# Illinois Department of Human Services
## Management Information Services - Provider Claims Section
## Community Provider FTP Registration Request

**Provider Information** (*Please Print*)

Provider FEIN ____________________________ Provider Satellite _____ *(If applicable)*

Provider Name ____________________________________________________________________

Provider Address __________________________________________________________________

City __________________________________ State ______ Zip Code _____________

**Contact Person Information**

Last Name ___________________________________ First Name ________________________

Telephone ___________________________________

E-Mail Addresses for Results Notification

Primary _________________________________ Secondary ___________________________________

I certify that all claims submitted via File Transfer Protocol (FTP) are true, accurate, and complete. I agree to keep and make available such hard copy records and source documents associated with the above-described submissions as necessary to disclose fully the nature and extent of service provided and to furnish such information regarding any payments claimed as State and Federal officials may request. I understand that payment is made from State and Federal funds and that any false claims, statements, or documents, or concealment of material facts may be cause for criminal prosecution or other appropriate legal action.

If DHS billing for a Mental Health service is included in the file, my signature below certifies that all Mental Health claims submitted comply with the appropriate DHS rules for claiming Mental Health Services especially but not limited to Rule 132- "Medicaid Community Mental Health Services Program." I agree that payment received as a result of these claims will be accepted according to the applicable rules particularly but not limited to Rule 132.

If DHS billing for a Developmental Disabilities Service is included in the file, my signature below certifies that all Developmental Disabilities claims submitted comply with appropriate DHS rules for claiming Developmental Disabilities Services especially but not limited to Rule 120- "Medicaid Home and Community based Services Waiver Program for Individuals with Developmental Disabilities." I agree that payment received as a result of these claims will be accepted according to the applicable rules particularly but not limited to Rule 120.

If DHS billing for Alcohol and Substance Abuse Service is included in the file, my signature below certifies that all Alcohol and Substance Abuse claims submitted comply with appropriate DHS rules for claiming Alcohol and Substance Abuse Services especially but not limited to Rules 2060 and 2090 - "Alcohol and Substance Abuse Clinical Program" and "Alcohol and Substance Abuse Medicaid Program." I agree that payment received as a result of these claims will be accepted according to the applicable rules particularly but not limited to Rules 2060 and 2090.

Provider Executive Director __________________________________ Date __________________

**APPROVAL** *(Required)*

MH/DD/ASA Authorization __________________________________ Date __________________

FTP Provider ID ________________________ Assigned by _____________ Date __________________
*(Assigned by DHS/MIS/BSPQA)*