CHECK LIST FOR <u>FACILITIES, AGENCIES, ORGANIZATIONS</u> PROVIDER REVALIDATION

1. ® **SINGLE SIGN ON(SSO) NAME AND PASSWORD**
2. ® **CHAMPS PROVIDER APPLICATION NOTIFICATION NUMBER**
3. ® National Provider Identifier (NPI)
4. ® Address Information
5. ® Federal Tax ID Number (EIN/TIN)
6. ® License/Certification Numbers
    a. Associated dates
    b. Choices:

AABB	American Association of Blood Banks	All Labs
ABC	American Board for Certification in Orthotics and Prosthetics Inc	Orthotics and Prosthetics Required
ASHI	American Society of Histocompatibility and Immunogenetics	All Labs
CARF	Commission on Accreditation of Rehabilitation Facilities	Private Duty
CCC(A)	Certificate of Clinical Competence	All Labs
CHAP	Community Health Accreditation Program	Private Duty Agencies
CLIA	Clinical Lab Improvement Amendments	All Labs Required
CMS	Centers for Medicare and Medicaid Services - Certification Number	Entities
CN	State Contract/State Programs	MCO/Contractor/Special Programs Required
COLA	Commission on Office Laboratory Accreditation	All Labs
CON	Certificate of Need	Entities
DE	MI Department of Education	ISD Required
JCAHO	Joint Commission for the Accreditation of healthcare organizations	Private Duty Agencies
ST	State Certificate	Entities/Clinics

7. ® Ownership Information **and** Ownership in other Medicare/Medicaid Entities
    a. Names
    b. Doing Business As (DBA)
    c. Phone numbers
    d. Owner address
    e. SS#/EIN/TIN#
    f. Percentage of ownership 5% or greater
    g. Relationship
    h. Associated Dates
    i. Owner Type
        i. Individual/Sole Proprietor

ii. Partnership
iii. Corporate
iv. Corporate-Charitable 501[c]3
v. Corporate-Non Charitable
vi. Government
vii. Foreign, Nonresident Alien

8. ® Provider Specialty/Subspecialty Information
9. ® Taxonomy Code
    a. Start Date
10. Billing Provider NPI and/or Billing Agent ID
    a. Association Start and End Date
11. ® Phone Number
12. Entity Business Name (DBA)
13. Managing Employee
    a. Name
    b. Social Security Number
14. Accept 835
15. Fax Number
16. Email Address
17. Web Page
18. Office Hours
19. Handicap Accessible
20. Communication Preference
21. Language Spoken
22. Mode of Claim Submission
    a. Data Exchange Gateway (DEG)
    b. Electronic Batch
    c. Billing Agent
    d. Direct Data Entry
    e. Paper
23. ® Facilities, Agencies, Organizations (Hospital and LTC)
    a. Fiscal Year End Date
    b. Number of each type of beds
        i. Medicaid Beds
        ii. Medicaid-Medicare Beds
        iii. Medicare Beds
        iv. Swing Beds
        v. LTC Units
        vi. Ventilator Dependent Units
        vii. Acute Care Beds
        viii. Temporarily Non Available
        ix. Distinct Part Unit
24. Questions:
    a. Have you ever had a Program Exclusion/Debarment?
    b. Have you ever had a Criminal or Health Related Conviction?
    c. Have you ever had a Judgment Under any False Claims Act?
    d. Have you ever had a Civil Monetary Penalty?
    e. Do you need to request a Retro Enrollment Date? If so, what date are you requesting?
    f. If Hospital, Nursing Facility, End Stage Renal Dialysis has your Certificate of Need been approved? If so, date of approval

g. Has this location been approved as a Family Planning Clinic or Maternal & Infant Support? If so, date of approval
h. Is your W-9 current on Vendor Registration? If not please go to www.cpexpress.state.mi.us
i. If you are using a Billing Agent, has the Billing Agent been approved?
j. ®Are you accepting new clients?

® REQUIRED INFORMATION