ERA Payer Agreement Instructions for Alabama Medicaid – Payer ID MC018

Important Notes

ERA transactions are available as an additional McKesson contracted service. To add ERAs to your contract please contact your McKesson Sales person or Value Added Reseller. ERAs must be part of your McKesson contract BEFORE requesting ERA service through the McKesson EDI Enrollment Department.

Electronic Funds Transfer (EFT) is an arrangement between the Physician/Provider and the Payer. McKesson does not manage or transmit EFTs.

Before receiving ERAs for Alabama Medicaid the Physician/Provider must:

- Be processing claims electronically with this payer
- Contract with McKesson for All Payer ERA service
- Complete an ERA Enrollment Request Form
- Complete Alabama Medicaid's Electronic Remittance Advice Enrollment Form.

Guidelines for completing: Alabama Medicaid Electronic Remittance Advice Form:

- Complete all required fields
- Submit one ERA Payer Agreement for each Physician/Group Tax ID.
- Once the agreement is open in Adobe Reader you can type information onto the form.
- Forward original ERA agreement to Medicaid.and fax the McKesson ERA Enrollment Request Form to the McKesson Enrollment Team for processing.
- Please allow up to 30 days for approval and receipt of Alabama Medicaid ERA.

Electronic Explanation of Payment (EOP) Agreement

Section	Instructions
Group/Billing Provider Number:	Please insert your 9 digit Provider ID Number
Group/Billing Name:	Self Explanatory
Address, City, State and Zip:	Self Explanatory
Submitter ID, Vendor Name, Address, City, State, Zip, Vendor Phone and Contact:	Pre-filled by MedAvant
Contact, Phone Number	Self Explanatory
Authorized Signature, Date, and Title:	Signature of Provider or person authorized to sign on behalf of the provider. Date and Title.

Return Electronic Explanation of Payment (EOP) Agreement to Payer:

Fax: (334) 215-4272 Attn: ECS Department

Fax completed McKesson ERA Enrollment Request Form to:

McKesson EDI Enrollment

800-633-4763

MCKESSON
Empowering Healthcare

ERA Enrollment Request Form

Client Information: ☐ **Existing Phoenix Customer** ☐ **New Phoenix Customer**			
Client Name:			
Client ID: If new Customer leave this field blank		**Date of Request:**	
Phone Number:		**Fax Number:**	

Provider Information: **Complete one form for each Tax ID**				**Individual NPI:** **Group NPI:**	
Provider/Group Name:					
Address:				**Tax ID:**	
City:		**State:**		**Zip:**	

ERA Payer Information:
Refer to Instruction sheet attached for location of the Phoenix Payer List and Carrier Agreement Map.

Provider #	Payer ID	Payer Name	Date Sent to Payer	Service Used (ie: FedEx, UPS, USPS)	Tracking # (if applicable)

Return to McKesson Support Services – Fax # 800-633-4763

ELECTRONIC EXPLANATION OF PAYMENT (EOP) AGREEMENT

GROUP/BILLING PROVIDER NUMBER: ____________________

GROUP/BILLING NAME: ____________________

ADDRESS: ____________________

CITY: ____________________ **STATE:** ____________ **ZIP:** ________

CONTACT: ____________________ **PHONE NUMBER:** ____________

SUBMITTER ID: ____________________

VENDOR NAME: ____________________

ADDRESS: ____________________

CITY: ____________________ **STATE:** ____________ **ZIP:** ________

VENDOR PHONE NUMBER: ____________________

VENDOR CONTACT: ____________________

I (we) request to receive Electronic Explanation of Payment (EOP) information and authorize the information to be deposited in our electronic mailbox. I (we) accept financial responsibility for costs associated with receipt of Electronic EOP information.

I (we) understand that paper-formatted EOP information will continue to be sent to my (our) mailing address as maintained at EDS until I (we) submit an Electronic EOP Certification Request Form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature: ____________________ **Date:** ____________

Title: ____________________ **Internet Address:** ____________________

Mail form to: EDS • Attn: ECS Department • P.O. Box 244035 • Montgomery, AL 36124
FAX form to: 334-215-4272 Attn: ECS Department

FOR EDS USE ONLY

BILLING MODE: ________ **EOP MODE:** ________ **PROTOCOL:** ____________

CONTACT DATE: ____________ **SOFTWARE MAILED:** ____________

TEST DATE: ________ **AGREEMENT DATE:** ________ **APPROVAL DATE:** ________

BEGIN DATE: ____________ **END DATE:** ____________

NOTES: ____________________

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