PROVIDER ENROLLMENT INSTRUCTIONS FOR:

Illinois MEDI System
(Illinois Medicaid)

INSTRUCTIONS:

Illinois Medicaid provides access to all electronic claims submissions through its MEDI website. For EAC Submissions to be able to submit claims on your behalf, three processes must be completed.

- You must become a registered Medicare Provider for Electronic Claims Submissions
- EAC Submissions must request authorization to process claims on your behalf
- You must grant authorization for EAC Submissions to process claims on your behalf

To complete this process, please complete the following steps:

1. Complete the Request for Authorization form on page 3 of these instructions and return to EAC Submissions along with a copy of your Illinois Medicaid Provider Information Form
2. Determine who will be your Illinois Medicaid MEDI Administrator
   a. You can have only one Administrator
   b. The Administrator will have the authority to access all claims and to grant authority for EAC Submissions to process claims
3. Establish a State of Illinois Digital ID for the Administrator
   a. Access to the MEDI site is only granted to individuals with Digital IDs
   b. If the Administrator is a resident of Illinois register on-line at: https://autora01.illinois.gov/medi_regis1.htm
   c. If the Administrator is NOT a resident of Illinois, complete the application form on pages 4-5 of these instructions and return to Medicaid.
4. Using the Administrator’s Digital ID, register your company as a Medicaid Provider with the MEDI System
   a. Log in to the MEDI system at: https://secure.myhfs.illinois.gov/AuthenticateUserRoamingEFP.html
   b. Click on MEDI to go to your MEDI home page
   c. Click on Registration Menu in the left column
   d. Click on Medicaid Provider to go to the registration page
   e. Complete the registration page
5. Once you are registered, exit the MEDI site and wait for notification from Illinois Medicaid that EAC Submissions has requested to be authorized to submit claims on your behalf to Illinois Medicaid.

6. Once you receive the notification you will need to return to the MEDI site to grant this authorization.
   a. Log-in to the MEDI system again
      https://secure.myhfs.illinois.gov/login/AuthenticateUserRoamingEPF.html
   b. Click on Manage My Account in the left column
   c. You should see your information displayed on the screen
   d. Click on Authorization to access the authorizations for your account
   e. Click authorizations for the IEC System (Internet Electronic Claims)
   f. You should see the request from EAC Submissions
   g. Check first and last boxes (submit claims and view claim status) and submit

7. Please call EAC Submissions when this is completed.
Illinois Medicaid MEDI System Authorization Request

PURPOSE:

Illinois Medicaid requires documentation of the relationship between a Medicaid Provider (ambulance agency) and the clearinghouse (EAC Submissions). The procedure requires the following three steps:

- You must become a registered MEDI Provider for Electronic Claims Submissions
- EAC Submissions must request authorization to process claims on your behalf
- You must grant authorization for EAC Submissions to process claims on your behalf

This form is used to document your desire to have EAC Submissions submit claims on your behalf to Illinois Medicaid. Please complete the items below and return to EAC Submissions by fax, mail, or email to support@eacsubmissions.com.

When your authorization is received, EAC Submissions will make the request to Illinois Medicaid to submit claims on your behalf. Medicaid and EAC will notify you by email when this step has been completed. At that time, you will need to go to the MEDI site and grant permission for the request (see instructions for registering for Illinois Medicaid electronic submissions). Please enter the following information from your Illinois Medicaid “Provider Information Form”.

* Illinois Medicaid Provider Key: ______________________________________________________

* Illinois Medicaid Provider Name (exact company name):

__________________________________________

I authorize EAC Submissions to submit electronic Medicaid Claims through the MEDI system to Illinois Medicaid.

__________________________________________  __________________________________________  ___________
Printed Name                                                                 Signature                                               Date

__________________________________________  _____________________________________________
Email address for notification             Phone number for notification

Please fax this form and a copy of your Medicaid Provider Information Form to EAC Submissions at 815-385-4022
STATE OF ILLINOIS DIGITAL ID REGISTRATION FORM
FOR ADMINISTRATORS WHO ARE NOT ILLINOIS RESIDENTS
(ILLINOIS RESIDENTS REGISTER ON-LINE...SEE INSTRUCTIONS)

Complete the following form and mail to Illinois Medicaid
I, the undersigned, am hereby advised and understand that State law strictly forbids my use of State of Illinois data processing facilities or resources for any purpose other than Official State business. Any unauthorized usage of State data processing facilities or resources will be cause for severe disciplinary action.

Further, I understand that data processing facilities or resources include, but are not limited to, mainframe, intranet or internet access, Personal Computers (PC’s) or distributed data processing (DDP) computer equipment used in some aspect of data processing including terminals (irrespective of geographic location), software of any type, and/or programming. Further, I understand that Illinois statute and Certificate Authority policy prohibits disclosure or discussion of any State customer information or other confidential information with anyone outside the proper authorization level.

Further, I am hereby advised and understand the requirements for non-disclosure of any confidential retention of all passwords or password information acquired by me whether such information pertains to my individual password or the password(s) of others. I will exercise diligence in the safekeeping of password information and will report unauthorized disclosure promptly to the State Certificate Authority.

Mail form to the following address:
Central Management Services – State of Illinois
PKI Section
201 West Adams Room 210
Springfield Il. 62704-1874
<table>
<thead>
<tr>
<th>Entry</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST NAME</td>
<td>Requestor’s Legal Last Name</td>
</tr>
<tr>
<td>FIRST NAME</td>
<td>Requestor’s Legal First Name</td>
</tr>
<tr>
<td>MIDDLE NAME</td>
<td>Requestor’s Entire Middle Name</td>
</tr>
<tr>
<td>DATE OF BIRTH</td>
<td>Requestor’s Birth Date in MM/DD/YYYY Format</td>
</tr>
<tr>
<td>ILLINOIS DRIVERS/IDENTIFICATION CARD NUMBER</td>
<td>Requestor’s Card Number &amp; State of Issuance</td>
</tr>
<tr>
<td>E-MAIL ADDRESS</td>
<td>Requestor’s E-mail Address</td>
</tr>
<tr>
<td>OFFICE ADDRESS &amp; PHONE NUMBER</td>
<td>Requestor’s Office Address And Phone Number</td>
</tr>
<tr>
<td>HOME ADDRESS &amp; PHONE NUMBER</td>
<td>Requestor’s Home Address And Phone Number</td>
</tr>
<tr>
<td>QUESTION FOR SHARED SECRET</td>
<td>A Question the Requestor would know the answer to but no one else would</td>
</tr>
<tr>
<td>ANSWER FOR SHARED SECRET</td>
<td>The Answer to the Shared Secret Question that the Requestor would Always Remember</td>
</tr>
<tr>
<td>REQUESTOR’S SIGNATURE/DATE</td>
<td>Requestor Must Read, Sign And Date The Security Disclosure Statement For All Options Except Delete.</td>
</tr>
<tr>
<td>NOTARY’S NAME (PRINTED)</td>
<td>The Name of the Notary That inspected the document and can verify the identity of the person filling out the application. (Printed)</td>
</tr>
<tr>
<td>NOTARY’S SIGNATURE/DATE</td>
<td>Notary’s signature that validated the information and Date.</td>
</tr>
<tr>
<td>CMS LRA SIGNATURE/DATE</td>
<td>The signature of the CMS LRA that will add the person to the system. This is for internal CMS office use only.</td>
</tr>
</tbody>
</table>