



Provider Enrollment New Individual/Sole Proprietor Step 2: Add Locations

“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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 - Step 2: Add Locations
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Provider Enrollment Process Overview

- Step 1: Determine if provider needs to enroll with CHAMPS Michigan Medicaid
 - Policy Bulletin MSA: [13-17](#)
 - Policy Bulletin MSA: [18-47](#)
 - Policy Bulletin MSA: [19-20](#)
- Step 2: [Determine CHAMPS Enrollment Type](#)
- Step 3: [Enroll with SIGMA – Vendor Self Service](#)
 - 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.
- Step 4: [Register for a MIlogin Account for Access to CHAMPS](#)
- Providers wishing to elect another person to have Domain Administrator rights are required to submit:
 - Form: Electronic Signature Agreement Cover Sheet ([MDHHS-5405](#))
 - Form: Electronic Signature Agreement ([DCH-1401](#))

Starting a New Provider Enrollment Application

Details to Step 2: Add Locations

Track Application - [PDF](#), [Recording](#)

Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

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

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 11/15/2017 | 11/15/2017 | Complete | |
| Step 2: Add Locations | Required | | | Incomplete | |
| Step 3: Add Specialties | Required | | | Incomplete | |
| Step 4: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Incomplete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Required | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 9: Add Taxonomy Details | Required | | | Incomplete | |
| Step 10: Associate MCO Plan | Optional | | | Incomplete | |
| Step 11: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 12: Upload Documents | Optional | | | Incomplete | |
| Step 13: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 14: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Individual 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: 20171115618358

Name: Tester, Test

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 |
|-----------------------------|---------------|------------------|----------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| No Records Found ! | | | |

- Click Add, to enter Primary Location information

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

Application ID: 20171115618358 Name: Tester, Test

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, DRAWNR 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: _____ * - _____ Validate Address

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: | _____ * | AM PM * | _____ * | AM PM * | Thursday: | _____ * | AM PM * | _____ * | AM PM * |
| Monday: | _____ * | AM PM * | _____ * | AM PM * | Friday: | _____ * | AM PM * | _____ * | AM PM * |
| Tuesday: | _____ * | AM PM * | _____ * | AM PM * | Saturday: | _____ * | AM PM * | _____ * | AM PM * |
| Wednesday: | _____ * | AM PM * | _____ * | AM PM * | | | | | |

Accepting New Clients: _____

Offers OB-Gyn Services: _____

Handicap Accessible: No _____

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

Maximum Clients: _____

Pediatric Services: _____

FQHC: _____

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

OK Cancel

Page ID: dlgEntAddLocation(Provider)

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

Application ID: 20171115618358

Name: Tester, Test

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

| Locations List | | | |
|--------------------------|---|--|------------|
| Doing Business As | Location Type | Location Details | End Date |
| <input type="checkbox"/> | Primary Practice Location | 320 S Walnut St, Lansing, MICHIGAN 48933 | 12/31/2999 |

- Click Primary Practice Location to add Correspondence and Pay-To address
(Please Note: Correspondence and Pay To address are required for all locations. Optionally enter a Remittance Advice address to receive a paper Remittance Advice)

Application ID: 20171115618358

Name: Tester, Test

Close Save 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:

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: | 07:00 | AM PM | 06:00 | AM PM |
| Monday: | 07:00 | AM PM | 06:00 | AM PM | Friday: | 07:00 | AM PM | 06:00 | AM PM |
| Tuesday: | 07:00 | AM PM | 06:00 | AM PM | Saturday: | 09:00 | AM PM | 03:00 | AM PM |
| Wednesday: | 07:00 | AM PM | 06:00 | AM PM | | | | | |

Accepting New Clients: No

Maximum Clients:

Handicap Accessible: No

Offers OB-Gyn Services:

Pediatric Services:

FQHC:

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

Language(s) Spoken: English Arabic Chinese

End Date: 12/31/2999

Address List

Add Address

| Address Type | Address | End Date |
|-----------------------------------|---------|------------|
| <input type="checkbox"/> Location | | 12/31/2999 |

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- Click Add Address

Application ID: 20171115618358

Name: Tester, Test

Add Provider Location Address

 Type of Address:

 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: *
(Enter Street Address or PO Box Only)

 Address Line 2:

 Address Line 3:

 City/Town: *

 State/Province: *

 County:

 Country: *

 Zip Code: - [Validate Address](#)
[OK](#) [Cancel](#)

- 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: 20171115618358

Name: Tester, Test

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: 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: | 07:00 | AM/PM | 06:00 | AM/PM |
| Monday: | 07:00 | AM/PM | 06:00 | AM/PM | Friday: | 07:00 | AM/PM | 06:00 | AM/PM |
| Tuesday: | 07:00 | AM/PM | 06:00 | AM/PM | Saturday: | 09:00 | AM/PM | 03:00 | AM/PM |
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Accepting New Clients: No
 Offers OB-Gyn Services:
 Accept 835(reported at EIN/TIN level): No
 End Date: 12/31/2999
 Maximum Clients:
 Pediatric Services:
 Language(s) Spoken: English, Arabic, Chinese
 Handicap Accessible: No
 FQHC:

Address List

| Address Type | Address | End Date |
|--|---------|------------|
| <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 |

- 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: 20171115618358

Name: Tester, Test

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

Locations List

Filter By [dropdown] [input] [input] Go

Save Filters My Filters ▾

| Doing Business As | Location Type | Location Details | End Date |
|-----------------------------|---|--|------------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| <input type="checkbox"/> | Primary Practice Location | 320 S Walnut St, Lansing, MICHIGAN 48933 | 12/31/2999 |

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- Click Close

Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

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| Step 13: Complete Enrollment Checklist | Required | | | Incomplete | |
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- Step 2 is complete
- Click on Step 3: Add Specialties

Provider Enrollment Resources

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