ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

Illinois Medical Assistance Program

PROVIDER ENROLLMENT APPLICATION

(Must be Typed or Printed Legible and Do Not Use Highlighter On Any Documents)

All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type NONE.

SECTION A: PROVIDER

1. New Enrollment ☐ Re-Enrollment ☐ Name Change ☐ Reinstatement Request ☐ 2. Provider Type ☐

3. Provider Name

4. Primary Office Address Street

5. City 6. County

7. State 8. Zip 9. Telephone ( ) 10. Fax ( )

11. Email Address (3)

12. National Provider Identification # - NPI ***Report Additional NPI's In Section D*** 13. FEIN

14. SSN 15. License/ Certification 16.DEA

17. Medicare Part A# 18. Organization Type 19. Control of Facility 20. Fiscal Year

21. CLIA #

SECTION B: SERVICE/SPECIALTY

22. Category Of Service 0 9 5

23. Provider Specialty: Primary Specialty Secondary Specialties

24. Physician UPIN No. 25. OBRA Qualification (Physicians Only)

26. Hospital Admitting Privilege: (Physicians Only)

Hospital Name Address

Hospital Name Address

27. Pharmacy Location 28. Pharmacy License # 29.Pharmacist In Charge License #

30. Electronic Billing? Yes ☐ No ☐ 31.If Yes, Pharmacy Software Vendor Name 32.Pharmacy NCPDP#

33. Transportation: Taxi Base/ Meter/Flag Rate 34. Taxi Mileage Rate 35.Medicar: Hydraulic Manual Lift or Ramp Yes ☐ No ☐

36. Long Term Care Medical Bed Capacity 37. Long Term Care Medicare Fiscal Intermediary

38. Long Term Care Building ID Code

SECTION C: FORMER PARTICIPATION

39. Change of Ownership Yes ☐ No ☐ Effective Date

40. Former Provider Number Former Provider Name

SECTION D: ADDITIONAL NPI – National Provider Identification

41. NPI NPI NPI

NPI NPI NPI

SECTION E: PAYEE INFORMATION

42. Name 43.Telephone ( )

44. DBA

45. Street Address

46. City 47. State 48. Zip 49. TIN Type Code

50. SSN/FEIN 51. Billing Provider/Pay To NPI #

52. Medicare Part B # 53.PIN 54.DMERC#

Name Telephone ( )

DBA

Street Address

City State Zip TIN Type Code

SSN/FEIN Billing Provider/Pay To NPI #

Medicare Part B # PIN DMERC#

SECTION F: CERTIFICATION/SIGNATURE

I understand that knowingly falsifying or willfully withholding information may be cause for termination of participation in the Medical Assistance Program.

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services to verify the information provided on this application with other state and federal agencies.

Illinois HFS website address: http://www.hfs.illinois.gov/
Illinois HFS Handbook updates are available: http://www.hfs.illinois.gov/handbooks
Illinois HFS Laws and Rule Regulations: http://www.hfs.illinois.gov/lawsrules/index.html

Check this box if you want a provider handbook mailed ☐

Signature: Date:

Printed name of person signing above