



IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM

(For Office Use Only)
 Application ID: _____

A: Individual Provider Information
 (Please print clearly)

First Name:	Last Name:	
Last Four of SSN:	Date of Birth:	
Street Address:	E-mail:	
City:	State:	
Zip Code:		
Provider Type: PA <input type="checkbox"/> CNA <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/>	License Number (LPN/RN only):	NPI (LPN/RN only):

B: Questionnaire for PA/CNA (If you're unsure of how to respond, please comment N/A)

Questions	Yes	No	Comments
1. 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.	<input type="checkbox"/>	<input type="checkbox"/>	
2. 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.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you wish to end date your enrollment? If yes, what date?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Are you currently excluded from any federal program? If yes, provide the program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you ever had a criminal or Healthcare program-related conviction? If yes, provide type of conviction and date.	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever had a judgment under any false claims act? If yes, list judgment and date.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you been certified or recertified by Medicare within the last year? If yes, provide date.	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have you been certified by another State's Medicaid Program? If yes, provide each state and effective date of certification.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have you ever had a program exclusion/debarment? If yes, provide program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you ever had civil monetary penalty? If yes, provide penalty type and date.	<input type="checkbox"/>	<input type="checkbox"/>	
12. 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.	<input type="checkbox"/>	<input type="checkbox"/>	
13. Are you a Home Health Agency, DME, Medigar, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Are you a Medigar, Service Car or Taxi/Livery Company that is not registered with the Secretary of State? If yes, provide the county clerk registration number.	<input type="checkbox"/>	<input type="checkbox"/>	
15. Have you signed an agreement authorizing you or your organization to participate as an All Kids Application Agent? If yes, enter the effective date of your participation.	<input type="checkbox"/>	<input type="checkbox"/>	
16. Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/DDD? If yes, complete "Associate MCO Plan" step in Business Process Wizard.	<input type="checkbox"/>	<input type="checkbox"/>	

Provider Signature: _____

Date: _____



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C: Questionnaire for LPN/RN (If you're unsure of how to respond, please comment N/A)

	Questions	Yes	No	Comments
1.	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.	<input type="checkbox"/>	<input type="checkbox"/>	
2.	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.	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Do you wish to end date your enrollment? If yes, what date?	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Are you currently excluded from any federal program? If yes, provide the program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Have you ever had a judgment under any false claims act? If yes, list judgment and date.	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Have you been certified or recertified by Medicare within the last year? If yes, provide date.	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Have you been certified by another State's Medicaid Program? If yes, provide each state and effective date of certification.	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Have you ever had a program exclusion/debarment? If yes, provide program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
11.	Have you ever had civil monetary penalty? If yes, provide penalty type and date.	<input type="checkbox"/>	<input type="checkbox"/>	
12.	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.	<input type="checkbox"/>	<input type="checkbox"/>	
13.	Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	<input type="checkbox"/>	<input type="checkbox"/>	
14.	Are you a Home Health Agency, DME, Medigar, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	<input type="checkbox"/>	<input type="checkbox"/>	
15.	Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/DDD. If yes, complete "Associate MCO Plan" step in Business Process Wizard.	<input type="checkbox"/>	<input type="checkbox"/>	
16.	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.	<input type="checkbox"/>	<input type="checkbox"/>	
17.	Are you a Nurse Midwife, with hospital admitting and/or delivery privileges? If yes, list name and address of all facilities.	<input type="checkbox"/>	<input type="checkbox"/>	
18.	Are you a Certified Registered Nurse Anesthetist without a collaborative agreement? If yes, list the names and addresses of all facilities where you practice.	<input type="checkbox"/>	<input type="checkbox"/>	
19.	Is Child/Adolescent Psychiatry Residency or General Psychiatry Residency your subspecialty? If yes, enter the place of your psychiatric residency and type(s).	<input type="checkbox"/>	<input type="checkbox"/>	
20.	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?	<input type="checkbox"/>	<input type="checkbox"/>	
21.	Are you enrolled in the Designated Family Planning Provider/Clinic Program? If yes, provide enrollment date and approving agency.	<input type="checkbox"/>	<input type="checkbox"/>	
22.	Are you enrolled in the Vaccines for Children Program (VFC) and have a specialty/subspecialty other than OB, GYN, OB/GYN? If yes, provide enrollment date.	<input type="checkbox"/>	<input type="checkbox"/>	
23.	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.	<input type="checkbox"/>	<input type="checkbox"/>	

Provider Signature: _____

Date: _____