Provider and Facility Enrollment Form

Check *one* ☐ **New** ☐ **Change** ☐ **Termination**

Check *all* that apply ☐ **BC3NP** ☐ **WISEWOMAN**

Check *all* that apply ☐ **Facility** ☐ **Enrollment Site**

Instructions: This form needs to be completed for each Provider and/or Facility that participates in the BC3NP and WISEWOMAN - including local health departments and sub-contracted providers. All **bolded** fields must be completed.

Billing information **must** be on file with the State of Michigan Budget Office Vendor Self-Service (VSS) (www.michigan.gov/SIGMAVSS). For more information regarding VSS, call 517-636-5270.

Provider/Facility Information

* **Federal Tax ID** (9 digits)	and	**NPI** (10 digits)

* **Name** as you would like it to appear in MBCIS (Example: John A Smith, MD **OR** Smith Pathology, PC)

Address (physical address)	Suite Number or P.O. Box Number

City	* **County**	* **State**	**Zip Code**

Phone Number with area code	Phone Extension	Fax Number with area code

Billing Contact Information to Receive Payment Detail Reports (EOBs)

Does the Provider use a **clearinghouse** for **electronic submission** of claims? ☐ NO ☐ YES

If *yes*, please provide clearinghouse name.

* Contact **Name** (1)	Contact **Email Address** (1)	
Phone Number with area code (1)	Phone Extension	* **Fax Number** with area code (1)
* Contact **Name** (2)	Contact **Email Address** (2)	
Phone Number with area code (2)	Phone Extension	* **Fax Number** with area code (2)

LCA Information	** LCA ID	** Billing Start Date	Termination Date	** **LCA Coordinator Signature:**

** **Please remember to include your LCA ID, Billing Start Date, and LCA Coordinator Signature** **

Email Form to MDHHS

SIGMA Information *to be filled out by MDHHS Staff*

* SIGMA Vendor ID (9 digits)

SIGMA Address ID	MBCIS Provider ID

LCA: Fax completed forms to MDHHS Cancer Section Fax # (517) 763-0290