Meridian Health Plan

State of Illinois
Department of Healthcare and Family Services

PROVIDER ENROLLMENT APPLICATION
ILLINOIS MEDICAL ASSISTANCE PROGRAM

(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 or print NONE.

SECTION A: PROVIDER

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

3. Provider Name

4. Primary Office Address

5. City 6. County

7. State 8. Zip Code 9. Telephone: 10. Fax:

11. E-mail 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 Qualifications (Physicians Only)

26. Hospital Admitting Privilege: (Physicians Only)

Hospital Name Address

Hospital Name Address

27. Pharmacy Location 28. Pharmacist In Charge 29. 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