NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY
REGION 9 AREA AGENCY ON AGING
VENDOR VIEW/VENDOR BILLING ENROLLMENT

PLEASE PRINT

VENDOR NAME:
VENDOR ADDRESS:
CITY/STATE/ZIP:
CONTACT PERSON NAME:
CONTACT PERSON PHONE NUMBER:
CONTACT PERSON E-MAIL:

NEW VENDOR VIEW/ VENDOR BILLING USERS:

NAME:
E-MAIL ADDRESS:
PASSWORD:
O Vendor View Only O Vendor View and Vendor Billing

- **Passwords cannot be full first/last names, "password", start with a number or contain a special character.**

NAME:
E-MAIL ADDRESS:
PASSWORD:
O Vendor View Only O Vendor View and Vendor Billing

NAME:
E-MAIL ADDRESS:
PASSWORD:
O Vendor View Only O Vendor View and Vendor Billing

Use Additional Pages, if needed.

FOR VENDOR BILLING, THE FOLLOWING CERTIFICATION MUST BE COMPLETED AND SIGNED BY EACH PERSON SUBMITTING INVOICES.

NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY
REGION 9 AREA AGENCY ON AGING

PROVIDER CERTIFICATION

Provider Name: _____

Provider NPI or Tax ID Number: _____

By signing this statement, I, the provider representative, certify that I am responsible for the accuracy and completeness of all claims transmitted to MDHHS by NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY – REGION 9 AREA AGENCY ON AGING and their billing agent.

I acknowledge that my signature on this document to support submission of claims will indicate my organization's agreement to abide by the rules and regulations for all purposes related to Title XIX (Medicaid) reimbursement by the MDHHS, including any administrative, civil and/or criminal action(s) relating to my participation in the Medicaid program. A lack of my Waiver Agent's or billing agent representative's signature on claims made on my behalf shall not be used to avoid criminal and/or civil responsibility.

This document will be kept on file to certify expenditures submitted to NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY – REGION 9 AREA AGENCY ON AGING for reimbursement and for reference when bills are submitted.

NAME: _____ TITLE: _____
(PLEASE PRINT)

SIGNATURE: _____ DATE: _____