

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 [ ]
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. Medigar: 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