

## Enrolling as a Medicaid Provider

Illinois Medicaid enrolls providers in the IMPACT system. Paper enrollment applications or updates are not accepted, and email is now the primary method for provider communication. IMPACT and more information about the enrollment process is available at:

<https://www.illinois.gov/hfs/impact/Pages/ContactIMPACT.aspx>

### To Begin the Application Process

Prior to starting an enrollment, a certified W9 must be on file. A certified W9 must be on file with the Comptroller for any provider receiving state/federal funds from the Comptroller for services rendered or provided to Medicaid clients. To obtain a certified W9, complete the W9 form and then scan and email the completed form to [IMPACT.Help@illinois.gov](mailto:IMPACT.Help@illinois.gov). In the subject line put "W9 approval needed". Impact will then forward the W9 to the Illinois Comptroller and once it is reviewed and approved by the Comptroller's Office an email will be sent that the W9 has been approved and the enrollment may begin.

To begin the enrollment, go to <http://IMPACT.Illinois.gov>. Anyone who needs access to the IMPACT system will need to create a User ID and password through the single sign-on process. To begin, click on "Create New Account".



Login to your account

\* = Required Fields

**\*User ID**

**\*Password**

Login

Forgot your password?

Need Help?

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Don't have an account?

Create New Account

To view a step-by-step presentation on how to create a new account click on the following link: <https://www.illinois.gov/hfs/impact/Documents/SingleSignOnProviders.pdf>. Also, general questions about IMPACT provider enrollment can be answered by calling 1-877-782-5565 (select options 1, 2, 1, 1).

To access the IMPACT provider portal, you must use an internet browser that is equivalent to Internet Explorer 8 – or a more recent browser.

### **Enrollment Types for Dental Groups and Dental Facilities**

Dental providers in Illinois may be able to enroll as a “Group” or as a “Facility, Agency, Organization” (FAO).

First, the Group or FAO should enroll as a Medicaid provider before your individual practitioners enroll as Medicaid providers (if they are not already enrolled with another medical group). Medicaid services are rendered by individual practitioners, but the Medicaid payments will be sent to the Billing Provider at the Group/FAO’s Primary Pay-To address. After the Group or FAO enrollment is completed and approved, then the individual practitioners will enroll and “associate” with the Group or FAO.

### **National Provider Identifier (NPI)**

The National Provider Identifier (NPI) number is a unique ten-digit identification number issued by the Centers for Medicare and Medicaid Services (CMS) and required by the Health Insurance Portability and Accountability Act (HIPAA) for health care providers in the United States. Providers must use their NPI to identify themselves in all HIPAA related transactions. There are two types of NPI:

NPI Type 1- Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.

NPI Type 2- Health care providers who are organizations, including physician groups, clinics, hospitals, nursing homes, etc. (Group and FAO)

### **Group**

A Group is an organization of individual providers that provides dental services. Groups will require a Type 2 NPI. No licensing is required for this type of organization. For enrolling in IMPACT, a “Group” includes a corporation, partnership, or LLC.

#### **Step 1:**

After logging into IMPACT, choose the Enrollment Type (Group) then click Submit. After clicking the Submit button you will be directed to the Basic Information Step.

☰	Enrollment Type	Select the Applicable Enrollment Type
<input type="radio"/> Individual/Sole Proprietor <ul style="list-style-type: none"> <li><input type="radio"/> Regular Individual/Sole Proprietor or Rendering/Servicing Provider</li> <li><input type="radio"/> EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP)</li> <li><input type="radio"/> Managed Care Network Provider Only</li> <li><input type="radio"/> Managed Care Network Provider and EHR</li> </ul>		
<input checked="" type="radio"/> Group Practice (Corporation, Partnership, LLC, etc.) <ul style="list-style-type: none"> <li><input type="radio"/> Billing Agent</li> <li><input type="radio"/> Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)</li> <li><input type="radio"/> Contractor/MCO</li> <li><input type="radio"/> Atypical (non-medical) provider (Choose this option if you do not have a NPI)                         <ul style="list-style-type: none"> <li><input type="radio"/> Individual (Driver, Home Help/Personal Care, Carpenter, etc.)</li> <li><input type="radio"/> Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)</li> </ul> </li> </ul>		

### Facility, Agency, Organization (FAO)

The “FAO” designation will apply to Clinics that are Federally Qualified Health Centers, Rural Health Clinics, School Based/Linked Health Clinics and Public Health Departments that have Dental Services. An FAO provider will require a type 2 NPI. FAO’s require a license.

#### Step 1:

After logging into IMPACT, choose the Enrollment Type (Facility/Agency/Organization) then click Submit. After clicking the Submit button you will be directed to the Basic Information Step.

☰	Enrollment Type	Select the Applicable Enrollment Type
<input type="radio"/> Individual/Sole Proprietor <ul style="list-style-type: none"> <li><input type="radio"/> Regular Individual/Sole Proprietor or Rendering/Servicing Provider</li> <li><input type="radio"/> EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP)</li> <li><input type="radio"/> Managed Care Network Provider Only</li> <li><input type="radio"/> Managed Care Network Provider and EHR</li> </ul>		
<input type="radio"/> Group Practice (Corporation, Partnership, LLC, etc.) <ul style="list-style-type: none"> <li><input type="radio"/> Billing Agent</li> <li><input checked="" type="radio"/> Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)</li> <li><input type="radio"/> Contractor/MCO</li> <li><input type="radio"/> Atypical (non-medical) provider (Choose this option if you do not have a NPI)                         <ul style="list-style-type: none"> <li><input type="radio"/> Individual (Driver, Home Help/Personal Care, Carpenter, etc.)</li> <li><input type="radio"/> Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)</li> </ul> </li> </ul>		

### Medicaid Enrollment for Dental Groups and Dental Facilities

#### Step 2

Complete the Basic Information step. Once all the information has been entered click “Confirm” and then “Finish” to complete this step.

## MANUAL FOR ENROLLING DENTAL PROVIDERS INTO IMPACT

Basic Information: Enter required fields and click Confirm button.

The screenshot shows a web form titled "Basic Information". It contains the following fields and options:

- Legal Entity Name:  (As shown on the Income Tax Return)
- Entity Business Name:  \* (Doing Business As)
- LLC (Disregarded Entity)
- EIN/TIN:  \*
- NPI:  \*
- Contact Email Address: \*
  - Email-1:  \*
  - Email-2:
  - Email-3:
  - Email-4:
  - Email-5:
  - Email-6:

After successful completion of this step the system will generate a 14-digit Application ID. Application IDs are valid for 30 calendar days; applications must be completed and submitted to the state for review and will be used to track the status of the submitted application until the application has been approved.

A step-by-step guide on how to enroll as a Group is at:

<https://www.illinois.gov/hfs/impact/Documents/IMPACTGroup.pdf>

A step-by-step guide on how to enroll as a FAO is at:

<https://www.illinois.gov/hfs/impact/Documents/IMPACTFAO.pdf>

If the dental group or clinic has multiple NPI's with the same tax number, there should be a separate enrollment for each NPI.

### Email Addresses

Email is the primary mode of communication in the IMPACT system. Email address listed in IMPACT need to be current and associated to the individual(s) who will be acting on the provider's half. The IMPACT system can hold up to 10 different email addresses.

### Documents to Have on Hand for IMPACT Enrollment

When enrolling in IMPACT the following information will be needed to complete the application process:

Information on your organization, including the Primary Practice Location address, a Correspondence Location, a Pay-To Location, office hours, whether ADA accessible, language spoken, communication preferences, telephone number, email address – and similar information on all other locations.

Contact information on each of the owners, including percent of ownership, social security numbers, address, telephone number, relationship between each owner.

Information about each owner's interest in other entities reimbursable by Medicaid or Medicare – it is required that ownership of 5% or more in any other Medicaid/Medicare entity be entered.

Specific information, including dates, of any adverse legal actions for each owner, including convictions, suspensions, revocations or exclusions – even if they were expunged or appeals are pending (note: if older lawsuits are unknown, state as such in the comments)

Licenses or certifications that your facility has that may be required (for FAO's)

## Site Locations

When completing the Location Details section of the application, the Primary Practice Location, Correspondence address, and Pay-To addresses will need to be listed. The same address can be used for the Primary Practice, Correspondence and Pay-To addresses.

The screenshot shows the 'Location Details' form with the following information:

- Doing Business As: Anderson Waiver Services
- Location Code: 1
- Location Type: Primary Practice
- Phone Number: (217) 782-5555
- Ext: \*
- Fax Number: \*
- Email: anderson@waiverpro
- Address: \*
- Communication Preference: Email

Below the form is a table for office hours:

Day	Open At	AM/PM	Close At	AM/PM	Day	Open At	AM/PM	Close At	AM/PM
Sunday	Close	AM/PM		AM/PM	Thursday	08:00	AM/PM	06:00	AM/PM
Monday	08:00	AM/PM	06:00	AM/PM	Friday	08:00	AM/PM	06:00	AM/PM
Tuesday	08:00	AM/PM	06:00	AM/PM	Saturday	Close	AM/PM		AM/PM
Wednesday	08:00	AM/PM	06:00	AM/PM					

The 'Address List' section below shows a table with the following data:

Address Type	Address	End Date
<input type="checkbox"/> Correspondence	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
<input type="checkbox"/> Location	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999
<input type="checkbox"/> Pay To	607 E Adams St, Springfield, ILLINOIS 62701	12/31/2999

To list Other Servicing Location address, click on Add and enter the address information for that locations.

For Other Servicing Location, in addition to the location address itself, a Correspondence and Pay-To address is also required.

## Specialty/Subspecialty

When enrolling as a Group, IMPACT will ask for the Provider Type, Specialty, and Subspecialty. It is recommended you use:

- Provider Type: Group
- Specialty: Dental
- Subspecialty: No Subspecialty

The screenshot shows the 'Manage Specialty/Subspecialty' form with the following information:

- NPI: 1174124945
- Name: Pro Smiles Dental
- Location: 01-Pro Smiles Dental
- Provider Type: GROUP
- Specialty: Dental
- Subspecialty: No Subspecialty
- Status: Approved
- Start Date: 11/09/2020
- End Date: 12/31/2999

When enrolling as a FAO, IMPACT will ask for the Provider Type, Specialty, and Subspecialty. It is recommended you use:

- Provider Type: Clinic
- Specialty: Federally Qualified Health Center, Rural Health Clinic, School Based/Linked Health Clinic, or Public Health Department
- Subspecialty: Dental Services

Manage Specialty/Subspecialty

Location: 01-Hardin County Dental Clinic

Provider Type: CLINIC

Specialty: Federally Qualified Health Center

Subspecialty: Dental Services

Status: Approved

Start Date: 09/18/2000 \* End Date: 12/31/2999

## Licenses

- Federally Qualified Health Centers are required to have their Health Resources and Services Administration Award (HRSA) listed on their IMPACT enrollment. Medicare Certification and Clinical Laboratory Improvement Amendments (CLIA) are optional to add.
- School Based/Linked Health Clinics are required to have their Public Health License/Certificate listed on their IMPACT enrollment. Clinical Laboratory Improvement Amendments (CLIA) is optional to add.
- Rural Health Clinics has the option to add their Clinical Laboratory Improvement Amendments (CLIA) and/or Medicare Certification
- Public Health Departments are required to have their Public Health License/Certificate listed on their IMPACT enrollment. Clinical Laboratory Improvement Amendments (CLIA) is optional to add.
- No licensing is required for a Group enrollment.

License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> MEDICARE CERTIFICATION	141857	01-Hardin County Dental Clinic	Yes	12/02/2015	12/31/2999	APPROVED	Active	
<input type="checkbox"/> HEALTH RESOURCES & SERVICES ADM AWARD	H80CS00680	01-Hardin County Dental Clinic	Yes	12/02/2015	12/31/2999	APPROVED	Active	

## Mode of Claim Submission

One of the six options must be selected to indicate how to process claims.

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EDI exchange		
Method	Description	Applicable Transactions
<input checked="" 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"/> Billing Agent	To submit/receive HIPAA transactions through billing agent	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

  

Other Claims Submission	
Method	Description
<input checked="" type="checkbox"/> Paper Claims	To submit FFS paper claims
<input type="checkbox"/> Direct Data Entry(DDE)	To submit FFS claims via online screens

## Provider Controlling Interest/Ownership Details

Ownership entries must include at least one Managing Employee and one other ownership type. Owner Relationships and Owners Adverse Action will need to be answered for each owner listed.

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:
 

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

Owners List												
Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date	Adverse Action	Percentage owned	Relationship Status	
<input type="checkbox"/>	[REDACTED]	Board of Directors/Officers/Principles	[REDACTED]	[REDACTED]	12/31/2999	Approved	Active		[REDACTED]	[REDACTED]	Completed	
<input type="checkbox"/>	[REDACTED]	Managing Employee	[REDACTED]	[REDACTED]	12/31/2999	Approved	Active		[REDACTED]	[REDACTED]	Completed	
<input type="checkbox"/>	[REDACTED]	Limited Liability Company	[REDACTED]	[REDACTED]	12/31/2999	Approved	Active		[REDACTED]	[REDACTED]	Completed	

## Complete Enrollment Checklist

All questions in the enrollment checklist must be answered either “yes” or “no” and comments made if directed to do so.

Question	Answer	Comments
AT	AT	AT
Are you ONLY enrolling to provide services related to COVID-19 emergency response? Answering 'Yes' to this question will create a temporary enrollment that will end within six months from the termination of the public health emergency. If you want to enroll to provide ongoing services to Illinois Medicaid participants, you should answer No to this question.	Not Completed	
If you are an out of state provider that provided emergent care to an Illinois Medicaid participant, you can request a retroactive enrollment back to the date the services were provided. If yes, enter the requested date to be considered in the comment field. Enrollment applications must be submitted within 45 days of the date of service to be considered for a retroactive enrollment date.	Not Completed	
Do you wish to end date your enrollment? If yes, what date?	Not Completed	
Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	Not Completed	
Are you currently excluded from any federal program? If yes, provide the program and date.	Not Completed	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	Not Completed	
Have you ever had a judgment under any false claims act? If yes, list judgment and date.	Not Completed	
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	Not Completed	
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	Not Completed	
Have you ever had a program exclusion/debarment? If yes, provide program and date.	Not Completed	
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	Not Completed	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If yes, provide details in "Add Ownership Details" step.	Not Completed	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	Not Completed	
Are you planning to provide services reimbursable through DaA, DCF, DSCC, DHS/DASA, DHS/DORS, DHS/DMH, DHS/EL, DHS/DDD. If yes, complete "Associate MCO Plan" step in Business Process Wizard.	Not Completed	
Do you carry professional liability insurance? If yes, please provide the name of your carrier and the policy coverage limit per occurrence and in aggregate.	Not Completed	

## Submit Enrollment Application for Approval

Click “next” to confirm that all the information submitted as a part of the application is accurate. Read through all the terms and conditions, and check the box certifying the agreement to the terms and conditions. Then select “Submit Application”.

The application is then submitted to the IMPACT staff to review. The application number created after completion of the Basic Information step can be used to check the status of the application by going through the “Track Application” option.

### Provider Information Sheet

Once your FAO application has been approved, a Provider Information Sheet will be generated and sent to the correspondence address on file. This document contains information that will be needed to file and submit claims. Do not disregard this document.

Groups do not receive Provider Information Sheets.

### Enrollment Timeline and Commitment

All providers are required to update the license expiration date when licenses expire. It is recommended that providers log into IMPACT and update license(s) expiration dates when the license is renewed. Not updating the license expiration date will result in the inactivation of your account.

The enrollment into IMPACT is not a contract – it is an opportunity to bill Medicaid.

## Medicaid Enrollment by Individual Practitioners

### Rendering/Service Provider

This information refers to the individual provider who renders services to Medicaid clients but does not submit claims directly to the state for reimbursement. Each provider must enroll separately. A step-by-step guide on how to enroll is at:

<https://www.illinois.gov/hfs/impact/Documents/IMPACTTypicalRenderingServicing.pdf>

Enrollment Type	Select the Applicable Enrollment Type
<ul style="list-style-type: none"> <li><input checked="" type="radio"/> Individual/Sole Proprietor                             <ul style="list-style-type: none"> <li><input checked="" type="radio"/> Regular Individual/Sole Proprietor or Rendering/Service Provider</li> <li><input type="radio"/> EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP)</li> <li><input type="radio"/> Managed Care Network Provider Only</li> <li><input type="radio"/> Managed Care Network Provider and EHR</li> </ul> </li> <li><input type="radio"/> Group Practice (Corporation, Partnership, LLC, etc.)</li> <li><input type="radio"/> Billing Agent</li> <li><input type="radio"/> Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)</li> <li><input type="radio"/> Contractor/MCO</li> <li><input type="radio"/> Atypical (non-medical) provider (Choose this option if you do not have a NPI)                             <ul style="list-style-type: none"> <li><input type="radio"/> Individual (Driver, Home Help/Personal Care, Carpenter, etc.)</li> <li><input type="radio"/> Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)</li> </ul> </li> </ul>	

### Individual Sole Proprietor

This information refers to the individual who owns his/her own practice. An Individual Sole Proprietor may receive payments directly or associate to Billing Providers and/or Billing Agents. An Individual Sole



Proprietor application includes Site Locations and Provider Controlling Interest/Ownership Details. A step-by-step guide on how to enroll is at:

<https://www.illinois.gov/hfs/impact/Documents/IndividualSoleProprietor.pdf>

Basic Information

EIN/TIN:

First Name:  \*

Last Name:  \*

Suffix:

SSN:  \*

Date of Birth:  \*

Middle Initial:

Gender:

Applicant Type:  \*

### Documents to Have on Hand for IMPACT Enrollment for Individual Practitioners

When enrolling in IMPACT the following information will be needed to complete the application process:

- State professional license(s) – number along with the effective and expiration date
- NPI of the Billing Provider you will be associating to.

### Specialty/Subspecialty

When enrolling as an individual, IMPACT will ask for the Provider Type, Specialty, and Subspecialty. It is recommended that you use provider type “Dental”. Choose which specialty you are. Subspecialty choose between Primary Specialty and No Subspecialty. Options for Specialties include:

- Dental General Practice
- Endodontist
- General Dentistry Anesthesia
- Oral Pathologist
- Oral Surgeon/Maxillofacial Surgery
- Orthodontist
- Pedodontist
- Periodontist
- Prosthodontist
- Dental Hygienists

A specialty license must be included in your enrollment if you are choosing a specialty other than General Practice.

Manage Specialty/Subspecialty

Provider Type: DENTAL

Specialty:

Subspecialty: No Subspecialty

Status: Approved

Start Date:  \*

End Date: 12/31/2999 \*

### Associate Billing Provider

Rendering Servicing providers must “associate” to a Billing Provider, which is the provider who submits claims and/or receives payment for the individual practitioners, i.e. a Group, FAO, or even an Individual Sole Proprietor where the dental provider performs services.

If a dental provider at your Group or FAO already has a Medicaid provider number for a different entity, the already-enrolled provider will then need to “associate” to your Group or FAO through a modification. A step-by-step guide on how to do a modification is at:

<https://www.illinois.gov/hfs/impact/Documents/IMPACTEnrollmentModification.pdf>.

Billing Provider/Other Associations List							
Filter By		And	Filter By		And Operational Status	Active	Go
NPI/Provider ID	Provider Name	Enrollment Type	Start Date	End Date	Status	Operational Status	
<input type="checkbox"/>							
<input type="checkbox"/>		Group Practice (Corporation, Partnership, LLC, etc.)		12/31/2999	Approved	Active	

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### License/Certification

Individual Practitioners are required to have their state professional license listed on IMPACT with the appropriate effective date and expiration date of the license.

License/Certification/Other List							
Filter By		And	Filter By		And Operational Status	Active	Go
License/Cert./Other Type	License/Cert./Other #	Location	Valid Flag	Effective Date	End Date	Status	Operational Status
<input type="checkbox"/>							
<input type="checkbox"/>		01-NPI Default Base Location	Yes			APPROVED	Active

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### Taxonomy Details

A taxonomy code for the specialty from the National Uniform Claim Committee Taxonomy Code list. Choose the code that best describes you as a provider. A couple examples are listed below.

- Dentist - 122300000X
- Oral and Maxillofacial Surgery - 1223S0112X

**Add Taxonomy**

Taxonomy Code:  \* [\(Click here for Taxonomy List\)](#) ←

Description:

Start Date:  \*

End Date:

### Associate MCO Plan

Enrolling as a Dental provider you must associate with DentaQuest of Illinois, LLC. The Plan ID you would add is: 2000001

Plan ID	Plan Name	Program Description	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date
2000001	DentaQuest of Illinois, LLC	Dental Benefits	Active	01/01/2015	06/30/2022	10/30/2020	06/30/2022
2000001	DentaQuest of Illinois, LLC	FFS Dental Program	Active	01/01/2015	06/30/2022	10/30/2020	06/30/2022

### Complete Enrollment Checklist

All questions in the enrollment checklist must be answered either “yes” or “no” and comments made if directed to do so.

Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	Not Completed	
Are you currently excluded from any federal program? If yes, provide the program and date.	Not Completed	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	Not Completed	
Have you ever had a judgment under any false claims act? If yes, list judgment and date	Not Completed	
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	Not Completed	
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	Not Completed	
Have you ever had a program exclusion/debarment? If yes, provide program and date	Not Completed	
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	Not Completed	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If yes, provide details in "Add Ownership Details" step.	Not Completed	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	Not Completed	
Are you a Home Health Agency, DME, Medicare, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	Not Completed	
Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/IDD. If yes, complete "Associate MCO Plan" step in Business Process Wizard.	Not Completed	
Are you an APN (Certified RN Anesth, Nurse Midwife, Clinical Nurse Special, NP) or a Registered Behavior Technician and you have a Collaborative Agreement? If yes, provide NPI(s) of collaborating provider.	Not Completed	
Are you a Nurse Midwife, with hospital admitting and/or delivery privileges? If yes, list name and address of all facilities.	Not Completed	
Are you a Certified Registered Nurse Anesthetist without a collaborative agreement? If yes, list the names and addresses of all facilities where you practice.	Not Completed	
Is Child/Adolescent Psychiatry Residency or General Psychiatry Residency your subspecialty? If yes, enter the place of your psychiatric residency and type(s).	Not Completed	
Are you a radiologist, hospital (outpatient), Imaging Center or Independent Diagnostic Testing Facility, and are participating or wish to participate in the Breast Cancer Quality Screening Program?	Not Completed	

### Submit Enrollment Application for Approval

Click “next” to confirm that all the information that you have submitted as a part of the application is accurate. Read through all the terms and conditions, and check the box certifying that you agree to the terms and conditions. Then select “Submit Application”.

The application is then submitted to the IMPACT staff to review. The application number you were given at the beginning of the process can be used to check the status of the application by going through the “track application” option.

### Provider Information Sheet

Once the Rendering Servicing application has been approved, each Associated Billing Provider that is listed will receive a Provider Information Sheet. Individual Sole Provider Information Sheets will go to the Primary address that is listed on the location step and to the address that is listed on the Associated Billing Provider you may have listed. Do not disregard this notice.