



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.

MILogin for Third Party

User ID

Password

LOGIN

Don't have an account?

 SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

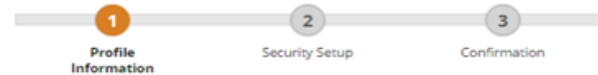
Copyright 2015-2019 State of Michigan

- 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?

I agree to the terms & conditions.

NEXT

RESET

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

MI Login for Third Party

[HOME](#)

Create Your Account



Security Setup

Provide user id and password information to complete your profile

* Required

* User ID

* Password

* Confirm New Password

* Security Options

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



i 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

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.

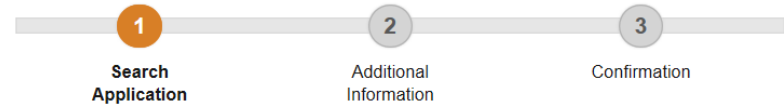
- Your Home Page will not show any applications
- Click Request Access

**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

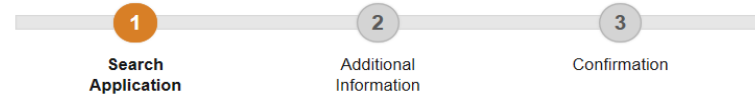
Search for an application with a keyword or select an agency to view its applications

- 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



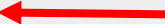
Search Application

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

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.

ederal 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

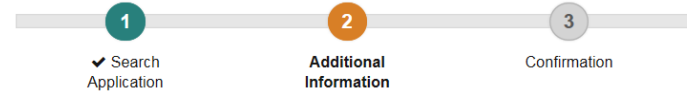
CANCEL ✕ **REQUEST ACCESS**

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

MI Login for Third Party

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

Request Access



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

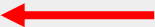
 Your password will expire in **48** days

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 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: www.michigan.gov/SIGMAVSS
 - If you have questions regarding this current process, contact the Vendor Support Call Center at 1-888-734-9749 or email SIGMA-Vendor@Michigan.gov
 - 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: <http://www.michigan.gov/lara/0,4601,7-154-72600---,00.html>

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.)

- Select Group Practice (Corporation, Partnership, LLC, etc.)
- Click Submit

Basic Information: Enter required fields and click Confirm button.

Basic Information

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

Entity Business Name: * (Doing Business As)

EIN/TIN: *

Vendor ID: *

NPI: *

Contact Email Address:

Email-1:

Email-2:

*

Email-3:

Email-4:

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

Application ID: 20171206268444

Name: TesterT Company

Basic Information

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

Your Application ID is: **20171206268444** ←

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.



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

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/06/2017	12/06/2017	Complete	
Step 2: Add Locations	Required			Incomplete	
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	
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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- Group Provider Enrollment steps are listed (Please Note: some steps are required versus optional)
- Step 1 has a status of Complete
- Click on Step 2: Add Locations

Application ID: 20171206268444

Name: TesterT Company

 To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink

Locations List

Filter By



Doing Business As

Location Type

Location Details

End Date



No Records Found !

- Click Add, to enter Primary Location information

Application ID: 20171206268444

Name: TesterT Company

For all locations, Correspondence address is required. For Primary Practice Location, Pay-To address is required. Enter Remittance Advice address only to receive a paper Remittance Advice.

Add Provider Location

Location Type: Primary Practice Location ▾ *

 Doing Business As:

 End Date:

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

 Address 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: -

 Phone Number: * Extn:

 Fax Number:

 Email Address:

 Web Page:

- Complete Address Line 1 and Zip Code, click Validate Address
 (Please Note: you should receive confirmation "Address Validation Successful")
- Complete all fields marked with an asterisk (*)
- Click Ok

Application ID: 20171206268444

Name: TesterT Company

[Close](#) [Add](#) To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink

Locations List

Filter By [Go](#)[Save Filters](#) [My Filters ▾](#)

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼ <input type="checkbox"/> Group Associates	▲▼ Primary Practice Location	▲▼ [Redacted]	▲▼ 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)

Application ID: 20171206268444

Name: TesterT Company

 To add additional addresses, click "Add Address" button.

Location Details

Doing Business As:

Location Code: 1

Location Type: Primary Practice Location

Phone Number: * Extn: Fax Number: Email Address: Web Page: Office Hours: ▾Communication ▾

Preference:

Handicap Accessible: No ▾

Accept 835(reported at EIN/TIN level): No ▾

Language(s) Spoken: ▲
(For Multiple Selection, use Ctrl Key) ▾
 ▾End Date:

Address List

Address Type	Address	End Date
<input type="checkbox"/> Δ ▾	▲ ▾	▲ ▾
<input type="checkbox"/> Location		12/31/2999

View Page: Viewing Page: 1

- Click Add Address

Application ID: 20171206268444

Name: TesterT Company

Add Provider Location Address

Type of Address: --SELECT-- ▾

End Date:

 Location Address: Copy This Location Address

If a department or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

 Address Line 1: *

 Address Line 2:

(Enter Street Address or PO Box Only)

 Address Line 3:

 City/Town: ▾ *

 State/Province: ▾ *

 County: ▾

 Country: ▾ *

 Zip Code: -

- From the drop-down list, select Type of Address
- Complete all fields marked with an asterisk (*)
- Click Validate Address
- Click Ok

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

Application ID: 20171206268444

Name: TesterT Company

 To add additional addresses, click "Add Address" button.

Location Details

Doing Business As: Group Associates

Location Code: 1

Location Type: Primary Practice Location

Phone Number: * Extn: Fax Number: Email Address: Web Page: Office Hours: Communication Preference:

Handicap Accessible: No

Accept 835(reported at EIN/TIN level): Yes

Language(s) Spoken: English
(For Multiple Selection, use Ctrl Key)

End Date: 12/31/2999

Address List

Address Type	Address	End Date
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Correspondence		12/31/2999
<input type="checkbox"/> Location		12/31/2999
<input type="checkbox"/> Pay To		12/31/2999
<input type="checkbox"/> Remittance Advice		12/31/2999

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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

Application ID: 20171206268444

Name: TesterT Company

To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink

Locations List

Filter By



Doing Business As



Location Type



Location Details



End Date

 Group Associates[Primary Practice Location](#)

12/31/2999

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- Click Close

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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	
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 2 is complete
- Click on Step 3: Add Specialties

Application ID: 20171206268444

Name: TesterT Company

Close **Add**

Specialty/Subspecialty List

Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date

 Δ ▾

▲ ▾

▲ ▾

No Records Found !

- Click Add

Application ID: 20171206268444

Name: TesterT Company

Add Specialty/Subspecialty

Location: 01-Group Associates ▾ *

Provider Type: ---SELECT--- ▾ *

Specialty: ▾ *

 End Date:

Add Subspecialty

Available Subspecialties

Associated Subspecialties *



OK Cancel

- 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

Application ID: 20171206268444

Name: TesterT Company

Add Specialty/Subspecialty

Location: 01-Group Associates *
▼Provider Type: GROUPS *
▼Specialty: Medical *
▼End Date:

Add Subspecialty

Available Subspecialties

Associated Subspecialties *



- 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

Application ID: 20171206268444

Name: TesterT Company

Specialty/Subspecialty List

Filter By ▾

Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date

 ▲▼

▲▼

▲▼

 Medical/No Subspecialty

GROUPS

12/28/2017

Delete

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Last

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

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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	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	
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

Application ID: 20171206268444

Name: TesterT Company

Mode of Claims Submission/EDI exchange

Please select the submission methods from EDI Exchange and/or Other Claims Submission as applicable.

EDI exchange

Method	Description	Applicable Transactions
<input type="checkbox"/> Electronic Batch	To upload/download HIPAA transactions from screens (Maximum file upload size is 50MB)	837P- Professional (FFS), 837I -Institutional(FFS), 837D -Dental(FFS), 270/271 -Eligibility, Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> CORE Batch	To upload/download HIPAA transactions using CORE Batch Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 835 Health Care Claim Payment/Advice
<input type="checkbox"/> CORE Real Time	To upload/download HIPAA transactions using CORE Real Time Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> Billing Agent	To submit/receive HIPAA transactions through billing agent	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter), 837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice

Other Claims Submission

Method	Description
<input type="checkbox"/> Paper Claims	To submit FFS paper claims
<input type="checkbox"/> Direct Data Entry(DDE)	To submit FFS claims via online screens

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

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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

Application ID: 20171206268444

Name: TesterT Company

Close

Add

Billing Agent List

Filter By



Go

Save Filters

My Filters ▾

Billing Agent ID

Billing Agent Name

835 Authorization

Start Date

End Date

 ▲ ▾

▲ ▾

▲ ▾

▲ ▾

▲ ▾

No Records Found !

- Click Add

Application ID: 20171206268444

Name: TesterT Company

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

 Billing Agent ID: *

Billing Agent Name:

 Association Start Date: *

 Association End Date:

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

- To locate Billing Agent information, click Confirm/Search Billing Agent

CHAMPS

Provider

https://milogintp.michigan.gov/ - Search Billing Agent List - Internet Explorer

Print Help

Application ID: 20171206268444 Name: TesterT Company

Billing Agent List

Filter By [] [] Go Save Filters My Filters

Billing Agent ID	Billing Agent Name	Start Date	End Date
<input type="checkbox"/>		01/01/1984	12/31/2999
<input type="checkbox"/>		01/01/1984	12/31/2999
<input type="checkbox"/>		04/30/1998	12/31/2999
<input type="checkbox"/>		12/08/1999	12/31/2999
<input type="checkbox"/>		02/25/2000	12/31/2999
<input type="checkbox"/>		06/04/1999	12/31/2999
<input type="checkbox"/>		02/19/2002	12/31/2999
<input type="checkbox"/>		02/25/2000	12/31/2999
<input type="checkbox"/>		05/02/2000	12/31/2999

Select Close

Confirm/Search Billing Agent OK Cancel

- 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)
- Click Select

Application ID: 20171206268444

Name: TesterT Company

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

 Billing Agent ID: *

 Billing Agent Name:

 Association Start Date: *

 Association End Date:

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

 Confirm/Search Billing Agent Cancel

- Billing Agent information will populate
- Click Ok

Application ID: 20171206268444

Name: TesterT Company

Close

Add

Billing Agent List

Filter By



Go

Save Filters

My Filters

Billing Agent ID	Billing Agent Name	835 Authorization	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>		No	12/28/2017	12/31/2999

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- Billing Agent information has been added
- Click Close

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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	

View Page: 1

Go

Page Count

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Next

Last

- Step 5 is complete
- Click on Step 6: Add Provider Controlling Interest/Ownership Details
 - **The screens for this step were updated 12/14/18*

Application ID: 20181204526214

Name: Testing

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling, or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By [dropdown] [input] And [input] Go [Save Filters] [My Filters]

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/>	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !

Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By [dropdown] [input] Go [Save Filters] [My Filters]

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>	▲▼	▲▼

No Records Found !

- To enter owner information, click Actions

Application ID: 20181204526214

Name: Testing

Close Actions

Add Owner

Import Owner

Providers Relationships Some address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

Required Owners Adverse Action

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By [dropdown] [input] And [input] Go Save Filters My Filters

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

Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By [dropdown] [input] Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address
---------------------	-------------------------	---------

No Records Found!

- Select Add Owner

Application ID: 20181204526214

Name: Testing

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling, or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By And

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/>								

No Records Found !

Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>		

No Records Found !

- To enter owner information, click Actions

Application ID: 20171206268444

Name: TesterT Company

Provider Controlling Interest/Ownership

 Type: *

 Percentage Owned: *

 SSN:

 EIN/TIN:

 Legal Entity Name:

 Entity Business Name:

(As shown on the Income Tax Return)

(Doing Business As)

 First Name:

 Last Name:

 Suffix:

 DOB:

 Phone Number: * Extn:

 Email:

 Start Date: *

 End Date:

 Address Line 1: *

 Address Line 2:

(Enter Street Address or PO Box Only)

 Address Line 3:

 City/Town: OTHER *

 State/Province: OTHER *

 County: OTHER

 Country: UNITED STATES *

 Zip Code: -

- Select an Owner Type from the drop-down menu
- Complete all fields marked with an asterisk (*)
- Complete Address Line 1 and Zip Code, click Validate Address
(Please Note: you should receive confirmation "Address Validation Successful")
- Click Ok

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

New Enrollment > Individual Enrollment > General

Application ID: 20181204171383 Name: Test, Testing

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By [] And [] Go [] Save Filters [] My Filters []

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 123456789	Example_One	Managing Employee	100 N Capital Ave	01/01/2015	12/31/2999	Not Completed	Not Completed	0
<input type="checkbox"/>	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Not Completed	Not Completed	100

Delete [] View Page: 1 [] Go [] Page Count [] SaveToXLS [] Viewing Page: 1 [] First [] Prev [] Next [] Last []

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By [] Go [] Save Filters [] My Filters []

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/> ▲▼	▲▼	▲▼

No Records Found !

- To add the relationship click the Actions drop-down menu

Application ID: 20181204171383

Name: Test, Testing

Close Actions

- There Add Owner ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least one of the following ownership types is required if one of the ownership types below is selected:
 - 501[c]3 Corporate - Not Publicly Traded Foreign, Nonresident Alien
 - Partnership/LLC Partnership Limited liability Company
 - Sub-contractor
 - Indirect Owner
 - Holding Company

Owners List

Filter By And Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 123456789	Example_One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Not Completed	Not Completed	0
<input type="checkbox"/>	Test_Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Not Completed	Not Completed	100

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

Add Other Owned Entity List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

- Select Owners Relationships from the Actions drop-down menu

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

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

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? Yes No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Test, Testing SSN/EIN/TIN: Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Test, Testing	Relation to Assoc. Owner
Example, One	123456789	Managing Employee		
Test, Testing		Individual		None

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

Selected Owner: Example, One SSN/EIN/TIN: 123456789 Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Answer question (at the top)
- If no relationships exist select No.
 - If the owners have a relationship to one another, refer to the [Step 8: Add Provider Controlling Interest/Ownership Details](#) user guide.

Application ID: 20181204171383

Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? Yes No (Click Save to update)

Owner List

Show Owners

All



Go

Save Filters

My Filters

- > Selected Owner: Test, Testing SSN/EIN/TIN: Status: Not Completed
- > Selected Owner: Example, One SSN/EIN/TIN: 123456789 Status: Not Completed

Save

Close

- The owner list boxes collapse
- Click Save

The screenshot shows the CHAMPS web application interface. At the top, there is a navigation bar with the CHAMPS logo and a 'Provider' dropdown menu. Below this, a status bar indicates the last login time as '04 DEC, 2018 11:42 AM'. The main content area displays 'Application ID: 20181204171383' and 'Name: Test, Testing'. A section titled 'Add Relationship' contains a question: 'Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?' with radio buttons for 'Yes' and 'No'. Below this is an 'Owner List' table with columns for 'Selected Owner', 'SSN/EIN/TIN', and 'Status'. A modal dialog box titled 'Message from webpage' is open in the foreground, displaying the message: 'All owner relationships will be set to 'None'. Do you want to continue?'. The 'OK' button in this dialog is highlighted with a red rectangle. At the bottom of the page, there is a 'Page ID: dlgAddModifyOwnerRelationship(Provider)' and a 'Save' button.

- After clicking save, click Ok.

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

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

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? Yes No (Click Save to update)

Owner List

Show Owners All Save Filters My Filters

> Selected Owner: Test, Testing	SSN/EIN/TIN: [REDACTED]	Status: Completed
> Selected Owner: Example, One	SSN/EIN/TIN: 123456789	Status: Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

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

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

New Enrollment > Individual Enrollment > General

Application ID: 20181204171383 Name: Test, Testing

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

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- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling, or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By [] And [] Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/>	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100

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

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Add Other Owned Entity

Filter By [] Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

- The Relationship Status now shows Completed for both owners

Application ID: 20181204171383

Name: Test, Testing

Close

Actions ▾

- There Add Owner ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one of the following ownership types is required if one of the ownership types below is selected:
 - 501(c)3 Corporate - Not Publicly Traded Foreign, Nonresident Alien
 - Partnership Sole Proprietorship Sub-contractor Limited liability Company
 - Trust Holding Company Indirect Owner



Owners List

Filter By ▾ [] And [] Go

Save Filters My Filters ▾

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> ▾	▾	▾	▾	▾	▾	▾	▾	▾
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/> !	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100

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

Add Other Owned Entity List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By ▾ [] Go

Save Filters My Filters ▾

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/> ▾	▾	▾
No Records Found !		

- Select Owners Adverse Action from the Actions drop-down menu to complete the Final Adverse Legal/Action/Convictions Disclosure

CHAMPS Provider

Application ID: 20181204171383 Name: Test, Testing

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries or recipients. Offenses include, but are not limited to: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any misdemeanor or felonies that may result in a mandatory or permissive exclusion under State or Federal law.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of 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 delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owner Name	Response	Comments
Test,Testing	<input type="radio"/> Yes <input type="radio"/> No	
Example,One	<input type="radio"/> Yes <input type="radio"/> No	

View Page: 1 Page Count SaveToXLS Viewing Page: 1

Page ID: pgEnrlmntAdverseAction(Provider)

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

Application ID: 20181204171383

Name: Test, Testing

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owners with Adverse Action

Owner Name	Response	Comments
Test,Testing	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Example,One	<input type="radio"/> Yes <input checked="" type="radio"/> No	

View Page: 1



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Ok

Cancel

- Click Ok

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

Application ID: 20181204171383 Name: Test, Testing

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

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- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By [] And [] Go [] Save Filters [] My Filters []

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	No	0
<input type="checkbox"/>	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	No	100

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Add Other Owned Entity

Filter By [] Go [] Save Filters [] My Filters []

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

- The Adverse Action column will show Yes or No indicating it's complete.
- Click Close

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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

Application ID: 20171206268444

Name: TesterT Company

Close **Add**

Taxonomy List

Filter By ▾

Go

Save Filters

My Filters ▾

Taxonomy Code

Description

Start Date

End Date

 ▲▼

▲▼

▲▼

▲▼

No Records Found !

- Click Add

Application ID: 20171206268444


Name: TesterT Company

Add Taxonomy

Taxonomy Code: * [\(Click here for Taxonomy List\)](#)Location: 01-Group Associates *

Description:

Start Date: *End Date: *

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

http://www.nucc.org/index.php National Uniform Claim Co... x

File Edit View Favorites Tools Help

NUCC

National Uniform Claim Committee

Search this site ...

MENU

Use the browser's find feature (Ctrl-F) to search for values. Taxonomy codes are self-selected. Choose the code that best identifies you as a provider.

- ⊕ Individual or Groups (of Individuals)
 - ⊕ Group [\[definition\]](#)
 - Multi-Specialty - **193200000X** [\[definition\]](#)
 - Single Specialty - **193400000X** [\[definition\]](#)
 - ⊕ Allopathic & Osteopathic Physicians [\[definition\]](#)
 - ⊕ Allergy & Immunology - **207K00000X** [\[definition\]](#)
 - Allergy - **207KA0200X** [\[definition\]](#)
 - Clinical & Laboratory Immunology - **207KI0005X** [\[definition\]](#)
 - ⊕ Anesthesiology - **207L00000X** [\[definition\]](#)
 - Addiction Medicine - **207LA0401X** [\[definition\]](#)
 - Critical Care Medicine - **207LC0200X** [\[definition\]](#)
 - Hospice and Palliative Medicine - **207LH0002X** [\[definition\]](#)
 - Pain Medicine - **207LP2900X** [\[definition\]](#)
 - Pediatric Anesthesiology - **207LP3000X** [\[definition\]](#)
 - Clinical Pharmacology - **208U00000X** [\[definition\]](#)
 - Colon & Rectal Surgery - **208C00000X** [\[definition\]](#)
 - ⊕ Dermatology - **207N00000X** [\[definition\]](#)
 - Clinical & Laboratory Dermatological

Clicking a [\[definition\]](#) link to the left displays code value definitions, when available, and additional information about the selected code in this space.

If you are unable to find a code to meet your need:

- [Submit a Question](#)
- [More Information](#)

- After clicking (⌘) the [National Uniform Claim Committee](#) webpage will pop-up
- Press (CTRL+F) to search for appropriate taxonomy code

Application ID: 20171206268444

Name: TesterT Company

Add Taxonomy

 Taxonomy Code: * [\(Click here for Taxonomy List\)](#)

Location: 01-Group Associates ▾ *

Description:

 Start Date: *

 End Date:

- Enter Start Date *(Please Note: Must be current date or date of application)*
- Click Confirm Taxonomy
- Click Ok

Application ID: 20171206268444

Name: TesterT Company

Close

Add

Taxonomy List

Filter By



Go

Save Filters

My Filters ▾

Taxonomy Code	Description	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 207LC0200X	Critical Care Medicine	01/01/2018	12/31/2999

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

- The Taxonomy Code information will now be displayed
- Click Close

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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)

Application ID: 20171206268444

Name: TesterT Company

☰ MCO Plan List ▲

Filter By ▾



Plan ID ▲▼	Plan Name ▲▼	Business Status ▲▼	Business Status Start Date ▲▼	Business Status End Date ▲▼	Association Start Date ▲▼	Association End Date ▲▼	Program Description ▲▼
---------------	-----------------	-----------------------	----------------------------------	--------------------------------	------------------------------	----------------------------	---------------------------

No Records Found !

- Step is optional, if you do not work with a Managed Care Organization (MCO) plan, click Close

Application ID: 20171206268444

Name: TesterT Company

Close

Add

MCO Plan List

Filter By



Go

Save Filters

My Filters ▾

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program Description
No Records Found !							

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

Application ID: 20171206268444

Name: TesterT Company

Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered

Please associate only to plans with which you have a signed contract

 Plan ID: *

Plan Name:

Program Name:

Program Description:

 Association Start Date: *

 Association End Date:

Confirm/Search Plan

OK

Cancel

- To locate the MCO Plan ID , click Confirm/Search Plan

Application ID: 20171206268444 Name: TesterT Company

MCO Plan Search List

Filter By [] [] [Go] Save Filters My Filters

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Program Name	Program Type
<input checked="" type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/21/1993	12/31/2999	MHP	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	01/01/2005	12/31/2999	MHP	Managed Care Comprehensive Medical Program Type

Select Close

Confirm/Search Plan OK Cancel

- 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)
- Click Select

Application ID: 20171206268444

Name: TesterT Company

Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered

Please associate only to plans with which you have a signed contract

Plan ID: *Plan Name:

Program Name: MHP

Program Description: ManagedCareProgram

Association Start Date: *Association End Date:

- MCO Plan information will populate
- Click Ok

Application ID: 20171206268444

Name: TesterT Company

MCO Plan List

Filter By

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program Description
<input type="checkbox"/>		Active	12/21/1993	12/31/2999	11/15/2017	12/31/2999	ManagedCareProgram

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- MCO Plan information has been associated
- Click Close

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete	
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete	
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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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- Finished walking through optional Step 8
- Click on Step 9: 835/ERA Enrollment Form (Please Note: This step is optional)

CHAMPS < Provider >

Tester, Testing > New Enrollment > Group Practice Enrollment

Application ID: 20171206268444 Name: TesterT Company

Close Submit Print Help

ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name: **Doing Business As Name (DBA):** TesterT Company

Provider Address

Street: State/Province: MICHIGAN
 City: LANSING Zip Code/Postal Code: 48933
 Country Code: UNITED STATES

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):
 National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority: Trading Partner ID:

Provider License Details

Provider License No: License Issuer:
 Provider Type:
 Provider Taxonomy Code:

PROVIDER CONTACT INFORMATION

Provider Contact Name

Contact: Title: Managing Employee
 Telephone Number: Telephone Number Extension:
 Email Address: Fax Number:

PROVIDER AGENT INFORMATION

Provider Agent Name

Agent Address

Street: State/Province:
 City: Zip Code/Postal Code:
 Country Code:

Provider Agent Contact Name

Provider Agent Contact Name: Title:
 Telephone Number: Telephone Number Extension:
 Email Address: Fax Number:

FEDERAL AGENCY INFORMATION (Not applicable at this time)

Federal Program Agency Name: Federal Program Agency Identifier:
 Federal Agency Location Code:

RETAIL PHARMACY INFORMATION(Not applicable at this time)

Pharmacy Name

Pharmacy Name: Chain Number:
 Parent: Organization ID:
 Payment Center ID:
 NCPDP Provider ID Number:
 Medicaid Provider Number:

- Step is optional, fill out if provider would like to directly receive their 835 (i.e., electronic remittance advice (ERA))
 (Please Note: within step 2 providers would have needed to select Yes, to question “Accept 835?”)
- Complete all fields marked with an asterisk (*)

☰ ELECTRONIC REMITTANCE ADVISE INFORMATION ▲

Preference for Aggregation of Remittance Data(e.g., Account Number Linkage to Provider Identifier)

NPI TAX ID *

MI Medicaid enumerates by Tax ID only.

Method of Retrieval: *

☰ ELECTRONIC REMITTANCE ADVISE CLEARINGHOUSE INFORMATION (Not applicable at this time) ▲

ClearingHouse Name:

ClearingHouse Contact Name

ClearingHouse Contact Name: Telephone Number:

Email Address:

☰ ELECTRONIC REMITTANCE ADVISE 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/ERA 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 (*)

Application ID: 20171206268444

Name: TesterT Company

 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/ERA 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.)

- Click Submit
- Click Close

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete	
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete	
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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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- Finished walking through optional Step 9
- Click on Step 10: Upload Documents *(Please Note: This step is optional)*

Application ID: 20171206268444

Name: TesterT Company

Document List

Filter By



Go

Save Filters

My Filters

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Status
<input type="checkbox"/>	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !

- This step is optional, if documentation needs to be uploaded, click Add
- If not, click Close

Application ID: 20171206268444

Name: TesterT Company

Upload Document

Document Type:

 * ←
 --SELECT--
 Certification
 Contract
 General
 License

Document Name:

 * ←
 ▾

Associated MCO ID:

Program Name:

 ▾

File Name:

Start Date:

End Date:

Remark:

- If provider chooses to upload a document;
- Select the document type and document name
- Click Browse to find the saved document on your computer
- Enter any other additional information
- Click Ok

Application ID: 20171206268444

Name: TesterT Company

Close

Document List

Add

Filter By ▾

Go

Save Filters

My Filters ▾

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Status
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>	General	Other					01/02/2018	In Process

Delete

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- The documentation has been added
- To return to the enrollment steps, click Close

Application ID: 20171206268444

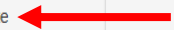
Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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	
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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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- Finished walking through optional Step 10
- Click on Step 11: Complete Enrollment Checklist

Application ID: 20171206268444

Name: TesterT Company

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	
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	
Are you a PA 161 Program?	Not Completed	
Do you contract with PA 161 program? If you contract with one of these programs, please provide the NPI in the comments.	Not Completed	
All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?	Not Completed	

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

Application ID: 20171206268444

Name: TesterT Company

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/06/2017	12/28/2017	Complete	
Step 2: Add Locations	Required	12/28/2017	12/28/2017	Complete	
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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	

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- 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

Application ID: 20171206268444

Name: TesterT Company

Close > Next

Final Submission

Application ID: 20171206268444

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

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

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

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

Application Document Checklist

Forms/Documents

Special Instructions

Source

Required

▲ ▼

▲ ▼

▲ ▼

▲ ▼

No Records Found !

- Final Submission: Click Next

Application ID: 20171206268444

Name: TesterT Company

 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. Before billing for any medical services I render, I will 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 payment for services billed under my National Provider Identifier (NPI) number will be made directly to me, unless Item 20 (below) applies.
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 entire list of Terms and Conditions

Application ID: 20171206268444

Name: TesterT Company

 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

Application ID: 20171206268444

Name: TesterT Company

Your Application Number 20171206268444 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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	01/02/2018	01/02/2018	Complete	

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Go

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SaveToXLS

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First

Prev

Next

Last

- 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

PROVIDER ENROLLMENT

New Enrollment ★

Track Application ★

New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

- Click Provider tab
- Select 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:

EIN/TIN: *Phone: *Owner SSN: * Owner Date Of Birth:  *

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

Application ID: 20171206268444

Name: TesterT Company

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

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	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	01/02/2018	01/02/2018	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](#)
 - [Update Other Insurance NOW!](#)
 - [Medicaid Provider Training Sessions](#)
- **Provider Support:**
 - ProviderSupport@michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program