MICHIGAN MEDICAID
ELECTRONIC REGISTRATION REQUIREMENTS

ELECTRONIC REGISTRATIONS

Agreements Required

Medicaid requires the following form to be completed before claims can be sent electronically.

Billing Agent Authorization

Medicaid will only allow original agreements and signatures. Copies or faxes are not allowed. If an original form signed by CPS is not included with this packet one may be obtained by contacting CPS Provider Enrollment. Please have ready the Provider's name, tax identification number, Medicaid license number, address, contact name and telephone number. CPS will mail an original form to your office.

After you have received and completed the enrollment form please mail to:

Provider Enrollment
Medical Services Administration
Michigan Department of Community Health
PO BOX 30238
Lansing MI 48909

Medicaid will notify the Provider when they may begin sending claims electronically. Enrollment status can be verified by calling Medicaid at (517) 335-5493.

Once Medicaid approves electronic claim submission CPS must be notified. Contact CPS Provider Enrollment at (888) 255-7293. Please have ready the two digit Provider type, two digit Provider locator code and the tax identification number and Provider Medicaid number in which claims will be submitted.

ECS Provider Re-Registrations

If currently submitting electronic claims through another clearinghouse, the provider must follow the above procedures for electronic registrations.

Michigan Department of Community Health
MEDICAL SERVICES ADMINISTRATION

BILLING AGENT AUTHORIZATION

COMPLETION INSTRUCTIONS:

Note: "Billing Agent" is the business authorized by the Medical Services Administration (MSA) to submit Medicaid claims via electronic media.

- Type Or Print All Information.
- Photocopies Of This Form Will Not Be Accepted.
- A Separate, Original Form Must Be Submitted For Each Provider.
- Copy Both Sides Of This Form For Your Files.

I Hereby Authorize:

1 BILLING AGENT NAME	2 BILLING AGENT IDENTIFICATION NUMBER
Claims Processing Service, Inc.	00EN

to act as my agent for the purpose of preparing, processing and submitting claims on my behalf under the following Medicaid provider identification number(s):

3. Medicaid Provider Number: ______

4. Provider Type Code: ______

- I understand that (1) payment will be from federal and state funds and (2) I may be prosecuted under applicable federal or state criminal and civil laws if my billing agent submits false claims or documents or if I or my agent make misrepresentations, conceal material facts, or conspire to engage in any of the above actions.
- I understand that it is my responsibility to notify my billing agent, upon receipt of the notice of my authorization from the MSA, before beginning to submit Medicaid claims.
- This authorization shall remain effective until I notify the MSA in writing to the contrary or MSA negates it.
- As a condition of receiving payment from Medicaid and program for which the MSA is the fiscal intermediary for services billed on my behalf, I certify and agree to all of the provider certification conditions above and on the **reverse side** of this document.

5. PROVIDER'S NAME (Print)	6. PROVIDER'S PHONE NUMBER
	( )
7. PROVIDER'S SIGNATURE (Facsimile Signatures Will Not Be Accepted)	**8. DATE**

BILLING AGENT: I am a representative of the business authorized by MSA to submit Medicaid claims via electronic media. My signature below signifies agreement to the billing agent certification conditions on the **reverse side** of this document.

9. BILLING AGENT REPRESENTATIVE'S NAME AND TITLE (Print)	10. BILLING AGENT'S PHONE NUMBER
Denise Perri, Registration Dept.	(860) 289-6090
11. BILLING AGENT REPRESENTATIVE'S SIGNATURE (Facsimile Signatures Will Not Be Accepted)	**12. DATE**

RETURN TO: PROVIDER ENROLLMENT
MEDICAL SERVICES ADMINISTRATION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P O BOX 30238
LANSING MI 48909