



Provider Enrollment Group Enrollment Type Revalidation of Enrollment Information

“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

Table of Contents

- Revalidation Overview
- Provider Enrollment Revalidation Process
- Group Revalidation Steps
- Provider Enrollment Resources

Revalidation Overview

- All providers are required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDHHS.
- This presentation will cover the provider enrollment steps that are required during revalidation, additional provider enrollment steps may need to be updated or reviewed by providers but are listed as optional and are not covered in this presentation.
 - For complete Group enrollment instruction: www.Michigan.gov/MedicaidProviders >> Provider Enrollment >> Step-by-Step CHAMPS Enrollment Guides >> Group >> [CHAMPS Enrollment Application: Group User Guide](#)
- Providers should review information within each enrollment step to ensure it's up to date and accurate.
- When providers update their enrollment information a new record is created for Provider Enrollment to review. Providers can change the updated information through the new record until the enrollment is submitted to the State for review.

Provider Enrollment Revalidation Process

- Providers have a 90-day period to complete their revalidation in CHAMPS.
 - 90 days prior to the beginning of the revalidation period, providers receive a letter mailed to their CHAMPS correspondence address located within the Provider Enrollment information.
 - 30 days prior to the revalidation period end date a second letter is mailed if the revalidation has not been completed.
 - If the revalidation has not been completed by the end of the last day of the revalidation period, a termination letter will be generated.
 - For example: 2/24/20 is the revalidation cycle end date the termination letter will be generated the night of 2/24/20.

If revalidation is not completed during the revalidation period, the provider will have their enrollment closed.

Once an enrollment is closed due to not completing revalidation providers must contact MDHHS Provider Enrollment to have the enrollment re-opened.

Please Note: when MDHHS opens the enrollment manually the changes cannot be made by the provider until the following day.

Group Revalidation

Details on the revalidation steps

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
- Enter your User ID and Password
- Click Login

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

- Providers will be directed to the MILogin Home Page
- Click the CHAMPS hyperlink

Michigan.gov

HELP CONTACT US

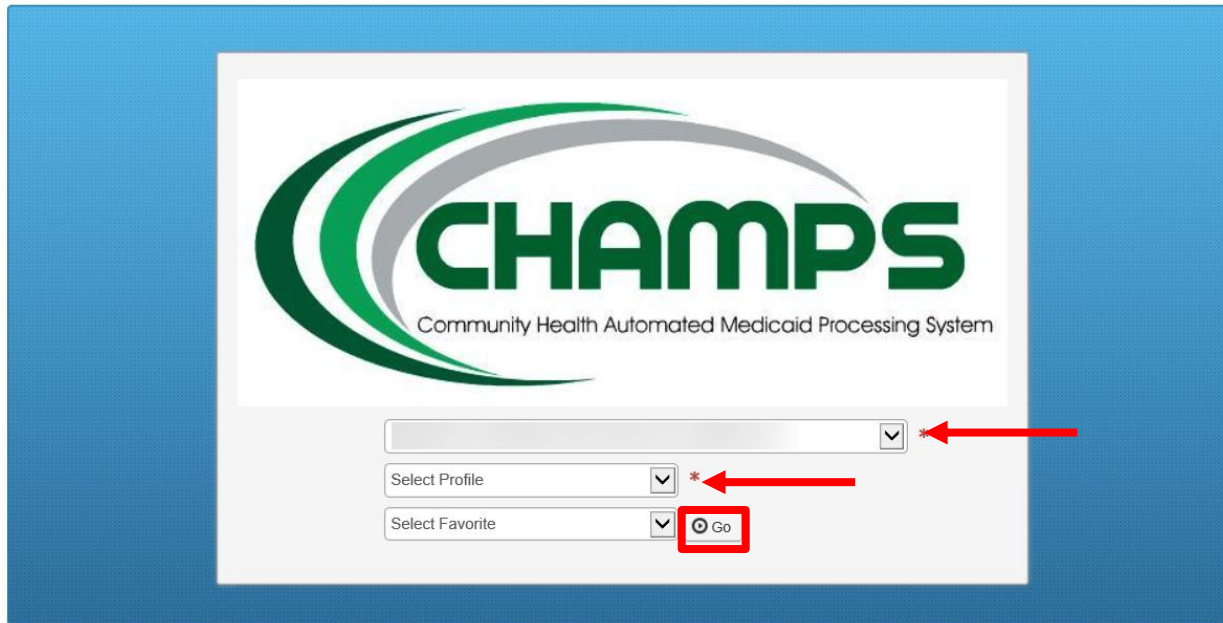
Terms & Conditions

CHAMPS

Terms & Conditions
The Michigan Department of Health & Human Services (MDHHS) computer information system (systems) are the property of the State Of Michigan and subject to state and federal 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 prosecution. By accessing information provided by the Michigan Department of Health & Human Services computer information systems and clicking on the button below, I acknowledge and agree to abide by all governing privacy and security terms,

CANCEL ✕ Acknowledge/Agree

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



The image shows a screenshot of the CHAMPS login interface. At the top left, there is a CHAMPS logo. Below it, there is a user profile icon. The main content area features a large CHAMPS logo with the text "Community Health Automated Medicaid Processing System" underneath. Below the logo, there is a search bar with a dropdown arrow and an asterisk. Below the search bar, there are two dropdown menus: "Select Profile" and "Select Favorite". The "Select Profile" dropdown has an asterisk next to it. Below the "Select Favorite" dropdown, there is a "Go" button with a magnifying glass icon, which is highlighted with a red box. Red arrows point to the asterisks next to the search bar and the "Select Profile" dropdown.

- Select the Domain of the Group provider needing to complete the revalidation.
- Select either CHAMPS Full Access or Provider Enrollment Access profile in order to complete the revalidation.
- Click Go

The screenshot shows the CHAMPS Provider Portal interface. At the top, the 'Provider' tab is highlighted with a red box. A dropdown menu is open under the 'MANAGE PROVIDER' section, with 'Manage Provider Information' selected and indicated by a red arrow. The main content area features a system notification banner with the following text:

Due to R10c-1.8.1 Release , the CHAMPS system will be unavailable between 7:00 PM EST Friday, January 24th through 2:00 AM EST Saturday, January 25th, 2020. Due to MILogin system maintenance, CHAMPS system will be unavailable between 9:00 PM EST Sunday, January 26th to 1:00 AM EST Monday, January

Below the notification is a 'My Reminders' section with a table header:

Alert Type	Alert Message	Alert Date	Due Date	Read
No Records Found !				

On the right side, there is a 'Calendar' widget showing the date as 6 February 2020, Thursday.

- Click the Provider Tab
- Select Manage Provider Information

NPI: Name:

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice).

<input type="checkbox"/> Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	06/29/2018	07/03/2018	Incomplete		
<input type="checkbox"/> Step 2: Locations	Required	01/23/2019	04/17/2019	Incomplete		
<input type="checkbox"/> Step 3: Specialties	Required	04/15/2008	04/15/2008	Incomplete		
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional	07/03/2018	07/03/2018	Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	04/15/2008	04/15/2008	Incomplete		
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	01/01/1900	07/09/2018	Incomplete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	09/30/2019	10/03/2019	Incomplete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	04/15/2008	04/15/2008	Incomplete		
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	11/03/2015	11/03/2015	Incomplete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/18/2019	04/15/2008	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/24/2014	10/24/2014	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	01/11/2018	01/11/2018	Incomplete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	09/30/2019	10/03/2019	Incomplete		Please Answer all the Questions.
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	09/30/2019	10/03/2019	Incomplete		

View Page: Viewing Page: 1

- The required column displays which steps are Required versus Optional for the completion of revalidation.
 - During revalidation, each step should be reviewed to ensure the information accuracy.
- Each required step will need to be clicked into, even if the step information doesn't need to be updated, to allow the step status to change from Incomplete to Complete.
- Click on Step 1: Provider Basic Information

NPI:

NPI: 1811044878

Name:

Provider Details

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

Entity Business Name: * (Doing Business As)

EIN/TIN:

Vendor ID:

NPI:

Contact Email Address:

Business Status: Active

Status: Approved

Business Elig.Date Range: 01/01/1970-12/31/2999

Revalidation Period: 12/01/2019-02/29/2020

Email-1: *

Email-2:

Email-3:

Email-4:

Email-5:

Email-6:

- Review all required information, as indicated with an asterisk (*), to ensure accuracy.
- Make any necessary updates
- Click Ok

NPI: Name:

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice).

<input type="checkbox"/> Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	06/29/2018	07/03/2018	Complete		
<input type="checkbox"/> Step 2: Locations	Required	01/23/2019	04/17/2019	Incomplete		
<input type="checkbox"/> Step 3: Specialties	Required	04/15/2008	04/15/2008	Incomplete		
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional	07/03/2018	07/03/2018	Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	04/15/2008	04/15/2008	Incomplete		
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	01/01/1900	07/09/2018	Incomplete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	09/30/2019	10/03/2019	Incomplete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	04/15/2008	04/15/2008	Incomplete		
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	11/03/2015	11/03/2015	Incomplete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/18/2019	04/15/2008	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/24/2014	10/24/2014	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	01/11/2018	01/11/2018	Incomplete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	09/30/2019	10/03/2019	Incomplete		Please Answer all the Questions.
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	09/30/2019	10/03/2019	Incomplete		

View Page:

Viewing Page: 1

- Step 1 is Complete
 - If changes were made an additional status of Updated would be listed in the Modification Status column.
- Click on Step 2: Locations

NPI: Name:

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

Locations List								
Filter By		Filter By		And Operational Status	Active	Go	Save Filters	My Filters
Doing Business As	Location Type	Location Details	Start Date	End Date	Status	Operational Status	Inactivation Date	
<input type="checkbox"/>	Primary Practice Location		01/01/2015	12/31/2999	Approved	Active		

View Page: 1 Page Count Viewing Page: 1

- Click the Primary Practice Location hyperlink

NPI: Name:

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

Location Details

Doing Business As: <input type="text"/>	Location Code: 01	Location Type: Primary Practice Location
Phone Number: <input type="text"/> * Extn: <input type="text"/>	Fax Number: <input type="text"/>	Email Address: <input type="text"/>
Web Page: <input type="text"/>		Communication Preference: Standard Mail <input type="button" value="v"/>

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	<input type="button" value="v"/> *	AM PM *	<input type="button" value="v"/> *	AM PM *	Thursday:	<input type="button" value="v"/> *	AM PM *	<input type="button" value="v"/> *	AM PM *
Monday:	<input type="button" value="v"/> *	AM PM *	<input type="button" value="v"/> *	AM PM *	Friday:	<input type="button" value="v"/> *	AM PM *	<input type="button" value="v"/> *	AM PM *
Tuesday:	<input type="button" value="v"/> *	AM PM *	<input type="button" value="v"/> *	AM PM *	Saturday:	<input type="button" value="v"/> *	AM PM *	<input type="button" value="v"/> *	AM PM *
Wednesday:	<input type="button" value="v"/> *	AM PM *	<input type="button" value="v"/> *	AM PM *					

 Handicap Accessible: Yes

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

 Language(s) Spoken: English
 Arabic
 Chinese

(For Multiple Selection, use Ctrl Key)

 Start Date: 01/01/2015

 End Date: 12/31/2999

Status: Approved

Address List

Filter By Filter By

 And Operational Status Active

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Correspondence	<input type="text"/>	01/01/2015	12/31/2999	Approved	Active	
<input type="checkbox"/> Location	<input type="text"/>	01/01/2015	12/31/2999	Approved	Active	
<input type="checkbox"/> Primary Pay To	<input type="text"/>	05/14/2015	12/31/2999	Approved	Active	

View Page: 2

 Viewing Page: 1

- If office hours are blank;
 - Update the hours section based on the hours your facility is open and closed each day.
 - If there is a day your facility is completely closed select closed from the Open At dropdown selection and you will not be required to enter AM or PM.

NPI: _____ Name: _____

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

Location Details

Doing Business As: Location Code: 01 Location Type: Primary Practice Location

Phone Number: * Extn: Fax Number: Email Address:

Web Page: Communication Preference:

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close ▾ *	AM PM *	▾ *	AM PM *	Thursday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *
Monday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *	Friday:	Close ▾ *	AM PM *	▾ *	AM PM *
Tuesday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *	Saturday:	Close ▾ *	AM PM *	▾ *	AM PM *
Wednesday:	09:00 ▾ *	AM PM *	04:30 ▾ *	AM PM *					

Handicap Accessible: Yes

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

Language(s) Spoken:
Arabic
Chinese

(For Multiple Selection, use Ctrl Key)

Start Date: 01/01/2015

End Date: 12/31/2999

Status: Approved

Address List

- Update office hours and any other required information.
- Click Save
- Scroll down to review address information

CHAMPS < My Inbox > Provider > Claims > Member > PA >

Last Login: 25 FEB, 2020 12:47 PM Note Pad External Links My Favorites Print Help

Provider Portal > Group Modification

NPI: _____ Name: _____

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

Location Details

Doing Business As: _____ Location Code: 01 Location Type: Primary Practice Location

Phone Number: _____ * Extn: _____ Fax Number: _____ Email Address: _____

Web Page: _____ Communication Preference: _____

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close *	AM/PM *	_____ *	AM/PM *	Thursday:	06:00 *	AM/PM *	05:00 *	AM/PM *
Monday:	06:00 *	AM/PM *	05:00 *	AM/PM *	Friday:	Close *	AM/PM *	_____ *	AM/PM *
Tuesday:	06:00 *	AM/PM *	05:00 *	AM/PM *	Saturday:	Close *	AM/PM *	_____ *	AM/PM *
Wednesday:	09:00 *	AM/PM *	04:30 *	AM/PM *					

Handicap Accessible: Yes No

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

Language(s) Spoken: English Arabic Chinese

(For Multiple Selection, use Ctrl Key)

Start Date: 01/01/2015 End Date: 12/31/2999 Status: Approved

Address List

Filter By _____ Filter By _____ And Operational Status Active Go

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Correspondence	_____	01/01/2015	12/31/2999	Approved	Active	
<input type="checkbox"/> Location	_____	01/01/2015	12/31/2999	Approved	Active	
<input type="checkbox"/> Primary Pay To	_____	05/14/2015	12/31/2999	Approved	Active	
<input type="checkbox"/> Remittance Advice	_____	01/01/2015	12/31/2999	Approved	Active	

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

- Review all required information, as indicated with an asterisk (*), to ensure accuracy.
 - If the listed address information is accurate, click Close to be returned to the [Locations List page](#).
- To update the Correspondence address, click the Correspondence hyperlink from the address type column.
 - The following screens will walk through the process of updating address information.



NPI: [text box] Name: [text box]

Close Save

Manage Provider Location Address

Type of Address: Correspondence Status: Approved

End Date: 12/31/2999

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWER 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: [text box] *
(Enter Street Address or PO Box Only)

Address Line 2: [text box]

Address Line 3: [text box]

City/Town: [dropdown] *

State/Province: [dropdown] *

County: [dropdown]

Country: UNITED STATES [dropdown] *

Zip Code: [text box] * - [text box] **Validate Address**

- Complete all fields marked with an asterisk (*).
- Click validate address

NPI: Name:

Manage Provider Location Address

Type of Address: Correspondence

Status: Approved

End Date:

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

Address validation successful

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: ▾ *

State/Province: ▾ *

County: ▾

Country: UNITED STATES ▾ *

Zip Code: * -

- The 'Address Validation Successful' message will appear indicating the address has been validated.
- Click Save
- Click Close to return to the Location Details screen to review the next address.

NPI: Name:

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

Location Details

Doing Business As: Location Code: 01 Location Type: Primary Practice Location
Phone Number: * Extn: Fax Number: Email Address:
Web Page: Communication: Preference:

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close ▾ *	AM PM *	▾ *	AM PM *	Thursday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *
Monday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *	Friday:	Close ▾ *	AM PM *	▾ *	AM PM *
Tuesday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *	Saturday:	Close ▾ *	AM PM *	▾ *	AM PM *
Wednesday:	09:00 ▾ *	AM PM *	04:30 ▾ *	AM PM *					

Handicap Accessible: Yes ▾

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

Language(s) Spoken: English
Arabic
Chinese

Start Date: 01/01/2015

End Date: 12/31/2999

Status: In Review

Address List

Filter By Filter By And Operational Status Active ▾

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Correspondence	<input type="text"/>	01/01/2015	12/31/2999	Approved	Active	
<input type="checkbox"/> Correspondence	<input type="text"/>	02/26/2020	12/31/2999	In Review	Active	
<input type="checkbox"/> Location	<input type="text"/>	01/01/2015	12/31/2999	Approved	Active	
<input type="checkbox"/> Primary Pay To	<input type="text"/>	05/14/2015	12/31/2999	Approved	Active	

View Page: 2 Viewing Page: 1

- Notice there are now two rows for correspondence address, one that is approved and one that is in review.
 - If no other addresses need to be updated, update hours, click save and close to return to the [Locations List page](#).
- Click the Location hyperlink from the address type if the Location address needs to be updated.

NPI: Name:

Manage Provider Location Address

Type of Address: Location Status: Approved

End Date: 12/31/2999

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWER 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: *

State/Province: *

County:

Country: UNITED STATES *

Zip Code: * -

- Complete all fields marked with an asterisk (*).
- Click validate address

NPI: Name:

Manage Provider Location Address

Type of Address: Location Status: Approved

End Date: 12/31/2999

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

Address validation successful

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: ▾ *

State/Province: ▾ *

County: ▾

Country: UNITED STATES ▾ *

Zip Code: * -

- The 'Address Validation Successful' message will appear indicating the address has been validated.
- Click Save
- Click Close to return to the Location Details screen to review the next address

CHAMPS My Inbox Provider Claims Member PA

Last Login: 26 FEB, 2020 02:49 PM Note Pad External Links My Favorites Print Help

Provider Portal > Group Modification

NPI: Name:

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

Location Details

Doing Business As: Location Code: 01 Location Type: Primary Practice Location

Phone Number: * Extn: Fax Number: Email Address:

Web Page: Communication Preference:

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close	AM/PM		AM/PM	Thursday:	06:00	AM/PM	05:00	AM/PM
Monday:	06:00	AM/PM	05:00	AM/PM	Friday:	Close	AM/PM		AM/PM
Tuesday:	06:00	AM/PM	05:00	AM/PM	Saturday:	Close	AM/PM		AM/PM
Wednesday:	09:00	AM/PM	04:30	AM/PM					

Handicap Accessible: Yes

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

Language(s) Spoken: English, Arabic, Chinese

Start Date: 01/01/2015 End Date: 12/31/2999 Status: In Review

Address List

Add Address

Filter By And Operational Status Active Go Save Filters My Filters

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
Correspondence		01/01/2015	12/31/2999	Approved	Active	
Correspondence		02/26/2020	12/31/2999	In Review	Active	
Location		01/01/2015	12/31/2999	Approved	Active	
Location		02/26/2020	12/31/2999	In Review	Active	
Primary Pay To		05/14/2015	12/31/2999	Approved	Active	

View Page: 2 Viewing Page: 1 First Prev Next Last

- Notice there are now two rows for Location address, one that is approved and one that is in review.
 - If no other addresses need to be updated, click save and close to return to the [Location List page](#).
- Notice there are now two pages of address types listed, click next to update the next address type.
 - Providers needing to update their Primary Pay To will need to submit a letter on company letterhead to Provider Enrollment requesting the update. The letter needs to include the NPI, EIN/SSN, Vendor ID, Old pay to address and new pay to address. The letter needs to be signed by someone with signing rights such as President, Owner, CEO, etc.

NPI: [text] Name: [text]

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

Location Details

Doing Business As: [text] Location Code: 01 Location Type: Primary Practice Location
Phone Number: [text] * Extn: [text] Fax Number: [text] Email Address: [text]
Web Page: [text] Communication Preference: [dropdown]

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close *	AM PM *	[dropdown] *	AM PM *	Thursday:	06:00 *	AM PM *	05:00 *	AM PM *
Monday:	06:00 *	AM PM *	05:00 *	AM PM *	Friday:	Close *	AM PM *	[dropdown] *	AM PM *
Tuesday:	06:00 *	AM PM *	05:00 *	AM PM *	Saturday:	Close *	AM PM *	[dropdown] *	AM PM *
Wednesday:	09:00 *	AM PM *	04:30 *	AM PM *					

Handicap Accessible: Yes [dropdown]

Accept 835 (reported at EIN/TIN level): No [dropdown]

Language(s) Spoken: English Arabic Chinese [dropdown]

Start Date: 01/01/2015 [calendar]

End Date: 12/31/2999 [calendar]

Status: In Review

Address List

Add Address

Filter By [dropdown] [text] Filter By [dropdown] [text] And Operational Status Active [dropdown] Go Save Filters My Filters

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Remittance Advice	[text]	01/01/2015	12/31/2999	Approved	Active	

View Page: 1 Page Count SaveToXLS Viewing Page: 2 First Prev Next Last

- Click the Remittance Advice hyperlink from the address type if the Remittance Advice address needs to be updated.
 - If no other addresses need to be updated, click save and close to return to the [Location List page](#).

CHAMPS

My Inbox ▾ Provider ▾ Claims ▾ Member ▾ PA ▾

Last Login: 25 FEB, 2020 12:47 PM

Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Portal > Group Modification

NPI: Name:

Close Save

Manage Provider Location Address

Type of Address: Remittance Advice Status: Approved

End Date: 12/31/2999

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWER 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: ▾ *

State/Province: ▾ *

County: ▾

Country: UNITED STATES ▾ *

Zip Code: * -

- Make any necessary updates. Ensure all fields marked with an asterisk (*) are complete.
 - If you would no longer like to receive a mailed paper copy of the remittance advice and would rather access it directly from CHAMPS via the My Inbox Archived Documents function, enter an End Date based on the system date or future end date.
- Click Validate Address

NPI: Name:

Manage Provider Location Address

Type of Address: Remittance Advice Status: Approved
End Date:

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

Address validation successful

Address Line 1: <input type="text"/> *	Address Line 2: <input type="text"/>
<small>(Enter Street Address or PO Box Only)</small>	
Address Line 3: <input type="text"/>	City/Town: <input type="text"/> ▾ *
State/Province: <input type="text"/> ▾ *	County: <input type="text"/> ▾
Country: UNITED STATES ▾ *	Zip Code: <input type="text"/> * - <input type="text"/> <input type="button" value="Validate Address"/>

- The 'Address Validation Successful' message will appear indicating the address has been validated.
- Click Save
- Click Close to return to the Location Details screen.

NPI: Name:

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

Location Details

Doing Business As: Location Code: 01 Location Type: Primary Practice Location
 Phone Number: * Extn: Fax Number: Email Address:
 Web Page: Communication Preference:

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

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close ▾ *	AM PM *	▾ *	AM PM *	Thursday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *
Monday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *	Friday:	Close ▾ *	AM PM *	▾ *	AM PM *
Tuesday:	06:00 ▾ *	AM PM *	05:00 ▾ *	AM PM *	Saturday:	Close ▾ *	AM PM *	▾ *	AM PM *
Wednesday:	09:00 ▾ *	AM PM *	04:30 ▾ *	AM PM *					

Handicap Accessible: Yes ▾

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

Language(s) Spoken: English ▾
 Arabic
 Chinese

Start Date: 01/01/2015

End Date: 12/31/2999

Status: In Review

Address List

Filter By Filter By And Operational Status Active ▾

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Remittance Advice	<input type="text"/>	02/26/2020	12/31/2999	In Review	Active	
<input type="checkbox"/> Remittance Advice	<input type="text"/>	01/01/2015	12/31/2999	Approved	Active	

View Page: 1 Viewing Page: 2

- Notice there are now two rows for Remittance Advice address, one that is approved and one that is in review.
- Click Close to return to the Location List page

NPI: [redacted] Name: [redacted]

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

Locations List							
Filter By	Filter By	Filter By	And Operational Status	Active	Go	Save Filters	My Filters
Doing Business As	Location Type	Location Details	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/>	Primary Practice Location	[redacted]	01/01/2015	12/31/2999	In Review	Active	
<input type="checkbox"/>	Primary Practice Location	[redacted]	01/01/2015	12/31/2999	Approved	Active	

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

- Notice there are now two rows for Primary Practice Location, one that is approved and one 'In Review'.
- Click Close to return to the Business Process Wizard steps.

NPI: Name:

Please update all steps to complete your revalidation process

Business Process Wizard - Provider Data Modification (Group Practice).						
Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 3: Specialties	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 6: Associate Billing Agent	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Incomplete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/26/2020	10/06/2015	Incomplete		Modification Request has not been Submitted.

View Page:

Viewing Page: 1

- Step 2 is Complete and a Modification Status of Updated as changes were made within this step.
 - If changes were made an additional status of Updated would be listed in the Modification Status column.
- Click on Step 3: Specialties

The screenshot displays the CHAMPS Provider Portal interface for Group Modification. At the top, there are navigation tabs for My Inbox, Provider, Claims, Member, and PA. Below this is a user profile section with the text 'Last Login: 26 FEB, 2020 02:49 PM' and utility icons for Note Pad, External Links, My Favorites, Print, and Help. The main content area is titled 'Provider Portal > Group Modification' and contains an NPI and Name search bar. Below the search bar are 'Close' and 'Add' buttons. The 'Specialty/Subspecialty List' section features a filter interface with 'Filter By' and 'Operational Status' dropdowns, and buttons for 'Save Filters' and 'My Filters'. A table lists the specialties, with the following data:

Specialty/Subspecialty	Start Date	End Date	Status	Operational Status	Inactivation Date	Primary Specialty (Y/N)
<input type="checkbox"/> Medical/No Subspecialty	01/01/2015	12/31/2999	Approved	Active		No

At the bottom of the table, there are controls for 'View Page: 1', 'Page Count', 'SaveToXLS', and 'Viewing Page: 1' with navigation arrows for First, Prev, Next, and Last.

- Each Specialty should be reviewed for accuracy.
 - If the information is accurate and there are no updates or additions, click Close to be returned to the [Business Process Wizard steps](#).
- To enter a new specialty that is not listed, click Add.
- To change an end date of a current Specialty listed click the Specialty/Subspecialty hyperlink.
 - Continue to next slide for further information on how to end date a Specialty.

NPI: Name:

Manage Specialty/Subspecialty

Location: 01-

Provider Type: GROUPS

Specialty: Medical

Subspecialty: No Subspecialty

Status: Approved

Start Date: *

End Date:

- Enter the end date to indicate the date the Specialty is no longer applicable
- Click Save
- Click Close to return to the Specialty/Subspecialties list screen

CHAMPS My Inbox Provider Claims Member PA

Last Login: 26 FEB, 2020 02:49 PM Note Pad External Links My Favorites Print Help

Provider Portal > Group Modification

NPI: _____ Name: _____

Close Add

Specialty/Subspecialty List

Filter By [] And Filter By [] And Operational Status Active [] Go Save Filters My Filters

Specialty/Subspecialty	Start Date	End Date	Status	Operational Status	Inactivation Date	Primary Specialty (Y/N)
<input type="checkbox"/> Medical/No Subspecialty	01/01/2015	12/31/2999	In Review	Active		No
<input type="checkbox"/> Medical/No Subspecialty	01/01/2015	12/31/2999	Approved	Active		No

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

- Notice there are now two rows for Specialty/Subspecialty, one that is approved and one that is in review.
- If end dates are needed for any other Specialty/Subspecialty listed, click into those hyperlinks to enter end dates.
- Click Close to return to the Business Process Wizard steps.

CHAMPS My Inbox Provider Claims Member PA

Last Login: 26 FEB, 2020 02:49 PM Note Pad External Links My Favorites Print Help

Provider Portal > Group Modification

NPI: _____ Name: _____

Close Undo Update

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice).

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 3: Specialties	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 6: Associate Billing Agent	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/27/2020	10/06/2015	Incomplete		Modification Request has not been Submitted.

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

- Step 3 is Complete and a Modification Status of Updated as changes were made within this step.
 - If changes were made an additional status of Updated would be listed in the Modification Status column.
- Click on Step 5: Mode of Claim Submission/EDI Exchange
 - Please Note: Step 4 is optional and can be reviewed or updated if needed but is not required.



NPI: _____ Name: _____

Close Add

Mode of Claim Submission List

Filter By [dropdown] [input] And Filter By [dropdown] [input] And Operational Status Active [dropdown] Go Save Filters My Filters

Mode of Claim Sub. Method	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Billing Agent, Online Direct Data Entry (DDE), Paper	11/21/2015	12/31/2999	Approved	Active	

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

- The current mode(s) of claim submission will be displayed.
 - If the information listed is accurate and no edits need to be made, click Close to be returned to the [Business Process Wizard steps](#).
- To add or remove a mode of claim submission click the Mode of Claim Submissions hyperlink.
 - Continue to the next slide for further instructions on how to remove a Mode of Claim Submission.

NPI:

Name:

Close Save

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

Status: Approved

- To remove a Mode(s) of Claim Submission click the check mark next to the method of submission.
 - Multiple methods can be updated at once, check or uncheck applicable methods.
- Click Save
- Click Close

NPI: _____ Name: _____

Close Add

Mode of Claim Submission List

Filter By [] And Filter By [] And Operational Status Active [] Go Save Filters My Filters

Mode of Claim Sub. Method	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Billing Agent, Online Direct Data Entry (DDE)	02/21/2020	12/31/2999	In Review	Active	
<input type="checkbox"/> Billing Agent, Online Direct Data Entry (DDE), Paper	11/21/2015	12/31/2999	Approved	Active	

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

- Notice there are now two rows for Mode of Claim Submission, one that is approved and one that is in review.
 - Please Note: due to Billing Agent has been added as a Mode of Claim Submission, Step 6 will now become required.
- Click Close to return to the Business Process Wizard steps.

NPI: Name:

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice).

<input type="checkbox"/> Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 3: Specialties	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	10/06/2015	10/06/2015	Incomplete		Please associate required Billing Agent.
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/27/2020	10/06/2015	Incomplete		Modification Request has not been Submitted.

View Page:

Viewing Page: 1

- Step 5 is Complete and a Modification Status of Updated as changes were made within this step.
 - If changes were made an additional status of Updated would be listed in the Modification Status column.
 - Step 6 is optional and becomes required based on the selections made within Step 5. If a billing agent is listed as a mode of claim submission, then Step 6 will become required.
- Click on Step 6: Associate Billing Agent
 - If step 6 is not required, continue to [Step 7: Provider Controlling Interest/Ownership Details](#)

CHAMPS My Inbox Provider Claims Member PA

Last Login: 20 FEB, 2020 02:11 PM Note Pad External Links My Favorites Print Help

Provider Portal > Group Modification

NPI: Name:

Close Add

Billing Agent List

Filter By And Filter By And Operational Status Active Go Save Filters My Filters

Billing Agent ID	Billing Agent Name	Start Date	End Date	835 Auth.	Auth. Start Date	Auth. End Date	Status	Operational Status	Inactivation Date
▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>		04/15/2008	12/31/2999	No			Approved	Active	

View Page: 2 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- The current billing agent(s) will be displayed.
 - If the information is accurate and no edits need to be made, click Close to be returned to the [Business Process Wizard steps](#).
- To add a billing agent click Add
- To end date an association to a billing agent or remove/add the 835 authorization click the Billing Agent ID hyperlink.
 - Continue to the next slide for further instructions on how to end date a billing agent association or add the 835 authorization.

NPI: _____ Name: _____

Manage Billing Agent Association

Billing Agent ID: _____ Billing Agent Name: _____
Association Start Date: 04/10/2015 * Association End Date: 12/31/2999
Status: Approved

Authorized Transaction Responses

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

- To end date the association enter an end date.
 - Please Note: if there is only one billing agent associated and an end date is entered a new billing agent will need to be associated, based on the information in Step 7 at least one billing agent would need to be associated.
- To add the 835 authorization check the box under Authorized and enter a Start and End date.
 - For further details about Associating to a billing agent or adding the 835 authorization [click here](#)
- Click Save
- Click Close

NPI: _____ Name: _____

Billing Agent List

Filter By [] And Filter By [] And Operational Status Active [] Go

Billing Agent ID	Billing Agent Name	Start Date	End Date	835 Auth.	Auth. Start Date	Auth. End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>		04/10/2015	12/31/2999	No			In Review	Active	
<input type="checkbox"/>		04/10/2015	12/31/2999	No			Approved	Active	

View Page: 1 Viewing Page: 1

- There will be an In Review record as edits were made to the existing information.
 - In this example the 835 authorization was added.
- Click Close to be returned to the Business Process Wizard steps.



NPI: [] Name: []

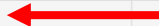
Close Undo Update

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice)

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 3: Specialties	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/27/2020	10/06/2015	Incomplete		Modification Request has not been Submitted.



View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

<< First < Prev > Next >> Last

- Step 6 is Complete and a Modification Status of Updated as changes were made within this step.
 - If changes were made an additional status of Updated would be listed in the Modification Status column.
- Click on Step 7: Provider Controlling Interest/Ownership Details

NPI: _____ Name: _____

Close **Actions**

- Add Owner
- Import Owner
- OWNERS RELATIONSHIPS
- OWNERS ADVERSE ACTION

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 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.
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Sub-contractor	Foreign, Nonresident Alien
Corporate - Non Charitable	Holding Company	Limited Liability Company
Indirect Owner		

Owners List

Filter By [] And Filter By [] And Operational Status Active [] Go [] Save Filters [] My Filters []

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date	Adverse Action	Percentage owned	Relationship Status
[]	[]	Corporate - Non Charitable	[]	01/01/2015	12/31/2999	Approved	Active	[]	No	100	Completed
[]	[]	Managing Employee	[]	01/01/2015	12/31/2999	Approved	Active	[]	No	0	Completed
[]	[]	Board of Directors/Officers/Principles	[]	01/01/2015	12/31/2999	Approved	Active	[]	No	0	Completed

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 [] And Filter By [] And Operational Status Active [] Go [] Save Filters [] My Filters []

Other Owner EIN/TIN	Other Owner Information	Address	Status	Operational Status	Inactivation Date
No Records Found !					

- The current Owner(s) will be displayed. For complete instructions on the Ownership step [click here](#).
 - Review all owners, if no updates need to be made, click Close to be returned to the [Business Process Wizard steps](#).
- To edit owner information select the owner SSN hyperlink.
- To add a new owner, edit relationship information, or complete the Adverse Action, select the option from the Actions dropdown. Please Note: if any owner information is updated the Adverse Action will need to be completed.
 - Continue to the next slide for further instructions on how to edit current owner information.

NPI: [input] Name: [input]

Close Save

Manage Provider Controlling Interest/Ownership

Type: Managing Employee	Percentage Owned: 0 *
SSN: [input] *	EIN/TIN: [input]
Legal Entity Name: [input] <small>(As shown on the Income Tax Return)</small>	Entity Business Name: [input] <small>(Doing Business As)</small>
Owner NPI: [input]	Middle Initial: [input]
First Name: [input] *	DOB: [input] [calendar] *
Last Name: [input] *	Email: [input]
Suffix: [dropdown]	End Date: 12/31/2999 [calendar]
Phone Number: [input] * Extn: [input]	
Start Date: 01/01/2015 [calendar] *	

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

Address Type: Home Address

Address Line 1: [input] *	Address Line 2: [input]
<small>(Enter Street Address or PO Box Only)</small>	
Address Line 3: [input]	City/Town: [input] [dropdown] *
State/Province: [input] [dropdown] *	County: [input] [dropdown]
Country: UNITED STATES [dropdown] *	Zip Code: [input] * - [input] [button] Validate Address

- Make any necessary updates. Ensure all fields marked with an asterisk (*) are complete.
 - If the address information is updated the Validate Address will need to be clicked prior to Save.
- Click Save
- Click Close

CHAMPS My Inbox Provider Claims Member PA

Last Login: 27 FEB, 2020 10:51 AM Note Pad External Links My Favorites Print Help

Provider Portal > Group Modification

NPI: Name:

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.
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Sub-contractor	Foreign, Nonresident Alien
Corporate - Non Charitable	Holding Company	Limited Liability Company
Indirect Owner		

Owners List

Filter By And Filter By And Operational Status Active Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date	Adverse Action	Percentage owned	Relationship Status
		Managing Employee		01/01/2015	12/31/2999	In Review	Active		Not Completed	0	Completed
		Corporate - Non Charitable		01/01/2015	12/31/2999	Approved	Active		No	100	Completed
		Managing Employee		01/01/2015	12/31/2999	Approved	Active		No	0	Completed
		Board of Directors/Officers/Principles		01/01/2015	12/31/2999	Approved	Active		No	0	Completed

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

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

Filter By And Filter By And Operational Status Active Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address	Status	Operational Status	Inactivation Date
No Records Found!					

- Notice there are now two rows for the selected owner, one that is approved and one that is in review.
 - For complete instructions on the Ownership step [click here](#).
- As owner information was updated the Adverse Action for any owner(s) would also need to be completed
- Click Close to return to the Business Process Wizard steps.

NPI: Name:

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice).

<input type="checkbox"/> Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 3: Specialties	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 8: Taxonomy Details	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/27/2020	10/06/2015	Incomplete		Modification Request has not been Submitted.

View Page: Viewing Page: 1

- Step 7 is Complete and a Modification Status of Updated as changes were made within this step.
 - If changes were made an additional status of Updated would be listed in the Modification Status column.
- Click on Step 8: Taxonomy Details

NPI: _____ Name: _____

Taxonomy List

Filter By [dropdown] [input] And Filter By [dropdown] [input] And Operational Status Active [dropdown] [Go] Save Filters My Filters

Taxonomy Code	Description	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> [redacted]	Multi-Specialty	10/05/2015	12/31/2999	APPROVED	Active	
<input type="checkbox"/>	Internal Medicine	10/05/2015	12/31/2999	APPROVED	Active	

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

- The current Taxonomy Code(s) will be displayed.
 - If there are no edits that need to be made, click Close to be returned to the [Business Process Wizard steps](#).
- To add a Taxonomy Code click Add
- To end date the current Taxonomy Code click the Taxonomy Code hyperlink.
 - Please Note: that if there is only one taxonomy listed and an end date is entered a new Taxonomy will need to be added.
 - Continue to the next slide for further instructions on how to end date a Taxonomy.

NPI: Name:

Manage Taxonomy Details ^

Taxonomy Code: Location: 01-
Description: Multi-Specialty
Status: Approved
Start Date: * End Date:

- Enter an End Date
- Click Save
- Click Close

NPI: _____ Name: _____

Close Add

Taxonomy List

Filter By [] And Filter By [] And Operational Status Active [] Go Save Filters My Filters

Taxonomy Code	Description	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/>	Multi-Specialty	10/05/2015	02/27/2020	IN REVIEW	Active	
<input type="checkbox"/>	Multi-Specialty	10/05/2015	12/31/2999	APPROVED	Active	
<input type="checkbox"/>	Internal Medicine	10/05/2015	12/31/2999	APPROVED	Active	

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

- Notice there are now two rows for the selected taxonomy, one in review and one that is approved .
- Click Close to be returned to the Business Process Wizard steps.

NPI: Name:

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice Business Process Wizard - Provider Data Modification (Group Practice).

<input type="checkbox"/> Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 3: Specialties	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 8: Taxonomy Details	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/27/2020	10/06/2015	Incomplete		Modification Request has not been Submitted.

View Page: Viewing Page: 1

- Step 8 is Complete and a Modification Status of Updated as changes were made within this step.
 - If changes were made an additional status of Updated would be listed in the Modification Status column.
- Click on Step 13: Complete Modification Checklist

CHAMPS My Inbox Provider Claims Member PA

Last Login: 20 FEB, 2020 02:11 PM Note Pad External Links My Favorites Print Help

Provider Portal > Group Modification > Provider Check List

NPI: _____ Name: _____

Close Save

Manage 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 <input type="checkbox"/>	<input type="text"/>
Do you accept new patients?	Not Completed <input type="checkbox"/>	<input type="text"/>
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 <input type="checkbox"/>	<input type="text"/>
Have you had any malpractice settlement, judgment, or agreement? If yes, enter dollar amount(s) and date(s).	Not Completed <input type="checkbox"/>	<input type="text"/>
Do you wish to end date your enrollment or association? If yes, what date and to which NPI association?	Not Completed <input type="checkbox"/>	<input type="text"/>
Are you currently excluded from any State Program?	Not Completed <input type="checkbox"/>	<input type="text"/>
Are you currently excluded from any Federal Program?	Not Completed <input type="checkbox"/>	<input type="text"/>
Have you ever had a criminal or health-related conviction?	Not Completed <input type="checkbox"/>	<input type="text"/>
Have you ever had a judgment under any false claims act?	Not Completed <input type="checkbox"/>	<input type="text"/>
Have you ever had a program exclusion/debarment?	Not Completed <input type="checkbox"/>	<input type="text"/>
Have you ever had a civil monetary penalty?	Not Completed <input type="checkbox"/>	<input type="text"/>
Are you a PA 161 Program?	Not Completed <input type="checkbox"/>	<input type="text"/>
Do you contract with PA 161 program? If you contract with one of these programs, please provide the NPI in the comments.	Not Completed <input type="checkbox"/>	<input type="text"/>
All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?	Not Completed <input type="checkbox"/>	<input type="text"/>

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

- Review each question and select Yes or No from the dropdown.
- Enter comments if necessary or required
- Click Save
- Click Close

NPI: _____ Name: _____

Close Undo Update

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice).

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 3: Specialties	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 8: Taxonomy Details	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	02/27/2020	10/06/2015	Complete	Updated	
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/27/2020	10/06/2015	Incomplete		Modification Request has not been Submitted.

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

- Step 13 is Complete and a Modification Status of Updated as changes were made within this step.
 - Ensure all information has been reviewed for each of the required steps and make sure any updates have been completed.
- Click on Step 14: Submit Modification Request for Review

Please Note : If you chose not to complete optional steps you can still submit your revalidation

You must complete step 14 to submit your revalidation



NPI: [Redacted] Name: [Redacted]

Close Next

Final Submission

NPI: [Redacted] EnrollmentType: Group Practice (Corporation, Partnership, LLC, etc.)

The Information submitted 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



NPI: Name:

- Final Submission
- 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.
13. I agree to comply with all policies and procedures of the Medical Assistance Program when billing for services rendered. I also agree that disputed claims, including overpayments, may be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction. I further agree to reimburse the Medical Assistance Program for all overpayments, and I acknowledge that the Medicaid Audit System, which uses random sampling, is a reliable and acceptable method for determining such overpayments.
14. I agree to comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR Parts 160 and 164, Subparts A and E). I also agree to comply with the HIPAA security regulations, as applicable, for

- Scroll down the page to review the Provider Enrollment & Trading Partner Agreement-Conditions

NPI: _____ Name: _____

Close **Submit for Modification**

5. Liability.

MDHHS shall not be responsible to the Trading Partner nor anyone else for any damages caused by loss, delay, rejection, or any misadventure affecting such electronic information. In addition, MDHHS shall be excused from performing any EDI service or function, in whole or in part, as a result of an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including shortages or fluctuations in electrical power, heat, light, or air conditioning. MDHHS's sole liability to the Trading Partner or to any other person or entity in connection with MDHHS's responsibilities under this Agreement shall be to reprocess information supplied by the Trading Partner or duplicate information from a backup supplied by the Trading Partner upon MDHHS's request which shall be the sole remedy against MDHHS for claimed damage or injury of any nature. MDHHS shall not be liable for any indirect, special, or consequential damages arising out of any access, use, or any reliance upon, the EDI services MDHHS provides to the Trading Partner. MDHHS assumes no responsibility for claims preparation, review, information accuracy, pricing, adjudication, payment, adjustment, accounting, reconciliation or any other matter related to the claims transmitted for delivery to other third party payers. The Trading Partner agrees to defend, indemnify, and hold harmless MDHHS, its Trading Partners, officers, agents, employees, assigns and successors from and against any and all claims, losses, and actions, 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.

- Read through the entire list of Provider Enrollment & Trading Partner Agreement-Conditions
- Check the box at the end to agree to the Terms and Conditions
- Click 'Submit for Modification'
 - Once submitted to the State for review, changes cannot be made to the information.

NPI: Name:

The Modification Request has been submitted for State review. Return to here to track the status of your request. x

Please update all steps to complete your revalidation process

View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice)

<input type="checkbox"/> Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	02/26/2020	10/06/2015	Complete	In Review	
<input type="checkbox"/> Step 3: Specialties	Required	02/27/2020	10/06/2015	Complete	In Review	
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete		
<input type="checkbox"/> Step 5: Mode of Claim Submission/EDI Exchange	Required	02/27/2020	10/06/2015	Complete	In Review	
<input type="checkbox"/> Step 6: Associate Billing Agent	Required	02/27/2020	10/06/2015	Complete	In Review	
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	02/27/2020	10/06/2015	Complete	In Review	
<input type="checkbox"/> Step 8: Taxonomy Details	Required	02/27/2020	10/06/2015	Complete	In Review	
<input type="checkbox"/> Step 9: Associate MCO Plan	Optional	10/06/2015	10/06/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 11: 835/ERA Enrollment Form	Optional	10/06/2015	10/06/2015	Incomplete		
<input type="checkbox"/> Step 12: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 13: Complete Modification Checklist	Required	02/27/2020	10/06/2015	Complete	In Review	
<input type="checkbox"/> Step 14: Submit Modification Request for Review	Required	02/27/2020	10/06/2015	Complete		

View Page:

Viewing Page: 1

- Step 14 is now complete, and the revalidation has been submitted to the State for review.
- Click Close
 - (Please Note: Optional steps may show as incomplete if you chose not to complete. This is ok.)

Provider Enrollment Resources

- **Provider Enrollment website:** http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_85441---,00.html
- **SIGMA:**
 - New Group Providers must register with SIGMA as Vendors
 - Please visit: Michigan.gov/SIGMAVSS
- **Trainings:**
 - CHAMPS Enrollment Application: Group User Guide - [PDF](#)
 - Domain Administrator Functions - [PDF](#)
 - Track Application – [PDF](#)
 - Provider Controlling Interest/Ownership Tip - [PDF](#)
- **Forms:**
 - Electronic Signature Agreement Cover Sheet ([MDHHS-5405](#))
 - Electronic Signature Agreement ([DCH-1401](#))
- **Provider Enrollment:**
 - 1-800-292-2550
 - ProviderEnrollment@Michigan.gov
 - ProviderSupport@Michigan.gov