



New Billing Agent Application Instructions

“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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New Billing Agent Overview

- The purpose of this presentation is to provide guidance to entities seeking to complete a new billing agent application.
- An authorized billing agent **MUST** be able to complete HIPAA-compliant transactions through the use of v5010 software, review the Electronic Submissions Manual, Companion Documents, and successfully complete file testing.
- All new Billing Agent applications must be completed utilizing the CHAMPS system.

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 provided.

MILogin for Third Party

User ID

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

MI Login 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

MI Login for Third Party

[HOME](#)

Create Your Account



Security Setup

Provide user id and password information to complete your profile

* Required

* User ID

* Password

* Confirm New Password

* Security Options

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



i 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

LOGIN

[Don't have an account?](#)

SIGN UP

[Forgot your User ID?](#)

[Forgot your password?](#)

[Need Help?](#)


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- 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.

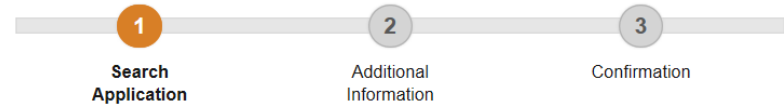
- Your Home Page will not show any applications
- Click Request Access

**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

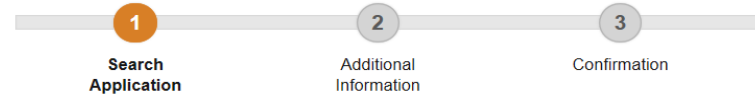
Search for an application with a keyword or select an agency to view its applications

- 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



Search Application

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

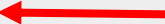


-- Select Agencies --



Michigan Department of Health & Human Services (MDHHS)

CHAMPS



- Click on 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

I agree to the terms & conditions ←

I do not agree

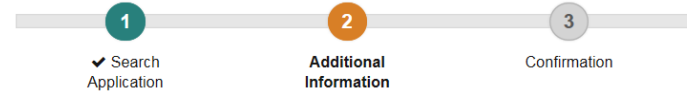
CANCEL ✕ **REQUEST ACCESS**

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

MI Login for Third Party

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

Request Access



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

The screenshot shows the Michigan.gov website interface. At the top left is the Michigan.gov logo. At the top right are links for HELP and CONTACT US. The main heading is "MILogin for Third Parties". Below this are navigation links for HOME and REQUEST ACCESS. A notification states "Your password will expire in 42 days". A button for "Access your applications by clicking on the" is visible. The MDHHS logo and "Michigan Department of Health & Human Services" are also present. At the bottom left, the "CHAMPS" link is highlighted. A modal window titled "Terms & Conditions" is open in the center. The modal contains the following text:

Terms & Conditions
The Michigan Department of Health & Human Services (MDHHS) computer information system (systems) are the property of the State Of Michigan and subject to state and federal 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. By accessing information provided by the Michigan Department of Health & Human Services computer information systems and clicking on the button below, I acknowledge and agree to abide by all governing privacy and security terms,

At the bottom of the modal are two buttons: "CANCEL ✕" and "Acknowledge/Agree". A red arrow points to the "Acknowledge/Agree" button.

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

Billing Agent Application

CHAMPS Application

Provider Enrollment



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

- Click New Enrollment

☰ Enrollment Type

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
 - Regular Individual/Sole Proprietor or Rendering/Service 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 Billing Agent
- Click Submit

https://milogintpmichigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Basic Information

Entity Business Name: * (Doing Business As)

Indicate Claim Submission Type: Dental Institutional Professional * (Must select at least one claim type)

Support Contact

First Name: * Middle Initial:

Last Name: *

Phone Number: * Extn:

Fax Number:

Contact Email Address:

Email-1: * Email-2:

Email-3: Email-4:

Email-5: Email-6:

Technical Contact

Same as Support Contact

First Name: * Middle Initial:

Last Name: *

Phone Number: * Extn:

Fax Number:

Contact Email Address:

Email-1: * Email-2:

Email-3: Email-4:

Email-5: Email-6:

Billing Agent Address Details

End Date:

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: * Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3: City/Town: OTHER *

Page ID: dlqAddBasicInformationStep1(Provider)

- Complete all fields marked with an asterisk (*)
- The technical contact is used by Automated Billing as a point of contact for issues related to electronic files or FTS Password reset requests
- Click Finish

CHAMPS < My Inbox > Provider >

https://milogintpmichigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20180404470595 Name: Testing Billing Agent

Basic Information

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: **20180404470595**

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

Page ID: dlgAddBasicInformationStep3(Provider)

Submit

Ok

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

Application ID: 20180404470595

Name: Testing Billing Agent

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	04/04/2018	04/04/2018	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 4: Upload Documents	Optional			Incomplete	
Step 5: Complete Enrollment Checklist	Required			Incomplete	
Step 6: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Viewing Page: 1

- Billing Agent Enrollment steps are listed (Please Note: some steps are required versus optional)
- Step 1 has a status of Complete
- Click on Step 2: Add Mode of Claim Submission/EDI Exchange

Application ID: 20180404470595

Name: Testing Billing Agent

Mode of Claims Submission/EDI exchange

Please select the submission methods from EDI Exchange and/or Other Claims Submission as applicable.

EDI exchange

Method	Description	Applicable Transactions
<input type="checkbox"/> Electronic Batch	To upload/download HIPAA transactions from screens (Maximum file upload size is 50MB)	837P- Professional (FFS), 837I -Institutional(FFS), 837D -Dental(FFS), 270/271 -Eligibility,Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> CORE Batch	To upload/download HIPAA transactions using CORE Batch Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 835 Health Care Claim Payment/Advice
<input type="checkbox"/> CORE Real Time	To upload/download HIPAA transactions using CORE Real Time Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> Data Exchange Gateway (DEG)	To submit/receive HIPAA Transactions via Data Exchange Gateway (DEG) using SFTP/SSLFTP/HTTPS	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter),837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice NCPDP Post Adjudication

- Check each mode of claim submission applicable (Please Note: DEG has been renamed to File Transfer Service FTS)
- Click ok

Application ID: 20180404470595

Name: Testing Billing Agent

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	04/04/2018	04/04/2018	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	04/04/2018	04/04/2018	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 4: Upload Documents	Optional			Incomplete	
Step 5: Complete Enrollment Checklist	Required			Incomplete	
Step 6: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

- Step 2 has a status of Complete
- Click on Step 3: Add Provider Controlling Interest/Ownership Details

Application ID: 20180404470595

Name: Testing Billing Agent

Close Add

Owners List

Filter By [] [] Go

Save Filters My Filters ▾

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼
No Records Found !				

Add Other Owned Entity

List Ownership Interest in other Entities reimbursible 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 !		

- To enter owner information, click Add

Application ID: 20180404470595

Name: Testing Billing Agent

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: * - Validate Address
OK [Cancel](#)

- 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

Application ID: 20180404470595

Name: Testing Billing Agent

Close Add

Owners List

Filter By Go Save Filters My Filters ▾

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
<input type="checkbox"/> 123456789	Testing Billing Agent	Corporate - Non Charitable	01/01/2018	12/31/2999
<input type="checkbox"/>	board,director	Board of Directors/Officers/Principles	01/01/2018	12/31/2999
<input type="checkbox"/>	testing,test	Managing Employee	01/01/2018	12/31/2999

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 reimbursible by Medicaid and/or Medicare.

Filter By Go Save Filters My Filters ▾

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

- After entering all required Owner Types, continue to Ownership Details;
- Click on Owner ID hyperlink
(Please Note: this process must be completed for all Owner Types listed)

Application ID: 20180404470595

Name: Testing Billing Agent

Close Save

Modify Provider Controlling Interest/Ownership

Type: Percentage Owned: *

SSN: EIN/TIN: *

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

First Name: Last Name:

Suffix: DOB:

Phone Number: * Extn: Email:

Start Date: * End Date:

Address Type: Business Address

Address Line 1: * Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

State/Province: * City/Town: *

Country: * County: *

Zip Code: * -

Relationship

Add Inactivate

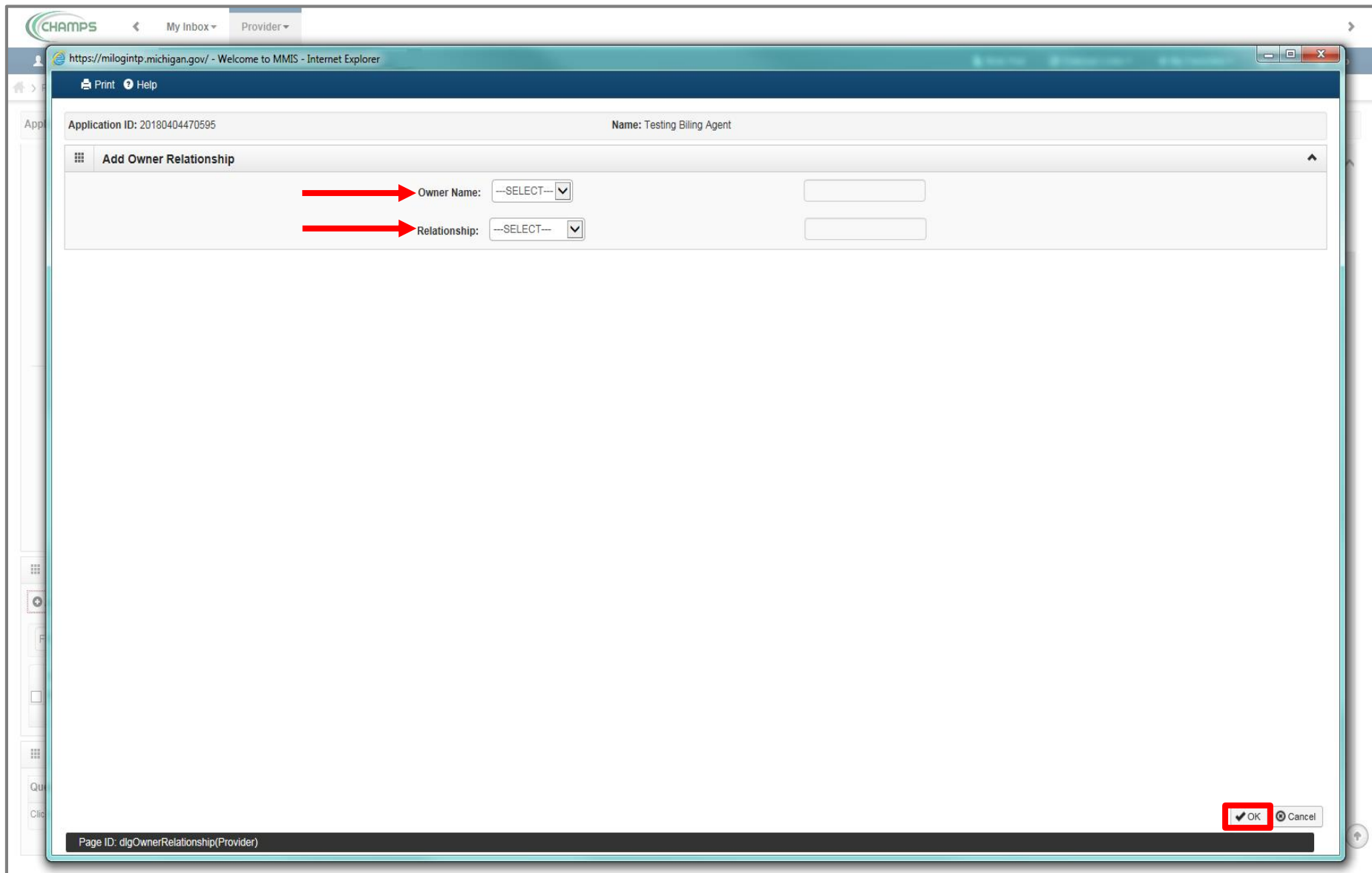
Filter By

Owner Name	Relationship	Modified Date	Operational Status
No Records Found !			

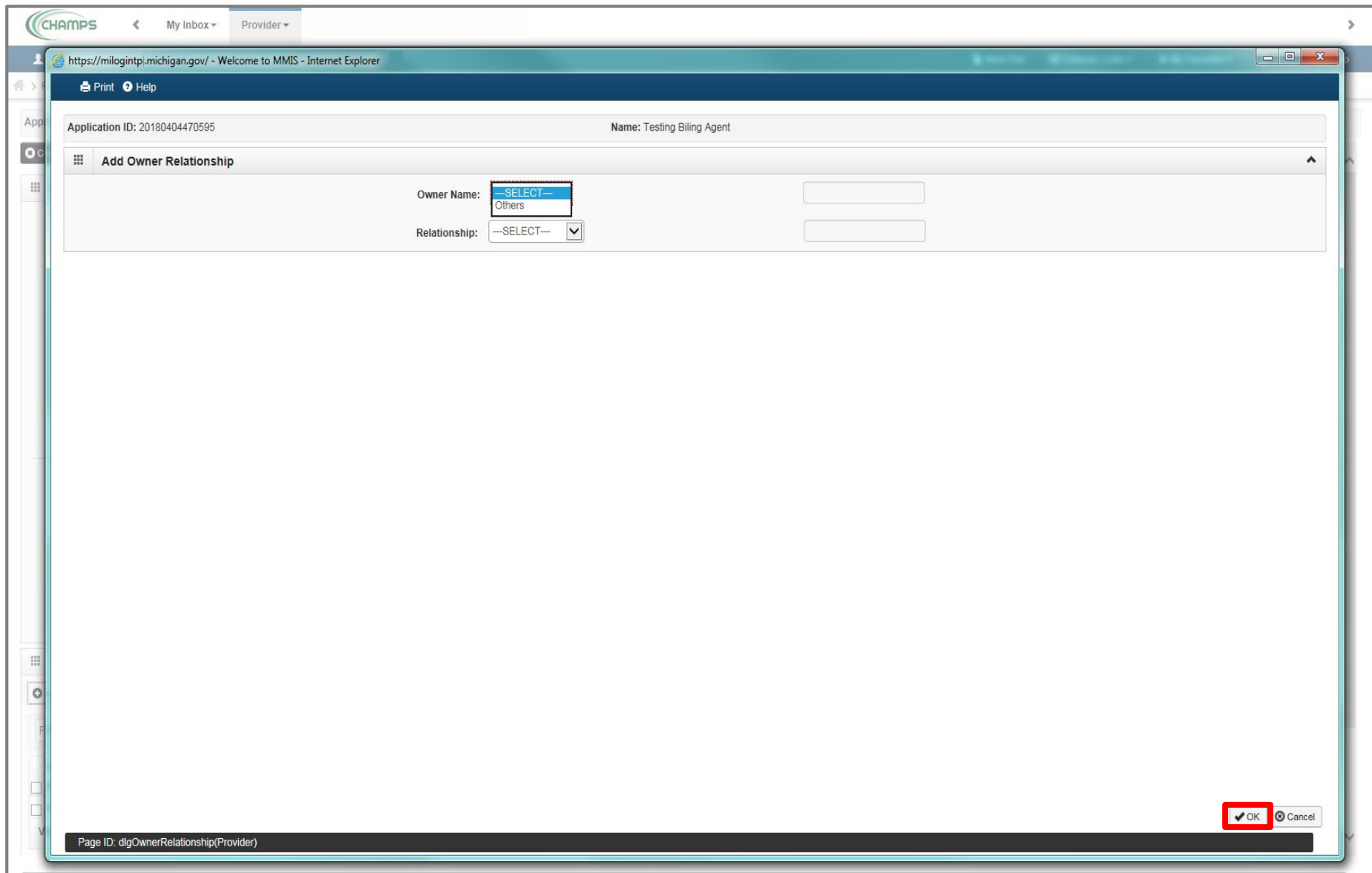
Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

- To enter relationship information for all owner types, click Add
- To review what relationship is required when each owner is entered review http://www.michigan.gov/documents/mdhhs/PE_ownership_step_616880_7.pdf



- Select Owner Name *(Name of self if there is only one owner or name of other Owner Type if multiple)*
- Select Relationship *(From Owner to Owner it would be self or Owner to Managing Employee could be Spouse or None)*
- Click Ok



- Please Note: If you click on Add, under Relationships, and you receive this screen where Owner Name only shows Others; you are no longer required to enter additional relationships.
- Click Cancel

Application ID: 20180404470595

Name: Testing Billing Agent

Close Save

Modify Provider Controlling Interest/Ownership

Type:		Percentage Owned:	100 *
SSN:	<input type="text"/>	EIN/TIN:	123456789 *
Legal Entity Name:	Testing Billing Agent * <small>(As shown on the Income Tax Return)</small>	Entity Business Name:	Testing Billing Agent * <small>(Doing Business As)</small>
First Name:	<input type="text"/>	Last Name:	<input type="text"/>
Suffix:	<input type="text"/>	DOB:	<input type="text"/>
Phone Number:	(517) 333-3333 * Extn: <input type="text"/>	Email:	<input type="text"/>
Start Date:	01/01/2018 * <input type="text"/>	End Date:	12/31/2999 * <input type="text"/>

Address Type: Business Address

Address Line 1:	320 S Walnut St * <small>(Enter Street Address or PO Box Only)</small>	Address Line 2:	<input type="text"/>
Address Line 3:	<input type="text"/>	City/Town:	LANSING *
State/Province:	MICHIGAN *	County:	INGHAM *
Country:	UNITED STATES *	Zip Code:	48933 * - 2014 <input type="button" value="Validate Address"/>

Relationship

Add Inactivate

Filter By

Owner Name	Relationship	Modified Date	Operational Status
<input type="checkbox"/> board_director	None	04/04/2018 13:11:20	Active
<input type="checkbox"/> testing_test	Self	04/04/2018 13:05:32	Active

View Page: 1 Viewing Page: 1

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

- Once a Relationship is created for each Owner Type
- Click the hyperlink, Final Adverse Legal/Action/Convictions Disclosure

Application ID: 20180404470595

Name: Testing Billing Agent

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. Offenses include: 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 felonies that would result in a mandatory exclusion under Section 1129(a) of the Social Security Act.
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

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? Yes No

Comments (optional): Ok Cancel

- Read through Final Adverse Legal Actions/Convictions statement, check Yes or No
- Click Ok

Application ID: 20180404470595

Name: Testing Billing Agent

Close Save

Modify Provider Controlling Interest/Ownership

Type: Percentage Owned: 100 *

SSN: EIN/TIN: 123456789 *

Legal Entity Name: Testing Billing Agent * (As shown on the Income Tax Return) Entity Business Name: Testing Billing Agent * (Doing Business As)

First Name: Last Name:

Suffix: DOB:

Phone Number: (517) 333-3333 * Extn: Email:

Start Date: 01/01/2018 * End Date: 12/31/2999 *

Address Type: Business Address

Address Line 1: 320 S Walnut St * (Enter Street Address or PO Box Only) Address Line 2:

Address Line 3:

State/Province: MICHIGAN * City/Town: LANSING * County: INGHAM * Zip Code: 48933 * - 2014 Validate Address

Country: UNITED STATES *

Relationship

Add Inactivate

Filter By Go Save Filters My Filters

Owner Name	Relationship	Modified Date	Operational Status
<input type="checkbox"/> board_director	None	04/04/2018 13:11:20	Active
<input type="checkbox"/> testing_test	Self	04/04/2018 13:05:32	Active

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

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Completed	No	

- After you have completed all required Relationships and read and completed Final Adverse Legal Actions/Convictions statement, click Save
- Click Close

Application ID: 20180404470595

Name: Testing Billing Agent

Close Add

Owners List

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

Save Filters My Filters ▾

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 123456789	Testing Billing Agent	Corporate - Non Charitable	01/01/2018	12/31/2999
<input type="checkbox"/> [blurred]	board_director	Board of Directors/Officers/Principles	01/01/2018	12/31/2999
<input type="checkbox"/> [blurred]	testing.test	Managing Employee	01/01/2018	12/31/2999

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

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

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

Save Filters My Filters ▾

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

No Records Found !

- After going through each Owner ID, completing the required Relationships and reading and completing the Final Adverse Legal Actions/Convictions statement, click Close

Application ID: 20180404470595

Name: Testing Billing Agent

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	04/04/2018	04/04/2018	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	04/04/2018	04/04/2018	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	04/04/2018	04/04/2018	Complete	
Step 4: Upload Documents	Optional			Incomplete	
Step 5: Complete Enrollment Checklist	Required			Incomplete	
Step 6: Submit Enrollment Application for Approval	Required			Incomplete	

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- Step 3 is complete
- Click on Step 4: Upload Documents *(Please Note: This step is optional)*

Application ID: 20180404470595

Name: Testing Billing Agent

Close

Document List

Add

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

Save Filters My Filters ▾

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Status
-------------	---------------	---------------	-----------	------------	----------	-------------	---------------	--------

No Records Found !

- This step is optional, if documentation needs to be uploaded, click Add
- If not, click Close

Application ID: 20180404470595

Name: Testing Billing Agent

Upload Document

Document Type: *

- Certification
- Contract
- General
- License

Document Name: *

Program Name:

Associated MCO ID:

File Name:

Start Date:

End Date:

Remark:

- If billing agent chooses to upload a document;
- Select the document type and document name
- Click Browse to find the saved document on your computer
- Enter any other additional information
- Click Ok

Application ID: 20180404470595

Name: Testing Billing Agent

Close

Document List

Add

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

Save Filters My Filters ▾

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Status
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>	Certification	CMS Certification Letter					04/04/2018	In Process

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- The documentation has been added
- To return to the enrollment steps, click Close

Application ID: 20180404470595

Name: Testing Billing Agent

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	04/04/2018	04/04/2018	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	04/04/2018	04/04/2018	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	04/04/2018	04/04/2018	Complete	
Step 4: Upload Documents	Optional	04/04/2018	04/04/2018	Complete	
Step 5: Complete Enrollment Checklist	Required			Incomplete	
Step 6: Submit Enrollment Application for Approval	Required			Incomplete	



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- Step 4 is complete
- Click on Step 5: Complete Enrollment Checklist

Application ID: 20180404470595

Name: Testing Billing Agent

Close Save

Provider Checklist

Question	Answer	Comments
Are you able to produce HIPAA-Compliant v 5010A1 or 5010A2 transactions?	Not Completed ▾	<input type="text"/>
Will you be submitting claims directly to Michigan Medicaid?	Not Completed ▾	<input type="text"/>
Have you viewed the Electronic Submissions Manual, Companion Documents and Implementation Guides?	Not Completed ▾	<input type="text"/>
Would you be willing to submit HIPAA-Compliant transactions for new providers?	Not Completed ▾	<input type="text"/>
Will you be submitting HIPAA 270/271 Eligibility (Inquiry/Response) transactions?	Not Completed ▾	<input type="text"/>

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- Answer the questions in the Provider Checklist
- Add Comments when necessary
- Click Save
- Click Close

Application ID: 20180404470595

Name: Testing Biling Agent

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	04/04/2018	04/04/2018	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	04/04/2018	04/04/2018	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	04/04/2018	04/04/2018	Complete	
Step 4: Upload Documents	Optional	04/04/2018	04/04/2018	Complete	
Step 5: Complete Enrollment Checklist	Required	04/04/2018	04/04/2018	Complete	
Step 6: Submit Enrollment Application for Approval	Required			Incomplete	

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- Step 5 is complete
- Click on Step 6: 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 6 to submit your application

Application ID: 20180404470595

Name: Testing Billing Agent

Close **Next**

Final Submission

Application ID: 20180404470595

EnrollmentType: Billing Agent

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

Application ID: 20180404470595

Name: Testing Billing Agent

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

Billing Agent Enrollment & Trading Partner Agreement - Conditions

In applying for enrollment as a provider or trading partner in the Medical Assistance Program (and programs for which the Michigan Department Of Health and Human Services (MDHHS) is the fiscal intermediary), I represent and certify as follows:

1. The applicant, and the employer (if applicable), certify that the undersigned has/have the authority to execute this Agreement.
2. Enrollment in the Medical Assistance Program does not guarantee participation in MDHHS managed care programs nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished on this Medical Assistance Provider Enrollment & Trading Partner Agreement form is true and complete.
4. The providers and fiscal agents of ownership and control information agree to provide proper disclosure of provider's owners and other persons criminal related to Medicare, Medicaid or Title XX involvement. [42 CFR 455.100]
5. The applicant and the employer agree to provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX), and other State Health Care Programs (Title V, Title XX, and Title XXI) involvement since the inception of Medicare, Medicaid, or Title XX programs. [42 CFR 455.106 and 42 U.S.C. § 1320a-7]
6. Before billing for any medical services I render, I will read the Medicaid Provider Manual from the Michigan Department Of Health and Human Services (MDHHS). I also agree to comply with 1) the terms and conditions of participation noted in the manual, and 2) MDHHS's policies and procedures for the Medical Assistance Program contained in the manual, provider bulletins and other program notifications.
7. I agree to comply with the provisions of 42 CFR 455.104, 42 CFR 455.105, 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.
8. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to, or on behalf of, a Medical Assistance Program beneficiary. These records also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or other healthcare provider.
9. I agree to include a clause in any contract I enter into which allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
10. I am not currently suspended, terminated, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.
11. I agree to comply with all policies and procedures of the Medical Assistance Program when billing for services rendered. I also agree that disputed claims, including overpayments, may be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction. I further agree to reimburse the Medical Assistance Program for all overpayments, and I acknowledge that the Medicaid Audit System, which uses random sampling, is a reliable and acceptable method for determining such overpayments.
12. I agree to comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, 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, Public Law 104-191) and Health Information Technology for Economic and Clinical Health (HITECH Act, Public Law

- Read through the entire list of Terms and Conditions

Application ID: 20180404470595

Name: Testing Billing Agent

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

agents, employees, assigns and successors of the Indemnified Party, harmless from and against any and all claims, losses, and actions, including all costs and reasonable attorney fees, caused by the Indemnifying Party or any subcontractor, agent, person or entity under the Indemnifying Party's control, in connection with electronic Transactions.

6. Standard Transactions.

All Standard Transactions, as defined by HIPAA, will be conducted by the parties using only code sets, data elements, and formats specified by the Transaction Rules and instructions in the MDHHS Companion Guides. The parties agree that when conducting Standard Transactions, they will not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.

7. Testing.

All New Trading Partners will cooperate with MDHHS upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with MDHHS upon request in testing processes for any changes in submission format prior to submission of production files. MDHHS will notify the Trading Partner of the effective date for production data after successful testing.

8. Data and Network Security.

The parties agree to use reasonable security measures to protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with MDHHS data and network security requirements, which may change from time to time and as may be required by the HIPAA security regulations.

9. Automatic Amendment for Regulatory Compliance.

This Agreement will automatically be amended to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

10. Miscellaneous.

Provisions 3 and 8 shall survive termination of this Agreement.

The Trading Partner will notify MDHHS of any changes in trading partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at least 30 calendar days prior to the effective date of such change.

By checking this, I certify that I have read and that I agree and accept the enrollment conditions in the Trading Partner Agreement.

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

Application ID: 20180404470595

Name: Testing Billing Agent

Your Application Number 20180404470595 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

Enroll Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	04/04/2018	04/04/2018	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	04/04/2018	04/04/2018	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	04/04/2018	04/04/2018	Complete	
Step 4: Upload Documents	Optional	04/04/2018	04/04/2018	Complete	
Step 5: Complete Enrollment Checklist	Required	04/04/2018	04/04/2018	Complete	
Step 6: Submit Enrollment Application for Approval	Required	04/04/2018	04/04/2018	Complete	

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- Step 6 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 Existing Application

How to track a submitted application within CHAMPS

CHAMPS

Provider ▾

PROVIDER ENROLLMENT

- New Enrollment
- Track Application

Enroll As A New Provider
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

[Close](#)[Submit](#)

Verify Application Details

For Additional security, please enter following information:

Contact Last Name: *

Phone Number: *

Zip Code: *

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

Application ID: 20180404470595

Name: Testing Biling Agent

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 Billing Agent

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	04/04/2018	04/04/2018	Complete	
Step 2: Add Mode of Claim Submission/EDI Exchange	Required	04/04/2018	04/04/2018	Complete	
Step 3: Add Provider Controlling Interest/Ownership Details	Required	04/04/2018	04/04/2018	Complete	
Step 4: Upload Documents	Optional	04/04/2018	04/04/2018	Complete	
Step 5: Complete Enrollment Checklist	Required	04/04/2018	04/04/2018	Complete	
Step 6: Submit Enrollment Application for Approval	Required	04/04/2018	04/04/2018	Complete	

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

Resources

- Trading Partner Resources
 - [Michigan Department of Health & Human Services- Trading Partners](#)
 - [HIPAA Companion Guides](#)
 - [Electronic Submission Manual](#)
- For electronic file submission and 835/ERA inquiries
 - automatedbilling@Michigan.gov
- For encounter file inquiries
 - MDHHSencounterData@Michigan.gov
- Provider Support (claim adjudication/reimbursement questions)
 - www.michigan.gov/medicaidproviders
 - ProviderSupport@Michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program