

CHECK LIST FOR FACILITIES, AGENCIES, ORGANIZATIONS (F.A.O.) PROVIDER ENROLLMENT

1. SINGLE SIGN ON(SSO) USER ID AND PASSWORD
2. Legal Entity Name
3. Entity Business Name
4. Federal Tax ID Number (EIN/TIN)
5. National Provider Indicator (NPI)
6. Contact Email Address
7. **Add Provider Location**
 - a. Location Type (must have Primary Practice Location)
 - b. Address
 - c. Zip Code
 - d. Office Manager First Name
 - e. Office Manager Last Name
 - f. Office Manager SSN
 - g. Office Phone Number
8. **Facility Details**
 - a. Fiscal Year End Date
 - b. Licensed Medicaid Bed(s)
 - c. Licensed Medicare Bed(s)
 - d. Licensed Medicaid/Medicare Bed(s) – (Dual Certified)
 - e. Ventilator Dependent Unit(s)
 - f. Swing Bed(s)
 - g. Acute Care Bed(s)
 - h. Licensed LTC Unit(s) – (Long Term Care)
 - i. Temporarily Non Available
 - j. Distinct Part Unit
 - i. None
 - ii. Psych
 - iii. Skilled Nursing
9. **Add Address Location Types (must have Pay to and Correspondence Addresses)**
 - a. Pay To
 - b. Correspondence
 - c. Remittance Advice – Optional
10. **Provider Type(s)**
 - a. Clinics
 - b. Entities
 - c. Home Health
 - d. Hospice
 - e. Laboratory
 - f. Special Programs
 - g. Suppliers
 - h. Transportation

11. **Provider Specialty/Subspecialty Information (see drop down list)**

12. **License/Certification Numbers**

- a. **Effective Date & Expiration Date**
- b. **License/Certification Numbers depending on Provider Type**
- c. **Choice:**

AABB	American Association of Blood Banks	All Labs
ABC	American Board for Certification in Esthetics and Prosthetics Inc	Orthotics and Prosthetics Required
ASHI	American Society of Histocompatibility and Immunogenetics	All Labs
CARF	Commission on Accreditation Of Rehabilitation Facilities	Private Duty
CCC(A)	Certificate of Clinical Competence	All Labs
CHAP	Community Health Accreditation Program	Private Duty Agencies
CLIA	Clinical Lab Improvement Amendments	All Labs Required
CMS	Centers for Medicare and Medicaid Services - Certification Number	Entities
CN	State Contract/State Programs	MCO/Contractor/Special Programs Required
COLA	Commission on Office Laboratory Accreditation	All Labs
CON	Certificate of Need	Entities
DE	MI Department of Education	ISD Required
JCAHO	Joint Commission for the Accreditation of healthcare organizations	Private Duty Agencies
ST	State Certificate	Entities/Clinics

13. **Mode of Claim Submission (must check at least one)**

- a. Data Exchange Gateway (DEG) - How Medicaid receives electronic claims from Billing Agents
- b. Electronic Batch – Electronic batch submitted directly from a Provider/Entity
- c. Billing Agent – If a Provider uses a Billing Agent for electronic claim submissions
- d. Online Direct Data Entry – Provider can submit their primary, secondary or tertiary claims to Medicaid one claim at a time on a claim form
- e. Paper - Provider submits their claim on paper

14. Associate Billing Agent

- a. Start Date of Billing Agent (when the association began)
- b. Billing Agent ID #

15. Owner Type

- a. Corporate – Charitable 501 [c] 3 – (Not for Profit)
- b. Corporate – Non Charitable
- c. Corporate
- d. Foreign, Nonresident Alien
- e. Government
- f. Individual/sole Proprietor
- g. Partnership

16. Add Provider Owner Details

- a. Legal Entity Name
- b. Entity Business Name
- c. Percentage Owned of Practice - Has to be at least 5% and no more than 100%
- d. Start Date of the Ownership
- e. Address, City, State and Zip Code
- f. Phone number of the practice
- g. Social Security Number of the Owner(s) (Please specify SSN if owner is individual/Sole Proprietor or EIN/TIN if owner is Entity/Corporation)

17. Taxonomy Code(s)

- a. Taxonomy Code number(s)
- b. Start Date (the date you reported the Taxonomy Code to Medicaid)

18. Enrollment Checklist Questions:

- a. Do you need to request a Retro Enrollment Date? If yes, enter the requested Retro Enrollment Date in the comment field.
- b. Have you had any malpractice settlement, judgment or agreement? If yes, enter dollar amount(s) and date(s) in the comment field.
- c. Are you currently excluded from any State program?
- d. Are you currently excluded from any Federal program?
- e. Have you ever had a criminal or health related conviction?
- f. Have you ever had a judgment under any false claims act?
- g. Have you ever had a program exclusion/debarment?
- h. Have you ever had a civil monetary penalty?
- i. Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If yes, provide details in “Add Ownership Details” step.
- j. Are you accepting new clients?

REQUIRED INFORMATION