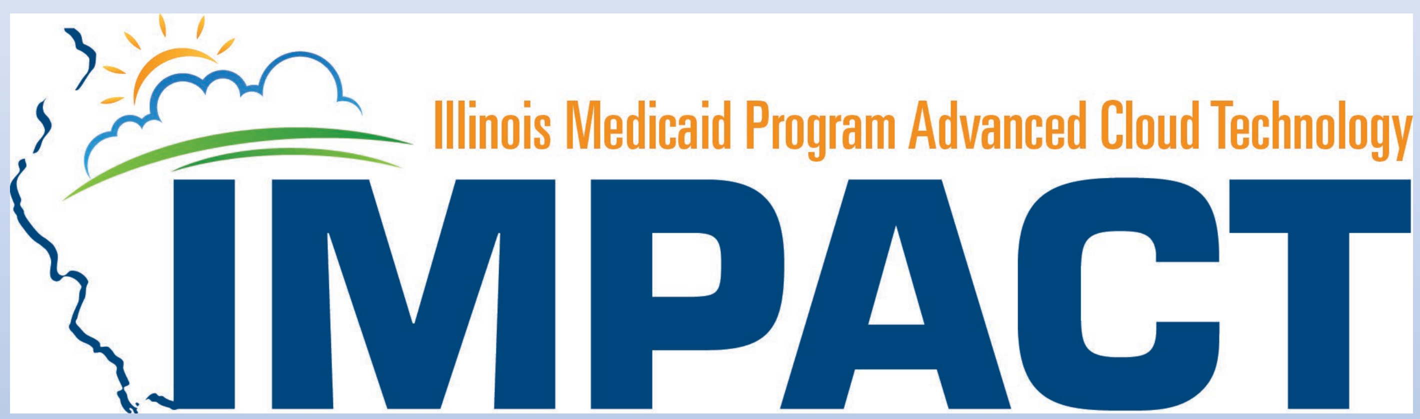
ILLINOIS PROVIDER ENROLLMENT



Groups

OKTA LOGIN

ILogin

Sign In

Username

Please enter a username

Password

Please enter a password

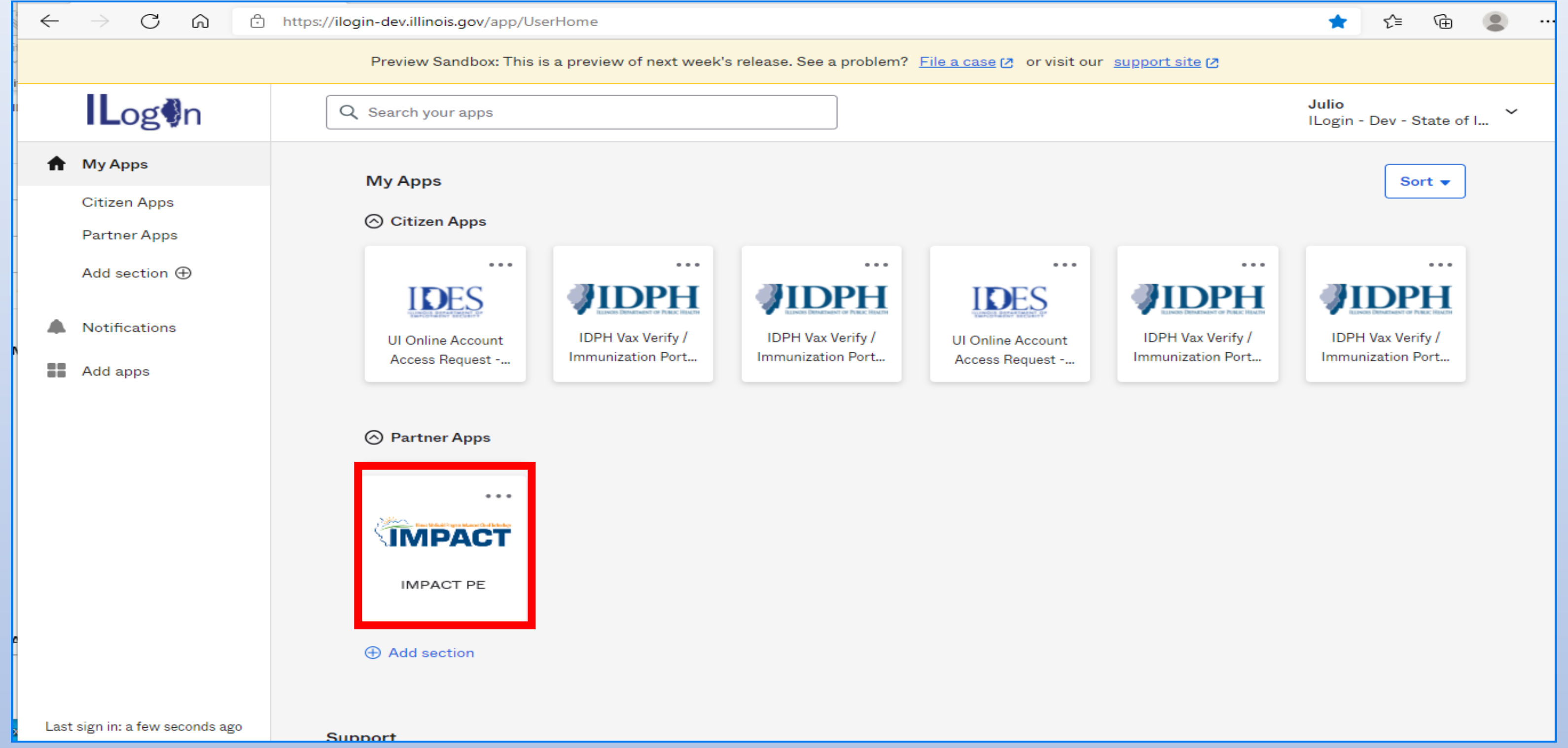
Remember me

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

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

Application Process

IMPACT

My Inbox ▾ | Provider ▾

Anderson,Teresa ▾

> MyInbox

My Reminders

Filter By | Read Status | Go

Alert Type	Alert Message

Notification

User1 sent you message *Yesterday*
User1 sent you message *Yesterday*
User1 sent you message *Yesterday*

PROVIDER ENROLLMENT
- New Enrollment
- Track Application
- List Applications

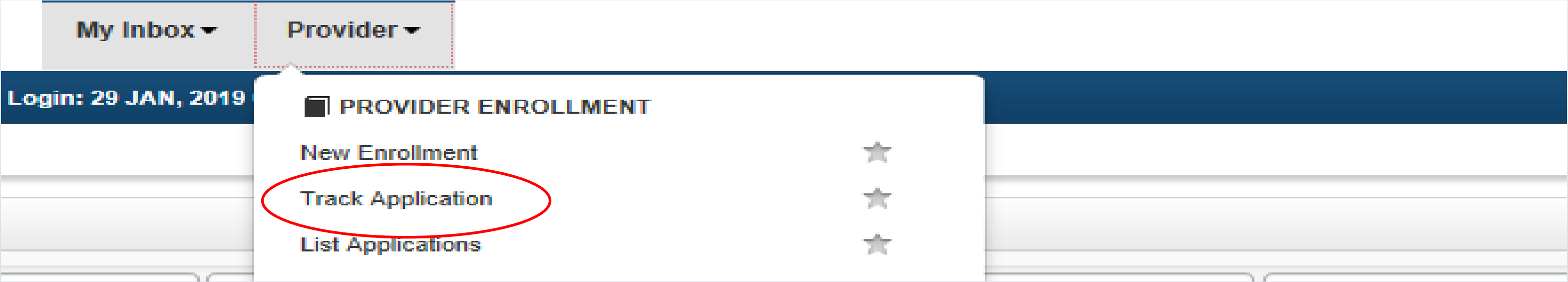
MANAGE PROVIDER
- Provider List
- Provider Modification Request List

ALL PROVIDER LIST
- All Provider List

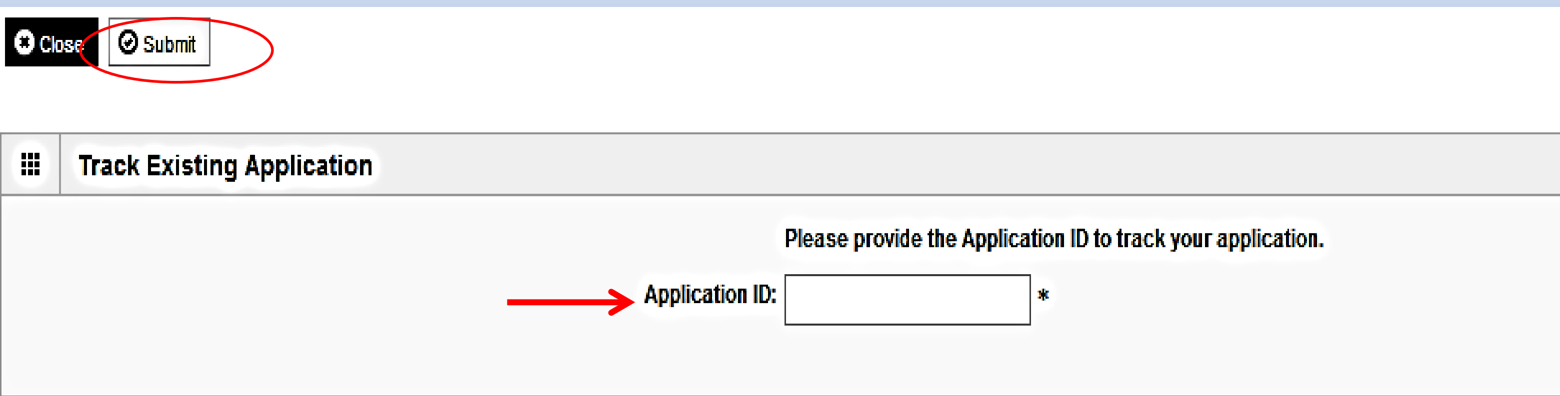
ADMINISTER
- Provider Types
- Provider Type/Specialty/Subspecialty Matrix
- Provider Specialty/Subspecialty
- License/Certification List

- 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

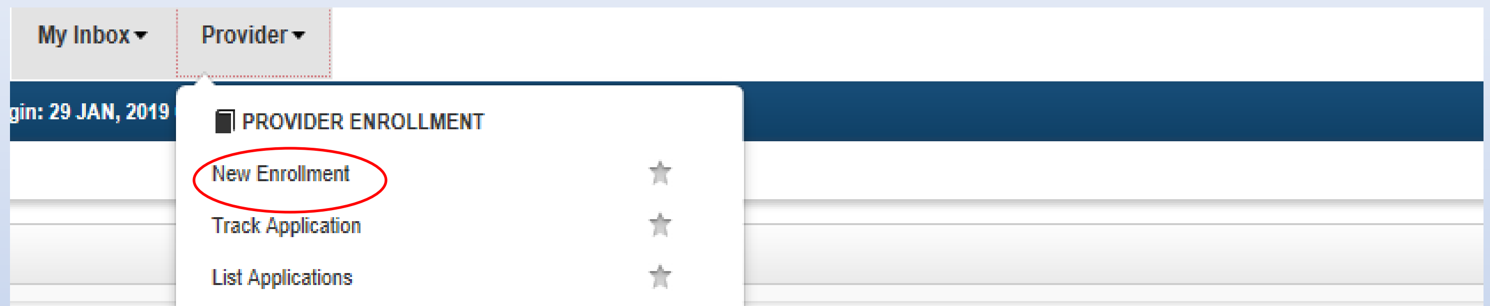


- To resume an application, click on ***Track Application***.



- 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

Basic Information: Enter required fields and click Confirm button.

Basic Information

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

☐ **LLC (Disregarded Entity)**

Entity Business Name: Illinois Group * (Doing Business As)

EIN/TIN: 100021508 *

NPI: 1000215081 *

Contact Email Address:

Email-1:	xxx.xxx.@xxx.com *	**Email-2:**	xxx.xxx.@xxx.com
Email-3:	xxx.xxx.@xxx.com	**Email-4:**	xxx.xxx.@xxx.com
Email-5:	xxx.xxx.@xxx.com	**Email-6:**	xxx.xxx.@xxx.com

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

- If the following error message is received after entering the required basic information, your EIN/TIN or SSN has not been certified by the Illinois Comptroller.
- Upon receipt of this error message submit your **completed** W9 to IMPACT.HELP@illinois.gov

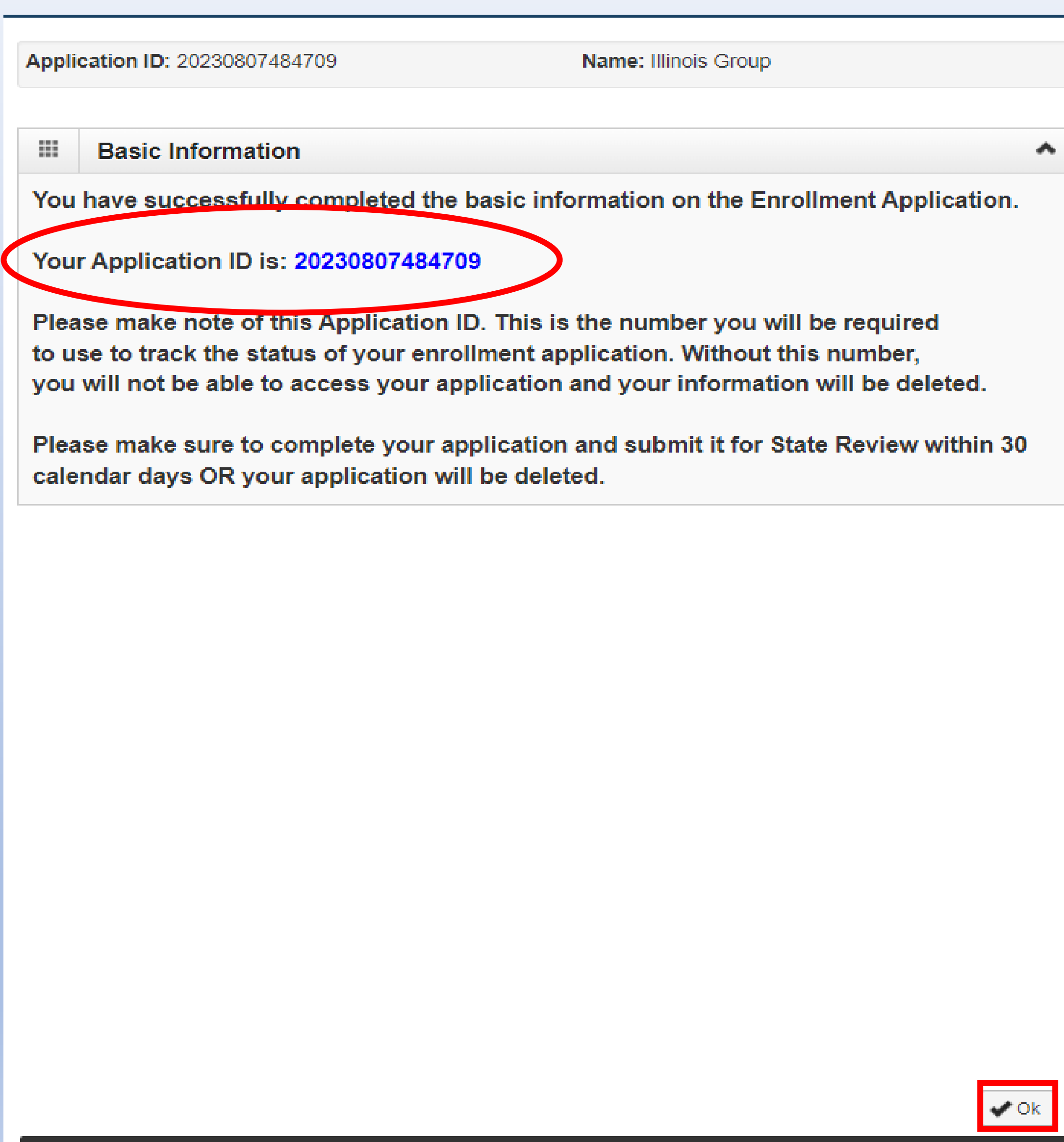
Close

VM_PRV.300003:The system cannot confirm your Employer ID Number/Tax ID Number (EIN/TIN) or the information associated with your reported number. The state requires all providers to certify their social security or EIN/TIN numbers using the W-9 [Request for Taxpayer Identification Number and Certification] form prior to enrollment. Please contact IMPACT.Help@illinois.gov or call 1-877-782-5565 for further assistance.

Details | Copy To Clipboard

Start New Application

Step 1: Basic Provider Information



- Application ID: systematically generated.
- Name: should reflect name from the Basic Information screen.
- The system will generate an application ID after the successful completion of the Basic Information screen; the application ID is a 14-digit number that has the following components:
  - –The system date in yyyymmdd format
  - –A 6-digit system generated random number
  - –Example: 20230807484709
- 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 the application has been approved.
- After documenting the application ID, click *OK*.

Using the Business Process Wizard (BPW)

The BPW serves as the "Control Center" of the application.

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	08/07/2023	08/07/2023	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties/Taxonomy	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Upload Documents	Optional			Incomplete	
Step 10: Complete Enrollment Checklist	Required			Incomplete	
Step 11: 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: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

Step 2: Add Locations

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

Application ID: 20230807484709 **Name:** Illinois Group

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 Group

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

- Complete all boxes marked with an asterisk *.
- Enter the street address and zip code, then click ***Validate Address***.
- Scroll down the page to continue.

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:	Closec *	AM PM *	*	AM PM *	Thursday:	07:30 *	AM PM *	06:30 *	AM PM *
Monday:	07:30 *	AM PM *	06:30 *	AM PM *	Friday:	07:30 *	AM PM *	05:00 *	AM PM *
Tuesday:	07:30 *	AM PM *	06:30 *	AM PM *	Saturday:	Closec *	AM PM *	*	AM PM *
Wednesday:	07:00 *	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)

OK Cancel

- When all the information has been entered, scroll down, click ***OK*** in the lower right corner.
- Note that the office hours section must be filled out completely to proceed.

Step 2: Add Locations

- Click on ***Primary Practice Location*** to add each address for this Location.
- For the Primary Practice Location, a ***Correspondence*** and a ***Pay To*** address are required.

Step 2: Add Locations

Application ID: 20230807484709 **Name:** Illinois Group

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

Web Page:

Communication Preference: Email

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Closec *	AM PM *	*	AM PM *	Thursday:	07:30 *	AM PM *	06:30 *	AM PM *
Monday:	07:30 *	AM PM *	06:30 *	AM PM *	Friday:	07:30 *	AM PM *	05:00 *	AM PM *
Tuesday:	07:30 *	AM PM *	06:30 *	AM PM *	Saturday:	Closec *	AM PM *	*	AM PM *
Wednesday:	07:00 *	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

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 address information.

Step 2: Add Locations

Application ID: 20230807484709 **Name:** Illinois Group

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: 20230807484709 **Name:** Illinois Group

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

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 *	06:30 *	PM *
Monday:	07:30 *	AM *	06:30 *	PM *	Friday:	07:30 *	AM *	05:00 *	PM *
Tuesday:	07:30 *	AM *	06:30 *	PM *	Saturday:	Closed *	AM PM *	*	AM PM *
Wednesday:	07:00 *	AM *	05:00 *	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

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

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

- When all the addresses have been entered for the Primary Practice Location, click ***Close***.

Step 2: Add Locations

- To enter an Other Servicing Location, click on ***Add*** and repeat the previous steps. A Correspondence address will need to be entered for the Other Servicing Location.
- Once all address details have been entered, click on ***Close***.

Business Process Wizard

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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

- The system will place the current date in the End Date field and will place ***Complete*** for Step 2.
- Click on Step 3: ***Add Specialties/Taxonomy*** to continue with the application.

Step 3: Add Specialties/Taxonomy

Application ID: 20230807484709 **Name:** Illinois Group

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

Step 3: Add Specialties/Taxonomy

Application ID: 20230807484709 **Name:** Illinois Group

Add Specialty/Subspecialty

Location: 01-Illinois Group *

Provider Type: GROUP *

Specialty: Dental *

End Date:

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. A ***Subspeciality*** is not required for this provider type.
- If no ***Subspeciality*** automatically populates move to the next step.
- Once all Specialty information has been added , click ***OK*** in the bottom right corner

Application ID: 20230807484709 **Name:** Illinois Group

Add Specialty/Subspecialty

Location: 01-Illinois Group *

Provider Type: GROUP *

Specialty: Dental *

End Date:

Add Subspecialty

Available Subspecialties **Associated Subspecialties** *

No Subspecialty

OK Cancel

- If ***No Subspeciality*** automatically populates click the double arrows to move ***No Subspeciality*** over to the ***Associated Subspecialities*** box.

Step 3: Add Specialties/Taxonomy

Application ID: 20230807484709 **Name:** Illinois Group

Close

Specialty/Subspecialty List

Add

Filter By | Go | Save Filters | My Filters

Specialty/Subspecialty	Provider Type	End Date
Dental/No Subspecialty	GROUP	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
261QD0000X	Dental	08/07/2023	12/31/2999

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

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

Step 3: Add Specialties/Taxonomy

Application ID: 20230807484709 **Name:** Illinois Group

Close

Specialty/Subspecialty List

Add

Filter By | Go | Save Filters | My Filters

Specialty/Subspecialty	Provider Type	End Date
Dental/No Subspecialty	GROUP	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
261QD0000X	Dental	08/07/2023	12/31/2999

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

- The Taxonomy Code should automatically populate but if it does not click on the Add tab under Taxonomy List.
- At least one of the Taxonomy Codes entered in IMPACT must be the Taxonomy Code registered with the National Plan and Provider Enumeration System (NPPES).
- If taxonomy code automatically populates proceed to slide 34.

Step 3: Add Specialties/Taxonomy

Application ID: 20230807484709 **Name:** Illinois Group

Add Taxonomy

Taxonomy Code: * (Click here for Taxonomy List)

Location: 01-Illinois Group *

Description:

Start Date: *

End Date:

Confirm Taxonomy | Ok | Cancel

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

Step 3: Add Specialties/Taxonomy

NUCC National Uniform Claim Committee

Search this site ...

HOME ANNOUNCEMENTS NUCC STRUCTURE CALENDAR 1500 CLAIM FORM CODE SETS DEFINITIONS RESOURCES

CONDITION CODES
PROVIDER CHARACTERISTICS >
PROVIDER TAXONOMY >

CODE LOOKUPS
MORE INFORMATION
NEW CODES
MODIFICATIONS
PDF
CSV

Code Sets

1. Condition Codes
2. Provider Characteristic Codes
3. Provider Taxonomy Codes

Copyright 2023 American Medical Association

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

Step 3: Add Specialties/Taxonomy

NUCC
National Uniform Claim Committee

Search this site …

HOME | ANNOUNCEMENTS | NUCC STRUCTURE | CALENDAR | 1500 CLAIM FORM | CODE SETS | DEFINITIONS | RESOURCES

CODE LOOKUPS

CODE LOOKUP

The Provider Taxonomy code lookup is available online at https://taxonomy.nucc.org/.

- Click on the ***red*** hyperlink

Step 3: Add Specialties/Taxonomy

Health Care Provider Taxonomy Code Set

search

Expand / Collapse All

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

Health Care Provider Taxonomy Code Set

Single Specialty Group

Code	193400000X
Name	Single Specialty
Definition	A business group of one or more individual practitioners, all of who practice with the same area of specialization.
Notes	*[7/1/2003: new]*
Effective Date	10/1/2003

Step 3: Add Specialties/Taxonomy

Application ID: 20230807484709 **Name:** Illinois Group

Add Taxonomy

Taxonomy Code: 193400000X * (Click here for Taxonomy List) **Location:** 01-Illinois Group *

Description:

Start Date: 08/07/2023 * **End Date:** 12/31/2999

Confirm Taxonomy | Ok | Cancel

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

Step 3: Add Specialties/Taxonomy

Application ID: 20230807484709 **Name:** Illinois Group

Close

Specialty/Subspecialty List

Add

Filter By | Go | Save Filters | My Filters

	Specialty/Subspecialty	Provider Type	End Date
☐	Dental/No Subspecialty	GROUP	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
☐	261QD0000X	Dental	08/07/2023	12/31/2999

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

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

Business Process Wizard (BPW)

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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

- You have completed Step 3: ***Add Specialties/Taxonomy.*** The system will place the current date in the ***End Date*** field and will place ***Complete*** in the corresponding ***Status*** field.
- Click on Step 4: ***Associate Billing Provider/Other Associations*** to continue your application if applicable.
- If not adding a billing provider proceed to Step 5 on slide 37 .

Step 4: Associate Billing Provider/Other Associations

Note: This Step Is Optional.

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

Step 4: Associate Billing Provider/Other Associations

Application ID: 20230807484709 **Name:** Illinois Group

Associate Billing Provider/Other Associations

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

Type: NPI *

ID: 1487856944 *

Provider Name: TAZEWELL MASON CNTYS SP ED

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

Applicant Type:

Start Date: 08/07/2023 *

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.

Business Process Wizard (BPW)

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

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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Step 5: Mode of Claim Submission/EDI Exchange

Application ID: 20230807484709 **Name:** Illinois Group

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.
- If Billing Agent is selected Step 6 becomes required.
- After claim submission types have been selected click ***OK***.

Business Process Wizard

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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- The system will place the current date in the End Date field and will place ***Complete*** for Step 5.
- Click on Step 6: ***Associate Billing Agent*** (if applicable) to continue with the application.

Step 6: Associate Billing Agent

Note: *this is an optional step unless Billing Agent is selected in Step 5*

- If applicable, click ***Add*** to input a Billing Agent.

Step 6: Associate Billing Agent

Application ID: 20230807484709 **Name:** Illinois Group

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	☐		

Confirm/Search Billing Agent | 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 6: Associate Billing Agent

Application ID: 20230807484709 **Name:** Illinois Group

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 6: Associate Billing Agent

Application ID: 20230807484709 **Name:** Illinois Group

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: 5308923 *
Association Start Date: 08/07/2023 *
Billing Agent Name: Claimcare Inc.
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 Confirm/Search Billing Agent then ***OK*** to return to the Billing Agent list.

Business Process Wizard (BPW)

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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- You have completed Step 6: ***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 7: ***Add Provider Controlling Interest/Ownership Details*** to continue your application.

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

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… …vidences of ownership in the provider; (2) if the provider is a sole proprietorship, the owner of the provider; (3) if the provider is a partnership, each partner of the provider; (4) each individual who is a member of the provider's Board of Directors; and (5) each individual e… …who has management responsibility.During enrollment and revalidation, the provider shall provide the following information:

- The name, home address date of birth, and Social Security Numbers of any individual or corporate entity with an ownership or controlling interest in the provider. The addresses for corporate entities must include as applicable, primary business address, the address of each business location, and the address of any PO Box used. For each of the provider's subcontractors, the Tax Identification Number of any corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidence of ownership in the subcontractor.
- If any of the disclosed individuals with ownership or controlling interest are related disclose the nature of relation. In this context, "relation" means spouse, parent, child, or sibling.
- Where an individual with ownership or controlling interest in any of the provider's subcontractors is related to another individual who also has an ownership or controlling interest in the provider, the name of each related individual and his or her relation. In this context, "relation" means spouse, parent, child, or sibling.
- For each individual with ownership or controlling interest in the provider, the name of each fiscal agent or managed-care entity that is reimbursable by Medicaid and/or Medicare, in which that individual also has an ownership or controlling interest.

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

Owners List

Filter By And Indicator Go Save Filters My Filters

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

- Ownership entries must include at least one Managing Employee and one other Ownership type.
- To add Ownership listings, click on ***Actions, Add Owner or Import Owner.***

Step 7: Add Provider Controlling Interest/Ownership Details

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

Application ID: 20230807484709 **Name:** Illinois Group

Provider Controlling Interest/Ownership

Type:	Managing Employee *	Percentage Owned:	0 *
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:	03/15/1971 *
Phone Number:	(217) 555-1212 * Extn:	Email:	xxx.xxx.@xxx.com
Start Date:	08/07/2023 *	End Date:	

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

Address Type: Home Address

Address validation successful

Address Line 1:	119 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 (as prompted by the system).
- Enter ***Percentage Owned*** as a whole number.
- Enter the street address and zip code information, then click ***Validate Address***.
- When all details are entered, click ***OK.***

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

Close | Actions

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

Pe… anual

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- 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 !								

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

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

Close | Actions ▾

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

Pe... anual

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- 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
100001478	Jones,Cameron	Partnership	1516 Seven Pines Rd	08/07/2023	12/31/2999	Not Completed	Not Completed	50
100002816	Smith,Sam	Partnership	350 E Madison St	08/07/2023	12/31/2999	Not Completed	Not Completed	50
100002818	Anderson,Elizabeth	Managing Employee	119 Ruth Rd	08/07/2023	12/31/2999	Not Completed	Not Completed	0

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

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

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

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

> **Selected Owner**:Smith, Sam **SSN/EIN/TIN**:100002816 **Status**:Not Completed

> **Selected Owner**:Jones, Cameron **SSN/EIN/TIN**:100001478 **Status**:Not Completed

Save Close

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

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

Close | Actions | i

- 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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- 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
100001478	Jones,Cameron	Partnership	1516 Seven Pines Rd	08/07/2023	12/31/2999	Completed	Not Completed	50
100002816	Smith,Sam	Partnership	350 E Madison St	08/07/2023	12/31/2999	Completed	Not Completed	50
100002818	Anderson,Elizabeth	Managing Employee	119 Ruth Rd	08/07/2023	12/31/2999	Completed	Not Completed	0

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

- After all the Owner Relationship information has been added, click the **Actions** drop drown box and select **Owner Adverse Action**.

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

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
Anderson,Elizabeth	100002818	Yes **No**	
Smith,Sam	100002816	Yes **No**	
Jones,Cameron	100001478	Yes **No**	

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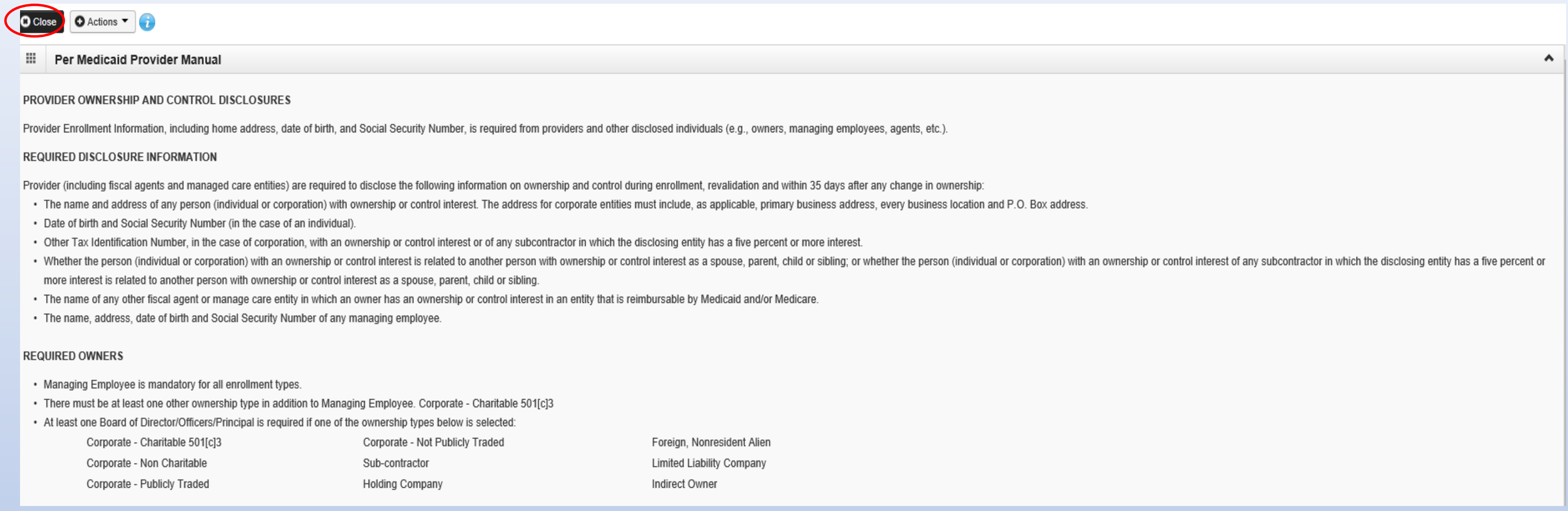
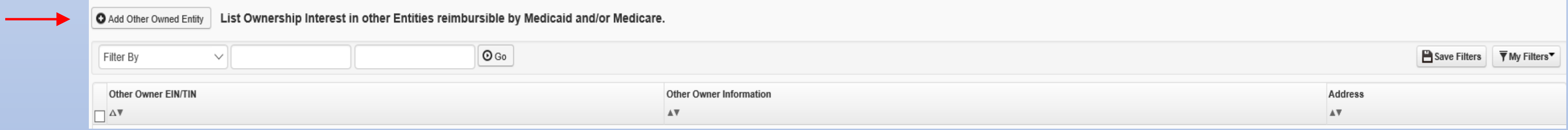
Ok | Cancel

- Read the section on *Final Adverse Legal Actions/Convictions*.
- Complete the ***Response and Comments (if applicable)*** section next to each owner.
- Select ***Ok***.

Step 7: Add Provider Controlling Interest/Ownership Details



- Select ***Close***.



- 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, go to the bottom of the page and click on ***Add Other Owned Entity***.

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

Provider Controlling Interest/Ownership in Other Medicaid/Medicare Entities

Type: Other Medicaid/Medicare Entity
Percentage Owned: *
EIN/TIN: *
Legal Entity Name: * (As shown on the Income Tax Return)
Entity Business Name: * (Doing Business As)
Owner NPI:
Phone Number: * **Extn:**
Email:
Start Date: *
End Date:

Address Type:
Address Line 1: * (Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town: OTHER *
State/Province: OTHER *
County: OTHER
Country: UNITED STATES *
Zip Code: * - Validate Address

OK Cancel

- After entering the street address and zip code, click ***Validate Address***.
- When all information is complete, click ***OK***.
- Repeat these steps to add ownership in another Medicaid/Medicare Entity.

Step 7: Add Provider Controlling Interest/Ownership Details

Application ID: 20230807484709 **Name:** Illinois Group

Close | Actions

Per Medicaid Provider Manual

During the Enrollment and Revalidation process, every Provider (including fiscal agents and managed-care entities) is required to detail the ownership and controlling interests that individuals and corporate entities have in the Provider.

For the purpose of this section, individuals or corporate entities with "ownership and controlling interest" in the provider include, but are not limited to, the following: (1) if the provider is a corporation or limited-liability company, any individual or corporate entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in the provider; (2) if the provider is a sole proprietorship, the owner of the provider; (3) if the provider is a partnership, each partner of the provider; (4) each individual who is a member of the provider's Board of Directors; and (5) each individual employed with the provider who has management responsibility.During enrollment and revalidation, the provider shall provide the following information:

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- 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
100001478	Jones,Cameron	Partnership	1516 Seven Pines Rd	08/07/2023	12/31/2999	Completed	No	50
100002816	Smith,Sam	Partnership	350 E Madison St	08/07/2023	12/31/2999	Completed	No	50
100002818	Anderson,Elizabeth	Managing Employee	119 Ruth Rd	08/07/2023	12/31/2999	Completed	No	0

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

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

Business Process Wizard

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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- The system will place the current date in the End Date field and will place ***Complete*** for Step 7.
- Click on Step 8: ***835/ERA Enrollment Form*** to continue with the application.

Step 8: 835/ERA Enrollment Form

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

Application ID: 20230807484709 **Name:** Illinois Group

Close | Submit | Print | Help

ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name:

Doing Business As Name (DBA): Illinois Group

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): 100021508

National Provider Identifier (NPI): 1000215081

Other Identifier(s)

Assigning Authority: **Trading Partner ID:**

Provider License Details

Provider License No: **License Issuer:**

Provider Type: GROUP

Provider Taxonomy Code:

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

Step 8: 835/ERA Enrollment Form

***Note:** this is an optional step*

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:

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

Step 8: 835/ERA Enrollment Form

***Note:** this is an optional step*

Application ID: 20230807484709 **Name:** Illinois Group

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: 08/07/2023

Requested ERA Effective Date:

(Once approve the next paycycle date.)

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

Business Process Wizard

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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- The system will place the current date in the End Date field and will place ***Complete*** for Step 8.
- Click on Step 9: ***Upload Documents*** to continue with the application.

Step 9: Upload Documents

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

Application ID: 20230807484709 **Name:** Illinois Group

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

Business Process Wizard

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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

Step 10: Complete Enrollment Checklist

Application ID: 20230807484709 **Name:** Illinois Group

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.	No	
Do you wish to end date your enrollment? If yes, what date?	No	
Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	No	
Are you currently excluded from any federal program? If yes, provide the program and date.	No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date	No	
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	No	
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	No	
Have you ever had a program exclusion/debarment? If yes, provide program and date	No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	No	
Do you carry professional liability insurance? If yes, please provide the name of your carrier and the policy coverage limit per occurrence and in aggregate.	Yes	1/3 Million

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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

Application ID: 20230807484709 **Name:** Illinois Group

Close

Enroll Provider - Group

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

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

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

Step 11: Submit Enrollment Application for Approval

Application ID: 20230807484709 **Name:** Illinois Group

Close | Next

Final Submission

Application ID: 20230807484709 EnrollmentType: Group Practice (Corporation, Partnership, LLC, etc.)

The information submitted for enrollment shall be verified and reviewed by the State.

During this time, any changes to the information shall not be accepted.

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

Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
No Records Found !			

- Read Statement
- Click on Next

Step 11: Submit Enrollment Application for Approval

Application ID: 20230807484709

Name: Illinois Group

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

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

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

Application ID: 20230807484709 **Name:** Illinois Group

Your Application Number 20230807484709 has been successfully submitted for State review. Return with this application number to track the status of your application.

Close

Enroll Provider - Group

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

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

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Business Process Wizard

Application ID: 20230807484709 **Name:** Illinois Group

Your Application Number 20230807484709 has been successfully submitted for State review. Return with this application number to track the status of your application. ×

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
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Step 4: Associate Billing Provider/Other Associations	Optional	08/07/2023	08/07/2023	Complete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	08/07/2023	08/07/2023	Complete	
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Step 8: 835/ERA Enrollment Form	Optional	08/07/2023	08/07/2023	Complete	
Step 9: Upload Documents	Optional	08/07/2023	08/07/2023	Complete	
Step 10: Complete Enrollment Checklist	Required	08/07/2023	08/07/2023	Complete	
Step 11: Submit Enrollment Application for Approval	Required	08/07/2023	08/07/2023	Complete	

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- The system will place the current date in the End Date field and will place ***Complete*** for Step 11.

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