



# Provider Enrollment

## New Rendering/Servicing Provider

“Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time.”

-Provider Relations

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# Register for MILogin and CHAMPS

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MILogin is a website that allows a user to enter one ID and password in order to access multiple applications.

CHAMPS (Community Health Automated Medicaid Processing System) is the program where providers enroll, update enrollment information, and report services provided.

# MILogin for Third Party

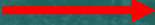
User ID

Password

Password

LOGIN

Don't have an account?

 SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

Copyright 2015-2019 State of Michigan

- Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.)
- Enter <https://milogintp.Michigan.gov> into the search bar
- Click Sign Up

## MILogin for Third Party

[HOME](#)

### Create Your Account



#### Profile Information

Enter your profile information

\* Required

\*First Name

Middle Initial

\*Last Name

Suffix

\*Email Address

\*Confirm Email Address

\*Work Phone Number

Mobile Number

\*Verification Question: Bee, chin, ankle, leg and dog: how many body parts in the list?

☐

agree to the [terms & conditions](#).

NEXT

RESET

- Complete all required fields
- Check the 'I agree' box
- Click Next

## MILogin for Third Party

HOME

## Create Your Account



## Security Setup

Provide user id and password information to complete your profile

\* Required

\* User ID

Enter a User ID

\* Password

Enter password

\* Confirm New Password

Confirm password

## \* Security Options

To choose your preferred password recovery method(s), please click on the buttons below. Multiple options can be selected.



CREATE ACCOUNT

BACK



## User ID guideline:

- Enter your last name, first initial, and any 4 numbers with no space between them. For Example: John Smith and using 9999 as an example for the four digit number, you would enter smithj9999.

## Password Guidelines:

- Must be at least 8 characters in length
- Must include characters from 3 of the following categories:
  - Upper case letters (A-Z)
  - Lower case letter (a-z)
  - Numbers (0-9)
  - Special characters (IS#,%@~^&\*\_-+=><)
- Should not be one of the last 3 used passwords
- Should not be based on your User ID

- Create the user ID and password following the listed guidelines
- Select the preferred password recovery method(s)
- Click Create Account

## MILogin for Third Party

[HOME](#)

### Create your account



### Confirmation

#### ✓ Success

Your account has been successfully created.

[LOGIN](#)

- Your MILogin account has now been created successfully
- Click the Login button to return to the login screen

# MILogin for Third Party

User ID

Password

Password

LOGIN

Don't have an account?

SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

Copyright 2015-2019 State of Michigan

- Enter your User ID and Password you just created
- Click Login

# MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Home Page

⌚ Your password will expire in **364** days

Access your applications by clicking on the application links below

You do not have access to any application. You can request access by clicking on [Request Access](#) link.

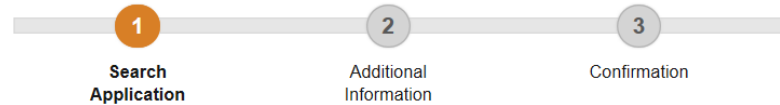
- Your Home Page will not show any applications
- Click Request Access

*\*MILogin resource links are listed at the bottom of the page*

## MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

### Request Access



### Search Application

Search for an application with a keyword or select an agency to view its applications

- Type CHAMPS in the search box
- Click the search/magnifying button

## MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

### Request Access

1

Search  
Application

2

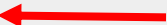
Additional  
Information

3

Confirmation

### Search Application

Search for an application with a keyword or select an agency to view its applications

**Michigan Department of Health & Human Services (MDHHS)****CHAMPS**

- Click on CHAMPS

MILogin for Third Party

HOME

Request A

Search App

Search for an applicati

CHAMPS

MDHHS Michigan

CHAMPS

### CHAMPS

(Community Health Automated Medicaid Processing System) is the Michigan Medicaid Management Information System (MMIS). It supports Medicaid provider enrollment and maintenance, beneficiary healthcare eligibility and enrollment, prior authorization, Home Help Electronic Service Verification (ESV), fee-for-service payments and managed care enrollments, payments, and encounters.

General laws, rules and regulations. The systems are intended for use only by authorized persons and only for official state business. Systems users are prohibited from using any assigned or entrusted access control mechanisms for any purposes other than those required to perform authorized data exchange with MDHHS. Logon IDs and passwords are never to be shared. Systems users must not disclose any confidential, restricted or sensitive data to unauthorized persons. Systems users will only access information on the systems for which they have authorization. Systems users will not use MDHHS systems for commercial or partisan political purposes. Following industry standards, systems users must securely maintain any information downloaded, printed, or removed in any format from the systems. When no longer needed, this information must be destroyed in an appropriate manner specific to the format type. All users of the systems give their expressed consent to the monitoring of their activities on the systems. If such monitoring reveals possible evidence of unauthorized or criminal activity, the evidence may be provided to administrative or law enforcement officials for disciplinary action and/or

☒ I agree to the terms & conditions

☐ I do not agree

CANCEL ✕ REQUEST ACCESS

- Select the 'I agree to the terms & conditions' radio button
- Click Request Access

## MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

### Request Access

1

✓ Search  
Application

2

Additional  
Information

3

Confirmation

### Additional Information

Provide following information to submit your access request

\* Required

\*Email Address

\*Work Phone Number

\*CHAMPS User Type

- ☒ Provider/Other  
☐ State User Only

**SUBMIT****RESET**

- Verify all information is correct
- Click Submit

# MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Request Access

1

✓ Search  
Application

2

✓ Additional  
Information

3

Confirmation

## Confirmation

### ✓ Success

The request for your access has been successfully submitted.

You will see the updated list of application(s) on your home page once it is processed.

[HOME](#)

- You will be given confirmation that your request has been submitted successfully
- Click the Home button to return to the MILogin Home Page

## MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

### Home Page

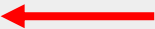
 Your password will expire in **48** days

Access your applications by clicking on the application links below

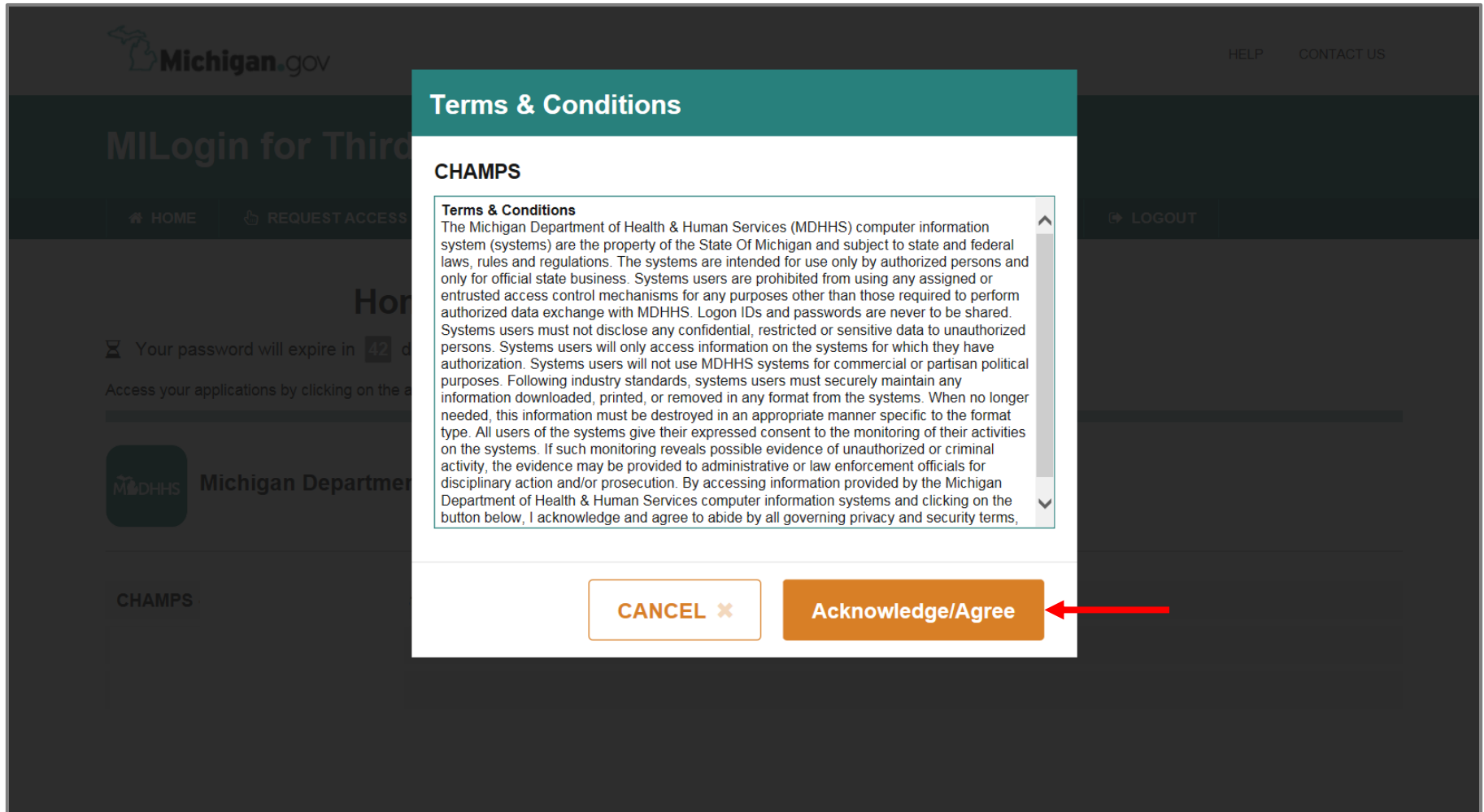


Michigan Department of Health & Human Services (MDHHS)

CHAMPS



- You will be directed back to your MILogin Home Page
- Click the CHAMPS hyperlink



- Click Acknowledge/Agree button to accept the Terms & Conditions to get into CHAMPS

# New Provider Enrollment

---

Steps on how to complete a new CHAMPS enrollment for a Rendering/Servicing Provider type



## Provider Enrollment


[New Enrollment](#)

Enroll As A New Provider

[Track Application](#)

Track Existing Provider Application

- Click New Enrollment

## Enrollment Type

## Select the Applicable Enrollment Type

- ☒ Individual/Sole Proprietor
- ☒ Regular Individual/Sole Proprietor or Rendering/Service Provider ←
  - ☐ Group Practice (Corporation, Partnership, LLC, etc.)
  - ☐ Billing Agent
  - ☐ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
  - ☐ 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

- Select Regular Individual/Sole Proprietor or Rendering/Service Provider
- Click Submit

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

### Basic Information

First Name:  \*

Last Name:  \*

Suffix:  ▼

SSN:  \*

Date of Birth:  \*

Middle Initial:

Gender:  ▼

Applicant Type:  Rendering/Service Only ▼ \*

NPI:  \*

Contact Email Address:

Email-1:  \*

Email-2:

Email-3:

Email-4:

### Home Address

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

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

☒ Finish

- Select Applicant Type: Rendering/Service Only
- Basic Information: Complete all fields marked with an asterisk (\*)
- Home Address: Complete Address Line 1 and Zip Code, click Validate Address  
(Please Note: you should receive confirmation "Address validation successful")
- Click Finish

Application ID: 20171106241608

Name: Tester, Testing

Basic Information

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

Your Application ID is: 20171106241608

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

✓ Ok

- Confirmation, Basic Information is complete
- Take note of the Application ID, as this is used to track your application status
- Click Ok

Application ID: 20171106241608

Name: Tester, Testing

Close

## Enroll Provider - Individual

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

| Step                                                        | Required | Start Date | End Date   | Status     | Step Remark |
|-------------------------------------------------------------|----------|------------|------------|------------|-------------|
| <a href="#">Step 1: Provider Basic Information</a>          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 2: Add Specialties</a>                     | Required |            |            | Incomplete |             |
| Step 3: Associate Billing Provider                          | Required |            |            | Incomplete |             |
| Step 4: Add License/Certification/Other                     | Optional |            |            | Incomplete |             |
| Step 5: Add Provider Controlling Interest/Ownership Details | Optional |            |            | Incomplete |             |
| Step 6: Add Taxonomy Details                                | Required |            |            | Incomplete |             |
| Step 7: Associate MCO Plan                                  | Optional |            |            | Incomplete |             |
| Step 8: Upload Documents                                    | Optional |            |            | Incomplete |             |
| Step 9: Complete Enrollment Checklist                       | Required |            |            | Incomplete |             |
| Step 10: Submit Enrollment Application for Approval         | Required |            |            | Incomplete |             |

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Page Count

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Next &gt;

&gt;&gt; Last

- Individual Provider Enrollment steps are listed (Please Note: some steps are required verses optional)
- Step 1 has a status of Complete
- Click on Step 2: Add Specialties



Provider ▾

Tester, Testing ▾

Quick Find

Note Pad

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Help

New Enrollment > Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close

Add

Primary Speciality



### Specialty/Subspecialty List

Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date

□ ▲▼

▲▼

▲▼

No Records Found !

- Click Add

Application ID: 20171106241608

Name: Tester, Testing

## Add Specialty/Subspecialty

Provider Type: ---SELECT--- ▾ \*

Specialty: ▾ \*

End Date:  

## Add Subspecialty

Available Subspecialties

Associated Subspecialties \*



OK

Cancel

- Choose appropriate Provider Type and Specialty (Please Note: There is no need to fill in an End Date)
- Dependent on the Specialty chosen, Available Subspecialties will populate
- Select Available Subspecialties click >> to add to Associated Subspecialties list
- Click Ok

**CHAMPS** < Provider ▾

Tester, Testing ▾ Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

> New Enrollment > Individual Enrollment

Application ID: 20171106241608 Name: Tester, Testing

Close Add Primary Specialty

**Specialty/Subspecialty List**

Filter By ▾   Go Save Filters My Filters ▾

| Specialty/Subspecialty                                                                         | Provider Type                                 | End Date                                  |
|------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> ▲▼<br><input type="checkbox"/> Professional Counselor/No Subspecialty | <input type="checkbox"/> ▲▼<br>NON-PHYSICIANS | <input type="checkbox"/> ▲▼<br>12/31/2999 |

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First Prev Next >> Last

- Once all Specialties/Subspecialties have been added, click Primary Specialty

Application ID: 20171106241608

Name: Tester, Testing

Close Save



## Primary Specialty For Enrollment



Primary Specialty/Subspecialty: NON-PHYSICIANS/Professional Counselor/No Subspecialty ▾ \*

Board Certified: ☐ Yes ☒ NoBoard Eligible: ☐ Yes ☒ No

Start Date: 01/01/2015 \*

Your designation and attestation of a primary specialty will be utilized to identify and evaluate your eligibility for the Primary Care Rate Increase.

(If Board Certified, please provide Board Certification No. in License/Certification/Other step.)

(If Board Eligible, please provide Board Eligibility Information. in License/Certification/Other step.)

End Date: 12/31/2999

- Choose Primary Specialty/Subspecialty from the drop-down list of already added specialties
- Select Yes if Board Certified or Board Eligible
- Enter Start Date
- Click Save
- Click Close


Provider ▾

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Individual Enrollment

Application ID: 20171106241608
Name: Tester, Testing

Close Add Primary Speciality

Specialty/Subspecialty List

Filter By
Go
Save Filters
My Filters ▾

| Specialty/Subspecialty                                          | Provider Type               | End Date                    |
|-----------------------------------------------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> ▲▼                                     | <input type="checkbox"/> ▲▼ | <input type="checkbox"/> ▲▼ |
| <input type="checkbox"/> Professional Counselor/No Subspecialty | NON-PHYSICIANS              | 12/31/2999                  |

Delete
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Next
Last

- Click Close to return to the enrollment steps

Application ID: 20171106241608

Name: Tester, Testing

Close

## Enroll Provider - Individual

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

| Step                                                                        | Required | Start Date | End Date   | Status     | Step Remark                                |
|-----------------------------------------------------------------------------|----------|------------|------------|------------|--------------------------------------------|
| <a href="#">Step 1: Provider Basic Information</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |                                            |
| <a href="#">Step 2: Add Specialties</a>                                     | Required | 11/06/2017 | 11/06/2017 | Complete   |                                            |
| <a href="#">Step 3: Associate Billing Provider</a>                          | Required |            |            | Incomplete |                                            |
| <a href="#">Step 4: Add License/Certification/Other</a>                     | Required |            |            | Incomplete | Please add required License/Certification. |
| <a href="#">Step 5: Add Provider Controlling Interest/Ownership Details</a> | Optional |            |            | Incomplete |                                            |
| <a href="#">Step 6: Add Taxonomy Details</a>                                | Required |            |            | Incomplete |                                            |
| <a href="#">Step 7: Associate MCO Plan</a>                                  | Optional |            |            | Incomplete |                                            |
| <a href="#">Step 8: Upload Documents</a>                                    | Optional |            |            | Incomplete |                                            |
| <a href="#">Step 9: Complete Enrollment Checklist</a>                       | Required |            |            | Incomplete |                                            |
| <a href="#">Step 10: Submit Enrollment Application for Approval</a>         | Required |            |            | Incomplete |                                            |

View Page: 1

Go

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- Step 2 is complete
- Click on Step 3: Associate Billing Provider



Provider ▾

Tester, Testing ▾

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My Favorites ▾

Print

Help

New Enrollment &gt; Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close

Add



## Billing Provider List

Filter By ▾

Go

Save Filters

My Filters ▾

Billing Provider NPI/ID

Billing Provider Name

Start Date

End Date

Status

☐ ▲▼

▲▼

▲▼

▲▼

▲▼

No Records Found !

Please Note: This step requires the NPI of the Provider/Facility you are rendering services for. Example, Provider A is working for Facility B; therefore, Facility B will be the Billing Provider and Provider A will be the Rendering Provider. Do not put your own NPI.

- Click Add

Application ID: 20171106241608

Name: Tester, Testing

## Associate Billing Provider

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

Type:  \*ID:  \*Start Date:  \*

Provider Name:

End Date:   

- Complete all fields marked with an asterisk (\*)
- Click Confirm Provider; Provider Name will populate
- Click Ok



Provider ▾

Tester, Testing ▾

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External Links ▾

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New Enrollment > Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close

Add



### Billing Provider List

Filter By



Go

Save Filters

My Filters ▾

Billing Provider NPI/ID

Billing Provider Name

Start Date

End Date

Status

Δ ▾

Δ ▾

Δ ▾

Δ ▾

Δ ▾

☐

[Redacted]

11/06/2017

12/31/2999

Approved

Delete

View Page: 1

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Page Count

SaveToXLS

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Next

Last

- The associated providers information is now listed under the Billing Provider List
- Click Close

Application ID: 20171106241608

Name: Tester, Testing

Close

## Enroll Provider - Individual

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

| Step                                                                        | Required | Start Date | End Date   | Status     | Step Remark                                |
|-----------------------------------------------------------------------------|----------|------------|------------|------------|--------------------------------------------|
| <a href="#">Step 1: Provider Basic Information</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |                                            |
| <a href="#">Step 2: Add Specialties</a>                                     | Required | 11/06/2017 | 11/06/2017 | Complete   |                                            |
| <a href="#">Step 3: Associate Billing Provider</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |                                            |
| <a href="#">Step 4: Add License/Certification/Other</a>                     | Required |            |            | Incomplete | Please add required License/Certification. |
| <a href="#">Step 5: Add Provider Controlling Interest/Ownership Details</a> | Optional |            |            | Incomplete |                                            |
| <a href="#">Step 6: Add Taxonomy Details</a>                                | Required |            |            | Incomplete |                                            |
| <a href="#">Step 7: Associate MCO Plan</a>                                  | Optional |            |            | Incomplete |                                            |
| <a href="#">Step 8: Upload Documents</a>                                    | Optional |            |            | Incomplete |                                            |
| <a href="#">Step 9: Complete Enrollment Checklist</a>                       | Required |            |            | Incomplete |                                            |
| <a href="#">Step 10: Submit Enrollment Application for Approval</a>         | Required |            |            | Incomplete |                                            |

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Last

- Step 3 is complete
- Click on Step 4: Add License/Certification/Other



Provider ▾



Tester, Testing ▾

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Help

Home > New Enrollment > Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close

Add



### License/Certification/Other List



Filter By



Go

Save Filters

My Filters ▾

License/Cert./Other Type

License/Cert./Other #

Valid Flag

Effective Date

End Date



No Records Found !

- Click Add

CHAMPS < Provider ▾

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171106241608 Name: Tester, Testing

**Add License/Certification/Other**

License/Certification/Other Type:  ▾ \*

License/Certification/Other #:  \*

Valid Flag:

Effective Date:  \*

End Date:

☒ Confirm License/Certification/Other ☒ OK

- Complete all fields marked with an asterisk (\*)
- Click Confirm License/Certification/Other
- Click Ok



Provider ▾

Tester, Testing ▾

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New Enrollment &gt; Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close

Add

## License/Certification/Other List

Filter By



Go

Save Filters

My Filters ▾

License/Cert./Other Type

License/Cert./Other #

Valid Flag

Effective Date

End Date



State Professional License

1234567

No

01/01/2010

12/31/2999



Delete

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- The License/Certification/Other information will now be displayed
- To add additional License/Certification repeat the same process
- Click Close

Application ID: 20171106241608

Name: Tester, Testing

Close

## Enroll Provider - Individual

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

| Step                                                                        | Required | Start Date | End Date   | Status     | Step Remark |
|-----------------------------------------------------------------------------|----------|------------|------------|------------|-------------|
| <a href="#">Step 1: Provider Basic Information</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 2: Add Specialties</a>                                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 3: Associate Billing Provider</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 4: Add License/Certification/Other</a>                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 5: Add Provider Controlling Interest/Ownership Details</a> | Optional |            |            | Incomplete |             |
| <a href="#">Step 6: Add Taxonomy Details</a>                                | Required |            |            | Incomplete |             |
| <a href="#">Step 7: Associate MCO Plan</a>                                  | Optional |            |            | Incomplete |             |
| <a href="#">Step 8: Upload Documents</a>                                    | Optional |            |            | Incomplete |             |
| <a href="#">Step 9: Complete Enrollment Checklist</a>                       | Required |            |            | Incomplete |             |
| <a href="#">Step 10: Submit Enrollment Application for Approval</a>         | Required |            |            | Incomplete |             |

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- Step 4 is complete
- Click on Step 6: Add Taxonomy Details (Please Note: Step 5 is not required)



Provider ▾

Tester, Testing ▾

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Help

Home > New Enrollment > Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close Add

### Taxonomy List

Filter By ▾

Go

Save Filters

My Filters ▾

Taxonomy Code

Description

Start Date

End Date

☐ ▲▼

▲▼

▲▼

▲▼

No Records Found !

- Click Add

CHAMPS

Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171106241608 Name: Tester, Testing

**Add Taxonomy**

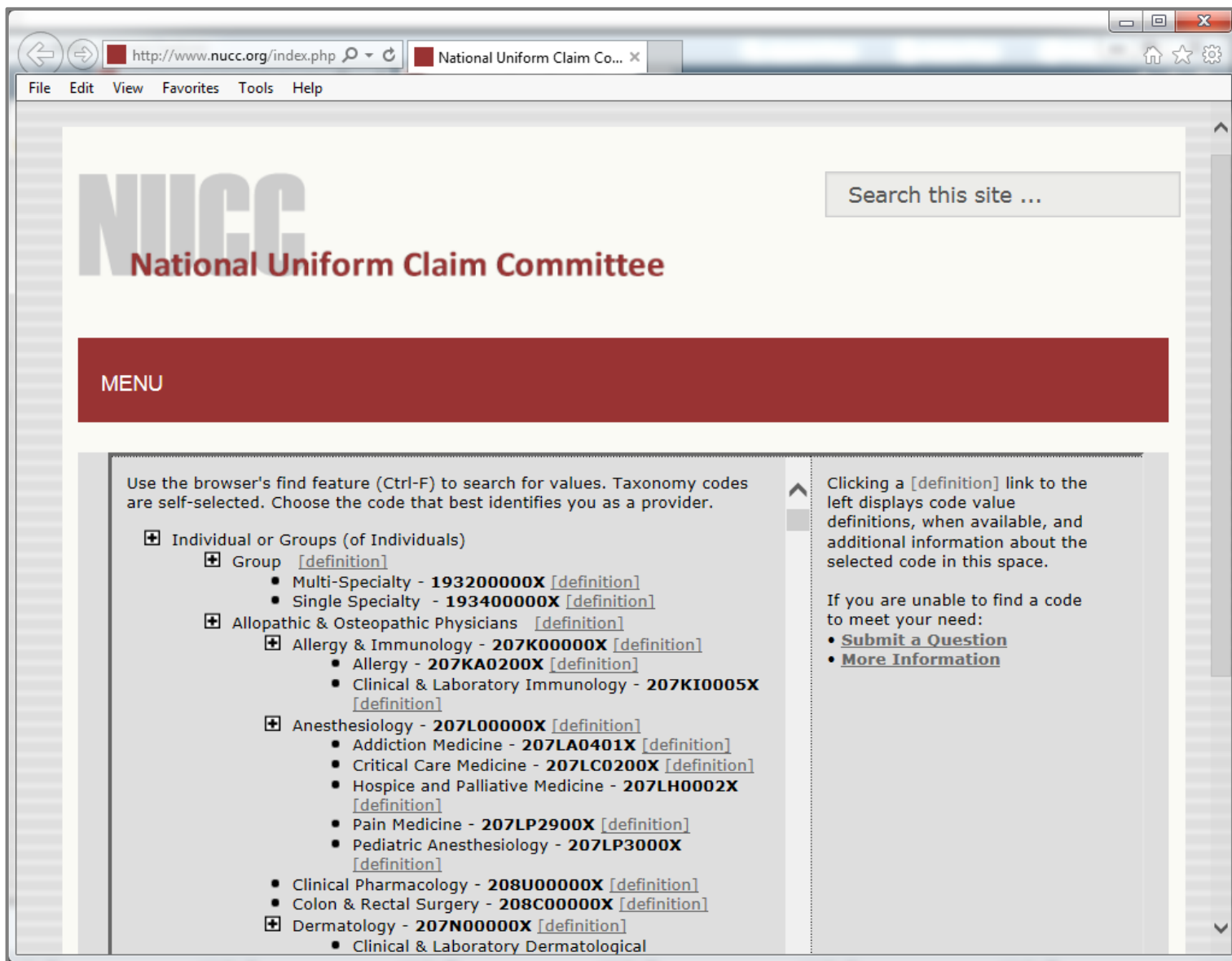
Taxonomy Code:  (Click here for Taxonomy List)

Description:

Start Date:  \* End Date:

Confirm Taxonomy Ok Cancel

- Enter in Taxonomy Code or click on ( ) next to the words, Click here for Taxonomy List, to look up appropriate taxonomy code



- After clicking (🔍) the [National Uniform Claim Committee](http://www.nucc.org/index.php) webpage will pop-up
- Press (CTRL+F) to search for appropriate taxonomy code

Application ID: 20171106241608

Name: Tester, Testing

## Add Taxonomy

Taxonomy Code:  \* (Click here for Taxonomy List)

Description:

Start Date:  \*End Date: 

Confirm Taxonomy

✓ Ok

Cancel

- Enter Start Date
- Click Confirm Taxonomy
- Click Ok



Provider ▾

Tester, Testing ▾

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Help

New Enrollment &gt; Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close

Add

## Taxonomy List

Filter By



Go

Save Filters

My Filters ▾

Taxonomy Code

Description

Start Date

End Date



101YP2500X

Professional

11/02/2017

12/31/2999



Delete

View Page:

1



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- The Taxonomy Code information will be displayed
- Click Close



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New Enrollment &gt; Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Close

## Enroll Provider - Individual

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

| Step                                                                        | Required | Start Date | End Date   | Status     | Step Remark |
|-----------------------------------------------------------------------------|----------|------------|------------|------------|-------------|
| <a href="#">Step 1: Provider Basic Information</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 2: Add Specialties</a>                                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 3: Associate Billing Provider</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 4: Add License/Certification/Other</a>                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 5: Add Provider Controlling Interest/Ownership Details</a> | Optional |            |            | Incomplete |             |
| <a href="#">Step 6: Add Taxonomy Details</a>                                | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 7: Associate MCO Plan</a>                                  | Optional |            |            | Incomplete |             |
| <a href="#">Step 8: Upload Documents</a>                                    | Optional |            |            | Incomplete |             |
| <a href="#">Step 9: Complete Enrollment Checklist</a>                       | Required |            |            | Incomplete |             |
| <a href="#">Step 10: Submit Enrollment Application for Approval</a>         | Required |            |            | Incomplete |             |

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- Step 6 is complete
- Click on Step 9: Complete Enrollment Checklist (Please Note: Steps 7 & 8 are not required)

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Name: Tester, Testing

Close Save

## Provider Checklist

| Question                                                                                                                                                                                                          | Answer        | Comments |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------|
| Do you need to request a Retro Enrollment Date? If Yes, enter the requested Retro Enrollment Date in the comment field.                                                                                           | Not Completed |          |
| Are you currently excluded from any State program?                                                                                                                                                                | Not Completed |          |
| Are you currently excluded from any Federal program?                                                                                                                                                              | Not Completed |          |
| Have you ever had a criminal or health-related conviction?                                                                                                                                                        | Not Completed |          |
| Have you ever had a judgment under any false claims act?                                                                                                                                                          | Not Completed |          |
| Have you ever had a program exclusion/debarment?                                                                                                                                                                  | Not Completed |          |
| Have you ever had a civil monetary penalty?                                                                                                                                                                       | Not Completed |          |
| Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?                                                                                                                                      | Not Completed |          |
| Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.                                                               | Not Completed |          |
| Do you accept new patients?                                                                                                                                                                                       | Not Completed |          |
| Have you had any malpractice settlement, judgment, or agreement? If yes, enter dollar amount(s) and date(s).                                                                                                      | Not Completed |          |
| If you are a Nurse Practitioner or Nurse Midwife, a Collaborative Agreement is required. Please provide NPI of servicing physician. If you don't have an agreement, please answer yes and provide an explanation. | Not Completed |          |
| Dental Hygienist-Do you have a collaborative agreement in place? If 'Yes', with what NPI?                                                                                                                         | Not Completed |          |
| Are you affiliated with a PA 161 program? If yes, please provide the NPI of that program(s) in the comments.                                                                                                      | Not Completed |          |
| All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?                                                                                                         | Not Completed |          |
| Have you completed American Pharmacists Assoc's Delivering Medication Therapy Mgmt Services or program approved by Accreditation Council of Pharmacy Education? If yes, then enter what you have completed.       | Not Completed |          |

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- Answer the questions in the Provider Checklist as appropriate
- Add Comments if necessary
- Click Save
- Click Close

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Name: Tester, Testing

Close

## Enroll Provider - Individual

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

| Step                                                                        | Required | Start Date | End Date   | Status     | Step Remark |
|-----------------------------------------------------------------------------|----------|------------|------------|------------|-------------|
| <a href="#">Step 1: Provider Basic Information</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 2: Add Specialties</a>                                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 3: Associate Billing Provider</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 4: Add License/Certification/Other</a>                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 5: Add Provider Controlling Interest/Ownership Details</a> | Optional | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 6: Add Taxonomy Details</a>                                | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 7: Associate MCO Plan</a>                                  | Optional |            |            | Incomplete |             |
| <a href="#">Step 8: Upload Documents</a>                                    | Optional |            |            | Incomplete |             |
| <a href="#">Step 9: Complete Enrollment Checklist</a>                       | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 10: Submit Enrollment Application for Approval</a>         | Required |            |            | Incomplete |             |

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- Step 9 is complete
- Click on Step 10: Submit Enrollment Application for Approval

(Please Note: If you chose not to complete optional steps you can still submit your application)

**You must complete this step to finalize your application submission**



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New Enrollment > Individual Enrollment

Application ID: 20171106241608

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Close

Next



### Final Submission



Application ID: 20171106241608

EnrollmentType: Individual/Sole Proprietor

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

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

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



### Application Document Checklist



Forms/Documents

Special Instructions

Source

Required

▲ ▼

▲ ▼

▲ ▼

▲ ▼

No Records Found !

- Final Submission: Click Next

Application ID: 20171106241608

Name: Tester, Testing

  After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.**Medical Assistance Provider Enrollment & Trading Partner Agreement - Conditions**

In applying for enrollment as a provider or trading partner in the Medical Assistance Program (and programs for which the Michigan Department Of Health and Human Services (MDHHS) is the fiscal intermediary), I represent and certify as follows:

1. The applicant, and the employer (if applicable), certify that the undersigned has/have the authority to execute this Agreement.
2. Enrollment in the Medical Assistance Program does not guarantee participation in MDHHS managed care programs nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished on this Medical Assistance Provider Enrollment & Trading Partner Agreement form is true and complete.
4. The providers and fiscal agents of ownership and control information agree to provide proper disclosure of provider's owners and other persons criminal related to Medicare, Medicaid or Title XX involvement. [42 CFR 455.100]
5. The applicant and the employer agree to provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX), and other State Health Care Programs (Title V, Title XX, and Title XXI) involvement since the inception of Medicare, Medicaid, or Title XX programs. [42 CFR 455.106 and 42 U.S.C. § 1320a-7]
6. I agree to read the Medicaid Provider Manual from the Michigan Department Of Health and Human Services (MDHHS). I also agree to comply with 1) the terms and conditions of participation noted in the manual, and 2) MDHHS's policies and procedures for the Medical Assistance Program contained in the manual, provider bulletins and other program notifications.
7. I agree to comply with the provisions of 42 CFR 455.104, 42 CFR 455.105, 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.
8. I agree to comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005, codified at section 1902 (a)(68) of the Social Security Act which relates to the conditions and requirements of "Employee Education About False Claims Recovery."
9. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to, or on behalf of, a Medical Assistance Program beneficiary. These records also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or other healthcare provider.
10. I agree to include a clause in any contract I enter into which allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
11. I understand that the incentive payment requested using my National Provider Identifier (NPI) number will be made directly to the Tax ID Number (TIN) that was indicated during the registration process.
12. I am not currently suspended, terminated, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.

- Read through the Terms and Conditions

Application ID: 20171106241608

Name: Tester, Testing

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

including all costs and reasonable attorney fees, arising out of electronic transactions the Trading Partner submits to MDHHS.

#### 6. Standard Transactions.

All Standard Transactions, as defined by HIPAA, will be conducted by the parties using only code sets, data elements, and formats specified by the Transaction Rules and instructions in the MDHHS Companion Guides. The parties agree that when conducting Standard Transactions, they will not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.

#### 7. Testing.

All new Trading Partners will cooperate with MDHHS upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with MDHHS upon request in testing processes for any changes in submission format prior to submission of production files. MDHHS will notify the Trading Partner of the effective date for production data after successful testing.

#### 8. Data and Network Security.

The parties agree to use reasonable security measures to protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with MDHHS data and network security requirements, which may change from time to time and as may be required by the HIPAA security regulations.

#### 9. Automatic Amendment for Regulatory Compliance.

This Agreement will automatically be amended to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

#### 10. Miscellaneous.

Provisions 3 and 8 shall survive termination of this Agreement.

The Trading Partner will notify MDHHS of any changes in trading partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at least 30 calendar days prior to the effective date of such change.

☒ By checking this, I certify that I have read and that I agree and accept the enrollment conditions in the Medical Assistance Provider Enrollment & Trading Partner Agreement.

- Check the box at the end to agree to the Terms and Conditions
- Click Submit Application



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New Enrollment &gt; Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Your Application Number 20171106241608 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

## Enroll Provider - Individual

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

| Step                                                        | Required | Start Date | End Date   | Status     | Step Remark |
|-------------------------------------------------------------|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| Step 2: Add Specialties                                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| Step 3: Associate Billing Provider                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| Step 4: Add License/Certification/Other                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| Step 5: Add Provider Controlling Interest/Ownership Details | Optional | 11/06/2017 | 11/06/2017 | Complete   |             |
| Step 6: Add Taxonomy Details                                | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| Step 7: Associate MCO Plan                                  | Optional |            |            | Incomplete |             |
| Step 8: Upload Documents                                    | Optional |            |            | Incomplete |             |
| Step 9: Complete Enrollment Checklist                       | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| Step 10: Submit Enrollment Application for Approval         | Required | 11/06/2017 | 11/06/2017 | Complete   |             |

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- Step 10 is now complete and application has been submitted to the State for review
- Take note of your Application ID for further tracking
- Click Close

(Please Note: Optional steps may show as incomplete if you chose not to complete. This is ok.)

# Track Existing Application

---

Rendering/Service Provider

The screenshot displays the CHAMPS web application interface. At the top left is the CHAMPS logo. A navigation bar contains a 'Provider' dropdown menu, which is highlighted with a red box. Below this, a dark blue header bar includes links for 'Quick Find', 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. The main content area features a 'Provider Enrollment' tab, which is also highlighted with a red box. A dropdown menu is open from this tab, showing 'New Enrollment' and 'Track Application' options. A red arrow points to the 'Track Application' option. Below the dropdown, a table is visible with two rows: 'Enroll As A New Provider' and 'Track Existing Provider Application'.

|                                     |
|-------------------------------------|
| Enroll As A New Provider            |
| Track Existing Provider Application |

- Select Provider tab
- Click Track Application

Close

Next

## Track Existing Application

Please provide the Application ID to track your application.

Application ID:  \*

## Request Access to Home Help Provider Info

Click the below link if you are an Existing Home Help Individual or Agency accessing CHAMPS system for the first time. provide the Application ID to track your application.

[Home Help Providers requesting access to their Information.](#)

- Fill in Application ID
- Click Next

Close Submit



## Verify Application Details



For Additional security, please enter following information:

SSN:  \*

Date Of Birth:   \*

Home Zip Code:  \*

- Complete all fields marked with an asterisk (\*)
- Click Submit



Provider ▾

Tester, Testing ▾

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Note Pad

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My Favorites ▾

Print

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Track Application &gt; Individual Enrollment

Application ID: 20171106241608

Name: Tester, Testing

Your application is currently In-Review by the Provider Enrollment Unit. You cannot make any modifications to your enrollment information at this time.

X

Close

## Enroll Provider - Individual

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

| Step                                                                        | Required | Start Date | End Date   | Status     | Step Remark |
|-----------------------------------------------------------------------------|----------|------------|------------|------------|-------------|
| <a href="#">Step 1: Provider Basic Information</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 2: Add Specialties</a>                                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 3: Associate Billing Provider</a>                          | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 4: Add License/Certification/Other</a>                     | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 5: Add Provider Controlling Interest/Ownership Details</a> | Optional | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 6: Add Taxonomy Details</a>                                | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 7: Associate MCO Plan</a>                                  | Optional |            |            | Incomplete |             |
| <a href="#">Step 8: Upload Documents</a>                                    | Optional |            |            | Incomplete |             |
| <a href="#">Step 9: Complete Enrollment Checklist</a>                       | Required | 11/06/2017 | 11/06/2017 | Complete   |             |
| <a href="#">Step 10: Submit Enrollment Application for Approval</a>         | Required | 11/06/2017 | 11/06/2017 | Complete   |             |

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- Confirmation your Provider Enrollment Application has been submitted and is being reviewed by the state
- Click Close

# Provider Enrollment Final Steps

- Please allow the State time to review the Provider Enrollment Application.
- After the State has looked over the Provider Enrollment Application Providers will receive a letter letting them know whether they have been approved or denied.
  - Letter for a Rendering/Servicing provider is sent to the Billing Provider's Correspondence address provided in the Provider Enrollment Application.

# Provider Resources

- **MDHHS website:** [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders)
- **We continue to update our Provider Resources, just click on the links below:**
  - [Listserv Instructions](#)
  - [Medicaid Alerts and Biller “B” Aware](#)
  - [Quick Reference Guides](#)
  - [Update Other Insurance NOW!](#)
  - [Medicaid Provider Training Sessions](#)
- **Provider Enrollment:**
  - [ProviderEnrollment@Michigan.gov](mailto:ProviderEnrollment@Michigan.gov) or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program