Table of Contents

R-1 Claim Preparation and Mailing Instructions – Form HFS 2212 (pdf), Health Agency Invoice

R-2 Preparation and Mailing Instructions – Form HFS 1409 (pdf), Prior Approval Request

R-3 Explanation of Information on Provider Information Sheet

R-3a Facsimile of Provider Information Sheet

R-4 Internet Quick Reference Guide

Appendix R-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2212 (pdf), Health Agency Invoice

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL letters. The character pitch must be 10-12 printed characters per inch. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

A sample of the HFS 2212 (pdf) may be found on the Department's website. Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of provider services.

Completion	**Item**	**Explanation and Instructions**
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** – Enter the NPI number.
Required	**3.**	**Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.
Not Required	4.	**Group** – Leave blank.
Not Required	5.	**Role** – Leave blank.
Conditionally Required	6.	**Acc/Inj** – When applicable enter one of the following codes to indicate the probable reason the participant sought treatment: 1 - Employment related accident or illness. 2 - Injury received while operating a motor vehicle, as a passenger in a motor vehicle, or in another type of accident involving a motor vehicle. 3 - Injury due to participation in an organized sport or school activity. 4 - Injury due to an act of violence (non-accidental). 5 - Injury is the result of an unspecified accident.

Completion	Item	Explanation and Instructions
Optional	**7.**	**Provider Reference** – Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form HFS-194-M-2, Remittance Advice, returned to the provider.
Optional	**8.**	**Provider Street** – Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections.
Conditionally Required	**9.**	**Facility & City Where Service Rendered** – This entry is required when Place of Service Code is other than 12 (patient's home).
Conditionally Required	**10.**	**Prior Approval** – This entry is required when reporting a qualifying hospital discharge date. The participant's hospital discharge date is reported in 8 digit format (MMDDYYYY format). *Do not enter the prior approval number. Leave blank if there is no applicable hospital discharge date.
Optional	**11.**	**Provider City State Zip** – Enter city, state and zip code of provider address. See item 8 above.
Required	**12.**	**Referring Practitioner Name** – Name of referring physician.
Required	**13.**	**Ref Prac No. –** Enter the referring physician's NPI.
Required	**14.**	**Recipient Name –** Enter the participant's name exactly as it appears on HFS records. Separate the components of the name (first, middle initial, last) in the proper sections of the name field. Do not use punctuation between the names.
Required	**15.**	**Recipient No.** – Enter the nine-digit number assigned to the participant. Do not use the Case Identification Number.
Conditionally Required	**16.**	**Birth date** – Enter the month, day and year of birth of the participant. Use the MMDDYY format. If the birth date is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birth date is not entered, the Department will not attempt corrections.
Not Required	**17.**	**Healthy Kids –** Leave blank.
Not Required	**18.**	**Fam Plan –** Leave blank.
Not Required	**19.**	**Cr Child –** Leave blank.
Not Required	**20.**	**St/Ab –** Leave blank.
Required	**21.**	**Billing Date –** Enter the date the invoice was prepared. Use the 6 digit, MMDDYY, format.
Required	**22.**	**Primary Diagnosis Description –** Enter the primary diagnosis description from the ICD-9-CM for dates of service prior to 10/01/2015, or the ICD-10-CM for dates of service on/after 10/01/2015, which describes the condition primarily responsible for the participant's treatment.
Conditionally Required	**23.**	**Prefix –** When the ICD-9-CM diagnosis code has an alphabetic prefix of E or V, enter it here.

Completion	Item	Explanation and Instructions
Required	**24.**	**Diag Code** – Enter the primary diagnosis code exactly as it appears in the ICD-9-CM or ICD-10-CM manual. For ICD-10-CM diagnosis codes, this field will contain both the alpha and numeric characters of the diagnosis code. Do not enter the decimal point.
Conditionally Required	**25.**	**Secondary Diagnosis** – When treatment is the result of dissimilar conditions, the diagnosis description from the ICD-9-CM or ICD-10 for the secondary diagnosis is entered.
Conditionally Required	**26.**	**Prefix** – When the ICD-9-CM diagnosis code has an alphabetic prefix of E or V, enter it here. Do not use this field for the ICD-10 diagnosis. This entry is required only if a secondary diagnosis is entered.
Conditionally Required	**27.**	**Diag Code** – Enter the secondary diagnosis code exactly as it appears in the ICD-9-CM or ICD-10-CM manual. For ICD-10-CM diagnosis codes, this field will contain both the alpha and numeric characters of the diagnosis code. Do not enter the decimal point.
	28.	**Service Sections** **Intermittent Services** – Complete one service section per date of service for each service provided to the participant. **In-home Shift Nursing** – For dates of service prior to January 1, 2016 complete one service section at the end of each work week. For dates of service on/after January 1, 2016, complete one service section for each date of service.
Required	**Proc. Desc.**	**Intermittent Services** – Enter the appropriate description of the service provided. **In-home Shift Nursing** – Enter the appropriate description of the service provided.
Required	**Proc. Code**	**Intermittent Services** – Enter the appropriate five-digit procedure code listed on the Provider Information Sheet or the Home Health Agency fee schedule. **Modifier U2** – Report the 2-byte modifier immediately following the procedure code to designate an initial skilled nurse assessment visit or the initial therapy evaluation visit. **In-home Shift Nursing** – Enter procedure code G0299, G0300 or G0156.
Conditionally Required	**Delete**	When an error has been made that cannot be corrected, enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	**Date of Serv.**	**Intermittent Services** – Enter the date the service was performed. Use the 6 digit, MMDDYY, format. **In-home Shift Nursing** – For dates of service prior to January 1, 2016, enter the last day of the work week. For dates of service on/after January 1, 2106, enter the date the service was performed. Use the 6 digit, MMDDYY, format.
Required	**Cat. Serv.**	Enter 66 – Home Health Services.

Completion	Item	Explanation and Instructions
Required	**Place of Serv.**	**Intermittent Services** – Enter the appropriate two digit Place of Service Code: Code: Place of Service: 04 Homeless Shelter 12 Home 13 Assisted Living 14 Group Home 32 Nursing Facility 33 Custodial Care Facility **In-home Shift Nursing** – Enter “12” for home.
Required	**Units**	**Intermittent Services** – Enter the number of visits per day. **In-home Shift Nursing** – For dates of services prior to January 1, 2016, enter “1” for one week. For dates of services on/after January 1, 2016, enter the number of hours of service provided for the date of service. If less than an hour of service is provided, round the quantity up to the next hour.
Not Required	Shaded Field	Leave blank.
Conditionally Required	**TPL Code**	If payment was received from a third party resource, enter the appropriate TPL Code. Do not include the leading alpha character. **Spenddown** – Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the “Spenddown Met” date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual participant liability as shown on the HFS 2432 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in 6 digit, MMDDYY, format. If the HFS 2432 shows a participant liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in a 6 digit, MMDDYY, format.

Completion	Item	Explanation and Instructions
Conditionally Required	**TPL Status**	If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL Code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the participant’s third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – participant not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the participant was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the participant’s HFS 2432 shows $0.00 liability. **05 – Participant not covered:** TPL Status Code 05 is to be entered when a participant informs the provider that the third party resource identified on the Identification Card is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Explanation and Instructions
Conditionally Required	**TPL Amount**	Enter the amount of payment received from the third party resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field. For TPL Status Codes 02-10, enter 000. If there is no TPL code, no entry is required.
Conditionally Required	**TPL Date**	A TPL date is required when any status code is shown in field 37B. Use the date specified below for the applicable TPL Status Code: **Code** **Date to be entered** 01 Third Party Adjudication Date 02 Third Party Adjudication Date 03 Third Party Adjudication Date 04 Date from the HFS 2432, Split Bill Transmittal 05 Date of Service 06 Date of Service 07 Date of Service 10 Third Party Adjudication Date
Required	**Provider Charge**	**Intermittent Services** – Enter the total charge for the service, not deducting any TPL. **In-home Shift Nursing** – Effective with dates of service January 1, 2016, enter the approved hourly rate multiplied by the number of hours of service per date of service. Charges for services less than one hour should be adjusted in accordance with the chart below: Service Time — Charge Amount Less than 8 minutes — Not billable 9 – 22 minutes — ¼ of the hourly rate 23 – 37 minutes — ½ of the hourly rate 38 – 52 minutes — ¾ of the hourly rate 53 – 60 minutes — Full hourly rate For services prior to January 1, 2016 enter the total weekly charge amount determined by the approved hourly rate multiplied by the total number of hours for the week ending.
Conditionally Required	**Repeat**	Place "X" if the service is done on the next date.
Not Required	29.	Shaded Area – Leave blank.
	30.	**Charges and Deductions Section** – The information field in the lower right of the HFS 2212 (pdf) is to be used: 1) to identify additional third party resources in instances where the participant has access to two or more resources; 2) to identify uncoded TPL carriers by name, and; 3) to calculate total and net charges. If a second third party resource was identified for one or more of the services billed in Services Section 1 through 7, complete the TPL field in accordance with the following instructions:

Completion	Item	Explanation and Instructions
Conditionally Required	**Sect. #**	If more than one third party made a payment for a particular service, enter the Service Section number (1 through 7) in which that service is reported. If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in this section will be applied to the total of all Service Sections on the Invoice.
Conditionally Required	**TPL Code**	Enter the appropriate TPL Resource Code. Enter 999 and enter the name of the payment source in the Uncoded TPL Name field if unknown.
Conditionally Required	**Status**	Enter the appropriate TPL Status Code. See Item 28 in this Appendix for correct coding of this field.
Conditionally Required	**TPL Amount**	Enter the amount of payment received from the third party resource.
Conditionally Required	**TPL Date**	Enter the date the claim was adjudicated by the third party resource. (See Item 28 in this Appendix for correct coding of this field.)
Conditionally Required	**Uncoded TPL Code**	Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

The following three claim summary fields must be completed on all invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom right of the HFS 2212 (pdf).

Completion	Item	Explanation and Instructions
Required	**Total Charge**	Enter the sum of all charges submitted on the invoice in Service Sections 1 through 7.
Required	**Total Deduct.**	Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).
Required	**Net Charge**	Enter the difference between Total Charge and Total Deductions fields.
Required	**31.**	**# Sects** – Enter the total number of Service Sections completed correctly in the top part of the form. This entry must be at least one (1) and not more than seven (7). Do not count any sections that were deleted.
Not Required	32.	Original DCN – Leave blank.
Not Required	33.	Original Voucher Number – Leave blank.
Required	**Provider Certific. Signature and Date**	After reading the certification statement, the provider or an authorized representative must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered.

Mailing Instructions

The Health Agency Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The pin-feed guide strip should be detached from the sides of continuous feed forms. The copy of the claim is to be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 2246, Health Agency Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
P.O. Box 19125
Springfield, Illinois 62794-9125

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 1414, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more documents are attached:

Mailing address: Healthcare and Family Services
PO Box 19118
Springfield, Illinois 62794-9118

Forms Requisition - Billing forms may be requested on our Web site at the Medical Provider Forms Request page, or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

Appendix R-2

Preparation and Mailing Instructions for Form HFS 1409 (pdf), Prior Approval Request

Form **HFS 1409 (pdf)**, Prior Approval Request is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services requiring prior approval are identified in this handbook and the Home Health Fee Schedule.

A sample of Form **HFS 1409 (pdf)**, Prior Approval Request may be found on the Department's website.

Instructions for Completion

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of provider services.

Completion	Item	Explanation and Instructions
Required	**1.**	**Recipient ID Number** – Enter the nine-digit recipient identification number assigned to the participant for whom the service is requested.
Required	**2.**	**Recipient Name** - Enter the name of the participant for whom the service is requested.
Required	**3.**	**Birthdate** - Enter the participant's birthdate.
Required	**4.**	**Provider#/NPI #** - Enter the provider number or NPI number as shown on the Provider Information Sheet.

Completion	Item	Explanation and Instructions
Required	**5.**	**Provider Telephone #** - Enter the telephone number of the provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Required	**6.**	**Provider Name** – Enter the name of the provider who will provide the service or item.
Required	**7.**	**Physician Name** – Enter the name of the physician or other practitioner who signed the order or prescription recommending that the participant receive the specific service.
Required	**8.**	**Provider Street Address** – Enter the address of the provider.
Required	**9.**	**Physician Street Address** – Enter the address of the ordering practitioner.
Required	**10.**	**Provider City, State ZIP Code** – Enter the address of the provider.
Required	**11.**	**Physician City, State, ZIP Code** – Enter the address of the ordering practitioner.
Required	**12.**	**Diagnosis Code** – Enter the ICD-10 diagnosis code that corresponds to the description listed in item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis** – Enter additional ICD-10 diagnosis code, if applicable.
Required	**14.**	**Diagnosis Description** – Enter the written description, which corresponds with the diagnosis code listed in item 12.
Not Required	15.	Participant Height/Weight – Leave blank.
Required	**16.**	**Procedure Code** – Enter the five-digit HCPCS or CPT code that identifies the specific service being requested.
Required		**Description** – For home health services, specify if the services requested are either intermittent visits or hourly in-home shift nursing.
Required		**Qty** – Enter the number of times the service is to be performed. Enter the total number of visits that will be provided during the requested time period.
Required		**Cat Serv** – Enter the two-digit category of service corresponding to the service. **66** – Home Health Services

Completion	Item	Explanation and Instructions
Required		**Prov Charge** – Enter the total amount to be charged for the service being requested.
Not Required		Approved HFS Amt – Leave blank.
Conditionally Required		**Begin Date** – If a service has already been provided, enter the date the service was provided.
Conditionally Required		**End Date** – Indicate the ending date of service.
Required		**Pur/Rent** – Enter "P".
Not Required		Mod – To be used for modifiers at a later date.
Conditionally Required	**17-20**	To be used for additional procedures. If you list more than five (5) procedures another request must be submitted.
Conditionally Required	**21.**	**Additional Medical Necessity** – To be used for other medical information.
Conditionally Required	**22.**	**Approving Authority Signature** – To be used by the Department of Children and Family Services to authorize in-home shift nursing.
Required	**23.**	**Provider Signature/Date** – To be signed in ink by the provider's authorized designee.

Mailing Instructions

Before mailing, carefully review the request for completeness and accuracy. The signed copy of the Form **HFS 1409 (pdf)** may be mailed to:

Mailing Address: Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Post Office Box 19124
Springfield, Illinois 62794-9124

A copy may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider and participant.

Fax Instructions

The signed copy of the Form **HFS 1409 (pdf)** may be faxed Monday through Friday, 8:30 AM – 5:00 PM, except holidays, to the following number 217-524-0099.

Appendix R-3
Explanation of Information on Provider Information Sheet

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via IMPACT.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix R-3a.

Field	Explanation
Provider Key	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI.
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** Code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative, which indicates the provider's classification.

<table>
<tr><th>Field</th><th>Explanation</th></tr>
<tr><td>Enrollment Specifics</td><td>Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation
04 = Group Practice

Enrollment Status is a one-digit code and corresponding narrative, which indicates whether or not the provider is currently an active participant in the Department’s Medical Programs. The possible codes are:

B = Active
I = Inactive

Immediately following the enrollment status indicator are the Begin date indicating when the provider was most recently enrolled in Department’s Medical Programs and the End date indicating the end of the provider’s most current enrollment period. If the provider is still actively enrolled, the word “ACTIVE” will appear in the End date field.

Exception Indicator may contain a one-digit code and corresponding narrative indicating that the provider’s claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested by Audits
C = Citation to Discover Assets
G = Garnishment
T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the Exception Indicator is the Begin date indicating the first date when the provider’s claims are to be manually reviewed and the End date indicating the last date the provider’s claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.</td></tr>
<tr><td></td><td></td></tr>
</table>

Field	Explanation
Enrollment Specifics	**AGR** (Agreement) indicates whether the provider has agreed to the Terms & Conditions in IMPACT. If the value of the field is yes, the provider is eligible to submit claims electronically.
Certification/License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.
Categories of Service	This area identifies special licensure information and the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a practitioner is authorized to render to participants covered under the Department's Medical Programs. 066 – Home Health Each entry is followed by the date that the provider was approved to render services for each category listed.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid. **If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.** **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.
NPI	The National Provider Identification Number contained in the Department's database.
Signature	The provider is required to affix an original signature when submitting charges to the Department of Healthcare and Family Services. Stamped signatures are not acceptable.

Appendix R-3a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
HEALTHCARE AND FAMILY SERVICES
PROVIDER INFORMATION SHEET

MEDICAID SYSTEM (MMIS)
PROVIDER SUBSYSTEM
REPORT ID: A2741KD1
SEQUENCE: PROVIDER TYPE
PROVIDER NAME

RUN DATE: 8/02/15
RUN TIME: 11:47:06
MAINT DATE: 8/02/15
PAGE: 84

- -PROVIDER KEY- -
000011111

PROVIDER NAME AND ADDRESS
ABC COMMUNITY HEALTH
1421 MY STREET
ANYTOWN, IL 62000

PROVIDER GENDER:
COUNTY 089-SCOTT
TELEPHONE NUMBER 217-742-4567

PROVIDER TYPE: 050 – HOME HEALTH AGENCY
ORGANIZATION TYPE: 03 – CORPORATION
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/15/08 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 000011111 ENDING 03/31/10
UPIN#:
LAST TRANSACTION ADD AS OF 04/21/97
SS #: 00000000
CLIA#:

D.E.A.#:
RE-ENROLLMENT INDICATOR: N DATE: 11/15/08

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
066	HOME HEALTH SERVICES	01/01/09				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	ABC COMMUNITY HEALTH DBA: MEDICARE/PIN: 999999	1421 MY STREET	ANYTOWN	IL	62000	001010101-6200-01 VENDOR ID: 01		08/02/15

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
0000000000

********** PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE ________ X ____________________

Appendix R-4
Internet Quick Reference Guide

The Department's handbooks are designed for use via the Web and contain hyperlinks to the pertinent information.

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Claims Processing System Issues
Child Support Enforcement
Dental Program
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
State Chronic Renal Disease Program
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
Place of Service Codes
Centers for Medicare and Medicaid Services (CMS)