



Michigan Department of Health & Human Services

Provider Enrollment New Local Education Agency (LEA) Atypical Agency Provider

“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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Register for MILogin and CHAMPS

MILogin is a website that allows a user to enter one ID and password in order to access multiple applications.

CHAMPS (Community Health Automated Medicaid Processing System) is the program where providers enroll, update enrollment information, and report services performed.

MILogin for Third Party

User ID

Password

Password

LOGIN

Don't have an account?

 SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

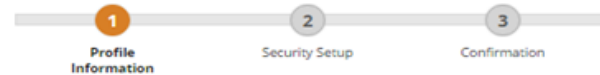
Copyright 2015-2019 State of Michigan

- Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.)
- Enter <https://milogintp.Michigan.gov> into the search bar
- Click Sign Up

MILogin for Third Party

[HOME](#)

Create Your Account



Profile Information

Enter your profile information

* Required

*First Name

Middle Initial

*Last Name

Suffix

*Email Address

*Confirm Email Address

*Work Phone Number

Mobile Number

*Verification Question: Bee, chin, ankle, leg and dog: how many body parts in the list?

☐

agree to the [terms & conditions](#).

NEXT

RESET

- Complete all required fields
- Check the 'I agree' box
- Click Next

MILogin for Third Party

HOME

Create Your Account



Security Setup

Provide user id and password information to complete your profile

* Required

* User ID

Enter a User ID

* Password

Enter password

* Confirm New Password

Confirm password

* Security Options

To choose your preferred password recovery method(s), please click on the buttons below. Multiple options can be selected.



CREATE ACCOUNT

BACK



User ID guideline:

- Enter your last name, first initial, and any 4 numbers with no space between them. For Example: John Smith and using 9999 as an example for the four digit number, you would enter smithj9999.

Password Guidelines:

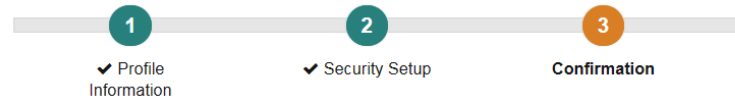
- Must be at least 8 characters in length
- Must include characters from 3 of the following categories:
 - Upper case letters (A-Z)
 - Lower case letter (a-z)
 - Numbers (0-9)
 - Special characters (IS#,%@~^&*_-+=><)
- Should not be one of the last 3 used passwords
- Should not be based on your User ID

- Create the user ID and password following the listed guidelines
- Select the preferred password recovery method(s)
- Click Create Account

MILogin for Third Party

[HOME](#)

Create your account



Confirmation

✓ Success

Your account has been successfully created.

LOGIN

- Your MILogin account has now been created successfully
- Click the Login button to return to the login screen

MILogin for Third Party

User ID

Password

Password

LOGIN

Don't have an account?

SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

Copyright 2015-2019 State of Michigan

- Enter your User ID and Password you just created
- Click Login

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Home Page

⌚ Your password will expire in **364** days

Access your applications by clicking on the application links below

You do not have access to any application. You can request access by clicking on [Request Access](#) link.

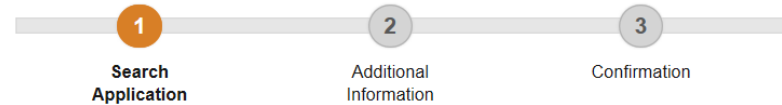
- Your Home Page will not show any applications
- Click Request Access

**MILogin resource links are listed at the bottom of the page*

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access



Search Application

Search for an application with a keyword or select an agency to view its applications

- Type CHAMPS in the search box
- Click the search/magnifying button

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

Search
Application

2

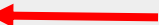
Additional
Information

3

Confirmation

Search Application

Search for an application with a keyword or select an agency to view its applications

**Michigan Department of Health & Human Services (MDHHS)****CHAMPS**

- Click on CHAMPS

MILogin for Third Party

HOME

Request Access

Search Applications

Search for an application

CHAMPS

MDHHS Michigan Department of Health & Human Services

CHAMPS

CHAMPS

(Community Health Automated Medicaid Processing System) is the Michigan Medicaid Management Information System (MMIS). It supports Medicaid provider enrollment and maintenance, beneficiary healthcare eligibility and enrollment, prior authorization, Home Help Electronic Service Verification (ESV), fee-for-service payments and managed care enrollments, payments, and encounters.

General 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.

☒ I agree to the terms & conditions

☐ I do not agree

CANCEL X REQUEST ACCESS

- Select the 'I agree to the terms & conditions' radio button
- Click Request Access

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

✓ Search
Application

2

Additional
Information

3

Confirmation

Additional Information

Provide following information to submit your access request

* Required

*Email Address

*Work Phone Number

*CHAMPS User Type

- ☒ Provider/Other
☐ State User Only

SUBMIT**RESET**

- Verify all information is correct
- Click Submit

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

✓ Search
Application

2

✓ Additional
Information

3

Confirmation

Confirmation

✓ Success

The request for your access has been successfully submitted.

You will see the updated list of application(s) on your home page once it is processed.

[HOME](#)

- You will be given confirmation that your request has been submitted successfully
- Click the Home button to return to the MILogin Home Page

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Home Page

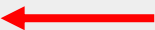
⌚ Your password will expire in **48** days

Access your applications by clicking on the application links below

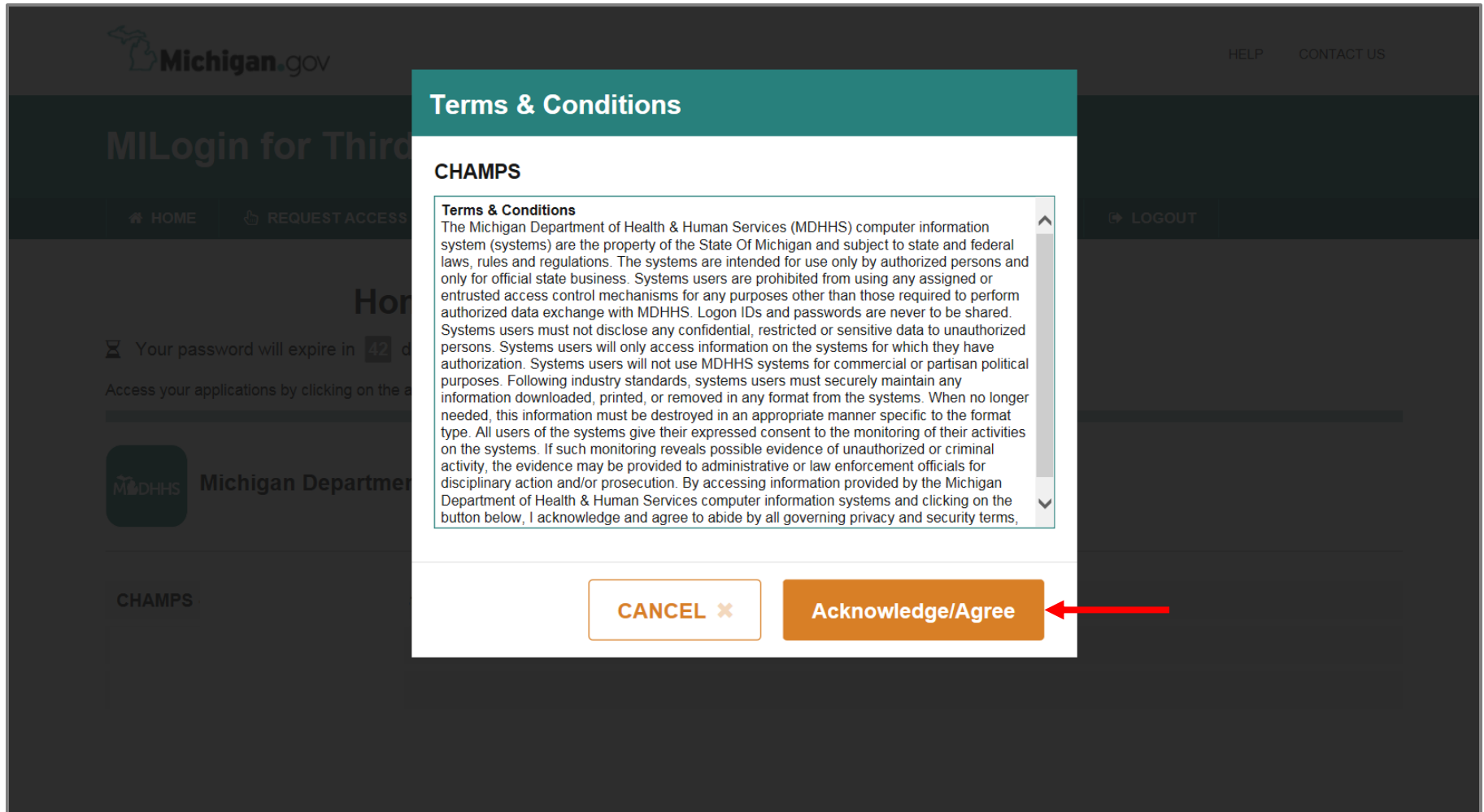


Michigan Department of Health & Human Services (MDHHS)

CHAMPS



- You will be directed back to your MILogin Home Page
- Click the CHAMPS hyperlink




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

New Local Education Agency (LEA) Provider Enrollment

Steps on how to complete a new CHAMPS enrollment
for an Atypical Agency Provider type



Provider Enrollment

 [New Enrollment](#)

Enroll As A New Provider

[Track Application](#)

Track Existing Provider Application

- Click New Enrollment



Provider ▾

▾

Quick Find

Note Pad

External Links ▾

My Favorites ▾

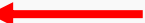
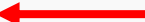
Print

Help

Home > New Enrollment

Enrollment Type

Select the Applicable Enrollment Type

- ☐ Individual/Sole Proprietor
 - ☐ Regular Individual/Sole Proprietor or Rendering/Servicing Provider
- ☐ Group Practice (Corporation, Partnership, LLC, etc.)
- ☐ Billing Agent
- ☐ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- ☒ Atypical (non-medical) provider (Choose this option if you do not have a NPI) 
- ☐ Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
- ☒ Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.) 

Submit

- Select Atypical (non-medical) provider
- Select Agency
- Click Submit

Basic Information: Enter required fields and click Confirm button.

Basic Information

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

Entity Business Name: * (Doing Business As)

Organization/Business Type: ▾ *

EIN/TIN: *

Vendor ID:

NPI:

Contact Email Address:

Email-1: *

Email-2:

Email-3:

Email-4:

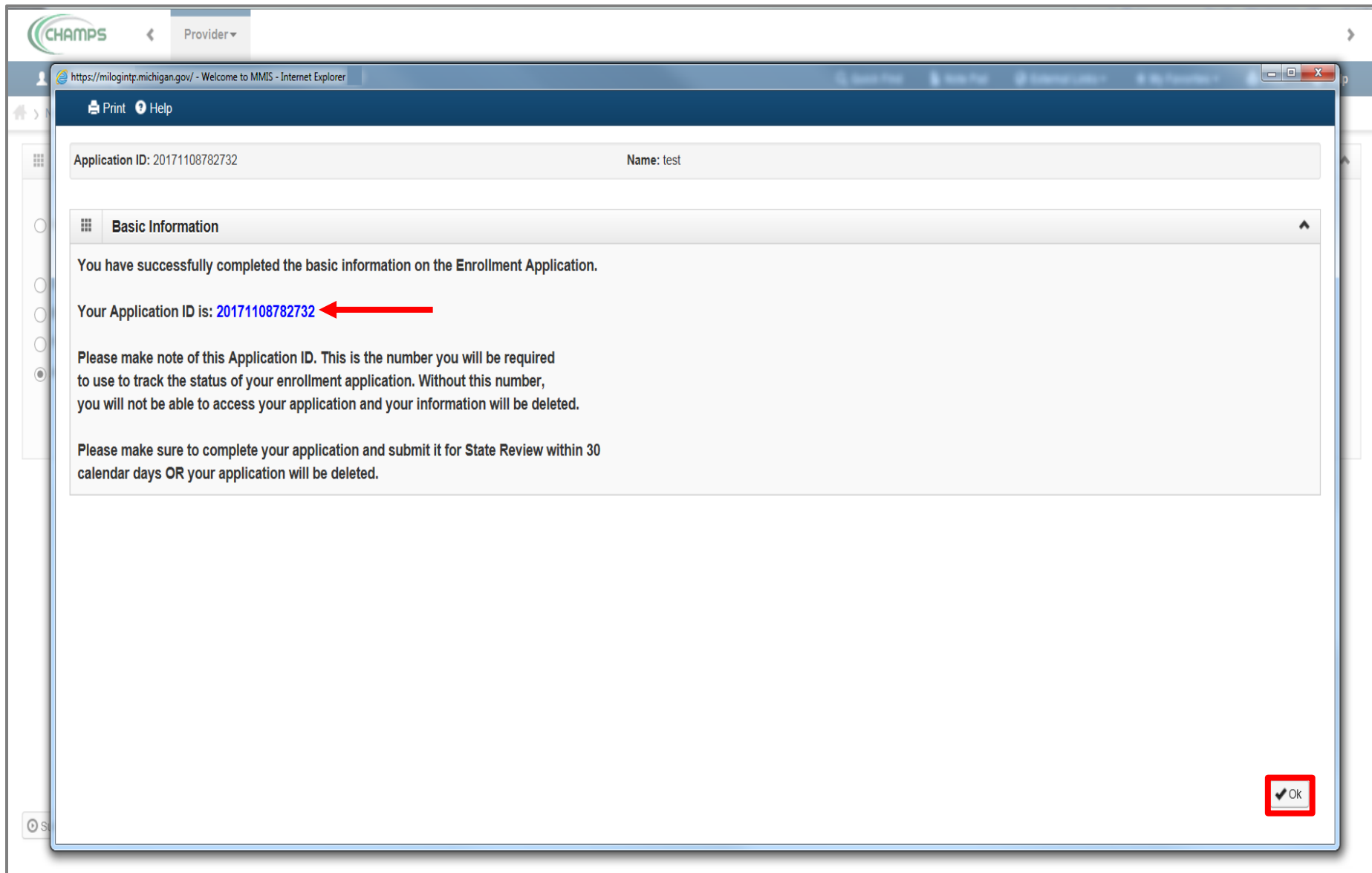
Email-5:

Email-6:

Please note that all providers are subject to a criminal background screening that could affect your ability to be paid through the Home Help program.

Confirm Cancel

- From the Organization/Business Type, Select Local Education Agency
- Complete all fields marked with an asterisk (*)
- Click Finish



- Confirmation, Basic Information is complete
- Take note of the Application ID, as this is used to track your application status
- Click Ok

Application ID: 20171108782732

Name: test

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add Additional Information	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required			Incomplete	
Step 15: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

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SaveToXLS

Viewing Page: 1

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Last

- Individual Provider Enrollment steps are listed (Please Note: some steps are required verses optional)
- Step 1 has a status of Complete
- Click on Step 2: Add Locations

Application ID: 20171108782732

Name: test

[Close](#) [Add](#) To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink

Locations List

Filter By



Go

Save Filters

My Filters▼

Doing Business As

Location Type

Location Details

End Date



No Records Found !

- Click Add, to enter Primary Location information

CHAMPS Provider

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

Print Help

Application ID: 20171108782732 Name: 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, 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: * Address Line 2:

(Enter Street Address or PO Box Only)

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:

Office Hours: Communication Preference:

Handicap Accessible: No

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

Language(s) Spoken: English, Arabic, Chinese, French, German, Japanese, Polish, Russian, Spanish, Other (For Multiple Selection, use Ctrl Key)

Facility Details

State Facility ID: Fiscal Year End Date: * (mm/dd)

OK Cancel

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

Provider ▾

Quick Find
Note Pad
External Links ▾
My Favorites ▾
Print
Help

New Enrollment
Atypical Agency Enrollment

Application ID: 20171108782732
Name: test

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

Locations List

Filter By ▾
Go
Save Filters
My Filters ▾

Doing Business As	Location Type	Location Details	End Date
<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼ Primary Practice Location	<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼ 12/31/2999

Delete
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- Click Primary Practice Location to add Pay-To address
(Please Note: Correspondence address is required for all locations. Enter Remittance Advise address only to receive a paper Remittance Advice)



Provider

Quick Find Note Pad External Links My Favorites Print Help

New Enrollment Atypical Agency Enrollment General

Application ID: 20171108782732

Name: test

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

Location Details

Doing Business As:

Phone Number: * Extn:

Web Page:

Handicap Accessible: No

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

Location Code: 1

Fax Number:

Office Hours:

Location Type: Primary Practice Location

Email Address:

Communication Preference:

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

- English
- Arabic
- Chinese
- French
- German
- Japanese
- Polish
- Russian
- Spanish
- Other

End Date: 12/31/2999

Facility Details

State Facility ID:

Fiscal Year End Date: 10/17
(mm/dd)

Address List

Add Address

Address Type

Location

Address

End Date

12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS

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First Prev Next Last

- Click Add Address

Application ID: 20171108782732

Name: test

Add Provider Location Address

Type of Address: --SELECT--



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, 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 3:

Address Line 2:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER *

Country: UNITED STATES *

Zip Code: -

- From the drop-down list, select Type of Address
- Complete all fields marked with an asterisk (*)
- Click Validate Address

(Please Note: you should receive confirmation "Address Validation Successful")

- Click Ok

CHAMPS < Provider ▾

Tester, Testing ▾

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> New Enrollment > Atypical Agency Enrollment > General

Application ID: 20171108782732 Name: 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: Office Hours: ▾ Communication Preference: ▾

Handicap Accessible: No ▾

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

Language(s) Spoken:

English
Arabic
Chinese
French
German
Japanese
Polish
Russian
Spanish
Other

(For Multiple Selection, use Ctrl Key)

End Date: 12/31/2999

Facility Details

State Facility ID: Fiscal Year End Date: 10/17 *
(mm/dd)

Address List

Add Address

Address Type	Address	End Date
<input type="checkbox"/> Δ ▾	Δ ▾	Δ ▾
<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

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

- 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



Provider

Tester, Testing

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New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Close

Add

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

Locations List

Filter By



Go

Save Filters

My Filters

Doing Business As

Location Type

Location Details

End Date



▲▼

▲▼

▲▼

▲▼



Primary Practice Location

12/31/2999

Delete

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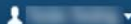
Next

Last

- Click Close



Provider ▾



Quick Find

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★ My Favorites ▾

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Help

New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
Step 2: Add Locations	Required	11/08/2017	11/08/2017	Complete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add Additional Information	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required			Incomplete	
Step 15: Submit Enrollment Application for Approval	Required			Incomplete	

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- Step 2 is complete
- Click on Step 3: Add Specialties



Provider ▾



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Print

Help

Home > New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Close

Add



Specialty/Subspecialty List



Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty



Provider Type



End Date



No Records Found !

- Click Add

Application ID: 20171108782732

Name: test

Add Specialty/Subspecialty

Location: 01- ▾ *

Provider Type: ---SELECT--- ▾ *

Specialty: ▾ *

End Date: 

Add Subspecialty

Available Subspecialties

Associated Subspecialties *



✓ OK

Cancel

- Choose appropriate Location, Provider Type, and Specialty (*Please Note: There is no need to fill in an End Date*)
- Dependent on the Specialty chosen, Available Subspecialties will populate
- Select Available Subspecialties, click >> to add to Associated Subspecialties list
- Click Ok

Provider

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New Enrollment
Atypical Agency Enrollment

Application ID: 20171108782732
Name: test

Close
Add

Specialty/Subspecialty List

Filter By
Go
Save Filters
My Filters

Specialty/Subspecialty	Provider Type	End Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ATYPICAL AGENCY	12/31/2999

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- Once all Specialties/Subspecialties have been added, click Close



Provider ▾



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New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
Step 2: Add Locations	Required	11/08/2017	11/08/2017	Complete	
Step 3: Add Specialties	Required	11/08/2017	11/08/2017	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add Additional Information	Required			Incomplete	Please add Contacts information.
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Optional			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required			Incomplete	
Step 15: Submit Enrollment Application for Approval	Required			Incomplete	

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- Step 3 is complete (Please Note: Steps 4 is optional)
- Click on Step 5: Add Additional Information


Provider

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New Enrollment
Atypical Agency Enrollment

Application ID: 20171108782732
Name: test

Close

Contact List

Add

Filter By
Go
Save Filters
My Filters

Contact Type	First Name	Last Name	Address	Location Name	Start Date	End Date
No Records Found !						

Identifier List

Add

Filter By
Go
Save Filters
My Filters

Identifier Type	Identifier Value	Location Name	Start Date	End Date
No Records Found !				

Bed Information

Add

Filter By
Go
Save Filters
My Filters

- Under Contact List, click Add

(Please Note: Providers have to at least fill in the General contact for Type of Contact. It is highly recommended providers fill in Facility Settlement contact as well. These contacts can be the same as the Owners.)

Application ID: 20171108782732

Name: test

Add Contact

Location: 01- ▾ *

Type of Contact: General ▾ *

Title: --SELECT-- ▾ *

First Name: *Last Name: *Phone Number: *Fax Number: Email Id: Start Date:  *End Date: Address Line 1: *Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town: OTHER ▾ *

State/Province: OTHER ▾ *

County: OTHER ▾

Country: UNITED STATES ▾ *

Zip Code: -  OK  Cancel

- Complete all fields marked with an asterisk (*)
- Click Validate Address (*Please Note: you should receive confirmation "Address Validation Successful"*)
- Click Ok

Application ID: 20171108782732

Name: test

Close

Contact List

Add

Filter By ▾

Go

Save Filters

My Filters ▾

Contact Type	First Name	Last Name	Address	Location Name	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> General					11/01/2017	12/31/2999

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First Prev Next Last

Identifier List

Add

Filter By ▾

Go

Save Filters

My Filters ▾

Identifier Type	Identifier Value	Location Name	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼
No Records Found !				

Delete View Page: 1 Go Page Count SaveToXLS

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First Prev Next Last

Bed Information

Add

- Under Identifier List, click Add

CHAMPS

Provider

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

Print Help

Application ID: 20171108782732 Name: test

Add Identifier

Identifier Type: School Code * Location: 01- *

Identifier Value: *

Notes:

Start Date: * End Date: *

OK Cancel

- Complete all fields marked with an asterisk (*)
- Click Ok

Application ID: 20171108782732

Name: test

Close

Contact List

Add

Filter By ▾

Go

Save Filters

My Filters ▾

Contact Type	First Name	Last Name	Address	Location Name	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> General					11/01/2017	12/31/2999
<input type="checkbox"/> Settlement Contact					11/01/2017	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS

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Identifier List

Add

Filter By ▾

Go

Save Filters

My Filters ▾

Identifier Type	Identifier Value	Location Name	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> School Code			11/01/2017	12/31/2999

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Bed Information

- After all Contact and Identifier information is complete, click Close



Provider ▾



Quick Find

Note Pad

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Print

Help

New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
Step 2: Add Locations	Required	11/08/2017	11/08/2017	Complete	
Step 3: Add Specialties	Required	11/08/2017	11/08/2017	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add Additional Information	Required	11/08/2017	11/08/2017	Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Optional			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required			Incomplete	
Step 15: Submit Enrollment Application for Approval	Required			Incomplete	

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Last

- Step 5 is complete (Please Note: Steps 6 through 8 are optional)
- Click on Step 9: Add Provider Controlling Interest/Ownership Details
 - *The screens for this step were updated 12/14/18

Provider

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New Enrollment
FAO Enrollment
General

Application ID: 20181204526214
Name: Testing

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. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:
 - Corporate - Charitable 501(c)3
 - Corporate - Non Charitable
 - Corporate - Publicly Traded
 - Corporate - Not Publicly Traded
 - Sub-contractor
 - Holding Company
 - Foreign, Nonresident Alien
 - Limited liability Company
 - Indirect Owner

Owners List

Filter By And

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/>								

No Records Found !

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

Filter By

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>		

No Records Found !

- To enter owner information, click Actions

Provider

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Note Pad

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New Enrollment

FAO Enrollment

General

Application ID: 20181204526214

Name: Testing

Close

Actions

Pe

Add Owner

Import Owner

Owners Relationships

Owners Adverse Action

PROVIDER

DISCLOSURES

Provider E

ome address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED OWNERS

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. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:
 - Corporate - Charitable 501(c)3
 - Corporate - Non Charitable
 - Corporate - Publicly Traded
 - Corporate - Not Publicly Traded
 - Sub-contractor
 - Holding Company
 - Foreign, Nonresident Alien
 - Limited liability Company
 - Indirect Owner

Owners List

Filter By

And

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
No Records Found !								

Add Other Owned Entity

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

Filter By

Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

- Select Add Owner

CHAMPS < Provider ▾

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Application ID: 20171108782732 Name: test

Provider Controlling Interest/Ownership

→ Type: * ⓘ

Percentage Owned: *

SSN:

EIN/TIN:

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

Entity Business Name:
(Doing Business As)

First Name:

Last Name:

Suffix: ▾

DOB: ⓘ

Phone Number: * Extn:

Email:

Start Date: ⓘ *

End Date: ⓘ

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

Address Line 2:

Address Line 3:

City/Town: ▾ *

State/Province: ▾ *

County: ▾

Country: ▾ *

Zip Code: -

- Select an Owner Type from the drop-down menu
- Complete all fields marked with an asterisk (*)
- Complete Address Line 1 and Zip Code, click Validate Address
(Please Note: you should receive confirmation "Address Validation Successful")
- Click Ok

CHAMPS Provider

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New Enrollment Individual Enrollment General

Application ID: 20181204171383 Name: Test, Testing

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. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By And Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
123456789	Example,One	Managing Employee	100 N Capital Ave	01/01/2015	12/31/2999	Not Completed	Not Completed	0
	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Not Completed	Not Completed	100

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

Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By And Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address

No Records Found !

- The managing employee is now added to the list of owners
- To add the relationship click the Actions drop-down menu
 - Note: The Relationship status for the individual provider enrolling is now marked as Not Completed

Application ID: 20181204171383

Name: Test, Testing

Close

+ Actions ▾



- There Add Owner ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least Import Owner icers/Principal is required if one of the ownership types below is selected:
 - 501[c]3 Corporate - Not Publicly Traded Foreign, Nonresident Alien
 - Partnership Sub-contractor Limited liability Company
 - Owners Relationships Sole proprietorship Holding Company Indirect Owner
 - Owners Adverse Action

Owners List

Filter By

And

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>
123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Not Completed	Not Completed	0
	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Not Completed	Not Completed	100

Delete

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Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By <div><div></div></div> <div></div> <div></div> <div>Go</div>		<div>Save Filters</div>	<div>My Filters</div>
Other Owner EIN/TIN	Other Owner Information	Address	
<div>▲▼</div>	<div>▲▼</div>	<div>▲▼</div>	
No Records Found !			

- Select Owners Relationships from the Actions drop-down menu

CHAMPS Provider

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

Print Help

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Test, Testing SSN/EIN/TIN: Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Test, Testing	Relation to Assoc. Owner
Example, One	123456789	Managing Employee		
Test, Testing		Individual		None

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Selected Owner: Example, One SSN/EIN/TIN: 123456789 Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Answer question (at the top)
- If no relationships exist select No.
 - If the owners have a relationship to one another, refer to the [Step 8: Add Provider Controlling Interest/Ownership Details](#) user guide.

CHAMPS Provider

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

Print Help

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☒ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

> Selected Owner: Test, Testing	SSN/EIN/TIN:	Status: Not Completed
> Selected Owner: Example, One	SSN/EIN/TIN: 123456789	Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- The owner list boxes collapse
- Click Save

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

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

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☒ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Test, Testing	SSN/EIN/TIN	Status: Not Completed
Selected Owner: Example, One	SSN/EIN/TIN: 123456789	

Message from webpage

? All owner relationships will be set to 'None'. Do you want to continue?

OK Cancel

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- After clicking save, click Ok.

CHAMPS

Provider

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

Print Help

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

> Selected Owner: Test, Testing	SSN/EIN/TIN: [REDACTED]	Status: Completed
> Selected Owner: Example, One	SSN/EIN/TIN: 123456789	Status: Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- The status for each owner will show Completed
- Click close to return to the owner list screen

Provider

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New Enrollment

Individual Enrollment

General

Application ID: 20181204171383

Name: Test, Testing

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. Corporate - Charitable 501[c]3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501[c]3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By

And

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/>	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100

Delete

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Add Other Owned Entity

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

Filter By

Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>		

No Records Found !

- The Relationship Status now shows Completed for both owners



Provider



Last Login: 04 DEC, 2018 11:42 AM

Note Pad

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New Enrollment > Individual Enrollment > General

Application ID: 20181204171383

Name: Test, Testing

Close

Actions



- There Add Owner ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least Import Owner Officers/Principal is required if one of the ownership types below is selected:
 - 501[c]3 Corporate - Not Publicly Traded Foreign, Nonresident Alien
 - Partnership Sub-contractor Limited liability Company
 - Partnership Holding Company Indirect Owner

Owners List

Filter By



And

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/> !	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100

Delete 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



Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/> ▲▼	▲▼	▲▼
No Records Found !		

- Select Owners Adverse Action from the Actions drop-down menu to complete the Final Adverse Legal/Action/Convictions Disclosure

CHAMPS Provider

https://milogintp.michigan.gov/ - Owners with Adverse Action - Internet Explorer

Print Help

Application ID: 20181204171383 Name: Test, Testing

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries or recipients. Offenses include, but are not limited to: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any misdemeanor or felonies that may result in a mandatory or permissive exclusion under State or Federal law.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owners with Adverse Action

Owner Name	Response	Comments
Test, Testing	<input type="radio"/> Yes <input type="radio"/> No	
Example, One	<input type="radio"/> Yes <input type="radio"/> No	

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Ok Cancel

Page ID: pgEnrlmntAdverseAction(Provider)

- Read through Final Adverse Legal Actions/Convictions statement for each owner listed, select Yes or No

Application ID: 20181204171383

Name: Test, Testing

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owners with Adverse Action

Owner Name ▲▼	Response ▲▼	Comments ▲▼
Test, Testing	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Example, One	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>

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☒ Ok☐ Cancel

- Click Ok

Provider

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New Enrollment

Individual Enrollment

General

Application ID: 20181204171383

Name: Test, Testing

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

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- 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. Corporate - Charitable 501[c]3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:
 - Corporate - Charitable 501[c]3
 - Corporate - Non Charitable
 - Corporate - Publicly Traded
 - Corporate - Not Publicly Traded
 - Sub-contractor
 - Holding Company
 - Foreign, Nonresident Alien
 - Limited liability Company
 - Indirect Owner

Owners List

Filter By

And

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My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	No	0
<input type="checkbox"/>	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	No	100

Delete

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Add Other Owned Entity

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

Filter By

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Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>		

No Records Found !

- The Adverse Action column will show Yes or No indicating it's complete.
- Click Close



Provider ▾



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Help

New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
Step 2: Add Locations	Required	11/08/2017	11/08/2017	Complete	
Step 3: Add Specialties	Required	11/08/2017	11/08/2017	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add Additional Information	Required	11/08/2017	11/08/2017	Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Optional			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	11/08/2017	11/08/2017	Complete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required			Incomplete	
Step 15: Submit Enrollment Application for Approval	Required			Incomplete	

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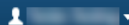
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- Step 9 is complete
- Click on Step 14: Complete Enrollment Checklist



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New Enrollment > Atypical Agency Enrollment > Provider Check List

Application ID: 20171108782732

Name: test

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Provider Checklist

Question	Answer	Comments
Are you interested in working for other Home Help clients? (If you say no this will not affect your current work.)	Not Completed ▾	
If you are interested in working for other clients do you authorize us to put your contact information on our Provider Registry List so that you can be contacted for additional work?	Not Completed ▾	
Do you want your name removed from our Provider Registry?	Not Completed ▾	
Have you ever been removed or told that you cannot participate in a State funded program? If yes, please tell us what program and why.	Not Completed ▾	
Have you ever been removed or told that you cannot participate in a Federally funded program? If yes, please tell us what program and why.	Not Completed ▾	
Have you ever had any criminal convictions? If yes, please tell us what for?	Not Completed ▾	
Do you perform services as an agency with 2 or more employees?	Not Completed ▾	
What county do you plan to work in?	Not Completed ▾	
What is the name of the Adult Services Worker you are working with?	Not Completed ▾	
Are you a Medicare certified home health agency?	Not Completed ▾	
I understand that my information will be used to conduct a review of my criminal history I may have and the results of that review could possibly make me ineligible to work as a provider in the Home Help program. I also understand that the results of my criminal history screening will be shared with necessary MDCH and MDHS staff, as well as any potential client.	Not Completed ▾	
I also acknowledge that I am required to update any changes in the enrollment within 10 days of that change.	Not Completed ▾	
All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?	Not Completed ▾	

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- Answer each question in the Provider Checklist as appropriate
- Add Comments when necessary
- Click Save
- Click Close



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> New Enrollment > Atypical Agency Enrollment

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Name: test

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Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
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Step 3: Add Specialties	Required	11/08/2017	11/08/2017	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add Additional Information	Required	11/08/2017	11/08/2017	Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
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Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required	11/08/2017	11/08/2017	Complete	
Step 15: Submit Enrollment Application for Approval	Required			Incomplete	

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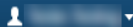
- Step 14 is complete
- Click on Step 15: Submit Enrollment Application for Approval

(Please Note: If you chose not to complete optional steps you can still submit your application)

You must complete step 15 to submit your application



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> New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

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Next



Final Submission



Application ID: 20171108782732

EnrollmentType: Atypical Agency Provider

The information submitted for enrollment 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



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New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

 After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.**Terms and Conditions Atypical Enrollment****Participation as Home Help Provider**

1. As an individual provider of Home Help services, I agree that the Medicaid beneficiary is considered the employer. I am not employed by the Michigan Department Of Health and Human Services (MDHHS), the Department of Human Services (DHS), or the State of Michigan.
2. As a Home Help provider agency, I agree that the agency contract is with the Medicaid beneficiary. The agency contract is not with the Michigan Department Of Health and Human Services (MDHHS), the Department of Human Services or the State of Michigan.
3. I agree that personal care services will be provided for a Michigan Medicaid beneficiary, as authorized by the Michigan Department of Human Services (DHS) according to the DHS Adult Services Comprehensive Assessment.
4. Under Section 3504 of the Internal Revenue Code, I agree to accept the Michigan Department Of Health and Human Services (MDHHS) as the acting agent of the beneficiary for the deduction of withholding of FICA taxes. I understand that federal, state and city taxes are not withheld. I further agree to accept payments issued by MDHHS as payment in full and not to seek or accept additional payments from the beneficiary or any other source.
5. I agree to return any payments received for Home Help services not provided. I understand that accepting payment for services I did not provide is fraudulent and could result in criminal charges.
6. I understand that the Home Help program is funded by Medicaid and payments will not be approved by the Department if the beneficiary's Medicaid eligibility is inactive.
7. In order to receive payment, I agree to keep and submit to MDHHS, DHS or their designee, any and all records necessary to disclose the extent of services provided to the beneficiary.
8. Upon request, I agree to provide MDHHS, DHS or their designee, any information regarding services or purchases for which payment was made.
9. Upon request, I agree to provide MDHHS, DHS or their designee, any business transaction information as specified by 42 CFR 455.105.
10. I understand I will be subject to a criminal history screening and may not qualify to be a home help provider.
11. I agree to cooperate with MDHHS, DHS or their designee, regarding any audits, investigations or inquiries related to Home Help services provided.
12. I agree to report any changes relative to the beneficiary including but not limited to hospitalizations, nursing home stays or discontinuation of services.
13. I agree to comply with the privacy, security and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information (PHI), 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 106 and 164, Subparts A, C, and E).
14. I agree to comply with the provisions of 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.

- Read through the entire list of Terms and Conditions



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New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Close

Submit Application

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

17. To be clean and maintain a neat appearance at all times.
18. To be polite and courteous to riders; riders shall be treated with respect and in a culturally appropriate manner when receiving transportation services. The Manager should notify the volunteer driver of any known cultural issues significant to providing transportation services.
19. To limit review of any confidential rider information to the minimum information necessary to provide the service.
20. To only use or record confidential rider information as necessary to provide the Department information necessary for the administration of the program (i.e. mileage reimbursement, if applicable).
21. To not retain any original or copy of any document rider shares with you for purposes of transport.
22. To not retain any original or copy of any document that may be provided by a health care provider to driver. Driver agrees to ensure that such documentation leaves with rider.
23. To report any breach of the terms of this user agreement to the Department. This includes, but is not limited to, accidental retention of medical record or other confidential rider information.
24. To return to the Department, as soon as possible, but in no event later than 3 business days after discovery, any confidential rider information retained left with driver after completing transport of the rider.
25. To never discuss, write, or share in any other format any information specific to a rider, except as necessary to communicate with the Department or with a health care provider or other staff at a facility rider is being transported to.
26. Not input or include any confidential rider information in any computer system of any kind, except as approved by the Department. This includes personal email accounts, file transfer systems, note applications, and any other electronic system of recording data not expressly approved for use by the Department.
27. Comply with any other agreements driver has entered into with respect to this program.
28. Respect the rider's privacy by not asking for more information about the individual's condition, reason for visit, or other personal information, while providing transport services. If the rider chooses to voluntarily share this information, it is subject to the same protections described above regarding protecting rider information.



By checking this, I acknowledge that I have read the terms and agreement and I agree to fully comply with all program requirements.

- Check the box at the end to agree to the Terms and Conditions
- Click Submit Application

Provider ▾

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> New Enrollment > Atypical Agency Enrollment

Application ID: 20171108782732
Name: test

Your Application Number 20171108782732 has been successfully submitted for State review. Return with this application number to track the status of your application.

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
Step 2: Add Locations	Required	11/08/2017	11/08/2017	Complete	
Step 3: Add Specialties	Required	11/08/2017	11/08/2017	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add Additional Information	Required	11/08/2017	11/08/2017	Complete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Optional			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	11/08/2017	11/08/2017	Complete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required	11/08/2017	11/08/2017	Complete	
Step 15: Submit Enrollment Application for Approval	Required	11/13/2017	11/13/2017	Complete	

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- Step 15 is now complete and the application has been submitted to the State for review
- Take note of your Application ID for further tracking
- Click Close

(Please Note: Optional steps may show as incomplete if you chose not to complete. This is ok.)

Track Application

How to track a submitted application within CHAMPS

The screenshot displays the CHAMPS web application interface. At the top left, the CHAMPS logo is visible. A red rectangle highlights the 'Provider' dropdown menu in the top navigation bar. Below this, a dropdown menu is open, showing 'PROVIDER ENROLLMENT' with two options: 'New Enrollment' and 'Track Application'. A red arrow points to the 'Track Application' option. The main content area shows a 'Provider Enrollment' tab with a table containing two rows: 'New Enrollment' and 'Track Application', each with a corresponding action link.

Provider Enrollment	
New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

- Select Provider tab
- Click Track Application

Close

Next

Track Existing Application

Please provide the Application ID to track your application.

Application ID: *

Request Access to Home Help Provider Info

Click the below link if you are an Existing Home Help Individual or Agency accessing CHAMPS system for the first time. provide the Application ID to track your application.

[Home Help Providers requesting access to their Information.](#)

- Fill in Application ID
- Click Next

CHAMPS < Provider ▾

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Track Application

Close Submit

Verify Application Details

For Additional security, please enter following information:

EIN/TIN: *

Phone: *

Owner SSN: * ⓘ

Owner Date Of Birth: *

- Complete all fields marked with an asterisk (*)
- Click Submit



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Track Application > Atypical Agency Enrollment

Application ID: 20171108782732

Name: test

Your application is currently In-Review by the Provider Enrollment Unit. You cannot make any modifications to your enrollment information at this time.

Close

Enroll Provider - Atypical Agency

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/08/2017	11/08/2017	Complete	
Step 2: Add Locations	Required	11/08/2017	11/08/2017	Complete	
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Step 5: Add Additional Information	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Mode of Claim Submission/EDI Exchange	Optional			Incomplete	
Step 8: Associate Billing Agent	Optional			Incomplete	
Step 9: Add Provider Controlling Interest/Ownership Details	Required	11/08/2017	11/13/2017	Complete	
Step 10: Add Taxonomy Details	Optional			Incomplete	
Step 11: Associate MCO Plan	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: 835/ERA Enrollment Form	Optional			Incomplete	
Step 14: Complete Enrollment Checklist	Required	11/13/2017	11/13/2017	Complete	
Step 15: Submit Enrollment Application for Approval	Required	11/13/2017	11/13/2017	Complete	

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- Confirmation your Provider Enrollment Application has been submitted and is being reviewed by the state
- Click Close

Provider Enrollment Final Steps

- Please allow the State time to review the Provider Enrollment Application.
- After the State has looked over the Provider Enrollment Application Providers will receive a letter letting them know whether they have been approved or denied.
 - Letter is sent to the Correspondence address provided in the Provider Enrollment Application.

Provider Resources

- **MDHHS website:** www.michigan.gov/medicaidproviders
- **We continue to update our Provider Resources, just click on the links below:**
 - [Listserv Instructions](#)
 - [Medicaid Alerts and Biller “B” Aware](#)
 - [Quick Reference Guides](#)
 - [Update Other Insurance NOW!](#)
 - [Medicaid Provider Training Sessions](#)
- **Provider Enrollment:**
 - MSA-AtypicalProviders@michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program