ILLINOIS PROVIDER ENROLLMENT

Atypical Agency

OKTA LOGIN

ILogin

Sign In

Username

Please enter a username

Password

Please enter a password

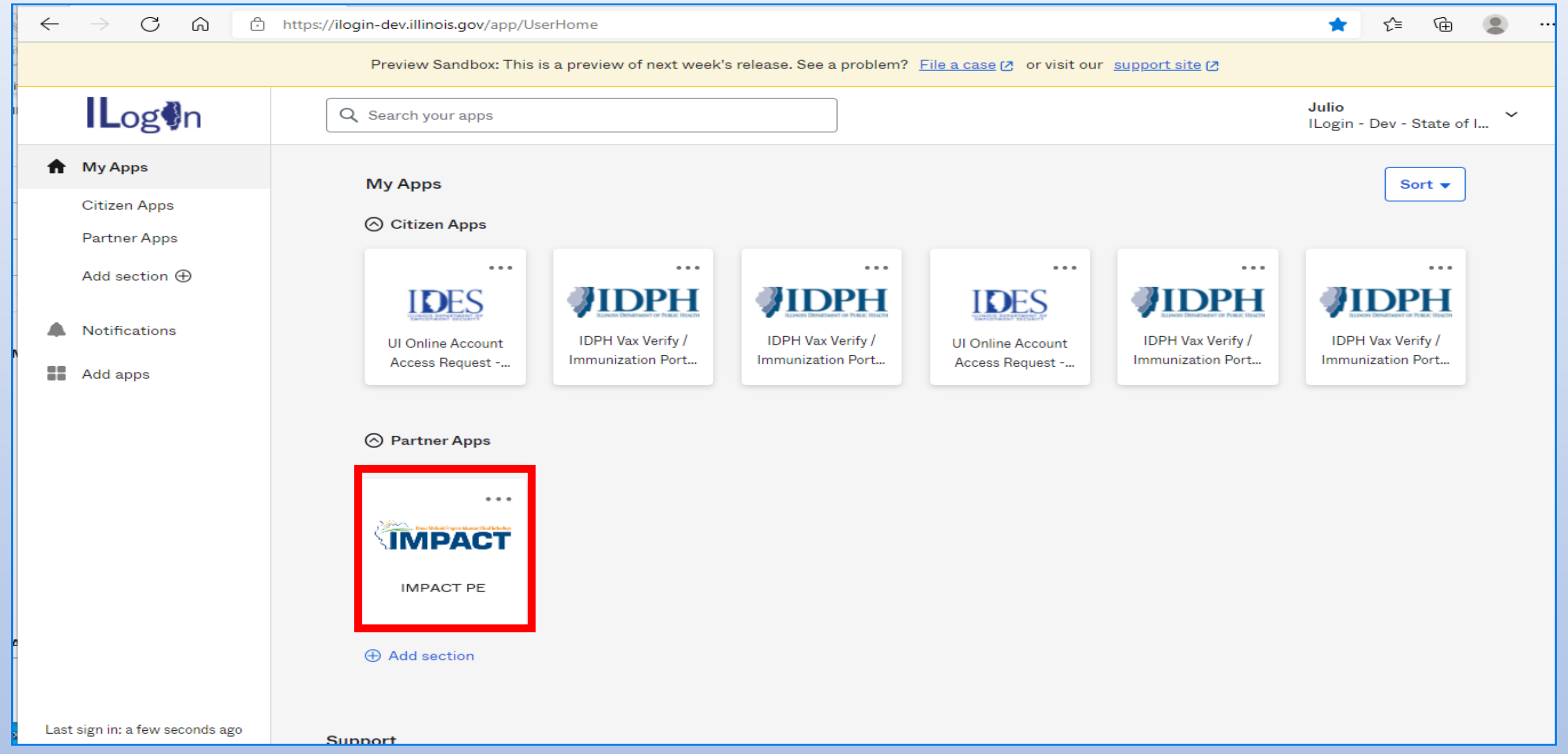
Remember me

Sign In

Need help signing in?

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

IMPACT CHICKLET



- Click on the IMPACT PE Chicklet to access IMPACT

IMPACT DASHBOARD

https://evo-pe-uat.il-hfs.com/ecams/SSOControlServlet

IMPACT

Gilhooly,Michelle

Illinois Medicaid Program Advanced Cloud Technology

IMPACT

*

Select Profile *

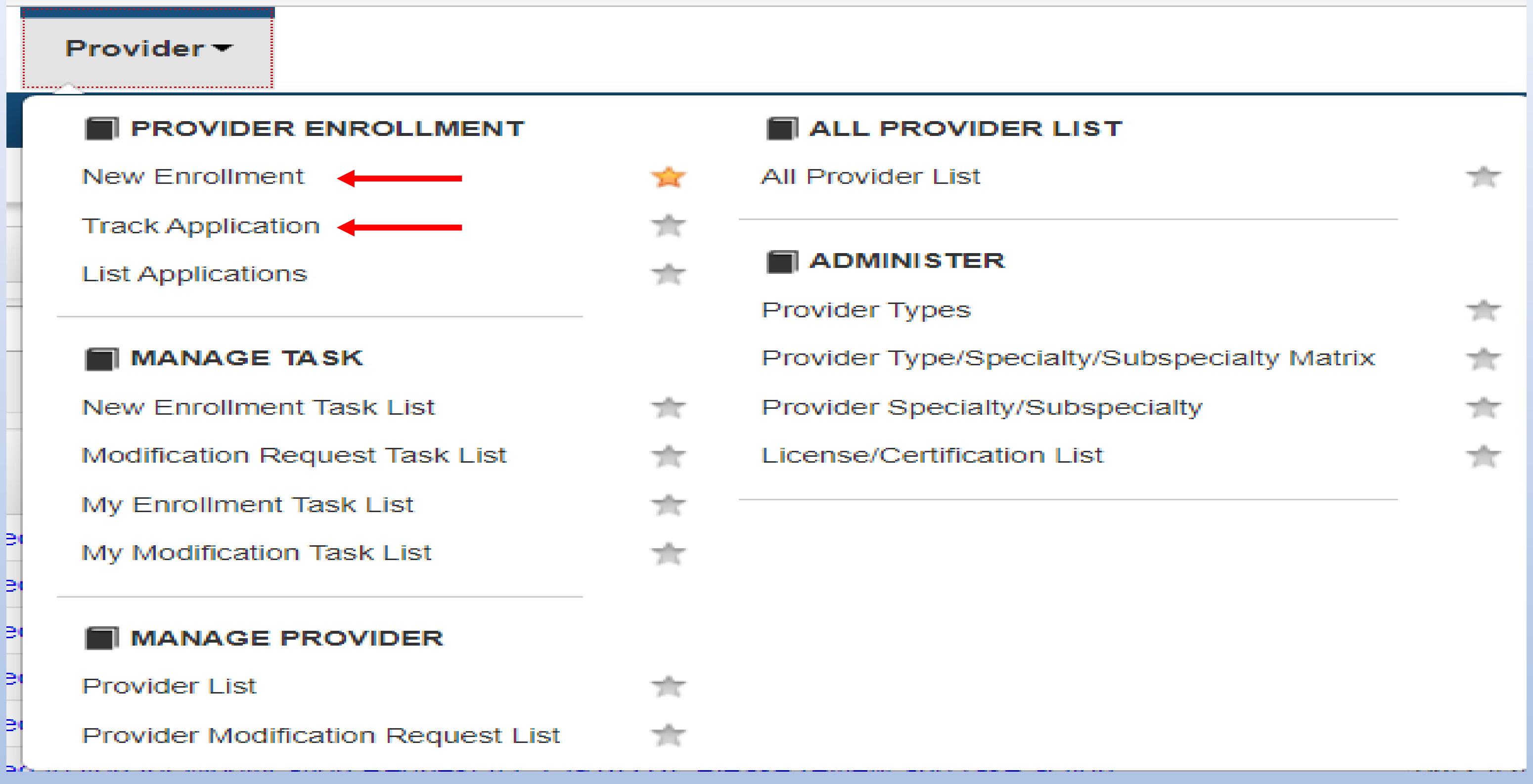
Select Favorite

Go

© CNSI 2017

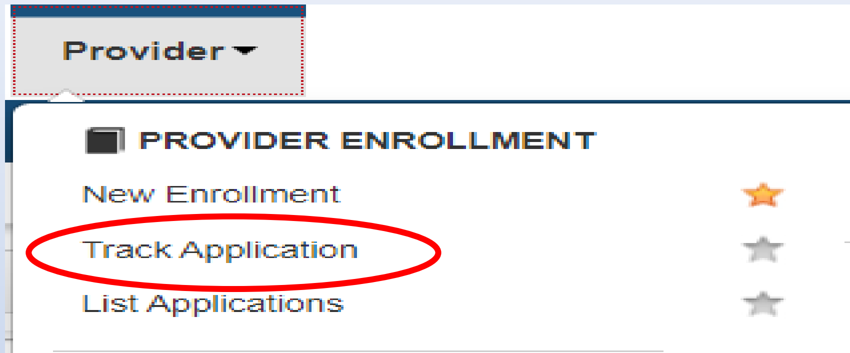
- Select the Domain and Profile from the drop-down menus
- Click **Go**

Application Process

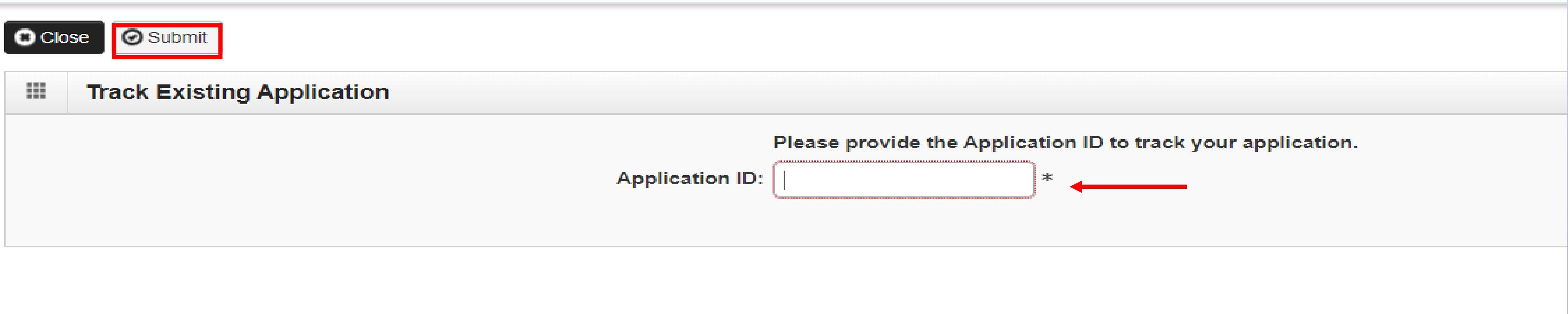


- Regarding completing an application, there are two options: New Enrollment or Resuming an application.
- If starting a new application, go to slide 7 for step-by-step instructions.
- If resuming an application previously started go to slide 6 for step-by-step instructions.

Resuming an Application

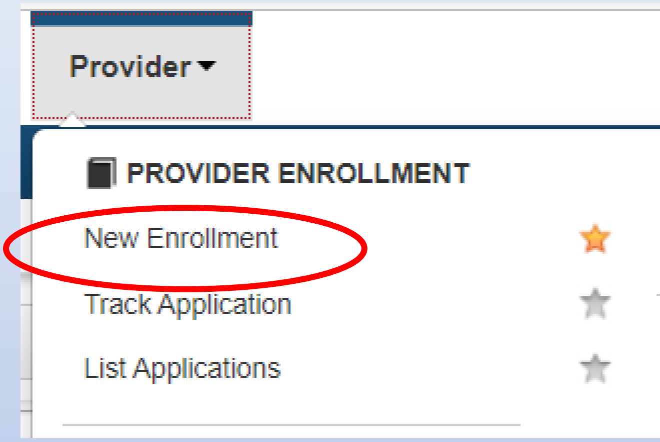


- To resume an application, click on ***Track Application***.



- 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).

Starting a New Application



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

Start New Application

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.)

Submit

- 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.*

https://evo-pe-uat.il-hfs.com/ecams/CNSIControlServlet

Print 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:	Susie Homemakers * (Doing Business As)	**EIN/TIN:**	100021048 *
Organization/Business Type:	Other Agencies *		

Contact Email Address:

NPI:		**Email-1:**	xxx.xxx.@xxx.com *
		Email-2:	xxx.xxx.@xxx.com
		Email-3:	xxx.xxx.@xxx.com

Please note that all providers are subject to a criminal background screening that could affect your ability to be paid through the Home Help program.

Confirm | View Screening Result | Finish | Cancel

- After all the information has been entered click ***Confirm***.
- Click ***Finish*** in the bottom right corner to complete this step.

Start New Application

(Step 1: Basic Provider Information)

Application ID: 20230830710369 **Name:** Susie Homemakers

Basic Information

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

Your Application ID is: 20230830710369

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 yyyymmdd format
  - A 6-digit system generated random number
  - Example: 20230830710369
- 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: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	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: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
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: Upload Documents	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

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

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

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

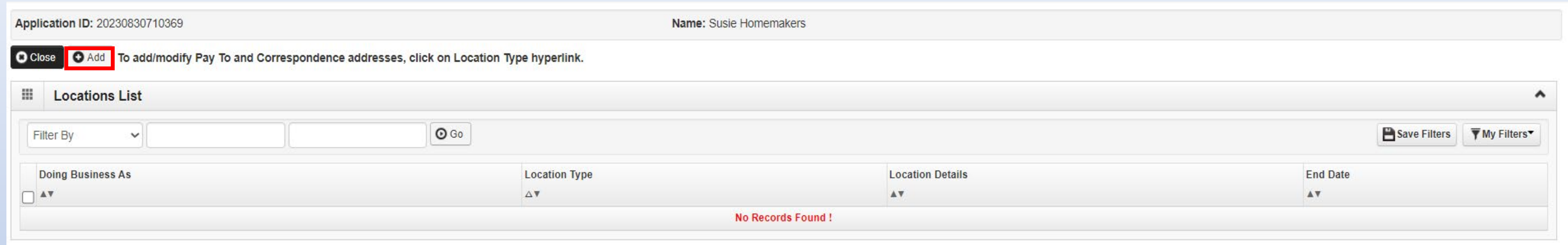
Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	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: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
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: Upload Documents	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: 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



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

Step 2: Add Locations

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

Application ID: 20230830710369 **Name:** Susie Homemakers

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: Illinois Medicaid Provider Enrollment
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 Validate Address

Phone Number: (217) 555-1212 * Extn:
Fax Number:
Email Address: xxx.xxx.@xxx.com
Web Page:
Communication Preference: Email

- Enter the street address and zip code, then click ***Validate Address***.
- Scroll down to input office hours.

Step 2: Add Locations

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:	07:30 *	AM *	05:00 *	PM *
Monday:	07:30 *	AM *	05:00 *	PM *	Friday:	07:30 *	AM *	05:00 *	PM *
Tuesday:	07:30 *	AM *	05:00 *	PM *	Saturday:	08:00 *	AM *	01:00 *	PM *
Wednesday:	07:30 *	AM *	05:00 *	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

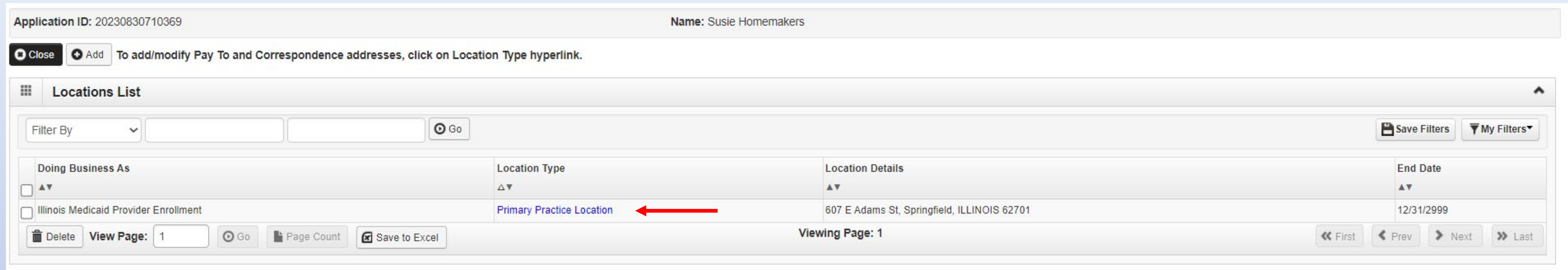
State Facility ID:

Fiscal Year End Date: 12/31 *
(mm/dd)

OK Cancel

- Enter the office hours.
- When all information has been entered, click ***OK*** at the lower right corner.

Step 2: Add Locations



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

Step 2: Add Locations

Application ID: 20230830710369
Name: Susie Homemakers

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

Sunday:	Closed *	AM PM *	*	AM PM *	Thursday:	07:30 *	AM PM *	05:00 *	AM PM *
Monday:	07:30 *	AM PM *	05:00 *	AM PM *	Friday:	07:30 *	AM PM *	05:00 *	AM PM *
Tuesday:	07:30 *	AM PM *	05:00 *	AM PM *	Saturday:	08:00 *	AM PM *	01:00 *	AM PM *
Wednesday:	07:30 *	AM PM *	05:00 *	AM PM *					

Handicap Accessible: 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

Facility Details

State Facility ID:

Fiscal Year End Date: 12/31 *
(mm/dd)

Address List

Add Address

Address Type	Address	End Date
Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

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

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

Step 2: Add Locations

Application ID: 20230830710369 Name: Susie Homemakers

Add Provider Location Address

Type of Address: Correspondence 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: 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 Validate Address

OK Cancel

- 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: 20230830710369 **Name:** Susie Homemakers

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

Monday:	07:30 *	AM/PM *	05:00 *	AM/PM *	Friday:	07:30 *	AM/PM *	05:00 * AM/PM *
Tuesday:	07:30 *	AM/PM *	05:00 *	AM/PM *	Saturday:	08:00 *	AM/PM *	01:00 * AM/PM *
Wednesday:	07:30 *	AM/PM *	05:00 *	AM/PM *				

Handicap Accessible: No

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

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

End Date: 12/31/2999

Facility Details

State Facility ID:

Fiscal Year End Date: 12/31 * (mm/dd)

Address List

Add Address

Address Type	Address	End Date
Correspondence	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
Pay To	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

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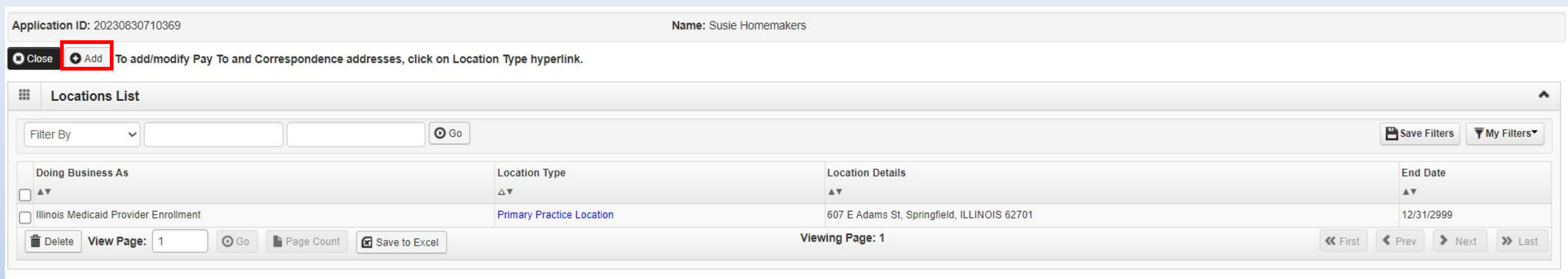
- After all addresses have been entered click on ***Save and the Close***.

Step 2: Add Locations



- 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)

- 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: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
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: Upload Documents	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

Step 3: Add Specialties/Taxonomy

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Specialty/Subspecialty List

Add

Filter By | Go | Save Filters | My Filters

Specialty/Subspecialty	Provider Type	End Date
No Records Found !		

Taxonomy List

Add

Filter By | Go | Save Filters | My Filters

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: 20230830710369 **Name:** Susie Homemakers

Add Specialty/Subspecialty

Location: 01-Illinois Medicaid Pı *

Provider Type: SOCIAL SERVICES - AA *

Specialty: Home Services Agency - AA *

End Date: 12/31/2999

Add Subspecialty

Available Subspecialties **Associated Subspecialties ***

No Subspecialty

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: 20230830710369 **Name:** Susie Homemakers

Add Specialty/Subspecialty

Location: 01-Illinois Medicaid Pr *

Provider Type: SOCIAL SERVICES - AA *

Specialty: Home Services Agency - AA *

End Date: 12/31/2999

Add Subspecialty

Available Subspecialties

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 Code is not needed. Skip this part of the step.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Specialty/Subspecialty List

Add

Filter By | Go | Save Filters | My Filters

Specialty/Subspecialty	Provider Type	End Date
Home Services Agency - AA/No Subspecialty	SOCIAL SERVICES - AA	12/31/2999

Delete | View Page: 1 | 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 !			

- If you have another Specialty to enter, click the ***Add*** button in the top left corner and repeat the steps as needed.
- When all the Specialty information has been entered, click on ***Close*** to return to the BPW.
- Taxonomy Code is not required because atypical providers do not need a taxonomy.

Business Process Wizard (BPW)

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

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	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: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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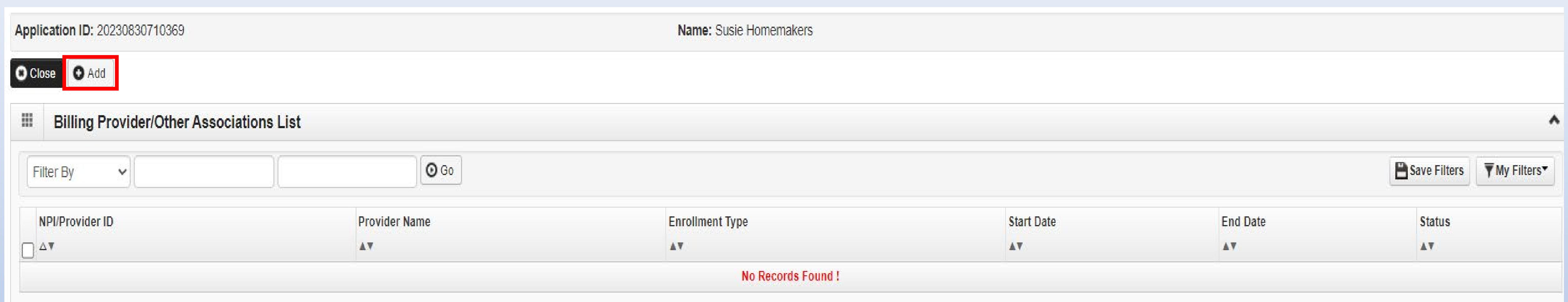
Step 4: Associate Billing Provider/Other Associations List

Noted: This Step is Optional for this Enrollment Type.



- This step is optional and not required for this enrollment type.
- Click ***Add*** to input an Associated Billing Provider.

Step 4: Associate Billing Provider/Other Associations

Application ID: 20230830710369 Name: Susie Homemakers

Associate Billing Provider/Other Associations

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

Type: *

ID: *

Provider Name:

Enrollment Type:

Applicant Type:

Start Date: *

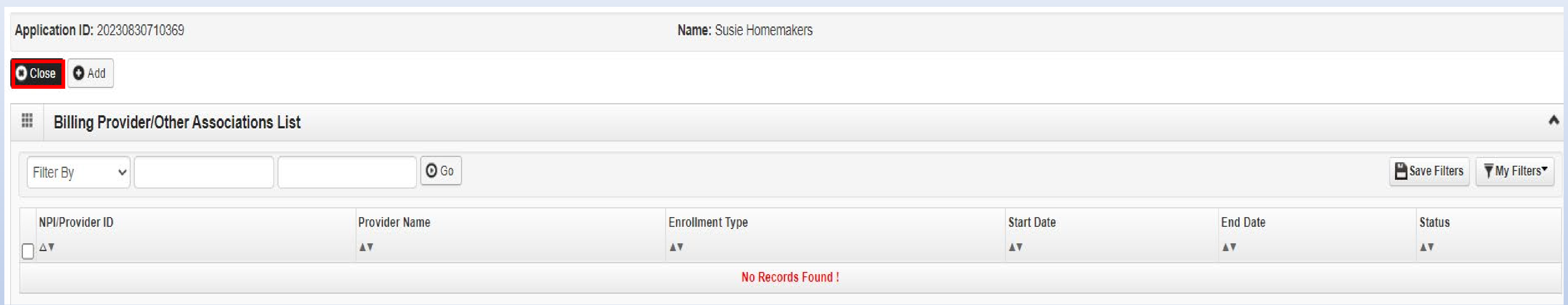
End Date:

Confirm Provider Ok Cancel

- 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.

Step 4: Associate Billing Provider/Other Associations List

Noted: This Step is Optional for this Enrollment Type.



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

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.
- Step 5: ***Bed Information***. **Skip this step. It is only applicable for Long Term Care Providers.**

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	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: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

Business Process Wizard (BPW)

- You have completed Step 5: **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 6: ***Add License/Certification/Other*** *to continue your application.*

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

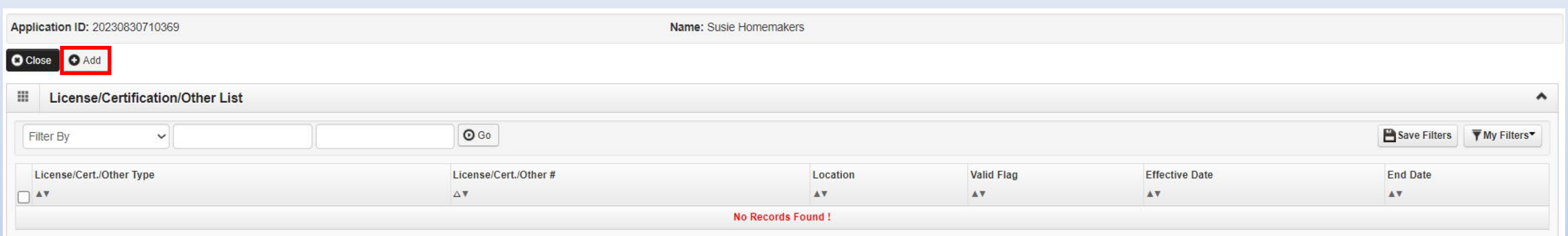
Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	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: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

Step 6: Add Licenses/Certifications/Other

Noted: This Step is Optional for this Enrollment Type.



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

Step 6: Add Licenses/Certifications/Other

Application ID: 20230830710369 **Name:** Susie Homemakers

Add License/Certification/Other

Location: 01-Illinois Medicaid Pı *

License/Certification/Other Type: *
DHS State License-Certificate
Public Health License-Certificate

License/Certification/Other #: *

Valid Flag:

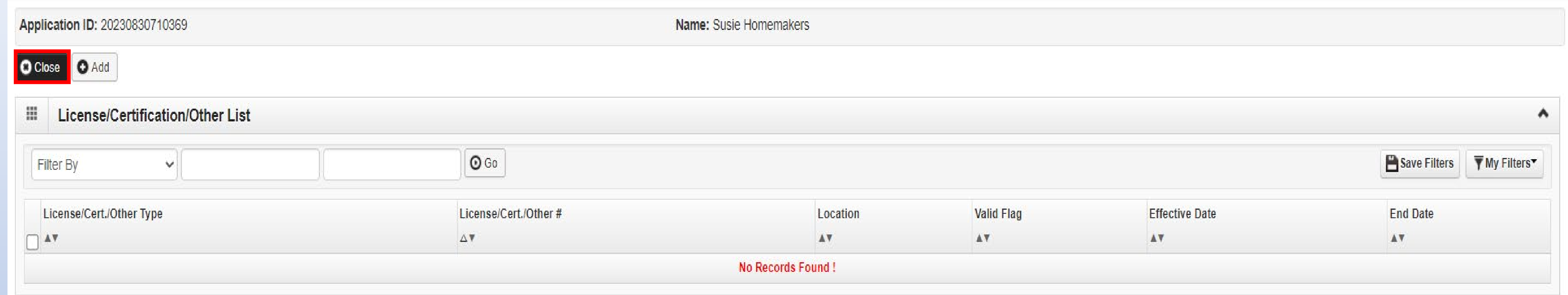
Effective Date: *

End Date:

Confirm License/Certification/Other | OK | Cancel

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

Step 6: Add Licenses/Certifications/Other



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

Business Process Wizard (BPW)

- You have completed Step 6: ***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 7: ***Add Mode of Claim Submission*** to continue your application.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	Please choose the Mode of Claim Submission.
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: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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Step 7: 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: 20230830710369 **Name:** Susie Homemakers

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
☑	Electronic Batch	To upload/download HIPAA transactions from screens (Maximum file upload size is 50MB)	837P- Professional (FFS), 837I -Institutional(FFS), 837D -Dental(FFS), 270/271 -Eligibility,Inquiry/Response, 276/277-Claim Status Inquire/Response
☑	CORE Batch	To upload/download HIPAA transactions using CORE Batch Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 835 Health Care Claim Payment/Advice
☑	CORE Real Time	To upload/download HIPAA transactions using CORE Real Time Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
☐	Billing Agent	To submit/receive HIPAA transactions through billing agent	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter), 837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice

Other Claims Submission

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

Ok Cancel

- Select any of the six options to indicate how you wish to process claims.
- Must select at least one option or claims will not be processed.
- After claim submission types have been selected click ***OK***.

Business Process Wizard (BPW)

- 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.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/05/2023	Complete	
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: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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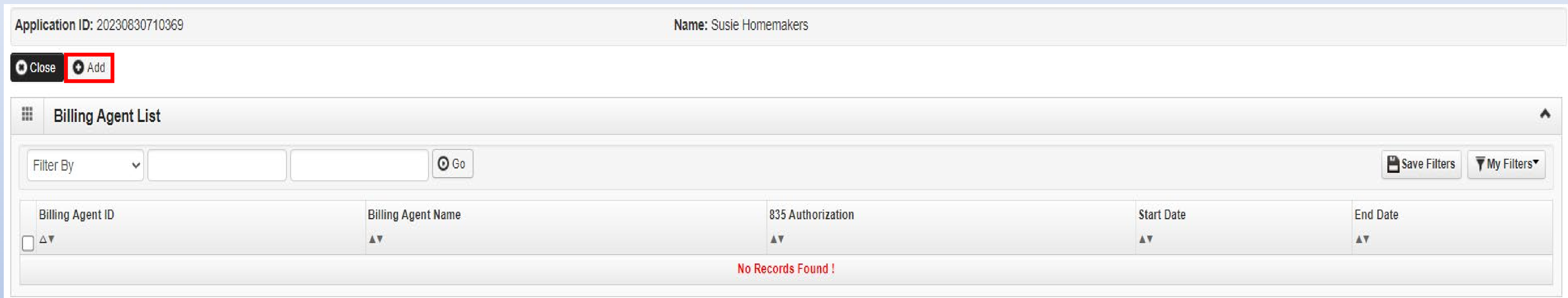
Step 8: Associate Billing Agent

Noted: This Step is Optional for this Enrollment Type.



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

Step 8: Associate Billing Agent

Application ID: 20230830710369 **Name:** Susie Homemakers

Associate Billing Agent

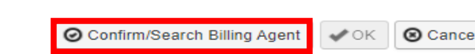
Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

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	☐		



OK Cancel

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

Step 8: Associate Billing Agent

Application ID: 20230830710369 **Name:** Susie Homemakers

Billing Agent List

Filter By | Go | Save Filters | My Filters

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

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Select | Close

- 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: 20230830710369 **Name:** Susie Homemakers

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: 7094629 *
Association Start Date: 09/05/2023 *
Billing Agent Name: DRS Billing Agent
Association End Date: 12/31/2999

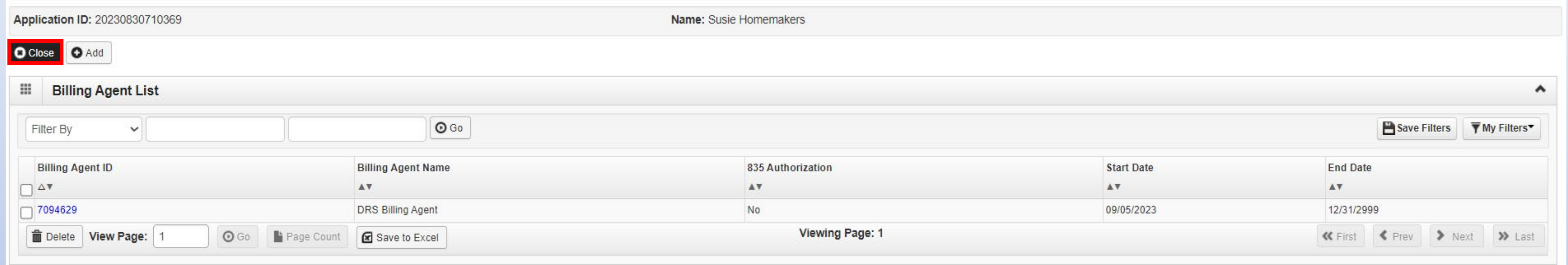
Authorized Transaction Responses

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

Confirm/Search Billing Agent | OK | Cancel

- 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



- 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)

- 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.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/05/2023	Complete	
Step 8: Associate Billing Agent	Optional	09/05/2023	09/05/2023	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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Step 9: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Actions

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

Pe... anual

During the ...n 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 pu... luals 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 s... ownership in the provider; (2) if the provider is a sole proprietorship, the owner of the provider; (3) if the provider is a partnership, each partner of the provider; (4) each individual who is a member of the provider's Board of Directors; and (5) each individual employed with the provide... sponsibility.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 !								

- 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: Controlling Interest/Ownership

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

Application ID: 20230830710369 **Name:** Susie Homemakers

Provider Controlling Interest/Ownership

Field	Value	Field	Value
Type:	Managing Employee *	Percentage Owned:	85 *
SSN:	100002818 *	EIN/TIN:	
Legal Entity Name:	(As shown on the Income Tax Return)	Entity Business Name:	(Doing Business As)
Owner NPI:	1000028302		
First Name:	Elizabeth *	Middle Initial:	
Last Name:	Anderson *		
Suffix:		DOB:	07/22/1995 *
Phone Number:	(217) 555-1212 * Extn:	Email:	xxx.xxx.@xxx.com
Start Date:	10/01/2020 *	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

Field	Value	Field	Value
Address Line 1:	117 Ruth Rd * (Enter Street Address or PO Box Only)	Address Line 2:	
Address Line 3:		City/Town:	Bloomington *
State/Province:	ILLINOIS *	County:	McLean
Country:	UNITED STATES *	Zip Code:	61701 * - 4350

Validate Address

OK Cancel

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

Step 9: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Actions

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

Pe... anual

During the ... n 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 pu... uals 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 s... ownership in the provider; (2) if the provider is a sole proprietorship, the owner of the provider; (3) if the provider is a partnership, each partner of the provider; (4) each individual who is a member of the provider's Board of Directors; and (5) each individual employed with the provide... sponsibility.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
100001002	Jones,Sarah	Board of Directors/Officers/Principles	350 E Madison St	10/01/2020	12/31/2999	Not Completed	Not Completed	10
100002818	Anderson,Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Not Completed	Not Completed	85
100021048	Susie Homemakers	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Not Completed	Not Completed	5

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- Click **Actions** and select **Add Owner** or **Import Owner** repeat the previous steps to list additional owners
- After all ownerships have been added, click the **Actions** drop drown box and select **Owner Relationships** or **Owners Adverse Action** to complete the relationship and adverse legal disclosure.

Step 9: Add Provider Controlling Interest/Ownership Details

Application ID: 20230830710369 **Name:** Susie Homemakers

Add Relationship

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

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner:Susie Homemakers	**SSN/EIN/TIN**:100021048	**Status**:Not Completed
Selected Owner:Anderson, Elizabeth	**SSN/EIN/TIN**:100002818	**Status**:Not Completed
Selected Owner:Jones, Sarah	**SSN/EIN/TIN**:100001002	**Status**:Not Completed

Save Close

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

Step 9: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

Add Relationship

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

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Susie Homemakers SSN/EIN/TIN: 100021048 Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Susie Homemakers	Relation to Assoc. Owner
Anderson,Elizabeth	100002818	Managing Employee	None	None
Jones,Sarah	100001002	Board of Directors/Officers/Principles	None	None

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

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

Selected Owner: Jones, Sarah **SSN/EIN/TIN:** 100001002 **Status:** Not Completed

Save Close

- Answer question regarding listed Owners and relationship.
- Select None or the relationship from the first drop-down list of ***Owner Name***, choose an owner name.
- From the second drop down list of ***Relationships***, choose how the chosen owner is related to the listed owner.
- Repeat this step until the relationship is set for each owner.
- When completed, click ***Save*** to return to the ownership listing.

Step 9: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Actions

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

Pe... anual

During the ...n 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.

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- 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
100001002	Jones,Sarah	Board of Directors/Officers/Principles	350 E Madison St	10/01/2020	12/31/2999	Completed	Not Completed	10
100002818	Anderson,Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Completed	Not Completed	85
100021048	Susie Homemakers	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Completed	Not Completed	5

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

Step 9: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

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, 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: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

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

Exclusions, revocations, or Suspensions

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

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

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

Owners with Adverse Action

Filter By | All | Go | Save Filters | My Filters

Owner Name	SSN/EIN/TIN	Response	Comments
Susie Homemakers	100021048	Yes No	
Jones,Sarah	100001002	Yes No	
Anderson,Elizabeth	100002818	Yes No	

View Page: 1 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.
  - If the response is Yes the comment section is used to describe adverse action.
- After responding for each provider listed click on **OK**.

Step 9: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Actions

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

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

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

Owners List

Filter By | And | Indicator | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
100001002	Jones,Sarah	Board of Directors/Officers/Principles	350 E Madison St	10/01/2020	12/31/2999	Completed	No	10
100002818	Anderson,Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Completed	No	85
100021048	Susie Homemakers	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Completed	No	5

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 9: Controlling Interest/Ownership

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Actions

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

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

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

Owners List

Filter By | And | Indicator | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
100001002	Jones,Sarah	Board of Directors/Officers/Principles	350 E Madison St	10/01/2020	12/31/2999	Completed	No	10
100002818	Anderson,Elizabeth	Managing Employee	117 Ruth Rd	10/01/2020	12/31/2999	Completed	No	85
100021048	Susie Homemakers	Corporate - Not Publicly Traded	607 E Adams St	10/01/2020	12/31/2999	Completed	No	5

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 !		

- Click **Close** to return to the BPW

Business Process Wizard (BPW)

- 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.
- Step10: ***835/ERA Enrollment Form*** is not applicable.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/05/2023	Complete	
Step 8: Associate Billing Agent	Optional	09/05/2023	09/05/2023	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	09/07/2023	09/07/2023	Complete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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

Step 10: Complete 835/ERA

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: 20230830710369 **Name:** Susie Homemakers

Close | Submit | Print | Help

ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name:

Doing Business As Name (DBA): Susie Homemakers

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): 100021048

National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority:

Trading Partner ID:

Provider License Details

Provider License No:

License Issuer:

Provider Type: SOCIAL SERVICES - AA

Provider Taxonomy Code:

PROVIDER CONTACT INFORMATION

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

Step 10: Complete 835/ERA

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Submit | Print | Help

ELECTRONIC REMITTANCE ADVICE 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: *

CORE
FTS
IMPACT

ELECTRONIC ... CLEARINGHOUSE INFORMATION (Not applicable at this time)

ClearingHouse Name:

ClearingHouse Contact Name

ClearingHouse Contact Name: **Telephone Number:**

Email Address:

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

Vendor Name:

Vendor Contact

Vendor Contact Name: **Telephone Number:**

Email Address:

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

Step 10: Complete 835/ERA

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Submit | Print | Help

Vendor Contact

Vendor Contact Name: **Telephone Number:**

Email Address:

SUBMISSION INFORMATION

Reason for Submission

○ Cancel Enrollment ○ Change Enrollment ◉ New Enrollment *

Authorized Signature

Electronic Signature of Person Submitting Enrollment:

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

Authorization Agreement

By signing this request, I am authorizing 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: Teresa, Anderson

Printed Title of Person Submitting Enrollment: andersoh64

Submission Date: 09/07/2023

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)

- 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: ***Upload Documents*** to continue your application.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/05/2023	Complete	
Step 8: Associate Billing Agent	Optional	09/05/2023	09/05/2023	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	09/07/2023	09/07/2023	Complete	
Step 10: 835/ERA Enrollment Form	Optional	09/07/2023	09/07/2023	Complete	
Step 11: Upload Documents	Optional			Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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Step 11: Upload Documents

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

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Upload Documents

Save Delete

Document Type *	Document Name *	File Name *	Remarks	Uploaded By	Uploaded Date
--Select--	--Select--	Choose File			

--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.
- Click the link below to find the checklist for required documentation for transportation, home health and DME providers.
    - High Risk Providers | HFS (illinois.gov)

Step 11: Upload Documents

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Upload Documents

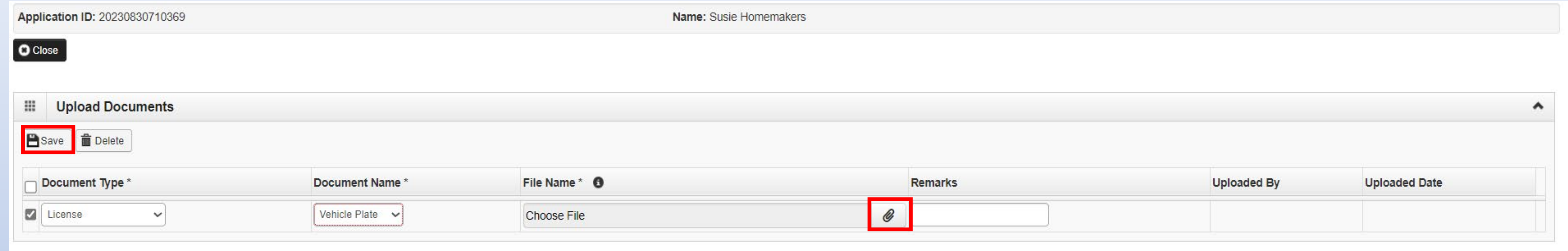
Save Delete

	Document Type *	Document Name *	File Name *	Remarks	Uploaded By	Uploaded Date
☑	License	--Select--	Choose File			

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

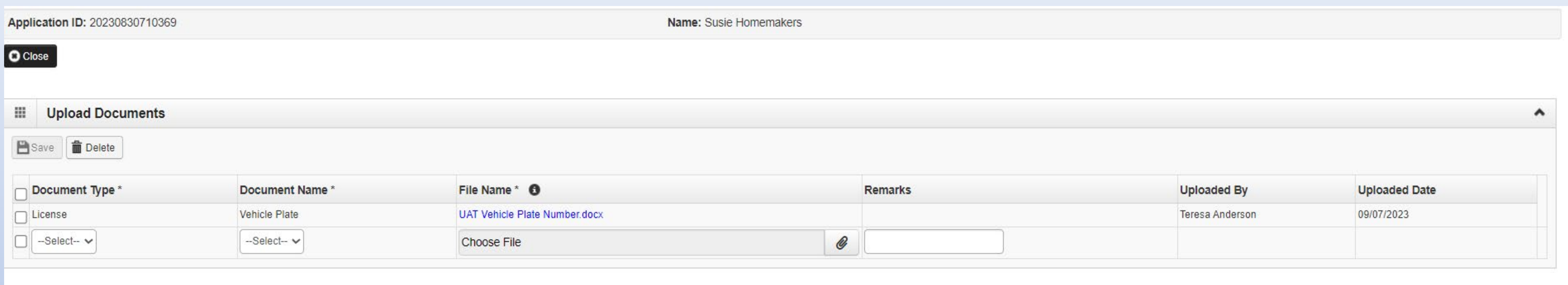
- From Document Name drop down box select the name of the document being uploaded.

Step 11: Upload Documents



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

Step 11: Upload Documents



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

Business Process Wizard (BPW)

- You have completed Step 11: ***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 12: ***Complete Checklist Questions*** to continue your application.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/05/2023	Complete	
Step 8: Associate Billing Agent	Optional	09/05/2023	09/05/2023	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	09/07/2023	09/07/2023	Complete	
Step 10: 835/ERA Enrollment Form	Optional	09/07/2023	09/07/2023	Complete	
Step 11: Upload Documents	Optional	09/07/2023	09/07/2023	Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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Step 12 Complete Enrollment Checklist

Application ID: 20230830710369 **Name:** Susie Homemakers

Close Save

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.	Not Completed (No / Not Completed / Yes)	
Do you wish to end date your enrollment? If yes, what date?		
Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	Not Completed	
Are you currently excluded from any federal program? If yes, provide the program and date.	Not Completed	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	Not Completed	
Have you ever had a judgment under any false claims act? If yes, list judgment and date	Not Completed	
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	Not Completed	
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	Not Completed	
Have you ever had a program exclusion/debarment? If yes, provide program and date	Not Completed	
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	Not Completed	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	Not Completed	
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?	Not Completed	

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

Business Process Wizard (BPW)

- You have completed Step 12: ***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 13 ***Submit Enrollment Application for Approval*** to continue your application.

Application ID: 20230830710369 **Name:** Susie Homemakers

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/07/2023	Complete	
Step 8: Associate Billing Agent	Required	09/05/2023	09/07/2023	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	09/07/2023	09/07/2023	Complete	
Step 10: 835/ERA Enrollment Form	Optional	09/07/2023	09/07/2023	Complete	
Step 11: Upload Documents	Optional	09/07/2023	09/07/2023	Complete	
Step 12: Complete Enrollment Checklist	Required	09/07/2023	09/07/2023	Complete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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Step 13: Submit Enrollment for Approval

Application ID: 20230830710369 **Name:** Susie Homemakers

Close | Next

Final Submission

Application ID: 20230830710369 EnrollmentType: Atypical Agency Provider

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 the information that you have submitted as a part of the application is accurate.

Step 13: Submit Enrollment for Approval

Application ID: 20230830710369 **Name:** Susie Homemakers

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

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***.

Business Process Wizard (BPW)

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

Application ID: 20230830710369 **Name:** Susie Homemakers

Your Application Number 20230830710369 has been successfully submitted for State review. Return with this application number to track the status of your application. ×

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/07/2023	Complete	
Step 8: Associate Billing Agent	Required	09/05/2023	09/07/2023	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	09/07/2023	09/07/2023	Complete	
Step 10: 835/ERA Enrollment Form	Optional	09/07/2023	09/07/2023	Complete	
Step 11: Upload Documents	Optional	09/07/2023	09/07/2023	Complete	
Step 12: Complete Enrollment Checklist	Required	09/07/2023	09/07/2023	Complete	
Step 13: Submit Enrollment Application for Approval	Required	09/07/2023	09/07/2023	Complete	

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Business Process Wizard (BPW)

- You have completed Step 13: ***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.

Application ID: 20230830710369 **Name:** Susie Homemakers

Your Application Number 20230830710369 has been successfully submitted for State review. Return with this application number to track the status of your application. ×

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/30/2023	08/30/2023	Complete	
Step 2: Add Locations	Required	08/30/2023	08/30/2023	Complete	
Step 3: Add Specialties/Taxonomy	Required	08/30/2023	08/30/2023	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional	09/05/2023	09/05/2023	Complete	
Step 5: Bed Information	Optional			Complete	
Step 6: Add License/Certification/Other	Optional	09/05/2023	09/05/2023	Complete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required	09/05/2023	09/07/2023	Complete	
Step 8: Associate Billing Agent	Required	09/05/2023	09/07/2023	Complete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	09/07/2023	09/07/2023	Complete	
Step 10: 835/ERA Enrollment Form	Optional	09/07/2023	09/07/2023	Complete	
Step 11: Upload Documents	Optional	09/07/2023	09/07/2023	Complete	
Step 12: Complete Enrollment Checklist	Required	09/07/2023	09/07/2023	Complete	
Step 13: Submit Enrollment Application for Approval	Required	09/07/2023	09/07/2023	Complete	

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Resources

- 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
  - Phone: 1-877-782-5565
    - Choose option 1 for IMPACT Help