Provider Enrollment Checklist

Individual/Sole Proprietor

The following Checklist includes a list of the fields required when enrolling in CHAMPS. The fields required are categorized per each required Provider Enrollment step based on Enrollment Type. Please note, the following checklist is specific to a *new* Provider Enrollment Application.

Intent

The intent of this resource is to provide a document that can be prefilled with the required information for completing a provider enrollment application to allow for ease of completion. The resources can be printed, emailed, or handed to the individual to fill out and give to management or a credentialing office who will be completing the CHAMPS provider enrollment application for the individual.

Modification:

Providers may find they need to make a change or a modification to their enrollment information. Providers are only able to submit a modification after their application has been approved.

When a modification is being submitted to change or modify an optional enrollment step, any required step, that is not marked as "complete" will need to be completed; before the modification can be submitted for approval.

Notes:

- All Applications must be completed and submitted for State Review within 30 calendar days of the original start date or they will be deleted.
- Within the application, required fields are marked with an asterisk **(*)**.
- When using the **Filter By** feature, the percent sign **(%)** acts as a wildcard. It can be used in conjunction with search criteria or by itself.
- Enter **Start** and **End Dates** using format **mm/dd/yyyy**

For expert assistance contact Provider Support at 1-800-292-2550 or ProviderEnrollment@michigan.gov

Individual/Sole Proprietor:

Step 1: Basic Information

- ☐ First Name:
- ☐ Last Name:
- ☐ Social Security Number (SSN):
- ☐ Date of Birth:
- ☐ NPI:
- ☐ SIGMA Vendor ID:
- ☐ Contact Email Address:
- ☐ Home Address:
- ☐ City/Town:
- ☐ State/Province:
- ☐ Country:
- ☐ Zip Code:

Step 2: Add Locations

Include the location or locations of the entity or any affiliated location that shares the same tax ID (for valid screening results). For the field "*doing business as*" it is recommended the provider enter in the business name or if there will be multiple locations fill in a phrase or term to distinguish the different locations from each other.

1. Primary Practice Location or Other Office/Servicing Location (pick one):

   - ☐ Doing Business As:
   - ☐ Address:
   - ☐ City/Town:
   - ☐ State/Province:
   - ☐ Zip Code:
   - ☐ Country:
   - ☐ Hours entity will be open:

   Correspondence and Pay To address are required for all locations. The Remittance Advice address to receive a paper Remittance Advice is optional. If these locations will be the same as the listed Primary or Other location write, "SAME".

   - ☐ Correspondence Address, City/Town, State/Province, Zip Code, Country:
   - ☐ Pay To Address, City/Town, State/Province, Zip Code, Country:
   - ☐ Remittance Advice (optional), City/Town, State/Province, Zip Code, Country:

2. Primary Practice Location or Other Office/Servicing Location (pick one):

   - ☐ Doing Business As:
   - ☐ Address:
   - ☐ City/Town:
   - ☐ State/Province:
   - ☐ Country:
   - ☐ Zip Code:
   - ☐ Hours entity will be open:

Correspondence and Pay To address are required for all locations. The Remittance Advice address to receive a paper Remittance Advice is optional.

- ☐ Correspondence Address, City/Town, State/Province, Zip Code, Country:
- ☐ Pay To Address, City/Town, State/Province, Zip Code, Country:
- ☐ Remittance Advice (optional), City/Town, State/Province, Zip Code, Country:

3. Primary Practice Location or Other Office/Servicing Location (pick one):

- ☐ Doing Business As:
- ☐ Address:
- ☐ City/Town:
- ☐ State/Province:
- ☐ Country:
- ☐ Zip Code:
- ☐ Hours entity will be open:

Correspondence and Pay To address are required for all locations. The Remittance Advice address to receive a paper Remittance Advice is optional.

- ☐ Correspondence Address, City/Town, State/Province, Zip Code, Country:
- ☐ Pay To Address, City/Town, State/Province, Zip Code, Country:
- ☐ Remittance Advice (optional), City/Town, State/Province, Zip Code, Country:

Step 3: Add Specialties

Individual may have multiple specialties. After adding specialties, select Primary Specialty.

- ☐ Provider Type:
- ☐ Specialty:
- ☐ Board Certified, Board Eligible, Not Board Certified/Eligible (Pick One):
- ☐ Subspecialties: range dependent on specialty chosen

Step 5: Add License/Certification/Other

- ☐ License/Certification/Other Type (ex. State Professional License):
- ☐ License/Certification/Other #:
- ☐ Effective Date:

Step 6: Add Mode of Claim Submission/EDI Exchange

- ☐ Determine appropriate claim submission method(s)
  - Electronic Batch
  - CORE Batch
  - CORE Real Time
  - Billing Agent
  - Paper Claims
  - Direct Data Entry (DDE)

Step 7: Associate Billing Agent

- ☐ Billing Agent ID
- ☐ Association Start Date
- ☐ Determine if authorization is needed for 835 (i.e., Electronic Remittance Advice) transaction response.

Step 8: Add Provider Controlling Interest/Ownership Details

When completing the Provider Controlling Interest/Ownership Details step, completing a revalidation, or any change in ownership within 35 days; Providers (including fiscal agents and managed care entities) are required to disclose:

- The Individual Owner (i.e., any person with ownership or controlling interest) and the relationship between the Individual with an ownership or controlling interest and another person with ownership or controlling interest in the entity. (e.g., from Owner to Owner it would be Self or Owner to Managing Employee could be Spouse or None); and/or
- The Individual with an ownership or controlling interest of any subcontractor in which the disclosing entity has a 5% or more interest and to another person with ownership or controlling interest; and/or
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or controlling interest in and is reimbursable by Medicaid and/or Medicare.

- ☐ Type of Controlling Interest/Ownership (e.g., Managing Employee):
- ☐ First Name:
- ☐ Last Name:
- ☐ Social Security Number (SSN):
- ☐ Date of Birth:
- ☐ Phone Number:
- ☐ Start Date:
- ☐ Address:
- ☐ City/Town:
- ☐ State/Province:
- ☐ Country:
- ☐ Zip Code:
- ☐ Relationship to Controlling Interest/Ownership (e.g., Self, Spouse, None):

Step 9: Add Taxonomy Details

- ☐ Taxonomy Code:
- ☐ Start Date:

Step 13: Complete Enrollment Checklist

1. Do you need to request a Retro Enrollment Date? If Yes, enter the requested Retro Enrollment Date in the comment field.
2. Do you accept new patients?
3. Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.
4. Have you had any malpractice settlement, judgment, or agreement? If yes, enter dollar amount(s) and date(s).
5. If you are a Nurse Practitioner or Nurse Midwife, a Collaborative Agreement is required. Please provide NPI of servicing physician. If you don't have an agreement, please answer yes and provide an explanation.
6. Do you wish to end date your enrollment or association? If yes, what date and to which NPI association?
7. Dental Hygienist – Do you have a collaborative agreement in place? If 'Yes', with what NPI?
8. Are you currently excluded from any State Program?
9. Are you currently excluded from any Federal Program?
10. Have you ever had a criminal or health-related conviction?
11. Have you ever had a judgment under any false claims act?
12. Have you ever had a program exclusion/debarment?
13. Have you ever had a civil monetary penalty?
14. Are you affiliated with a PA161 program? If 'Yes', please provide the NPI of that program(s) in the comments.
15. All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?
16. Have you completed American Pharmacists Assoc's Delivering Medication Therapy Mgmt Services or program approved by Accreditation Council of Pharmacy Education? If yes, then enter what you have completed.