



Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Provider Enrollment Group Practice

“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

New Group Practice Enrollment

MILogin for Third Party

Login to your account

User ID

Password

LOGIN

SIGN UP

[Forgot your User ID?](#)

[Forgot your password?](#)

[Need Help?](#)


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

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 to your MILogin Home Page
- Click the CHAMPS hyperlink

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

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Terms & Conditions

CHAMPS

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,

CANCEL x **Acknowledge/Agree**

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



Community Health Automated Medicaid Processing System

→ Select Domain *

→ Select Profile *

→ Select Favorite



My Inbox ▾

Provider ▾

Note Pad

External Links ▾

My Favorites ▾

Print

Help

Provider Portal

NPI:

Name:

Latest updates

System Notification

Attention All Providers: Due to system maintenance activities, the CHAMPS system will be down between 6:00 AM Saturday, January 10th through 9:00 PM Sunday, January 11th, 2015 with the exception of Health Care Eligibility Benefit Inquiry and Response (Core 270/271) Real-time transactions which will be down between 6:00am and 10:00am on Saturday January 10th. This outage will affect the CHAMPS system access for all functionality.



My Reminders

Filter By



Go

Save Filters

My Filters ▾

<input type="checkbox"/>	Alert Type ▲ ▾	Alert Message ▲ ▾	Alert Date ▲ ▾	Due Date ▲ ▾	Read ▲ ▾
--------------------------	-------------------	----------------------	-------------------	-----------------	-------------

No Records Found !

Calendar



11:48 AM

12 January 2015
Monday

2015 January

Mo	Tu	We	Th	Fr	Sa	Su
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	
←		Today				→



Enrollment Type

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
 - Regular Individual/Sole Proprietor (Choose this option to be a Medicaid Individual/Sole Proprietor, you may participate in the EHR-MIPP.)
 - EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP.)
 - Managed Care Network Provider Only
 - Managed Care Network Provider and EHR
- Group Practice (Corporation, Partnership, LLC, etc.)
- Billing Agent
- Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- Contractor/MCO
- HIPAA-Exempt Individual/Sole Proprietor
 - Regular
 - Home Help
- HIPAA-Exempt Facility/Agency/Organization (FAO)
 - Regular
 - Home Help



Submit

- Select appropriate Provider/Enrollment type

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) EIN/TIN: *


NPI: *

Contact Email Address:

Email-1 *

Email-2

Email-3



- Complete all required asterisk * fields
- Select “Confirm”, then select “Finish”

Application ID: 20150326987537

Name: TEST,LLC

Basic Information

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

Your Application ID is: 20150326987537

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.

OK

- Make note of the application ID number
- Select "Ok" to proceed



Application ID: 20150326987537

Name: TEST,LLC

Close

Enroll Provider - Group

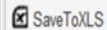
Business Process Wizard - Provider Enrollment (Group). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/26/2015	03/26/2015	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Add Mode of Claim Submission	Required			Incomplete	
Step 5: Associate Billing Agent	Optional			Incomplete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 7: Add Taxonomy Details	Required			Incomplete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Complete Enrollment Checklist	Required			Incomplete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1



Page Count



Viewing Page: 1



- All required steps will need to be completed in numerical order when submitting a new enrollment
- Continue with Step 2: Add Locations



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Group Practice Enrollment

Application ID: 20150326987537

Name: TEST,LLC

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!

- Select "ADD" to enter Primary Location Information

Application ID: 20150326987537

Name: TEST,LLC

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, 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 *

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: CHAMPS Notice

OK Cancel

- Complete address line 1 and zip code fields
- Select "Validate Address" and the remaining information will populate after validating
- Phone number is a required field

Application ID: 20150326987537

Name: TEST,LLC

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, DRAWR 1111 or DRAWER 1111)
If an attention line is required, please enter the information in Line THREE.
(For example: ATTN: Billing Dept.)

Address validation successful

Address Line 1: 320 S WALNUT ST *

Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town: LANSING *

State/Province: MICHIGAN *

County: INGHAM

Country: UNITED STATES *

Zip Code: 48933 - 2014 Validate Address

Phone Number: (555) 555-5555 * Extn:

Fax Number:

Email Address:

Web Page:

Office Hours:

Communication Preference: CHAMPS Notice



- Continue to complete all required Asterisk * fields
- When Primary Practice Location information is complete, select "OK" to proceed



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Group Practice Enrollment

Application ID: 20150326987537

Name: TEST,LLC

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	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999



View Page: 1



Go



Page Count



Save To XLS

Viewing Page: 1



- Select the “Primary Practice Location” hyperlink to add Pay To, Correspondence, and Remittance Advice Address (add only if a Paper RA is needed by mail)



Application ID: 20150326987537

Name: TEST,LLC

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

Location Details

Doing Business As:

Location Code: 01

Location Type: Primary Practice Location

Phone Number: (555) 555-5555 * Extn:

Fax Number:

Email Address:

Web Page:

Office Hours:

Communication Preference: CHAMPS Notice

Handicap Accessible: No

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

Language(s) Spoken: English, Arabic, Chinese

End Date: 12/31/2999

Add Address



Address List



Address Type	Address	End Date
Location	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999



Application ID: 20150326987537


Name: TEST,LLC

Add Provider Location Address

Type of Address: * 
Location Address: *
 *
 *
 *
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: *
(Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town: *
State/Province: *
County:
Country: *
Zip Code: -

Validate Address 




- From the drop-down menu, select Type of Address and enter all required fields
- Select "Validate Address"
- Select "OK" to proceed

CHAMPS < My Inbox > Provider >

Quick Find Note Pad External Links My Favorites Print Help

MyInbox > Enrollment List > Enrl App General > Track Application > Group Practice Enrollment > General

Application ID: 20150326987537 Name: TEST,LLC

Close Save To  Additional addresses, click 'Add Address' button.

Location Details

Doing Business As:

Phone Number: (555) 555-5555 * Extn:

Web Page:

Handicap Accessible: No

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

End Date: 12/31/2999

Location Code: 01 Location Type: Primary Practice Location

Fax Number:

Office Hours:

Email Address:

Communication Preference: CHAMPS Notice

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

- English
- Arabic
- Chinese

Address List

Address Type	Address	End Date
Correspondence	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999
Location	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999
Pay To	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999

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

- When all location addresses have been added, select "Save" then "Close" to continue



Application ID: 20150326987537

Name: TEST,LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/26/2015	03/26/2015	Complete	
Step 2: Add Locations	Required	03/26/2015	03/27/2015	Complete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Add Mode of Claim Submission	Required			Incomplete	
Step 5: Associate Billing Agent	Optional			Incomplete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 7: Add Taxonomy Details	Required			Incomplete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Complete Enrollment Checklist	Required			Incomplete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	

- Continue to Step 3 to add Specialties for a provider



My Inbox ▾

Provider ▾

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Help

MyInbox > Enrollment List > Enrl App General > Track Application > Group Practice Enrollment

Application ID: 20150326987537

Name: TEST,LLC

Close

Add



Specialty/Subspecialty List

Filter By

Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date



No Records Found !

- Select "Add" to enter Specialty Information

Application ID: 20150326987537

Name: TEST,LLC

Add Specialty/Subspecialty

Location: 01- *

Provider Type: ---SELECT--- *

Specialty: *

End Date: 

Add Subspecialty

Available Subspecialties



Associated Subspecialties *

OK Cancel

- From the drop-down menu, select both Provider Type and Specialty.

Application ID: 20150326987537

Name: TEST,LLC

Add Specialty/Subspecialty

Location: 01- *

Provider Type: GROUPS *

Specialty: Medical *

End Date: 

Add Subspecialty

Available Subspecialties



Associated Subspecialties *

No Subspecialty



- Select "OK" to proceed



Application ID: 20150326987537

Name: TEST,LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/26/2015	03/26/2015	Complete	
Step 2: Add Locations	Required	03/26/2015	03/27/2015	Complete	
Step 3: Add Specialties	Required	03/27/2015	03/27/2015	Complete	
Step 4: Add Mode of Claim Submission	Required			Incomplete	
Step 5: Associate Billing Agent	Optional			Incomplete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 7: Add Taxonomy Details	Required			Incomplete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Complete Enrollment Checklist	Required			Incomplete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	



- Continue to Step 4 - Add Mode of Claim Submission

Application ID: 20150326987537

Name: TEST,LLC

Mode of Claim Submission Details

You may check multiple Modes of Claim Submission.

Identify Claim Submission Details.

Mode of Claim Submission: Electronic Batch

CORE

Billing Agent

Online Direct Data Entry (DDE)

Paper

Not Applicable



- Select all Modes of Claim Submission for your practice and select “OK” to proceed



Application ID: 20150326987537

Name: TEST,LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/26/2015	03/26/2015	Complete	
Step 2: Add Locations	Required	03/26/2015	03/27/2015	Complete	
Step 3: Add Specialties	Required	03/27/2015	03/27/2015	Complete	
Step 4: Add Mode of Claim Submission	Required	03/27/2015	03/30/2015	Complete	
Step 5: Associate Billing Agent	Required			Incomplete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	03/27/2015	03/27/2015	Complete	
Step 7: Add Taxonomy Details	Required	03/27/2015	03/27/2015	Complete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Complete Enrollment Checklist	Required	03/27/2015	03/27/2015	Complete	
Step 10: Submit Enrollment Application for Approval	Required	03/27/2015	03/27/2015	Incomplete	

- If you select “Billing Agent” within Step 4, both Add Mode of Claim Submission and Step 5 - Associate Billing Agent are required



< My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Group Practice Enrollment

Application ID: 20150330422525

Name: TESTING INC, LLC

Close

Add



Billing Agent List

Filter By



Go

Save Filters

My Filters ▾

Billing Agent ID

Billing Agent Name

835 Authorization

Start Date

End Date



No Records Found !

- Select “Add” to enter your Billing Agent

Application ID: 20150330422525


Name: TESTING INC, LLC

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.



Billing Agent ID: *

Billing Agent Name:

Association Start Date:  *

Association End Date: 

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/> 	<input type="text"/> 

- Select "Confirm/Search Billing Agent" to choose your Billing Agent

Application ID: 20150326987537

Name: TEST,LLC

Close Select



Billing Agent List

Filter By



Go

Save Filters

My Filters

<input type="checkbox"/>	Billing Agent ID ▲ ▼	Billing Agent Name ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼
<input checked="" type="checkbox"/>	1200009	BLUE CROSS BLUE SHIELD	01/01/1984	12/31/2999
<input type="checkbox"/>	1200018	BLUE CROSS & BLUE SHIELD	01/01/1984	12/31/2999
<input type="checkbox"/>	1200027	CLAIMS PROCESSING SERVICE	04/30/1998	12/31/2999
<input type="checkbox"/>	1200036	GRAND OAKS NURSING CENTER	12/08/1999	12/31/2999
<input type="checkbox"/>	1200045	WEST HICKORY HAVEN	02/25/2000	12/31/2999
<input type="checkbox"/>	1200054	NORTHWOODS NURSING CENTER	06/04/1999	12/31/2999
<input type="checkbox"/>	1200073	HOME HEALTH OUTREACH	02/19/2002	12/31/2999
<input type="checkbox"/>	1200082	WESTWOODS OF NILES	02/25/2000	12/31/2999
<input type="checkbox"/>	1200091	PROFESSIONAL MED TEAM AMB	06/22/2000	12/31/2999
<input type="checkbox"/>	1200107	ABRAMSON/BRAUN/ERFOURTH	10/23/2000	12/31/2999

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Last

- Choose your Billing Agent by clicking the box next to your choice, then "Select"

Application ID: 20150326987537

Name: TEST,LLC

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID: *

Billing Agent Name:

Association Start Date: *

Association End Date:

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

- Select the authorize box for the 835 Healthcare Claim Status and ensure a start and end date and has been entered
- Select "Ok" to proceed



Application ID: 20150330422525

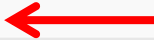
Name: TESTING INC, LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/30/2015	03/30/2015	Complete	
Step 2: Add Locations	Required	03/30/2015	03/30/2015	Complete	
Step 3: Add Specialties	Required	03/30/2015	03/30/2015	Complete	
Step 4: Add Mode of Claim Submission	Required	03/30/2015	03/30/2015	Complete	
Step 5: Associate Billing Agent	Required	03/30/2015	03/30/2015	Complete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 7: Add Taxonomy Details	Required			Incomplete	
Step 8: 835/ERA Enrollment Form	Required			Incomplete	Please complete ERA form.
Step 9: Complete Enrollment Checklist	Required			Incomplete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	



- Continue to Step 6 - Add Provider Controlling Interest/Ownership Details



Application ID: 20150326987537

Name: TEST,LLC

Close

Owners List

Add

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

Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
No Records Found !				

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

Filter By [dropdown] [input] Go

Save Filters | My Filters


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

- Select "Add" to enter owners

Application ID: 20150326987537

Name: TEST,LLC

Provider Controlling Interest/Ownership

Owner Type: * 


SSN:


Legal Entity Name:

First Name:

Suffix:

Phone Number:

Start Date:  *


Percentage Owned: * 

EIN/TIN:


Entity Business Name:

(Doing Business As)

Last Name:

DOB: 

Email:

End Date: 

Address Line 1: *

(Enter Street Address or PO Box Only)

Address Line 3:

State/Province: *


Country: *

Address Line 2:

City/Town: *

County:

Zip Code: -

Validate Address 



- Select the Owner Type and input Percentage Owned by selected Owner
- Complete all required asterisk * fields
- Select "Validate Address"
- Select "Ok" to proceed

Application ID: 20150326987537

Name: TEST,LLC

st/Ownership

Managing Employee



Percentage Owned:

0

is a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.

Entity Business Name:

(As shown on the Income Tax Return)

(Doing Business As)

Last Name:

DOB:

Email:

End Date:

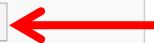
Address Line 2:

City/Town:

County:

Zip Code:

Validate Address



OK

Cancel



- Managing Employee information **must** be completed
- Select "Validate Address"
- Select "OK" to proceed



Application ID: 20150326987537

Name: TEST,LLC

Close

Owners List

Add

Filter By [] [] Go

Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
22222222	Test,Tester	Individual	03/27/2015	12/31/2999
11111111	Test,Tester	Managing Employee	03/27/2015	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 !

- Select the Owner ID hyperlink to continue the Ownership Details
- This process must be completed for all Owners listed



My Inbox

Provider

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

MyInbox > Track Application > Group Practice Enrollment > General

Application ID: 20150326987537

Name: TEST,LLC

Close | Save | View Screening Result

Address Line 1: 320 S WALNUT ST *

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: LANSING *

State/Province: MICHIGAN *

County: INGHAM

Country: UNITED STATES *

Zip Code: 48933 - 2014



Add | Inactivate

Relationship

Filter By [] []

	Owner Name	Relationship	Modified Date	Operational Status
--	------------	--------------	---------------	--------------------

No Records Found !

- Select "Add" to proceed



Application ID: 20150326987537

Name: TEST,LLC

Add Owner Relationship

Owner Name:

--SELECT--



Relationship:

Others
Test, Tester

- Select the Owner Name from the Drop-down Menu

Application ID: 20150326987537

Name: TEST,LLC

Add Owner Relationship

Owner Name: Test,Tester

Relationship:

- SELECT--
- Daughter
- Daughter-In Law
- Father
- Father-In Law
- Mother
- Mother-In Law
- None
- Others
- Sibling
- Son
- Son-In Law
- Spouse

OK Cancel

- Select the Relationship from the Drop-down Menu and click “Ok” to proceed



Application ID: 20150326987537

Name: TEST,LLC

Close Save View Screening Result

Address Line 3:

State/Province: MICHIGAN

Country: UNITED STATES

City/Town: LANSING

County: INGHAM

Zip Code: 48933 - 2014 Validate Address

Add Inactivate

Relationship

Filter By Go

Save Filters My Filters

Owner Name	Relationship	Modified Date	Operational Status
Test,Tester	None	03/27/2015 13:46:19	Active

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Final Adverse Legal Actions/Convictions Disclosure

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

- Select the "Final Adverse Legal/Action/Convictions Disclosure" hyperlink

Application ID: 20150326987537

Name: TEST,LLC

Under Section 12501 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):



- Select either “Yes” or “No”
- Select “Ok” to proceed



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MyInbox > Track Application > Group Practice Enrollment > General

Application ID: 20150326987537

Name: TEST,LLC

Close Save **Review Screening Result**

Address Line 3:

State/Province: MICHIGAN

Country: UNITED STATES

City/Town: LANSING

County: INGHAM

Zip Code: 48933 - 2014 Validate Address

Add Inactivate

Relationship

Filter By [] [] Go

Save Filters My Filters

Owner Name	Relationship	Modified Date	Operational Status
Test,Tester	None	03/27/2015 13:43:12	Active

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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 the relationship and adverse action question, select "Save"
- Select "Close" to proceed





Application ID: 20150326987537

Name: TEST,LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/26/2015	03/26/2015	Complete	
Step 2: Add Locations	Required	03/26/2015	03/27/2015	Complete	
Step 3: Add Specialties	Required	03/27/2015	03/27/2015	Complete	
Step 4: Add Mode of Claim Submission	Required	03/27/2015	03/27/2015	Complete	
Step 5: Associate Billing Agent	Optional			Incomplete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	03/27/2015	03/27/2015	Complete	
Step 7: Add Taxonomy Details	Required			Incomplete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Complete Enrollment Checklist	Required			Incomplete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	



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- Continue to Step 7 - Add Taxonomy Details



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Application ID: 20150326987537

Name: TEST,LLC

Close

Add



Taxonomy List

Filter By



Go

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Taxonomy Code



Description



Start Date



End Date



No Records Found !

- Select "Add" to enter a taxonomy

Application ID: 20150326987537

Name: TEST,LLC

Add Taxonomy

Taxonomy Code: * (Click here for Taxonomy List)

Location: 01- *

Description:

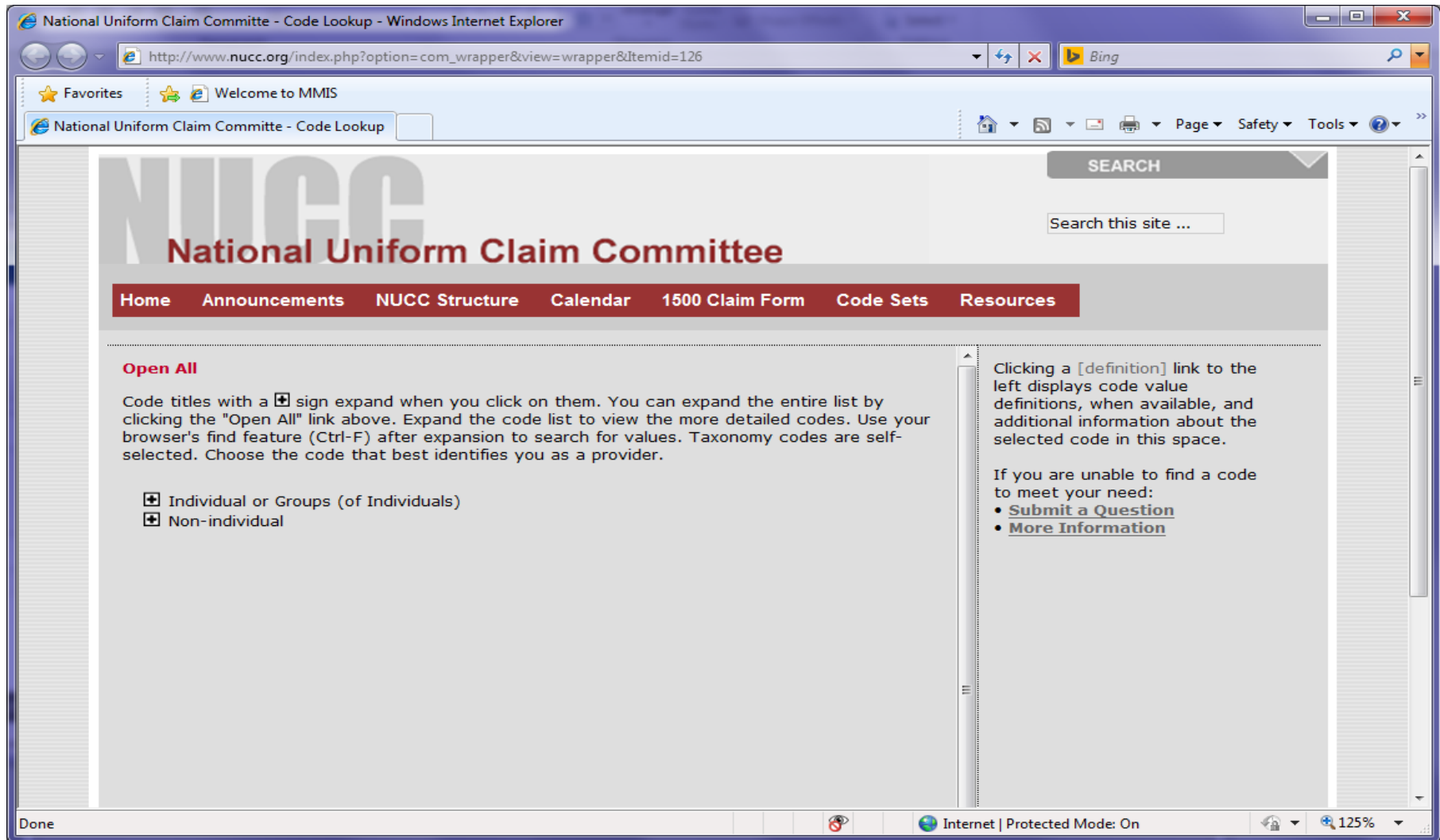
Start Date: *

End Date:



Confirm Taxonomy OK Cancel

- Select arrow < for a listing of Taxonomy Codes



- User will be directed to the National Uniform Claim Committee (NUCC) webpage to view all taxonomy codes

Application ID: 20150326987537

Name: TEST,LLC

Add Taxonomy

Taxonomy Code: 332B00000X * (Click here for Taxonomy List)

Location: 01- *

Description:

Start Date: 03/27/2015 *

End Date: *

Confirm Taxonomy OK Cancel

- Select Taxonomy Code, enter Start Date
- Select "Confirm Taxonomy"
- Select "OK" to proceed



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Application ID: 20150330422525

Name: TESTING INC, LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/30/2015	03/30/2015	Complete	
Step 2: Add Locations	Required	03/30/2015	03/30/2015	Complete	
Step 3: Add Specialties	Required	03/30/2015	03/30/2015	Complete	
Step 4: Add Mode of Claim Submission	Required	03/30/2015	03/30/2015	Complete	
Step 5: Associate Billing Agent	Required	03/30/2015	03/30/2015	Complete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	03/30/2015	03/30/2015	Complete	
Step 7: Add Taxonomy Details	Required	03/30/2015	03/30/2015	Complete	
Step 8: 835/ERA Enrollment Form	Required			Incomplete	Please complete ERA form.
Step 9: Complete Enrollment Checklist	Required			Incomplete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	

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- Continue to Step 8 – 835/ERA Enrollment Form



Application ID: 20150330422525

Name: TESTING INC, LLC

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ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name:

Doing Business As Name (DBA): TESTING INC, LLC

Provider Address

Street: 320 S WALNUT ST

State/Province: MICHIGAN

City: LANSING

Zip Code/Postal Code: 48933

Country Code: UNITED STATES

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): 100021048

National Provider Identifier (NPI): 1000210488

Other Identifier(s)

Assigning Authority:

Trading Partner ID: 1200009

Provider License Details

Provider License No:

License Issuer:

Provider Type: GROUPS

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MyInbox > Track Application > Enrollment List > Enrl App General > Track Application > Group Practice Enrollment >

Application ID: 20150330422525 Name: TESTING INC, LLC

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NPI TAX ID

MI Medicaid enumerates by Tax ID only.

Method of Retrieval: * ←

ELECTRONIC REMITTANCE ADVISE VENDOR INFORMATION (Not applicable at this time)

ELECTRONIC REMITTANCE ADVISE VENDOR INFORMATION (Not applicable at this time)

SUBMISSION INFORMATION

Reason for Submission

Cancel Enrollment Change Enrollment New Enrollment *

Authorized Signature

Electronic Signature of Person Submitting Enrollment:

* Authorization Agreement-By selecting the checkbox above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

Authorization Agreement

By signing this request, I am authorizing the Michigan Department of Community Health to establish an 835/ERA account for the Tax ID listed above and for 835/ERA files to be transmitted electronically to the designated entity.

- Select Method of Retrieval from Drop-down Menu (DEG most common selection)



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Application ID: 20150330422525

Name: TESTING INC, LLC

Close Submit **Submit** Help

NPI TAX ID

MI Medicaid enumerates by Tax ID only.

Method of Retrieval: CHAMPS

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Not applicable at this time)

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Not applicable at this time)

SUBMISSION INFORMATION

Reason for Submission

Cancel Enrollment Change Enrollment **New Enrollment**

Authorized Signature

Electronic Signature of Person Submitting Enrollment:

* Authorization Agreement-By selecting the checkbox above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

Authorization Agreement

By signing this request, I am authorizing the Michigan Department of Community Health to establish an 835/ERA account for the Tax ID listed above and for 835/ERA files to be transmitted electronically to the designated entity.

- Complete the Electronic Signature of Person Submitting Enrollment
- Select "Submit" to proceed



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Application ID: 20150326987537

Name: TEST,LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/26/2015	03/26/2015	Complete	
Step 2: Add Locations	Required	03/26/2015	03/27/2015	Complete	
Step 3: Add Specialties	Required	03/27/2015	03/27/2015	Complete	
Step 4: Add Mode of Claim Submission	Required	03/27/2015	03/27/2015	Complete	
Step 5: Associate Billing Agent	Optional			Incomplete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	03/27/2015	03/27/2015	Complete	
Step 7: Add Taxonomy Details	Required	03/27/2015	03/27/2015	Complete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Complete Enrollment Checklist	Required			Incomplete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	

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- Continue to Step 9 – Complete Enrollment Checklist Question

Application ID: 20150326987537

Name: TEST,LLC

Close Save



Provider Checklist

Question	Answer	Comments
Do you need to request a Retro Enrollment Date? If Yes, enter the requested Retro Enrollment Date in the comment field.	Not Completed	
Are you currently excluded from any State program?	Not Completed	
Are you currently excluded from any Federal program?	Not Completed	
Have you ever had a criminal or health-related conviction?	Not Completed	
Have you ever had a judgment under any false claims act?	Not Completed	
Have you ever had a program exclusion/debarment?	Not Completed	
Have you ever had a civil monetary penalty?	Not Completed	
Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Provider Controlling Interest/Ownership Details" step.	Not Completed	
Do you accept new patients?	Not Completed	
Have you had any malpractice settlement, judgment, or agreement? If yes, enter dollar amount(s) and date(s).	Not Completed	
Are you a PA 161 Program?	Not Completed	
Do you contract with PA 161 program? If you contract with one of these programs, please provide the NPI in the comments.	Not Completed	
Would you be willing to participate in the BMP program which restricts beneficiaries to a specific provider?	Not Completed	

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- Complete all questions on Provider Checklist and select "Save" once completed
- Select "Close" to proceed



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Application ID: 20150326987537

Name: TEST,LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/26/2015	03/26/2015	Complete	
Step 2: Add Locations	Required	03/26/2015	03/27/2015	Complete	
Step 3: Add Specialties	Required	03/27/2015	03/27/2015	Complete	
Step 4: Add Mode of Claim Submission	Required	03/27/2015	03/27/2015	Complete	
Step 5: Associate Billing Agent	Optional			Incomplete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	03/27/2015	03/27/2015	Complete	
Step 7: Add Taxonomy Details	Required	03/27/2015	03/27/2015	Complete	
Step 8: 835/ERA Enrollment Form	Optional			Incomplete	
Step 9: Complete Enrollment Checklist	Required	03/27/2015	03/27/2015	Complete	
Step 10: Submit Enrollment Application for Approval	Required			Incomplete	

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- Step 10 - Submit Enrollment Application for Approval. **You must complete this step or your application will not be submitted**

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Application ID: 20150326987537 Name: TEST,LLC

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Final Submission

Application ID: 20150326987537 Enrollment Type: Group Practice (Corporation, Partnership, LLC, etc.)

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 !			

- Select “Next” to read the Terms and Conditions



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Application ID: 20150326987537

Name: TEST,LLC

Close

Submit Application

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

agrees to defend, indemnify, and hold harmless MDCH, its Trading Partners, officers, agents, employees, assigns and successors from and against any and all claims, losses, and actions, including all costs and reasonable attorney fees, arising out of electronic Transactions the Trading Partner submits to MDCH.

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 MDCH 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 MDCH upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with MDCH upon request in testing processes for any changes in submission format prior to submission of production files. MDCH 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 MDCH 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 MDCH 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 Medical Assistance Provider Enrollment & Trading Partner Agreement.

- Read through the Terms and Conditions and check the box at the bottom of the screen
- Select "Submit" at the top of the screen



Application ID: 20150330422525

Name: TESTING INC, LLC


Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/30/2015	03/30/2015	Complete	
Step 2: Add Locations	Required	03/30/2015	03/30/2015	Complete	
Step 3: Add Specialties			03/30/2015	Complete	
Step 4: Add Mode of Claim Submission			03/30/2015	Complete	
Step 5: Associate Billing Agent			03/30/2015	Complete	
Step 6: Add Provider Controlling Interest/Ownership Details			03/30/2015	Complete	
Step 7: Add Taxonomy Details			03/30/2015	Complete	
Step 8: 835/ERA Enrollment Form			03/30/2015	Complete	
Step 9: Complete Enrollment Checklist	Required	03/30/2015	03/30/2015	Complete	
Step 10: Submit Enrollment Application for Approval	Required	03/30/2015	03/30/2015	Complete	

Message from webpage

 Your Application Number 20150330422525 has been successfully submitted for State review. Return to CHAMPS with this application number to track the status of your application.

OK

- You have now submitted your application
- Select "OK" to return to the BPW page



Application ID: 20150330422525

Name: TESTING INC, LLC

Close

Enroll Provider - Group

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

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/30/2015	03/30/2015	Complete	
Step 2: Add Locations	Required	03/30/2015	03/30/2015	Complete	
Step 3: Add Specialties	Required	03/30/2015	03/30/2015	Complete	
Step 4: Add Mode of Claim Submission	Required	03/30/2015	03/30/2015	Complete	
Step 5: Associate Billing Agent	Required	03/30/2015	03/30/2015	Complete	
Step 6: Add Provider Controlling Interest/Ownership Details	Required	03/30/2015	03/30/2015	Complete	
Step 7: Add Taxonomy Details	Required	03/30/2015	03/30/2015	Complete	
Step 8: 835/ERA Enrollment Form	Required	03/30/2015	03/30/2015	Complete	
Step 9: Complete Enrollment Checklist	Required	03/30/2015	03/30/2015	Complete	
Step 10: Submit Enrollment Application for Approval	Required	03/30/2015	03/30/2015	Complete	



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- The status states that all steps have been completed

Provider Resources

- [Medicaid Provider Training](#)
 - One on One trainings requests
 - Association requests
 - Current trainings available
- [Michigan Medicaid List Serve](#)

E-mail notification alerts relative to the Michigan Medicaid Program, Medicaid policy, billing issues, training opportunities, etc.
- [Provider Enrollment](#)
 - ProviderEnrollment@michigan.gov
 - 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program