medicine	
Hospice and Palliative Medicine	
No Subspecialty	
Sleep Medicine	
Sports Medicine	

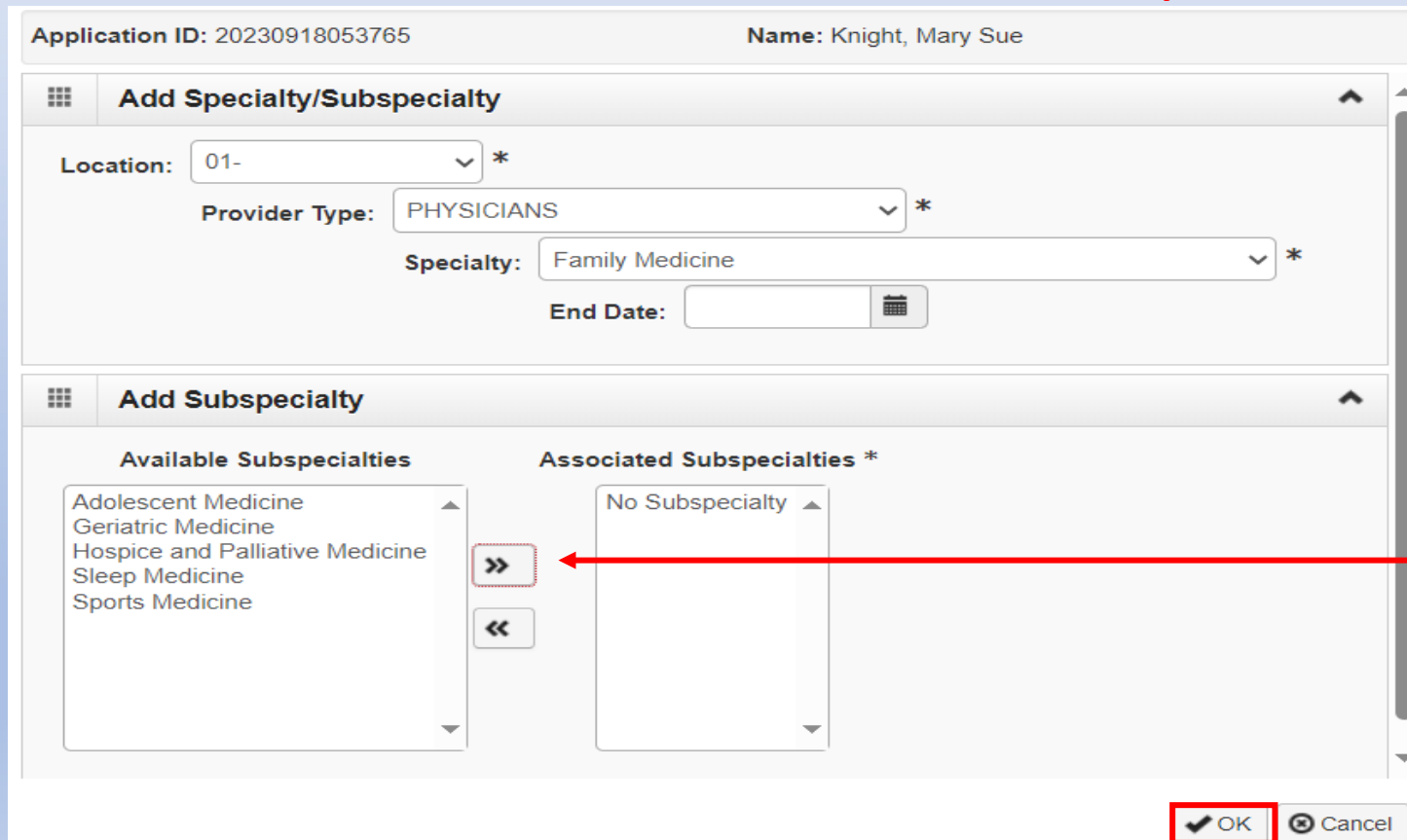
Navigation: >> <<

OK Cancel

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

Step 3: Add Specialties/Taxonomy

- 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



Application ID: 20230918053765 Name: Knight, Mary Sue

Add Specialty/Subspecialty

Location: 01- *
Provider Type: PHYSICIANS *
Specialty: Family Medicine *
End Date: [Calendar Icon]

Add Subspecialty

Available Subspecialties

- Adolescent Medicine
- Geriatric Medicine
- Hospice and Palliative Medicine
- Sleep Medicine
- Sports Medicine

Associated Subspecialties *

- No Subspecialty

OK Cancel

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: 20230918053765 Name: Knight, Mary Sue

Specialty/Subspecialty List

Filter By

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

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Taxonomy List

Filter By

Taxonomy Code	Description	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 207Q00000X	Family Medicine	09/22/2023	12/31/2999

 View Page: Viewing Page: 1

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

Step 3: Add Specialties/Taxonomy

Application ID: 20230918053765 Name: Knight, Mary Sue

Primary Specialty For Enrollment

Primary Specialty: *

Start Date: * End Date: *

- Choose the **Primary Specialty** for this enrollment from the drop-down menu.
- Complete the **Start Date** field. Leave **End Date** blank.
- When all information has been entered, click on **Save** then **Close**.

Step 2: Add Specialties/Taxonomy



Application ID: 20230918053765 Name: Knight, Mary Sue

[Close](#)

Specialty/Subspecialty List

[Add](#) [Primary Speciality](#)

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

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> Family Medicine/No Subspecialty	PHYSICIANS	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"/> 207Q00000X	Family Medicine	09/22/2023	12/31/2999

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

- 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 the Taxonomy code automatically populates proceed to slide 31.

Step 2: Add Specialties/Taxonomy

Application ID: 20230918053765 Name: Knight, Mary Sue

Add Taxonomy

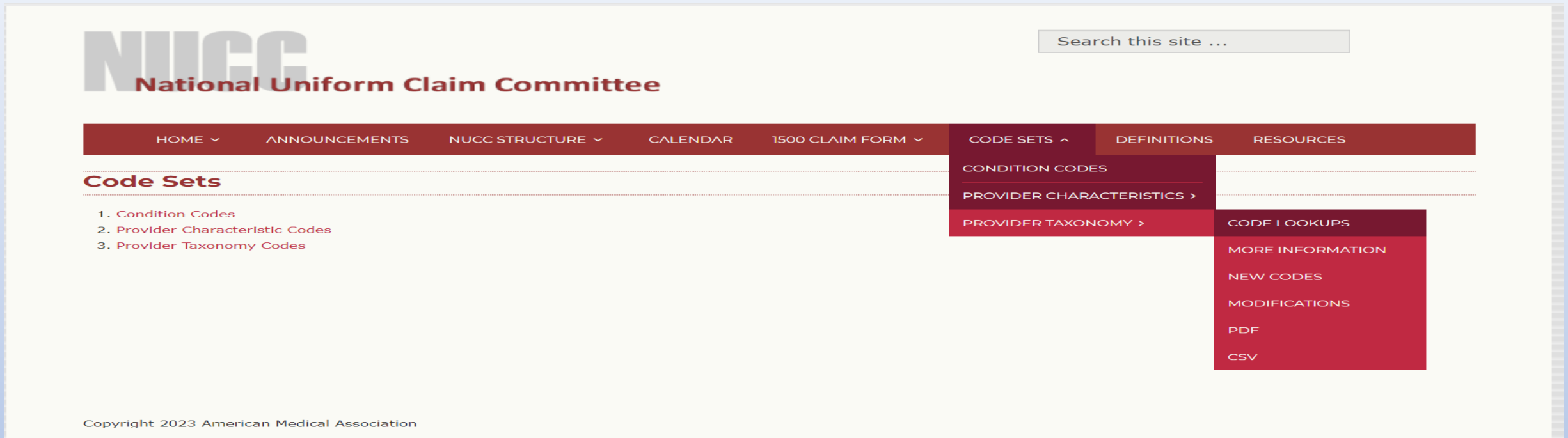
Taxonomy Code: * ◀ (Click here for Taxonomy List) Location: 01- *

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.

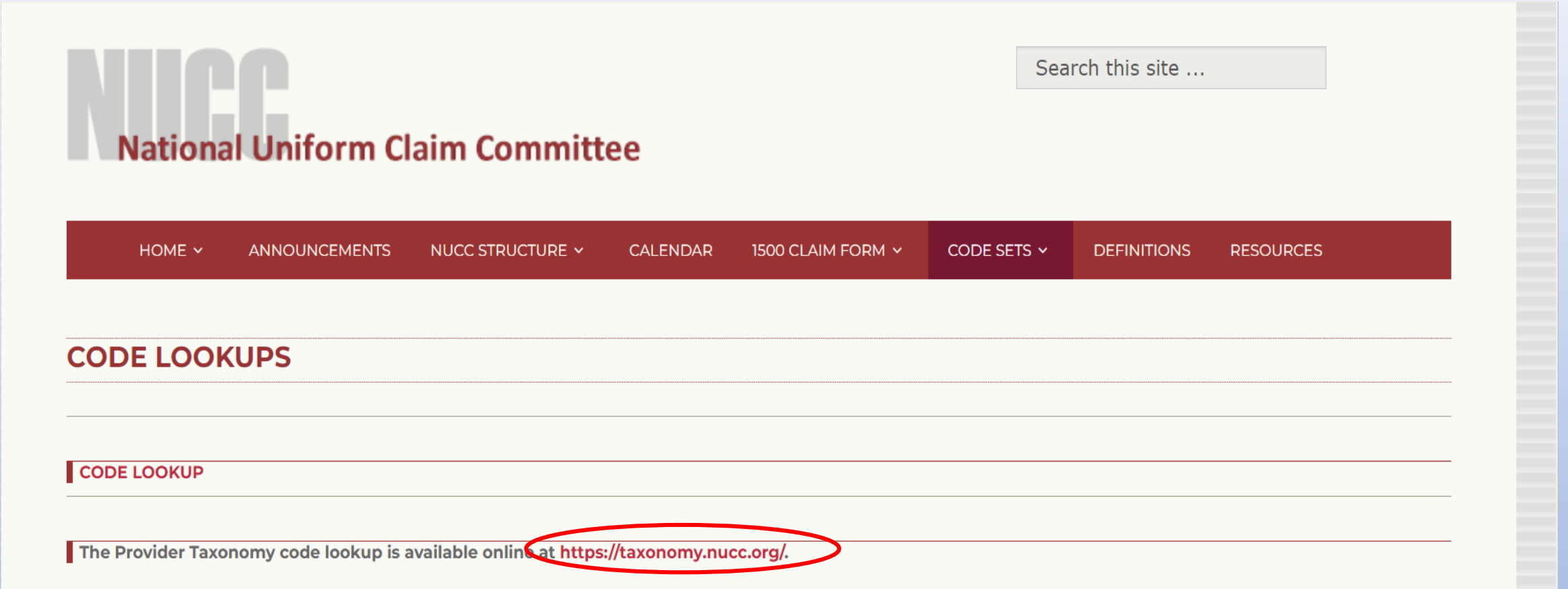
Step 2: Add Specialties/Taxonomy



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 navigation menu 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 list of options: CONDITION CODES, PROVIDER CHARACTERISTICS, PROVIDER TAXONOMY, 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 list of three items: 1. Condition Codes, 2. Provider Characteristic Codes, and 3. Provider Taxonomy Codes. At the bottom left of the page, there is a copyright notice: "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 2: 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 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 2: Add Specialties/Taxonomy



Health Care Provider Taxonomy Code Set

Expand / Collapse All

- 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
 - Dermatopathology
 - MOHS-Micrographic Surgery
 - Pediatric Dermatology
 - Procedural Dermatology
- Electrodiagnostic Medicine
- Emergency Medicine
 - Emergency Medical Services
 - Hospice and Palliative Medicine
 - Medical Toxicology
 - Pediatric Emergency Medicine
 - Sports Medicine
 - Undersea and Hyperbaric Medicine
- Family Medicine**
 - Addiction Medicine
 - Adolescent Medicine
 - Adult Medicine

Health Care Provider Taxonomy Code Set

Family Medicine Physician

Code	207Q00000X
Name	Family Medicine
Definition	Family Medicine is the medical specialty which is concerned with the total health care of the individual and the family. It is the specialty in breadth which integrates the biological, clinical, and behavioral sciences. The scope of family medicine is not limited by age, sex, organ system, or disease entity.
Notes	<p>Source: American Board of Family Medicine [1/1/2007: changed title; 7/1/2007: added definition, added source; 7/1/2017: modified definition]</p> <p>Note: The American Osteopathic Board of Family Physicians certification includes extensive use of Osteopathic Manipulative Treatment (OMT), which integrates the biological, clinical, and behavioral sciences.</p> <p>Additional Resources: American Board of Family Medicine, www.theabfm.org. American Osteopathic Board of Family Physicians, www.osteopathic.org/certification</p> <p>Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Physicians or the American Board of Family Medicine.</p>
Effective Date	4/1/2003
Last Modified Date	7/1/2007

- 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 2: Add Specialties/Taxonomy

Print Help

Application ID: 20230918053765

Name: Knight, Mary Sue

Add Taxonomy

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

Location: *

Description:

Start Date: *

End Date:

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

Step 2: Add Specialties/Taxonomy

Application ID: 20230918053765 Name: Knight, Mary Sue

[Close](#)

Specialty/Subspecialty List

[Add](#) [Primary Specialty](#)

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

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/> Family Medicine/No Subspecialty	PHYSICIANS	12/31/2999

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Taxonomy List

[Add](#)

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

Taxonomy Code	Description	Start Date	End Date
<input type="checkbox"/> 207Q00000X	Family Medicine	09/22/2023	12/31/2999

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- 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.

Application ID: 20230918053765

Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional			Complete	
Step 5: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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- 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** to continue your application.

Step 4: Associate Billing Provider

Note: This Step is Optional

Application ID: 20230918053765 Name: Knight, Mary Sue

Billing Provider/Other Associations List

Filter By

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

- This step is **Optional**.
- Click **Add** to associate to a Billing Provider.

Step 4: Associate Billing Provider

Input the Employer's NPI not Rendering/Serviceing Provider's NPI

Application ID: 20230918053765 Name: Knight, Mary Sue

Associate Billing Provider/Other Associations

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

Type: *

ID: *

Start Date: *

Provider Name:

Enrollment Type:

Applicant Type:

End Date:

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

Step 4: Associate Billing Provider

Application ID: 20230918053765 Name: Knight, Mary Sue

Billing Provider/Other Associations List

Filter By

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

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

Application ID: 20230918053765

Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other ←	Required			Incomplete	Please add required License/Certification.
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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

Step 5: Add Licenses/Certifications/Other

Application ID: 20230918053765

Name: Knight, Mary Sue

License/Certification/Other List

Filter By

License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !

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

Step 5: Add Licenses/Certifications/Other

Application ID: 20230918053765

Name: Knight, Mary Sue

License Requirements Per Medicaid

REQUIRED LICENSES

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

- State Professional License

Add License/Certification/Other

Location: 01- *

License/Certification/Other Type: State Professional License* *

License/Certification/Other #: 03612345 *

State: Illinois *

If your state has a prefix or an extension to the license number, please do not include this when entering the license number

Valid Flag: Yes *

Effective Date: 07/11/2022 *

End Date: 07/31/2024 *

If you choose to continue to enroll and wish to validate your license again prior to submitting your application, click "OK". Submission of an application with an invalid license will prolong the application approval process.

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

Step 5: Add Licenses/Certifications/Other

Application ID: 20230918053765 Name: Knight, Mary Sue

License/Certification/Other List

Filter By

License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> State Professional License	03612345	01-	Yes	07/11/2022	07/31/2024

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

Application ID: 20230918053765 Name: Knight, Mary Sue

[Close](#)

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange ←	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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

Step 6: Mode of Claim 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: 20230918053765 Name: Knight, Mary Sue

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

- Select any of the six options to indicate how you wish to process claims.
- Must select at least one option or claims will not be processed.
- After claim submission types have been selected click **OK**.
- It should be noted that paper claims are no longer accepted.

Application ID: 20230918053765

Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:

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

Step 7: Associate Billing Agent



Note: This Step is Optional

Application ID: 20230918053765 Name: Knight, Mary Sue

Billing Agent List

Filter By

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

- This step is **Optional** and only required if Billing Agent was select as Mode of Claim Submission.
- Click **Add** to input a Billing Agent.

Step 7: Associate Billing Agent

Application ID: 20230918053765 Name: Knight, Mary Sue

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 7: Associate Billing Agent

Application ID: 20230918053765 Name: Knight, Mary Sue

Billing Agent List

Filter By

Billing Agent ID	Billing Agent Name	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<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 checked="" 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

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

Step 7: Associate Billing Agent



Application ID: 20230918053765

Name: Knight, Mary Sue

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: Vinea Consulting INC.

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"/>

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

Step 7: Associate Billing Agent



Application ID: 20230918053765 Name: Knight, Mary Sue

Billing Agent List

Filter By

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

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

Business Process Wizard



Application ID: 20230918053765

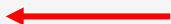
Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional	09/22/2023	09/22/2023	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	



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

Step 8: Controlling Interest/Ownership

Application ID: 20230918053765

Name: Knight, Mary Sue

Close Actions



Add Owner

Import Owner

Owners Relationships

Owners Adverse Action

During the enrollment process, every Provider (including fiscal agents and managed-care entities) is required to detail the ownership and controlling interests that individuals and corporate entities have in the Provider. For the purpose of this requirement, individuals or corporate entities with "ownership and controlling interest" in the provider include, but are not limited to, the following: (1) if the provider is a corporation or limited-liability company, any individual or corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences 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; (5) each individual employed with the provider 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"/> 100002812	Knight, Mary Sue	Individual/Sole Proprietor	350 E Madison St	09/18/2023	12/31/2999	Completed	Not Completed	100

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- 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 8: Controlling Interest/Ownership

Application ID: 20230918053765

Name: Knight, Mary Sue

Owner NPI: 1000010565

First Name: Mary Sue *

Last Name: Knight *

Suffix:

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

Start Date: 09/18/2023 *

Middle Initial:

DOB: 07/21/1980 *

Email: xxx.xxx.xxx.com

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: 350 E Madison St *

(Enter Street Address or PO Box Only)

Address Line 3:

State/Province: ILLINOIS *

Country: UNITED STATES *

Address Line 2:

City/Town: Springfield *


County: Sangamon

Zip Code: 62701 * - 1009

- 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 8: Controlling Interest/Ownership

Application ID: 20230918053765 Name: Knight, Mary Sue

Close Actions 

Add Owner

Import Owner

Owners Relationships

Owners Adverse Action

During the enrollment process, every Provider (including fiscal agents and managed-care entities) is required to detail the ownership and controlling interests that individuals and corporate entities have in the Provider. For the purpose of this requirement, individuals or corporate entities with "ownership and controlling interest" in the provider include, but are not limited to, the following: (1) if the provider is a corporation or limited-liability company, any individual or corporate entity owning (directly or indirectly) 5% or more of the stock or other evidences 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; (5) each individual employed with the provider 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"/> 100001056	Knight, Mary Sue	Managing Employee	350 E Madison St	09/18/2023	12/31/2999	Not Completed	Not Completed	0
<input type="checkbox"/> 100002812	Knight, Mary Sue	Individual/Sole Proprietor	350 E Madison St	09/18/2023	12/31/2999	Not Completed	Not Completed	100

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- Click **Actions** and select **Add Owner** or **Import Owner** then 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:8 Controlling Interest/Ownership

Application ID: 20230918053765 Name: Knight, Mary Sue

Close + Actions ⓘ

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

During the enrollment process, every Provider (including fiscal agents and managed-care entities) is required to detail the ownership and controlling interests that individuals and corporate entities have in the Provider. For the purpose of this requirement, individuals or corporate entities with "ownership and controlling interest" in the provider include, but are not limited to, the following: (1) if the provider is a corporation or limited-liability company, any individual or corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences 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; (5) each individual employed with the provider 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"/> 100001056	Knight, Mary Sue	Managing Employee	350 E Madison St	09/18/2023	12/31/2999	Not Completed	Not Completed	0
<input type="checkbox"/> 100002812	Knight, Mary Sue	Individual/Sole Proprietor	350 E Madison St	09/18/2023	12/31/2999	Not Completed	Not Completed	100

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

Step 8: Controlling Interest/Ownership

Application ID: 20230918053765

Name: Knight, Mary Sue

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: Knight, Mary Sue SSN/EIN/TIN: 100002812 Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Knight, Mary Sue	Relation to Assoc. Owner
Knight, Mary Sue	100001056	Managing Employee	Self	Spouse
Knight, Mary Sue	100002812	Individual/Sole Proprietor		Self

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Selected Owner: Knight, Mary Sue SSN/EIN/TIN: 100001056 Status: Not Completed

- Select **All** next to **Show Owners and** choose the relationship next to each drop-down menu.
- Choose **Save** to complete the screen.

Step 8: Controlling Interest/Ownership

Application ID: 20230918053765

Name: Knight, Mary Sue

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

For the purpose of this application, 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 evidences 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; (5) each individual employed with the provider who has management responsibility. During enrollment and revalidation, the provider shall provide the following information:

- The name, 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 individual employed with the provider, and 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

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 100001056	Knight, Mary Sue	Managing Employee	350 E Madison St	09/18/2023	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/> 100002812	Knight, Mary Sue	Individual/Sole Proprietor	350 E Madison St	09/18/2023	12/31/2999	Completed	Not Completed	100

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- Now complete the Owners Adverse Action by selecting **Actions, Owners Adverse Action**.

Step 8: Controlling Interest/Ownership



Application ID: 20230918053765

Name: Knight, Mary Sue

1. For the provider, any individual who has an ownership or controlling interest in the provider, and any of the provider's suppliers, each felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 42 C.F.R. § 1001.201
2. For the provider, any individual who has an ownership or controlling interest in the provider, and any of the provider's suppliers, each felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, revocations, or Suspensions

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

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

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

Owners with Adverse Action			
Owner Name	SSN/EIN/TIN	Response	Comments
Knight, Mary Sue	100002812	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Knight, Mary Sue	100001056	<input type="radio"/> Yes <input checked="" type="radio"/> No	

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Ok Cancel

- Read the final adverse legal action statements.
- A Yes or No response is required for each owner listed in the application.
- After responding for each provider listed click on **OK**.

Step 8: Controlling Interest/Ownership



Application ID: 20230918053765

Name: Knight, Mary Sue

Close Actions ?

"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"/> 100001056	Knight, Mary Sue	Managing Employee	350 E Madison St	09/18/2023	12/31/2999	Completed	No	0
<input type="checkbox"/> 100002812	Knight, Mary Sue	Individual/Sole Proprietor	350 E Madison St	09/18/2023	12/31/2999	Completed	No	100

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**.

Step 8: Controlling Interest/Ownership



Application ID: 20230918053765

Name: Knight, Mary Sue

Close Actions *i*

"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

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> <input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>	<input type="button" value="▲▼"/>
<input type="checkbox"/> 100001056	Knight, Mary Sue	Managing Employee	350 E Madison St	09/18/2023	12/31/2999	Completed	No	0
<input type="checkbox"/> 100002812	Knight, Mary Sue	Individual/Sole Proprietor	350 E Madison St	09/18/2023	12/31/2999	Completed	No	100

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

Filter By

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

No Records Found !

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

Application ID: 20230918053765

Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional	09/22/2023	09/22/2023	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	09/22/2023	09/22/2023	Complete	
Step 9: 835/ERA Enrollment Form ←	Optional			Incomplete	
Step 10: Upload Documents	Optional			Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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- You have completed Step 8: **Add Provider Controlling Interest**. The system will place the current date in the **End Date** field and will place **Complete** in the corresponding **Status** field.
- Click on Step 9: **835/ERA Enrollment Form**

Step 9: 835/ERA Enrollment Form



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

Application ID: 20230918053765 Name: Knight, Mary Sue

Close Submit Print Help

ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name: Knight, Mary Sue

Doing Business As Name (DBA):

Provider Address

Street: 607 E Adams St State/Province: ILLINOIS

City: Springfield Zip Code/Postal Code: 62701

Country Code: UNITED STATES

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): 100002812

National Provider Identifier (NPI): 1000028187

Other Identifier(s)

Assigning Authority: Trading Partner ID:

Provider License Details

Provider License No: 03612345 License Issuer: IL

Provider Type: PHYSICIANS

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

Step 9: 835/ERA Enrollment Form

Note: this is an optional step

Application ID: 20230918053765 Name: Knight, Mary Sue

NCDFP Provider ID Number:
Medicaid Provider Number:

ELECTRONIC REMITTANCE ADVISE INFORMATION

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

NPI TAX ID *

IL Medicaid enumerates by Tax ID only.

Method of Retrieval: * ←

ELECTRONIC CLEARINGHOUSE INFORMATION (Not applicable at this time)

ClearingHouse Name:

ClearingHouse Contact Name

ClearingHouse Contact Name: Telephone Number:

Email Address:

(Note: A red arrow points to the 'Method of Retrieval' dropdown menu, which is open and showing options: CORE, FTS, IMPACT.)

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

Step 9: 835/ERA Enrollment Form

Note: this is an optional step

Application ID: 20230918053765 Name: Knight, Mary Sue

Email Address:

SUBMISSION INFORMATION

Reason for Submission

Cancel Enrollment Change Enrollment New Enrollment *

Authorized Signature

Electronic Signature of Person Submitting Enrollment:

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

Authorization Agreement

By signing this request, I am authorizing 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: 09/22/2023

Requested ERA Effective Date:

(Once approve the next paycycle date.)

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

Application ID: 20230918053765

Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional	09/22/2023	09/22/2023	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	09/22/2023	09/22/2023	Complete	
Step 9: 835/ERA Enrollment Form	Optional	09/22/2023	09/22/2023	Complete	
Step 10: Upload Documents ←	Optional			Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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- The system will place the current date in the End Date field and will place **Complete** for Step 9.
- Click on Step 10: **Upload Documents** to continue with the application.

Step 10: Upload Documents

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

Application ID: 20230918053765 Name: Knight, Mary Sue

Upload Documents

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

Note: In the original image, a red box highlights the Save button, red arrows point to the Document Type and Document Name dropdowns, and a red circle highlights the paperclip icon in the File Name field.

- Select--
- Agreement
- Bills
- Certification
- Enrollment Verification
- Insurance
- License
- Organizational
- Others
- Proof of Fingerprinting
- Records
- Registration

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

Application ID: 20230918053765

Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional	09/22/2023	09/22/2023	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	09/22/2023	09/22/2023	Complete	
Step 9: 835/ERA Enrollment Form	Optional	09/22/2023	09/22/2023	Complete	
Step 10: Upload Documents	Optional	09/22/2023	09/22/2023	Complete	
Step 11: Complete Enrollment Checklist ←	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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

Step 11: Complete Enrollment Checklist

Application ID: 20230918053765

Name: Knight, Mary Sue

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.	No	
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	
Have you selected Collaborative Care as your subspecialty? If yes, enter the date you submitted the Collaborative Care Provider Attestation as required by the HFS Collaborative Care Model Guidelines.	No	
Is Child/Adolescent Psychiatry Residency or General Psychiatry Residency your subspecialty? If yes, enter the place of your psychiatric residency and type(s).	No	
Are you a radiologist, hospital (outpatient), Imaging Center or Independent Diagnostic Testing Facility, and are participating or wish to participate in the Breast Cancer Quality Screening Program?	No	
Are you enrolled in the Designated Family Planning Provider/Clinic Program? If yes, provide enrollment date and approving agency.	No	
Are you enrolled in the Vaccines for Children Program (VFC) and have a specialty/subspecialty other than OB, GYN, OB/GYN? If yes, provide enrollment date.	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.	No	

- 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.

Application ID: 20230918053765

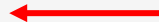
Name: Knight, Mary Sue

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional	09/22/2023	09/22/2023	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	09/22/2023	09/22/2023	Complete	
Step 9: 835/ERA Enrollment Form	Optional	09/22/2023	09/22/2023	Complete	
Step 10: Upload Documents	Optional	09/22/2023	09/22/2023	Complete	
Step 11: Complete Enrollment Checklist	Required	09/22/2023	09/22/2023	Complete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	



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

Step 12: Submit Enrollment Application for Approval



Application ID: 20230918053765 Name: Knight, Mary Sue

[Close](#) [Next](#)

Final Submission

Application ID: 20230918053765 EnrollmentType: Individual/Sole Proprietor

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

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

Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
No Records Found !			

- Read Statement
- Click on **Next**

Step 12: Submit Enrollment Application for Approval



Application ID: 20230918053765

Name: Knight, Mary Sue

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

9. The provider shall ensure that all residential treatment service recipients have access to all medically necessary physical healthcare services required, consistent with the policies outlined in all Handbooks for Providers of Residential Treatment Services.
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

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

- The message below will appear advising that the application has been submitted to the state for review. The application number can be used to check the status of the application by going through the Track Application option.
- Click **Close**.

Application ID: 20230918053765 Name: Knight, Mary Sue

Your Application Number 20230918053765 has been successfully submitted for State review. Return with this application number to track the status of your application. x

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional	09/22/2023	09/22/2023	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	09/22/2023	09/22/2023	Complete	
Step 9: 835/ERA Enrollment Form	Optional	09/22/2023	09/22/2023	Complete	
Step 10: Upload Documents	Optional	09/22/2023	09/22/2023	Complete	
Step 11: Complete Enrollment Checklist	Required	09/22/2023	09/22/2023	Complete	
Step 12: Submit Enrollment Application for Approval	Required	09/22/2023	09/22/2023	Complete	

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Application ID: 20230918053765

Name: Knight, Mary Sue

Your Application Number 20230918053765 has been successfully submitted for State review. Return with this application number to track the status of your application. x

Close

Enroll Provider - Individual

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	09/18/2023	09/18/2023	Complete	
Step 2: Add Locations	Required	09/18/2023	09/18/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	09/22/2023	09/22/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/22/2023	09/22/2023	Complete	
Step 5: Add License/Certification/Other	Required	09/22/2023	09/22/2023	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	09/22/2023	09/22/2023	Complete	
Step 7: Associate Billing Agent	Optional	09/22/2023	09/22/2023	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	09/22/2023	09/22/2023	Complete	
Step 9: 835/ERA Enrollment Form	Optional	09/22/2023	09/22/2023	Complete	
Step 10: Upload Documents	Optional	09/22/2023	09/22/2023	Complete	
Step 11: Complete Enrollment Checklist	Required	09/22/2023	09/22/2023	Complete	
Step 12: Submit Enrollment Application for Approval	Required	09/22/2023	09/22/2023	Complete	

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

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