

Provider Enrollment New Group Practice

"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

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 performed.



HELP CONTACT US



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



B Michigan.gov		HELP CONTACT US
MILogin for Third Party		
# НОМЕ		
Create Your Account	Profile	2 3 Security Setup Confirmation
Profile Information		
* Required		
*First Name Middle Ir	itial *Last Name	Suffix
*Email Address	*Confirm Email Addres	55
*Work Phone Number	Mobile Number	
*Verification Question: Bee, chin, ankle, leg and dog: how n	nany body parts in the list?	
agree to the terms & conditions.		
NEXT		

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





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



MILogin for Third Party			
A HOME			
Create your account	✓ Profile Information	2✓ Security Setup	3 Confirmation
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





HELP CONTACT US



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





Click Request Access

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





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





• Click on CHAMPS







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



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MILogin for Third	Party				
HOME			CHANGE I	PASSWORD 🕒 LOG	GOUT
Request Access		,	● Search pplication	2 Additional Information	3 Confirmation
Additional Information) iccess request				
* Required					
*Email Address					
spinisting grant con					
*Work Phone Number					
117-202-2008					
*CHAMPS User Type					
 Provider/Other State User Only 					
SUBMIT	RESET				

- Verify all information is correct Click Submit •
- •





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



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希 НОМЕ	🗄 REQUEST ACCESS	D UPDATE PROFILE		CHANGE PASSWORD	🕞 LOGOUT	
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	blications by clicking on the app	s lication links below				
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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 Group Practice (Corporation, Partnership, LLC etc.)Provider type

Prior to enrolling in CHAMPS

- Group providers will want to ensure they are enrolled in SIGMA VSS prior to enrolling within CHAMPS.
 - SIGMA VSS website: <u>www.michigan.gov/SIGMAVSS</u>
 - If you have questions regarding this current process, contact the Vendor Support Call Center at 1-888-734-9749 or email <u>SIGMA-Vendor@Michigan.gov</u>
 - After completing SIGMA registration allow 3-5 business days to begin and complete the CHAMPS application. If you attempt to enroll in CHAMPS during this time you may get an error when validating your information.
- Group providers must also be licensed prior to enrolling in CHAMPS
 - LARA: <u>http://www.michigan.gov/lara/0,4601,7-154-72600---</u>,00.html



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Provider Enrollment							
	New Enrollment	Enroll As A New Provider					
	Track Application	Track Existing Provider Application					
Click New Enrol	Iment						

New Enrollment Enrollment Type Select the Applicable Enrollment T Individual/Sole Proprietor O Regular Individual/Sole Proprietor or Rendering/Servicing Provider Group Practice (Corporation, Partnership, LLC, etc.)	ype	A hij ravones v	
Enrollment Type Select the Applicable Enrollment T Individual/Sole Proprietor O Regular Individual/Sole Proprietor or Rendering/Servicing Provider Group Practice (Corporation, Partnership, LLC, etc.)	уре		
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Individual/Sole Proprietor Regular Individual/Sole Proprietor or Rendering/Servicing Provider Group Practice (Corporation, Partnership, LLC, etc.)			
 ○ Regular Individual/Sole Proprietor or Rendering/Servicing Provider Group Practice (Corporation, Partnership, LLC, etc.) 			
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.)			
O Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc	:.)		
ubmit			
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Bas	sic Information: Enter required fields and click Confirm button.	
	Basic Information	^
	Legal Entity Name: (As shown on the	come Tax Return)
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		Vendor ID: *
		Contact Email Address:
	NPI: *	Email-1: Email-2:
		*
		Email-3: Email-4:

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Application ID:	20171206268444			Name: TesterT Company				
Basic I	nformation							^
You have su	ccessfully compl	eted the basic informa	ation on the Enrollment Ap	plication.				
Your Applica	ation ID is: 20171	206268444						
Please make	onote of this App	lication ID. This is the	number you will be require	ed				
to use to trac vou will not	ck the status of y be able to access	our enrollment application and	ation. Without this number your information will be de	, eleted.				
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calendar day	ys OR your applic	ation will be deleted.	I SUDMIT IT FOR STATE REVIEW	within 30				
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Confirn	nation, B	asic Inform	nation is comp	olete				6 -
lake no	ote of the	Applicatio	on ID, as this i	is used to track	your ap	plication s	tatus 💦	

Click Ok

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Viewing Page: 1

View Page: 1

- Group Provider Enrollment steps are listed (Please Note: some steps are required versus optional)
- Step 1 has a status of Complete

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Click on Step 2: Add Locations

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Close Add To add/modify Pay To, Correspondence and Remitta	nce Advice addresses, click on Location Type hyperlin	k				
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Doing Business As	Location Type	Location Details		End Date		
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• Click Add, to enter Primary Location information



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Application ID: 20171206268444		Name: TesterT Company		
For all locations, Correspondence address is require	d. For Primary Practice Location, Pay-To a	address is required. Enter Remittance Advice address only to r	receive a paper Remittance	Advice.
Add Provider Location				^
Location Type:	Primary Practice Location	k End Date:		
Doing Dusiness As.	If a department or drawer numbe	r 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 inform	nation in Line THREE. (For example: ATTN: Billing Dept.)		
Address Line 1:	*	Address Line 2:]
Address Line 3:	(Enter Street Address or PO Box Only)	City/Town:	OTHER)*
State/Province:	OTHER 🔽 *	County:	OTHER]
Country:	UNITED STATES ¥	Zip Code:		Validate Address
Phone Number:	* Extn:	Fax Number:		
Email Address:		Web Page:		
				✓ OK ③ Cancel

(Please Note: you should receive confirmation "Address Validation Successful")

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

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Group Associates	Primary Practice Location					12	/31/2999	
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Click Primary Practice Location to add Pay-To address

(Please Note: Correspondence address is required for all locations. Enter Remittance Advise address only to receive a paper Remittance Advice)

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Location Details							
Doing Business As:	Group Associates	Location Code:	1	Location	Type: Primary F	Practice Locati	on
Phone Number:	* Extn:	Fax Number:		Email Ado	dress:		
Web Page:		Office Hours:		Communi	cation	\checkmark	
Handicap Accessible:	No			Field	ence.		
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level):		(For Multiple Selection, use Ctrl Key)	Arabic Chinese				
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Address List							
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• Click Add Address



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	er Location Address				~
-	Type of Address:	SELECT	End Date:		
	Location Address:	○Copy This Location Address			
	lf a d DEP	epartment or drawer number is required enter the inform	nation in line TWO.(For example: DEPT 222 or		
	infor	mation in Line THREE. (For example: ATTN: Billing Dept	.)		
	Address Line 1:	320 S Walnut St	Address Line 2:		
	Address Line 3:	(Enter Street Address or PO Box Only)	Citu/Tours	Lansing ×	
	State/Province:	MICHIGAN ×	County:		
	State/Province.	UNITED STATES ×	Zin Code:	48933 - 2014 C Val	idate Address
	country.		Zip Gode.		iuale Auuress
A.					
					V OK
From the dro	op-down list, se	elect Type of Address			
Complete al	ll fields marked	with an asterisk (*)			
Click Validat	te Address				deres.
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Click Ok					Michigan Department or Health & Hu

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Application ID: 20171206268444		Name: TesterT Compan	у					
Close Save To add additional	addresses, click "Add Address" butto	n.						
Location Details								^ ,
Doing Business As:	Group Associates	Location Code:	1		Locatio	n Type: Primary	Practice Location	
Phone Number:	* Extn:	Fax Number:			Email A	ddress:		
Web Page:		Office Hours:			Commu	nication		
					Pref	erence:		
Handicap Accessible:								
Accept 835(reported at EIN/TIN	Yes 🗸	Language(s) Spoken:	English Arabic					
level):		(For Multiple Selection, use Ctrl Key)	Chinese Y					
End Date:	12/31/2999							
Address List								^
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• When all address locations are complete, click Save

(Please Note: If the address is the same you can click on the radio button that says, Copy This Location Address; example on previous slide.)

Click Close

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> New Enrollment > Group Practice Enrollment										
Application ID: 20171206268444		Name: TesterT Company								
Close Add To add/modify Pay To, Cor	respondence and Remittance Advice addresse	es, click on Location Type hyperlink								
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Group Associates	Primary Practice Location					12/31/2	999			
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• Click Close



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Enroll Provider - Group

Business Process Wizard - Provider Enrollment (Group). Click on the Step # under the Step Column. Step Remark Required Start Date End Date Status Step Step 1: Provider Basic Information Required 12/06/2017 12/06/2017 Complete Step 2: Add Locations Required 12/28/2017 12/28/2017 Complete < Step 3: Add Specialties Required Incomplete Step 4: Add Mode of Claim Submission/EDI Exchange Required Incomplete Step 5: Associate Billing Agent Optional Incomplete Step 6: Add Provider Controlling Interest/Ownership Details Required Incomplete Step 7: Add Taxonomy Details Required Incomplete Step 8: Associate MCO Plan Optional Incomplete Step 9: 835/ERA Enrollment Form Optional Incomplete Optional Step 10: Upload Documents Incomplete Step 11: Complete Enrollment Checklist Required Incomplete Step 12: Submit Enrollment Application for Approval Required Incomplete Viewing Page: 1 ≪ First < Prev > Next >> Last View Page: 1 O Go Page Count SaveToXLS

- Step 2 is complete
- Click on Step 3: Add Specialties



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Specialty/Subspecialty	Provider Type	End Date
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	Location: 01-Group Associates 🗸 *	
Fi	Provider Type:SELECT *	
	Specialty: *	
	End Date:	
_	Add Subspecialty	•
	Available Subspecialties *	
•	Choose appropriate Location, 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	Michigan Department or Health & Human Servicer

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CIC CIC	Add Specialty/Subspecialty	^	
	Location: 01-Group Associates 🗸 *		
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	Specialty: Medical *		
	End Date:		
4	Add Subspecialty	^	
	Available Subspecialties Associated Subspecialties *		
		Cancel	

- When Provider Type and Specialty have been chosen, the available subspecialties will be listed
- Select Available Subspecialties, click >> to add to Associated Subspecialties list
- When complete, click Ok

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Specialty/Subspecialty	Provider Type		End D)ate			
	AT			▼			
Medical/No Subspecialty	GROUPS 12/28/2017						
Delete View Page: 1 O Go Page Count SaveToXLS	Viewing Page: 1			« First	< Prev >	Next	> Last

• Once all Specialties/Subspecialties have been added, click Close



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Name: TesterT Company

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Step	Required	Start Date	End Date	Status	St	ep Remark	
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete			
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete			
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete 🔶			
Step 4: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete			
Step 5: Associate Billing Agent				Incomplete			
Step 6: Add Provider Controlling Interest/Ownership Details	Required			Incomplete			
Step 7: Add Taxonomy Details	Required			Incomplete			
Step 8: Associate MCO Plan	Optional			Incomplete			
Step 9: 835/ERA Enrollment Form	Optional			Incomplete			
Step 10: Upload Documents	Optional			Incomplete			
Step 11: Complete Enrollment Checklist	Required			Incomplete			
Step 12: Submit Enrollment Application for Approval	Required Incomplete						
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- Step 3 is complete
- Click on Step 4: Add Mode of Claim Submission/EDI Exchange


e	Print 3 Help											
Appli	ication ID: 201712	06268444		Name: TesterT Company								
	Mode of Claims	s Submissi	on/EDI exchange		^							
			Please select the s	submission methods from EDI Exchange and/or Other Claims Submission as applicable.								
	EDI exchang	e			^							
	Method	Descripti	on	oplicable Transactions								
	Electronic Batch	To upload screens (N	/download HIPAA transactions from /laximum file upload size is 50MB)	37P- Professional (FFS), 837I -Institutional(FFS), 837D -Dental(FFS), 270/271 -Eligibility,Inquiry/Response, 276/277-Claim Status iquire/Response								
		To upload CORE Ba	/download HIPAA transactions using tch Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 835 Health Care Claim Payment/Advice								
	CORE Real	To upload CORE Re	/download HIPAA transactions using al Time Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response								
	Billing Agent	To submit billing age	receive HIPAA transactions through nt	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	s Submis	sion		^							
	Method		Description									
	Paper Claim	s	To submit FFS paper claims									
	Direct Data E	Entry(DDE)	To submit FFS claims via online screer	ns								

- Under EDI exchange select appropriate claim submission method(s)
- Under Other Claims Submission select appropriate claim submission method(s)
- Click Ok



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Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete					
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete					
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete					
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete					
Step 5: Associate Billing Agent	Required			Incomplete	Please associate required Billing Agent.				
Step 6: Add Provider Controlling Interest/Ownership Details	Required			Incomplete					
Step 7: Add Taxonomy Details	Required			Incomplete					
Step 8: Associate MCO Plan	Optional			Incomplete					
Step 9: 835/ERA Enrollment Form	Optional			Incomplete					
Step 10: Upload Documents	Optional			Incomplete					
Step 11: Complete Enrollment Checklist	Required			Incomplete					
Step 12: Submit Enrollment Application for Approval	Required			Incomplete					
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- Step 4 is complete
- Click on Step 5: Associate Billing Agent



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Close • Add								
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Billing Agent ID	Billing Agent Name		835 Authorization		Start Date	End Date	÷	
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		N	o Records Found !					

• Click Add



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Application ID: 20171206268444	Nam	e: TesterT Company	
Associate Billing Agent			^
Click or	n the 'Confirm/Search Billing Agent' button to se	arch for a Billing Agent or confirm the Billin	g Agent entered.
Billing Agent ID:	*	Billing Agent Name:	
Association Start Date:	*	Association End Date:	
Authorized Transaction Response	S		*
Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status			
			Confirm/Search Billing Agent

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	Billing Agent ID	Billing Agent Name	Start Date	End Date	
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Transa			01/01/1984	12/31/2999	
X12 835			04/30/1998	12/31/2999	
			12/08/1999	12/31/2999	
			02/25/2000	12/31/2999	
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• Check the box next to the Billing Agent you want to select

(Please Note: There is more than one page of Billing Agents; you may select more than one)

Michigan Department + Health & Human Services

Click Select

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		Click on the 'Confirm/Search Billing	g Agent' button to search f	or a Billing Agent or confirm	n the Billing Agent entered.		
F	Billing Agent ID:	*		Billing Agent Name:			
	Association Start Date:	12/28/2017		Association End Date:	12/31/2999		
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- Billing Agent information has been added
- Click Close



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Enroll Provider - Group

B	usiness Process \	Vizard - Provider E	nrollment (Group). C	Click on the S	tep # ur	nder the Step	Column
Step	Required	Start Date	End Date	Status	5	Step Remark	
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete			
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete			
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete			
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete			
Step 5: Associate Billing Agent	Required	12/28/2017	12/28/2017	Complete		_	
Step 6: Add Provider Controlling Interest/Ownership Details	Required			Incomplete			
Step 7: Add Taxonomy Details	Required			Incomplete			
Step 8: Associate MCO Plan	Optional			Incomplete			
Step 9: 835/ERA Enrollment Form	Optional			Incomplete			
Step 10: Upload Documents	Optional			Incomplete			
Step 11: Complete Enrollment Checklist	Required			Incomplete			
Step 12: Submit Enrollment Application for Approval	Required			Incomplete			
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• Step 5 is complete

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Click on Step 6: Add Provider Controlling Interest/Ownership Details

*The screens for this step were updated 12/14/18



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PROVIDER OWNERSHIP AND CONTROL DISCLOSURES										
Provider Enrollment Information, including home address, date of birth, and Social Sec	urity Number, is required fro	om providers and (other disclosed individua	ls (e.g., owners, man	aging employees, agents, etc.).					
REQUIRED DISCLOSURE INFORMATION	he following information on a	ournership and car	ntrol during oprollmont re	validation and within	05 dava offer any shange in ourpershi					
The name and address of any person (individual or corporation) with ownership o	r control interest. The addre	ess for corporate e	ntities must include, as a	pplicable, primary bu	siness address, every business locatio	n and P.O. Box a	ddress.			
Date of birth and Social Security Number (in the case of an individual). Other Tay Identification Number in the case of comparison with an expension or	central interact or of any cul	boontractor in whi	ich the disclosing ontity h	ac a five percent or m	ara interact					
Whether the person (individual or corporation) with an ownership or control intere	st is related to another perso	on with ownership	or control interest as a s	pouse, parent, child o	or sibling; or whether the person (indivi	dual or corporatio	n) with an ownership or c	control interest of any su	bcontractor ir	n which
the disclosing entity has a five percent or more interest is related to another perso	n with ownership or control	interest as a spou	use, parent, child or siblin	g. disaid and/or Medicar						
The name, address, date of birth and Social Security Number of any managing er	nployee.	est in an enuty the	at is reinibul sable by me		с.					
REQUIRED OWNERS										
Managing Employee is mandatory for all enrollment types.										
There must be at least one other ownership type in addition to Managing Employe	e. Corporate - Charitable 50	01[c]3								
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Corporate - Non Charitable Sub-contractor		Limite	d liability Company							
Corporate - Publicly Traded Holding Company	ſ	Indired	ct Owner							
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• To enter owner information, click Actions



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PROVIDE Import Owner DISCLOSURES										
Provider E Owners Relationships ome address, date of birth, and Social Sec	curity Number, is require	d from providers and (other disclosed individu	als (e.g., owners, ma	inaging employees, agents, etc.).					
REQUIRE Owners Adverse Action										
Provider (including fiscal agents and managed care entities) are required to disclose the	ne following information o	in ownership and cont dress for corporate er	trol during enrollment, r	evalidation and with	n 35 days after any change in owners	ship: ation and P.O. Box a	2291h			
Date of birth and Social Security Number (in the case of an individual).	Control Interest. The ad	aress for corporate en	nues must include, as a	аррисавіе, рипату і	usiliess audiess, every busiliess loca		Juless.			
 Other Tax Identification Number, in the case of corporation, with an ownership or Whether the person (individual or corporation) with an ownership or control intere 	control interest or of any st is related to another p	subcontractor in whic erson with ownership	th the disclosing entity h or control interest as a	as a five percent or spouse, parent, chile	more interest. I or sibling; or whether the person (inc	dividual or corporatio	n) with an ownership or o	control interest of any su	bcontractor in	which
the disclosing entity has a five percent or more interest is related to another perso	on with ownership or cont	rol interest as a spou	se, parent, child or sibli	ng.						
 The name of any other liscal agent of manage care entry in which an owner has a The name, address, date of birth and Social Security Number of any managing er 	nployee.	interest in an entity that	at is reimbulsable by Me	edicald and/or Medic	are.					
REQUIRED OWNERS										
 Managing Employee is mandatory for all enrollment types. 										
There must be at least one other ownership type in addition to Managing Employe At least one Reard of Director/Officers/Principal is required if one of the ownership	ee. Corporate - Charitabl	a 501[c]3								
Corporate - Charitable 501[c]3 Corporate - Not F	Publicly Traded	Foreig	n, Nonresident Alien							
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• Select Add Owner



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PROVIDER OWNERSHIP AND CONTROL DISCLOSURES										
Provider Enrollment Information, including home address, date of birth, and Social Sec	urity Number, is required fro	om providers and (other disclosed individua	ls (e.g., owners, man	aging employees, agents, etc.).					
REQUIRED DISCLOSURE INFORMATION	he following information on a	ournership and car	ntrol during oprollmont re	validation and within	05 dava offer any shange in ourpershi					
The name and address of any person (individual or corporation) with ownership o	r control interest. The addre	ess for corporate e	ntities must include, as a	pplicable, primary bu	siness address, every business locatio	n and P.O. Box a	ddress.			
Date of birth and Social Security Number (in the case of an individual). Other Tay Identification Number in the case of comparison with an expension or	central interact or of any cul	boontractor in whi	ich the disclosing ontity h	ac a five percent or m	ara interact					
Whether the person (individual or corporation) with an ownership or control intere	st is related to another perso	on with ownership	or control interest as a s	pouse, parent, child o	or sibling; or whether the person (indivi	dual or corporatio	n) with an ownership or c	control interest of any su	bcontractor ir	n which
the disclosing entity has a five percent or more interest is related to another perso	n with ownership or control	interest as a spou	use, parent, child or siblin	g. disaid and/or Medicar						
The name, address, date of birth and Social Security Number of any managing er	nployee.	est in an enuty the	at is reinibul sable by me		с.					
REQUIRED OWNERS										
Managing Employee is mandatory for all enrollment types.										
There must be at least one other ownership type in addition to Managing Employe	e. Corporate - Charitable 50	01[c]3								
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• To enter owner information, click Actions



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Provider Controlling Interest/Ownership				~
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Legal Entity Na	me:	Entity Business Name:		
	(As shown on the Income Tax Return)		(Doing Business As)	
First Na	me:	Last Name:		
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	D CONTROL DISCLOS	JRES								
Provider Enrollment Information	on, including home addre	ss, date of birth, and Social Secu	urity Number, is required fro	m providers and oth	er disclosed indiv	iduals (e.g., owners,	managing employees,	agents, etc.).		
REQUIRED DISCLOSURE IN	FORMATION									
 Provider (including fiscal ager The name and address or address. Date of birth and Social S Other Tax Identification N Whether the person (indi an ownership or control in The name of any other fis The name, address, date 	nts and managed care en of any person (individual o Security Number (in the ca Number, in the case of coo vidual or corporation) with interest of any subcontrac scal agent or manage car e of birth and Social Secur	tites) are required to disclose the r corporation) with ownership or use of an individual). poration, with an ownership or co an ownership or control interes or in which the disclosing entity entity in which an owner has a ity Number of any managing em	e following information on or control interest. The addres control interest or of any sub t is related to another perso has a five percent or more i n ownership or control inter ployee.	wnership and contro s for corporate entit contractor in which i n with ownership or nterest is related to est in an entity that i	I during enrollmen ies must include, the disclosing ent control interest a another person w s reimbursable by	tt, revalidation and v as applicable, prima ity has a five percent a aspouse, parent, c ith ownership or con Medicaid and/or Me	vithin 35 days after any ry business address, ev t or more interest. shild or sibling, or wheth trol interest as a spouse adicare.	change in ownership: ery business location er the person (individi e, parent, child or sibli	and P.O. Box ual or corporation	n) with
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• To add the relationship click the Actions drop-down menu



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Select Owners Relationships from the Actions drop-down menu



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plication ID: 201812041	71383		Name: Test, Testing				
Add Relationshi	0						
)o any of the Owners ha	ve the following relationsh	ip (Daughter, Daughter-In Law, F	Father, Father-In Law, Mother, Mother-In Law, Si	ibling, Son, Son-In	Law, Self, Spouse) ?	⊖Yes ⊖No (Click Sa	ve to update)
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- Answer question (at the top)
- If no relationships exist select No.
 - If the owners have a relationship to one another, refer to the <u>Step 8: Add Provider Controlling</u>
 <u>Interest/Ownership Details</u> user guide.



0181204171383 Name: Test, Testing ationship where he following relationship (Daughter, Daughter-In Law, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)? OYes No (Click Save to up
ationship Dwners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? OYes 👀 (Click Save to up
Dwners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? OYes 💽 No (Click Save to up
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- The owner list boxes collapse
- Click Save



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Do any of the Owners have the following relationship (Daug	hter, Daughter-In Law, Father, Father-In Law, Mother, Moth	er-In Law, Sibling, Son, Son-In Law	/, Self, Spouse) ?)Yes No (Click Sa	ve to update)	
Owner List						
Show Owners All 🔽 O Go				Save Filters	▼ My Filters▼	
Selected Owner:Example, One SSN/EIN/TIN:1234	56789 S Message from webpage All owner relationships will be set to 'None'. Do y	v want to continue?				

• After clicking save, click Ok.



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	Application ID: 20181204171383 Name: Test, Testing				
	III 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-Ir	n Law, Self, Spouse) ?	⊖Yes ⊖No (Click Sa	ave to update)	
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	Selected Owner:Test, Testing SSN/EIN/TIN:: Status:Completed				
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			Bs	Save 🛛 🕲 Close	

- The status for each owner will show Completed
- Click close to return to the owner list screen



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> New Enrollment > Individual	Enrollment > General									
pplication ID: 201812041713	383		Name	e: Test, Testing						
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ROVIDER OWNERSHIP ANI	D CONTROL DISCLOSU	IRES								
rovider Enrollment Informatio	n, including home addres	s, date of birth, and Social Secu	rity Number, is required from	n providers and oth	er disclosed indiv	viduals (e.g., owners	s, managing employees,	, agents, etc.).		
EQUIRED DISCLOSURE IN	FORMATION									
 Date of birth and Social Soc	ecurity Number (in the ca umber, in the case of corp ridual or corporation) with aterest of any subcontract cal agent or manage care	ise of an individual). poration, with an ownership or co an ownership or control interest or in which the disclosing entity h e entity in which an owner has ar	ontrol interest or of any subc is related to another person has a five percent or more in ownership or control interest	ontractor in which t with ownership or terest is related to st in an entity that is	he disclosing ent control interest a another person w s reimbursable by	tity has a five percer s a spouse, parent, vith ownership or co y Medicaid and/or M	nt or more interest. child or sibling; or wheth ntrol interest as a spous fedicare.	her the person (individ se, parent, child or sibl	ual or corporation	on) with
The name, address, date EQUIRED OWNERS Managing Employee is ma There must be at least one At least one Board of Dire Corporate - Cha Corporate - Publ	of birth and Social Securi andatory for all enrollmen e other ownership type in sctor/Officers/Principal is r ritable 501[c]3 (Charitable licly Traded	ty Number of any managing emp t types. addition to Managing Employee required if one of the ownership t Corporate - Not Publicly Trader Sub-contractor Holding Company	ployee. e. Corporate - Charitable 501 types below is selected: d Foreign, Nonre Limited liability Indirect Owner	[c]3 Isident Alien Company						
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• The Relationship Status now shows Completed for both owners



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cation ID: 20181204171383	l		Name	e: Test, Testing					
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There Add Owner At lea: Import Owner Owners Relationship Owners Adverse Act	ownership type in addi icers/Principal is requi io1[c]3 Cor ible Sub ion cu Hol	ition to Managing Employee. red if one of the ownership ty porate - Not Publicly Traded o-contractor ding Company	Corporate - Charitable 501 rpes below is selected: Foreign, Nonre Limited liability Indirect Owner	[c]3 esident Alien Company					
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wner SSN/EIN/TIN	Owner Information	Owner Type ▲▼	Address	Start Date	End Date ▲▼	Relationship Status	Adverse Action ▲▼	Percentage ▲▼	e owned
3456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	Not Completed	0	
	Test, Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100	
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d Other Owned Entity	st Ownership Interest	in other Entities reimb	ursible by Medicaid ar	nd/or Medicare.				Cave Filtere	
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Select Owners Adverse Action from the Actions drop-down menu to complete the Final Adverse Legal/Action/Convictions Disclosure

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🕑 Help

🚔 Print

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Application ID: 20181204171383		Name: Test, Testing	
III FINAL ADVERSE LEGA	L ACTIONS/CONVICTIONS	^	~
This section captures information on expunged or any appeals are pendir	final adverse legal actions, such as convictions, excl Ig.	usions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were	
Convictions			
 The provider, supplier, or any own be detrimental to the best interest including guilty pleas and adjudica guilty pleas and adjudicated pre-tu- and any misdemeanor conviction, und delivery of a health care item or si 	er of the provider or supplier was, within the last 10 y s of the program and its beneficiaries or recipients. O ted pre-trial diversions; financial crimes, such as exto ial diversions; any felony that placed the Medicaid pr that may result in a mandatory or permissive exclusio der Federal or State law, related to: (a) the delivery of arvice.	rears preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to ffenses include, but are not limited to: Felony crimes against persons and other similar crimes for which the individual was convicted, ortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including ogram or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); on under State or Federal law. an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the	ļ
 Any misdemeanor conviction, und Any felony or misdemeanor convi Any felony or misdemeanor convi 	ter Federal or State law, related to theft, fraud, embez ction, under Federal or State law, relating to the interf ction, under Federal or State law, relating to the unlav	zlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service. erence with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201. vful manufacture, distribution, prescription, or dispensing of a controlled substance.	I
Exclusions, revocations, or Suspe	ensions		
 Any revocation or suspension of a authority. Any revocation or suspension of a 	license to provide health care by any State licensing ccreditation.	authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing	I
 Any suspension or exclusion from procurement program. 	participation in, or any sanction imposed by, a Feder	al or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-	
 Any current Medicaid payment su Any Medicaid revocation of any M 	spension under any Medicaid enrollment. ledicaid provider billing number.		I
FINAL ADVERSE LEGAL ACTION	CONVICTION ACTION HISTORY		
Do any of the owners, under any cur for each owner.	rrent 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	
Owners with Adverse A	ction	^	
Owner Name	Response	Comments	
Test, Testing	Yes ⊖No		
Example,One	⊖Yes ⊖No		
		Viewing Page: 1	

 Read through Final Adverse Legal Actions/Convictions statement for each owner listed, select Yes or No

Application ID: 2018120417138	3	Name: Test, Testing	
1. Any revocation or suspensior authority.	of a license to provide health care by any State licensing	authority. This includes the surrender of such a license while a for	formal disciplinary proceeding was pending before a State licensing
2. Any revocation or suspension	of accreditation.		
 Any suspension or exclusion procurement program. 	from participation in, or any sanction imposed by, a Feder	al or State health care program, or any debarment from participat	ation in any Federal Executive Branch procurement or non-
4. Any current Medicaid paymer	it suspension under any Medicaid enrollment.		
FINAL ADVERSE LEGAL ACT	ION/CONVICTION ACTION HISTORY		
FINAL ADVERSE LEGAL ACT Do any of the owners, under an for each owner.	TON/CONVICTION ACTION HISTORY y current or former name or business identity, ever had a t e Action	final adverse legal action listed above imposed against them? Ple	lease answer in the 'Owners with Adverse Action' section below
FINAL ADVERSE LEGAL ACT Do any of the owners, under an for each owner. Owners with Advers Owner Name	ION/CONVICTION ACTION HISTORY y current or former name or business identity, ever had a e Action Response	final adverse legal action listed above imposed against them? Ple Comments	lease answer in the 'Owners with Adverse Action' section below
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• Click Ok



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> New Enrollment > Individu	al Enrollment 🗲 General									
Application ID: 2018120417	1383		Nam	e: Test, Testing						
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Per Medicaid Pro	vider Manual									^
	ND CONTROL DISCLOS	URES								
Provider Enrollment Informat	ion, including home addr	ess, date of birth, and Social Sec	curity Number, is required from	n providers and oth	er disclosed indiv	riduals (e.g., owners	, managing employees, a	agents, etc.).		
REQUIRED DISCLOSURE I	NFORMATION									
address. Date of birth and Social Other Tax Identification Whether the person (ind an ownership or control The name of any other f The name address dat	Security Number (in the of Number, in the case of co ividual or corporation) wi interest of any subcontra iscal agent or manage ca	ase of an individual). proration, with an ownership or h an ownership or control intere: ctor in which the disclosing entity re entity in which an owner has a rity Number of any managing er	control interest or of any subc st is related to another persor / has a five percent or more ir an ownership or control intere molovee.	contractor in which t a with ownership or nterest is related to est in an entity that i	the disclosing ent control interest a another person w s reimbursable by	ity has a five percen s a spouse, parent, c rith ownership or cor r Medicaid and/or Mo	t or more interest. child or sibling; or whethe ntrol interest as a spouse edicare.	er the person (individu: , parent, child or siblin	al or corporatic g.	on) with
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- The Adverse Action column will show Yes or No indicating it's complete.
- Click Close



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🖨 Print

👤 Tester, Testing 🔻

Application ID: 20171206268444

Name: TesterT Company

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Enroll Provider - Group

B	usiness Process \	Nizard - Provider Ei	nrollment (Group). C	lick on the Step # ເ	Inder the Step Column.
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete	
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete	
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete	
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete	
Step 5: Associate Billing Agent	Required	12/28/2017	12/28/2017	Complete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	12/28/2017	12/28/2017	Complete	
Step 7: Add Taxonomy Details	Required			Incomplete	
Step 8: Associate MCO Plan	Optional			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	
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- Step 6 is complete
- Click on Step 7: Add Taxonomy Details



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A S New Enrollment S Group Practice Enrollment						
Application ID: 20171206268444	Name: TesterT Company					
Close Add						
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Filter By	O Go			Save Filters	▼ My Filters▼	
Taxonomy Code	Description	Start Date	End	Date		
	▲▼	AV	AV			
	No Records Found !					





Application ID: 20171206268444 Application ID: 20171206268444 Add Taxonomy Taxonomy Code: Description: Start Date: *	Location: 01-Group Associates
Add Taxonomy Taxonomy Code: * (Click here for Taxonomy List) Description: Start Date: *	Location: 01-Group Associates
Taxonomy Code: * (Click here for Taxonomy List) Description: Start Date: *	Location: 01-Group Associates 🖌 * End Date:
Description: Start Date:	End Date:
Start Date:	End Date:
	Oconfirm Taxonomy
Enten in Town one Onder an allah and (m) and that	
Lock up appropriate taxonomy code	anda Oliak hana far Tawaramu List ta



- After clicking (4) the <u>National Uniform Claim Committee</u> webpage will pop-up
- Press (CTRL+F) to search for appropriate taxonomy code



// https://i	milogintp.michigan.gov/ - Welcome to MMIS - Internet Explore			
Appli	ication ID: 20171206268444	Name: TesterT	ompany	
Ш	Add Taxonomy			*
	Taxonomy Code:	* 4 (Click here for Taxonomy List)	Location: 01-Group	Associates 🗸 *
	Description:			
-	Start Date:	*	End Date:	
				Confirm Taxonomy ✓ Ok Cancel

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207LC0200X	Critical Care Medicine		01/01/2018		12/31/29	99		
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- The Taxonomy Code information will now be displayed
- Click Close



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Enroll Provider - Group

В	usiness Process	Wizard - Provider E	nrollment (Group).	Click on the St	ep # unde	er the Step	Column
Step	Required	Start Date	End Date	Status	Step	Remark	
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete			
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete			
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete			
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete			
Step 5: Associate Billing Agent	Required	12/28/2017	12/28/2017	Complete			
Step 6: Add Provider Controlling Interest/Ownership Details	Required	12/28/2017	12/28/2017	Complete			
Step 7: Add Taxonomy Details	Required	12/28/2017	12/28/2017	Complete		-	
Step 8: Associate MCO Plan	Optional			Incomplete			
Step 9: 835/ERA Enrollment Form	Optional			Incomplete			
Step 10: Upload Documents	Optional			Incomplete			
Step 11: Complete Enrollment Checklist	Required			Incomplete			
Step 12: Submit Enrollment Application for Approval	Required			Incomplete			
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- Step 7 is complete
- Click on Step 8: Associate MCO Plan (Please Note: This step is optional)



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> New Enroll	lment 🖇 Group	Practice Enrollment								
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 Step is optional, if you do not work with a Managed Care Organization (MCO) plan, click Close

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- If choosing to add an MCO Plan;
- Click Add to associate an MCO plan



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App. A	Application ID: 201712	06268444			Ν	ame: TesterT C	ompany				
C	Associate MCO F	lan									^
			Click on the 'Confirm	n/Search Plan' butto	on to search for a MC	O Plan or confirm	the Plan ID entered				
F		Plan ID:	*	e associate only to p	plans with which you	nave a signed co	Plan Name	:			
		Program Name:					Program Description	:			
		Association Start Date:	*	ĸ			Association End Date	:	iii		
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Тс	o locate the	MCO Plar	ı ID , click	Confirm	n/Search	Plan				Mile	

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			Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medica	al Program Type					
			Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medica	al Program Type					
			Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medica	al Program Type					
			Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medica	al Program Type					
			Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medica	al Program Type					
			Active	12/21/1993	12/31/2999	MHP	Managed Care Comprehensive Medica	al Program Type	\checkmark				
			Activo	01/01/1005	10/01/0000	мир	Managod Caro Comprohancivo Modies						

Check the box next to the MCO Plan you want to select

(Please Note: There is more than one page of MCO plans; you may select more than one)

Tichigan Department of Health & Human Services

Click Select

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O CI	III Associa	te MCO Plan								^
			Click on th	e 'Confirm/Search Pla	an' button to search for a	MCO Plan or confirm the Plan	ID entered			
F		F	Plan ID:	Please associate o	only to plans with which y	ou have a signed contract	Plan Name:			
		Program	Name: MHP			Program	n Description:	ManagedCareF	Program	
		Association Sta	rt Date: 11/20/2017	*		Associat	tion End Date:	12/31/2999		
-										
								Øc	onfirm/Search Plan	Ok Ocancel
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Application ID: 20171206268444

Name: TesterT Company

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Enroll Provider - Group

Bu	Isiness Process \	Nizard - Provider E	nrollment (Group). C	Click on the Step	# under the Step	Column
Step	Required	Start Date	End Date	Status	Step Remark	
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete		
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete		
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete		
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete		
Step 5: Associate Billing Agent	Required	12/28/2017	12/28/2017	Complete		
Step 6: Add Provider Controlling Interest/Ownership Details	Required	12/28/2017	12/28/2017	Complete		
Step 7: Add Taxonomy Details	Required	12/28/2017	12/28/2017	Complete		
Step 8: Associate MCO Plan	Optional			Incomplete		
Step 9: 835/ERA Enrollment Form	Optional			Incomplete		
Step 10: Upload Documents	Optional			Incomplete		
Step 11: Complete Enrollment Checklist	Required			Incomplete		
Step 12: Submit Enrollment Application for Approval	Required			Incomplete		
View Page: 1 O Go Page Count SaveToXLS	Viewing Page: 1			« First	Prev > Next	» Last

- Finished walking through optional Step 8
- Click on Step 9: 835/ERA Enrollment Form (Please Note: This step is optional)



Dication ID: 20171206268444	Name: TesterT Company	
Close 🕑 Submit 🚔 Print 💽 Help		
ERA ENROLLMENT FORM		
III PROVIDER INFORMATION		
Provider N	e:	
Doing Business As Name (D): TesterT Company	
Provider Address		
Sti	t: State/Prov	ince: MICHIGAN
·	r: LANSING Zip Code/Postal (Code: 48933
Country C	e: UNITED STATES	
III PROVIDER IDENTIFIERS		
Provider Federa	av Identification Number (TIN) or Employer Identification Number (EIN):	
Provider Pedera	A denuication windle (TRV) of Employer identification windle (ERV). National Provider Identifier (NP):	
Other Identifier(s)		
Assigning Autho	/: Trading Partn	ər ID:
Provider License Details		
Provider License	D: License Is	suer:
Provider T	e:	
Provider Taxonomy C	e:	
PROVIDER CONTACT INFORMATION		
Provider Contact Name		
Cont	t	Title: Managing Employee
Telephone Num	r: Telephone Number Exter	sion:
Email Addr	s: Fax Nur	nber:
PROVIDER AGENT INFORMATION		
Provider Agent N	8:	
Agent Address		
Sti	t: State/Prov	ince:
c c	r: Zip Code/Postal C	Code:
Country C	ð7	
Provider Agent Contact Name		
Provider Agent Contact Na	êr	Title:
Telephone Num	r: Telephone Number Exter	sion:
Email Addr	a: Fax Nur	nber:
FEDERAL AGENCY INFORMATION (Not applicable	: this time)	
Federal Program Agency Na	1: Federal Program Agency Iden	tifier:
Federal Agency Location C		
III RETAIL PHARMACY INFORMATION(Not applicable	t this time)	
Pharmacy Name		
Pharmacy Na	Chain Nur	nber:
	t: Organizatio	n ID:
Par		
Par Payment Cente		
Par Payment Cente NCPDP Provider Day		

• Complete all fields marked with an asterisk (*)

ELECTRONIC REMITTANCE ADVICE INFORMATION	*
Preference for Aggregation of Remittance Data(e.g., Account Number Linkage to Provider Identifier)	
ONPI @TAX ID *	
MI Medicaid enumerates by Tax ID only.	
Method of Retrieval: *	
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Not applicable at this time)	^
ClearingHouse Name:	
ClearingHouse Contact Name	
ClearingHouse Contact Name:	Telephone Number:
Email Address:	
ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Not applicable at this time)	~
Vendor Name:	
Vendor Contact	
Vendor Contact Name:	Telephone Number:
Email Address:	
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 the Michigan Department Of Health and Human Services to establish an 835/ERA account for the Tax ID listed above and for 835/ER	A files to be transmitted electronically to the designated entity.
Written Signature of Person Submitting Enrollment:	
Printed Name of Person Submitting Enrollment:	
Printed Title of Person Submitting Enrollment:	
Submission Date: 01/02/2018	
Requested ERA Effective Date:	
(Once approve the next paycycle date.)	

• Complete all fields marked with an asterisk (*)



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New Enrollment) G	roup Prac	tice Enrollment										
pplication ID: 2017120	6268444				Name	: TesterT Compan	/					
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OCancel Enrollment (OChang	e Enrollment ON	ew Enrollment *									
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			Electron	ic Signature of Pe	erson Submitting Enrollme	ent:						
Authorization Agree and conditions stat	ement-B ted in the	y selecting the che Authorization Age	eckbox above, I he reement below.	ereby agree that I ha	nave read and agree to the te	erms						
Authorization Agree	ment											
By signing this request entity.	st, I am a	uthorizing the Mich	nigan Department	Of Health and Hum	nan Services to establish an	835/ERA account	or the Tax ID lis	ted above and for {	335/ERA files to be trans	mitted electronically to t	he designated	
			Writte	en Signature of Pe	erson Submitting Enrollme	ent:						
			Р	rinted Name of Pe	erson Submitting Enrollme	ent:						
				Printed Title of Pe	erson Submitting Enrollme	ent:						
		Submissio	on Date: 01/02/2	2018								
	Reque	sted ERA Effectiv	ve Date:									
(Once	approve	the next paycyc	le date.)									

- Click Submit
- Click Close



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Mew Enrollment > Group Practice Enrollment

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

В	usiness Process	Wizard - Provider E	nrollment (Group).	Click on the Step #	under the Step Column.
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete	
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete	
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete	
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete	
Step 5: Associate Billing Agent	Required	12/28/2017	12/28/2017	Complete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	12/28/2017	12/28/2017	Complete	
Step 7: Add Taxonomy Details	Required	12/28/2017	12/28/2017	Complete	
Step 8: Associate MCO Plan	Optional			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	
View Page: 1 O Go Page Count SaveToXLS	Viewing Page:	1		K First	vev 💙 Next 🔉 Last

- Finished walking through optional Step 9
- Click on Step 10: Upload Documents (Please Note: This step is optional)



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oplication ID: 20171206	6268444		Name: T	FesterT Company				
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- This step is optional, if documentation needs to be uploaded, click Add
- If not, click Close



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Application ID: 20171206268444	Name: TesterT Company		
Upload Document			^
Document Type: Associated MCO ID: File Name: Start Date: End Date:	ELECT tification tract teral ense Browse	Document Name: Program Name:	
Remark:			
If provider chooses to upload a de	ocument;		✓ OK OK
Click Browse to find the saved do Enter any other additional information	ument name cument on your computer tion		MEDHI

Click Ok

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plication ID: 2017120	6268444		Name: 1	FesterT Company				
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- The documentation has been added
- To return to the enrollment steps, click Close



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Application ID: 20171206268444

Name: TesterT Company

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Enroll Provider - Group

Business Process Wizard - Provider Enrollment (Group). Click on the Step # under the							
Step	Required	Start Date	End Date	Status	Step Remark		
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete			
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete			
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete			
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete			
Step 5: Associate Billing Agent	Required	12/28/2017	12/28/2017	Complete			
Step 6: Add Provider Controlling Interest/Ownership Details	Required	12/28/2017	12/28/2017	Complete			
Step 7: Add Taxonomy Details	Required	12/28/2017	12/28/2017	Complete			
Step 8: Associate MCO Plan	Optional			Incomplete			
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Step 10: Upload Documents	Optional			Incomplete			
Step 11: Complete Enrollment Checklist	Required			Incomplete			
Step 12: Submit Enrollment Application for Approval	Required			Incomplete			
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- Finished walking through optional Step 10
- Click on Step 11: Complete Enrollment Checklist



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New Enrollment Group Practice Enrollment Provider Check List					
Application ID: 20171206268444 Name: TesterT Comp	any				
III Provider Checklist					^
Question	Answe	r	Comments		
Do you need to request a Retro Enrollment Date? If Yes, enter the requested Retro Enrollment Date in the comment field.	Not C	ompleted 🔽			J
Are you currently excluded from any State program?	Not C	ompleted 🔽			
Are you currently excluded from any Federal program?	Not C	ompleted 🗸			
Have you ever had a criminal or health-related conviction?	Not C	ompleted 🔽			
Have you ever had a judgment under any false claims act?	Not C	ompleted 🔽			
Have you ever had a program exclusion/debarment?	Not C	ompleted 🗸			
Have you ever had a civil monetary penalty?	Not C	ompleted 🗸			
Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details"	step. Not C	ompleted 🔽			
Do you accept new patients?	Not C	ompleted 🔽			
Have you had any malpractice settlement, judgment, or agreement? If yes, enter dollar amount(s) and date(s).	Not C	ompleted 🗸			
Are you a PA 161 Program?	Not C	ompleted 🗸			
Do you contract with PA 161 program? If you contract with one of these programs, please provide the NPI in the comments.	Not C	ompleted 🗸			
All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?	Not C	ompleted 🗸			
View Page: 1 O Go Page Count SaveToYIS Viewing	Page: 1	<i>4</i>	irst & Prev	Next	Last

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



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Mew Enrollment > Group Practice Enrollment

Application ID: 20171206268444

Name: TesterT Company

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Enroll Provider - Group

B	usiness Process \	Nizard - Provider Er	nrollment (Group). C	lick on the Step # u	nder the Step Column.
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete	
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete	
Step 3: Add Specialties	Required	12/28/2017	12/28/2017	Complete	
Step 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete	
Step 5: Associate Billing Agent	Required	12/28/2017	12/28/2017	Complete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	12/28/2017	01/02/2018	Complete	
Step 7: Add Taxonomy Details	Required	12/28/2017	12/28/2017	Complete	
Step 8: Associate MCO Plan	Optional			Incomplete	
Step 9: 835/ERA Enrollment Form	Optional			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required	01/02/2018	01/02/2018	Complete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	
View Page: 1 O Go Page Count SaveToXLS	Viewing Page: 1			« First P re	> Next >> Last

- Step 11 is complete
- Click on Step 12: Submit Enrollment Application for Approval

(Please Note: If you chose not to complete optional steps you can still submit your application) You must complete step 12 to submit your application



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New Enrollment	S Group Practice	Enrollment							
pplication ID: 20	171206268444			Name: TesterT Company					
Close > Next	:								
Final Sub	omission								4
		Application ID:	20171206268444		Enro	IlmentType: Group Pra	ctice (Corporation, Par	tnership, LL(C, etc.)
			The inf	ormation submitted for enrollment shall be verified a	and reviewed by the State.				
			r	During this time, any changes to the information sha	Il not be accepted.				
			I agree that the	information submitted as a part of the application is	correct (Private and Confid	ential).			
Applicati	ion Document	Checklist							
						Source	Required		
Forms/Documents	s		Sp	pecial Instructions		Source			
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Application	ID: 201712(062684	44					1	Name: Te	esterT Cor	mpany									
Close	Submit Ap	plicatior	After reading	g the Terms a	nd Condition	ns be sure to	o check the	agreement	t box loca	ated at th	e end of	the docum	ent.							
III Med	lical Assis	stance	e Provider En	nrollment &	Trading Pa	artner Agre	eement - C	Conditions	s										^	~
In applying and certify	for enrolln as follows:	nent as	a provider or t	trading partne	er in the Med	lical Assistar	nce Progran	m (and prog	grams fo	or which th	he Michiç	gan Depart	nent Of Health	and H	luman Services (M	DHHS) i	s the fiscal inte	rmediary), l re	present	
	1. The ap	oplicant	, and the emplo	yer (if applicab	le), certify tha	at the undersi	igned has/ha	ave the auth	hority to e	execute this	is Agreem	ient.								
	2. Enrollr subcor	ment in ntractor	the Medical Ass	sistance Progra	am does not (guarantee pa	articipation in	n MDHHS ma	nanaged c	care progra	ams nor d	loes it repla	ce or negate the	contra	act process betweer	n a mana	aged care entity a	and its provider	rs or	
	3. All info	ormatio	n furnished on th	his Medical Ass	sistance Prov	vider Enrollme	ent & Trading	ig Partner Ag	greement	t form is tru	ue and co	mplete.								
	4. The pr 455.10	roviders)0]	and fiscal ager	nts of ownershi	p and control	l information a	agree to prov	ovide proper	r disclosur	re of provid	der's own	ers and oth	er persons crimi	nal rel	ated to Medicare, M	edicaid (or Title XX involv	ement. [42 CFF	R	
	5. The ap involve	oplicant ement s	and the employ	ver agree to pro on of Medicare	ovide proper , Medicaid, o	disclosure of or Title XX pro	[:] any criminal ograms. [42 (al convictions CFR 455.10	is related t 06 and 42	to Medicar 2 U.S.C. §	re (Title X 1320a-7]	VIII), Medic	aid (Title XIX), a	ind oth	ner State Health Car	e Progra	ams (Title V, Title	e XX, and Title 3	XXI)	
	6. Before partici	e billing pation r	for any medical noted in the mar	services I reno nual, and 2) MD	der, I will read DHHS's polici	d the Medicaid	id Provider M edures for the	Manual from le Medical As	n the Michi Assistance	nigan Depa e Program	artment O contained	f Health and d in the mar	Human Service ual, provider bu	es (ME Iletins	HHS). I also agree and other program	to comp notificati	ly with 1) the terr ons.	ns and conditio	ons of	
	7.1 agree the Me	e to cor edical A	nply with the pro ssistance Progr	ovisions of 42 C ram is allowed.	CFR 455.104,	, 42 CFR 455	5.105, 42 CFI	FR 431.107 a	and Act N	No. 280 of	the Public	c Acts of 19	39, as amended	, whicl	h state the condition	s and re	quirements unde	er which particip	pation in	
	8. I agree Educa	e to cor ition Ab	nply with the rec out False Claim	quirements of S is Recovery."	Section 6032	of the Deficit	Reduction A	Act of 2005,	, codified a	at section	1902 (a)(68) of the S	ocial Security A	ct whic	h relates to the con	ditions a	nd requirements	of "Employee		
	9. I agree or on b	e that, u behalf c	upon request an of, a Medical Ass	d at a reasonal sistance Progra	ble time and am beneficiar	place, I will al y. These reco	Illow authoriz ords also inc	zed state or t clude any se	r federal g ervice con	governmen ntract(s) I h	nt agents t have with	to inspect, o any billing	opy, and/or take igent/service or	any r servic	ecords I maintain pe e bureau, billing cor	ertaining Isultant,	to the delivery of or other healthca	f goods and sei are provider.	rvices to,	
	10. I agree of cost	e to incl ts and s	lude a clause in services furnishe	any contract I o	enter into wh ontract.	ich allows aut	uthorized stat	ite or federal	al governm	ment agent	ts access	to the subc	ontractor's acco	unting	records and other d	ocumen	ts needed to veri	ify the nature a	nd extent	
	11. I unde	rstand	that payment for	r services billed	d under my N	lational Provid	der Identifier	r (NPI) numb	iber will be	e made dir	rectly to m	ne, unless l	em 20 (below) a	pplies						
	12 .	-	anthe autopoind ad	terminated o	r excluded fro	om the Medic	al Assistance	ce Program t	by any sta	tate or by t	the U.S. D	Department	of Health and H	uman	Services.					~

Michigan Department or Health a Human Services

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A SNew Enrollment S Group Practice Enrollment

Submit Application 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 rees, ansing ou 6. Standard Transactions. All Standard Transactions, as defined by HIPAA, will be co parties agree that when conducting Standard Transactions set, use any code or data elements that are either marked standards implementation specifications. 	tor electronic transactions the trading Partner submits to MDHHS. Inducted by the parties using only code sets, data elements, and formats specified by the Transaction Rules and instructions in the MDHHS Companion Guides. Ithey 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 "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 HIP
 Testing. All new Trading Partners will cooperate with MDHHS upon changes in submission format prior to submission of produ Data and Network Security. 	request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with MDHHS upon request in testing processes for ction files. MDHHS will notify the Trading Partner of the effective date for production data after successful testing.
The parties agree to use reasonable security measures to and network security requirements, which may change from	protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with MDHHS n time to time and as may be required by the HIPAA security regulations.
 Automatic Amendment for Regulatory Compliance. This Agreement will automatically be amended to comply v Agreement upon the effective date of the final regulation or 	rith 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 amendment.
10. Miscellaneous. Provisions 3 and 8 shall survive termination of this Agreem	ent.
The Trading Partner will notify MDHHS of any changes in t 30 calendar days prior to the effective date of such change	rading partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at le
r checking this, I certify that I have read ar	nd that I agree and accept the enrollment conditions in the Medical Assistance Provider Enrollmen [.] Trading Partner Agreement.

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• Click Submit Application



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- Step 12 is now complete and the 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

How to track a submitted application within CHAMPS

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Track Application > Group Practice Enrollment						
plication ID: 20171206268444	Name: TesterT Company					
3						
Your application is currently In-Review by the Provider Enrollment Unit. You can	nnot make any modifications to you	ur enrollment informa	ation at this time.			
Enroll Provider - Group						
	Business Proce	ess Wizard - Provid	er Enrollment (Grou	up). Click on the Step	# under the Ste	p Colur
tep	Required	Start Date	End Date	Status	Step Remark	
tep 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete		
tep 2: Add Locations	Required	12/28/2017	12/28/2017	Complete		
		10/00/0017	10/00/0047			
tep 3: Add Specialties	Required	12/20/2017	12/28/2017	Complete		
tep 3: Add Specialties tep 4: Add Mode of Claim Submission/EDI Exchange	Required	12/28/2017	12/28/2017	Complete		
tep 3: Add Specialties tep 4: Add Mode of Claim Submission/EDI Exchange tep 5: Associate Billing Agent	Required Required Required	12/28/2017 12/28/2017 12/28/2017	12/28/2017 12/28/2017 12/28/2017	Complete Complete Complete		
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- Confirmation your Provider Enrollment Application has been submitted and is being reviewed by the state
- Click Close

Provider Resources

- MDHHS website: 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
 - <u>Update Other Insurance NOW!</u>
 - Medicaid Provider Training Sessions
- Provider Support:
 - ProviderSupport@michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program

