PROVIDER ELECTRONIC SIGNATURE AGREEMENT COVER SHEET

Michigan Department of Health and Human Services

Instructions

- Provider should retain a COPY in the office
- MUST be submitted with DCH-1401, Electronic Signature Agreement.

Mail to:
Michigan Department of Health and Human Services
Provider Enrollment Section
PO Box 30238
Lansing, MI 48909

Fax: 517-241-8233

Email to:
ProviderEnrollment@michigan.gov

Reason for Submission (check all that apply)

☐ Revalidation	☐ New Tax ID/SSN (List Provider Enrollment staff contact name)
☐ Domain Access ☐ Group ☐ Individual ☐ Both	☐ Other (List reason)
☐ Domain Administrator Contact Information	

Contact Information (REQUIRED)

Name	Email Address	Phone Number
MILogin User ID	Provider's NPI Number	
Provider's Date of Birth	Provider's Home Address	

Provider Enrollment Office Use Only

- ☐ Provided Domain Administrator contact information
- ☐ Sent/Gave to team lead for processing
- ☐ Sent to processor with W-9 attached
- ☐ Opened for revalidation

AUTHORITY: 42 CFR 455.104
COMPLETION: Voluntary, but required for access to CHAMPS.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.