Illinois Medicaid
835

EDI Enrollment Instructions:

- The billing provider must have an EDIinsight customer account.
- Providers must complete ONLINE Enrollment to enter or re-validate their information on the Medicaid Illinois IMPACT system
- To designate Practice Insight as the Billing Agent, please use the following information.
  Practice Insight Billing Agent # = **7145648**
  For assistance with the IMPACT system, call 1-877-782-5565 (Opt 1), or email IMPACT.Help@Illinois.gov.
- A copy of the State of Illinois Healthcare and Family Services Provider Information Sheet is needed for Payee ERA registration purposes. (The Provider Information Sheet is sent by HFS Medicaid to providers on an annual basis and shows current credentialed information such as state license, provider key, payee, etc.). Scan and/or Save copy of the Provider's Information Sheet onto your PC.
- If the Provider has logins to the MEDI system for more than 2 Administrators, one of the Administrators will need to be removed in order for Practice Insight to be designated as Administrator on MEDI system on behalf of the provider. See Sample Letter on page 3. This letter may be faxed directly to Medicaid IL by the provider. If the provider does not want to remove their Administrator, contact the EDIinsight Enrollment Team.
- ERA enrollment processing timeframe is approximately 3-5 business days.
- To check status of ERA enrollment, support vendors may contact the EDIinsight Enrollment Team.

Claim Transactions:

There is no EDI enrollment requirement for 837 electronic claim submission to Medicaid Illinois.

ERA Electronic Remittance Advice:

- Obtain copy of the State of Illinois Healthcare and Family Services Provider Information Sheet (The provider should have a copy of their Medicaid IL Provider Sheet, but if not a copy can be obtained.) The provider can call 1-877-782-5565 (Opt 1) or email IMPACT.Help@Illinois.gov to request their Provider Sheet.
  SEE SAMPLE PROVIDER SHEET ON NEXT PAGE.
- If more than one Payee is listed on the provider sheet, circle, or check the Payee to be setup for ERAs.

Submit Document:

LOGON to EDIinsight-Enrollment Manager
ADD or SELECT payer enrollment record.
CLICK [**ATTACH File**] to attach the document to the payer enrollment record.
Answer "Yes" to Submit.
Or, click [**SUBMIT Enrollment**] to submit.

MEDICAID SYSTEM (MMIS)
PROVIDER SUBSYSTEM
REPORT ID: A2741KD1
SEQUENCE: PROVIDER TYPE
PROVIDER NAME

STATE OF ILLINOIS
HEALTHCARE AND FAMILY SERVICES

PROVIDER INFORMATION SHEET

RUN DATE: 10/19/19
RUN TIME: 03:43:30
MAINT DATE: 10/19/19
PAGE: 3493

--PROVIDER KEY-- PROVIDER NAME AND ADDRESS

[redacted]

PROVIDER TYPE: 089 - PHYS ASST
ORGANIZATION TYPE: 01 - INDIVDUAL PRACT
ENROLLMENT STATUS: B - ACTV NOCST BEGIN 09/17/19 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

PROVIDER GENDER: F
COUNTY 080-PEORIA
TELEPHONE NUMBER: ( ) -
D.E.A. #:
RE-ENROLLMENT INDICATOR: M DATE: 07/01/2022

CERTIFIC/LICENSE NUM - [redacted] ENDING 06/30/20
LAST TRANSACTION MI AS-OF 10/17/19

UPIN #:
S.S. #: XXXXX3468
CLIA #:

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
001	PHYSICIANS SERVICES	09/17/19	030	HEALTHY KIDS SERVICES	09/17/19	
102	FLUORIDE VARNISH	09/17/19				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	STATE	ZIP	PAYEE ID NUMBER	EFF DATE
1	[redacted]	[redacted]	WILLIAMSPORT	IN	47993	[redacted]	09/17/18

DBA: IEMA INDIANA
TIN #: 01

SAMPLE MEDICAID ILLINOIS PROVIDER INFORMATION SHEET

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE: [redacted]

*** ATTENTION: PROVIDERS SHOULD CONTACT IMPACT.HELP@ILLINOIS.GOV WITH ANY QUESTIONS

(Type on Provider's Letterhead)

(Today's Date)

TO: Medicaid Illinois
HFS Illinois Dept of Healthcare and Family Services
MEDI System

FAX Number: 217-785-2335

Please accept this request/authorization to REMOVE from the MEDI system one of the Administrators currently associated with this provider.

Provider Name _____

Medicaid IL Provider Key or Payee Number _____

Please remove _____ as the Administrator on the MEDI system.
(Name to be Removed)

Thank you for advising once this has been done by contacting _____ at
(Name of Contact)

_____ or send email to _____ .
(Phone Number) **(Email Address)**

(Provider's Signature)

(Provider's Printed Name)