



Empowering Healthcare

## ERA Payer Agreement Instructions for Colorado Medicaid – Payer ID MC004

### 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 Colorado 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 Colorado Medicaid's Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form.

### **Guidelines for completing: Colorado Medicaid Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form:**

- Complete all required fields including:
  - EDI Update Form
  - Provider id
  - Section 2 is required
  - Skip sections 3-6
  - Complete Provider Authorization page
  - Complete EFT Enrollment form
- Submit one ERA/EFT 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 along with your McKesson ERA Enrollment Request Form to the Enrollment Team for processing.
- Please allow up to 30 days for approval and receipt of Colorado Medicaid ERA.

Fax completed Colorado Medicaid ERA Agreement and McKesson ERA Enrollment Request Form to:

**McKesson EDI Enrollment**

**800-633-4763**





# Colorado Medical Assistance Program

## EDI UPDATE FORM

**Provider ID:** \_\_\_\_\_ **Provider's Current Trading Partner ID:** \_\_\_\_\_

*Providers may change/update the following sections of the ELECTRONIC DATA INTERCHANGE PROVIDER ENROLLMENT & AGREEMENT*

### Section 1. I want to update the following information:

- |  |  |
|--|--|
| <input type="checkbox"/> Provider/Submitter Demographics | <input type="checkbox"/> Transactions for Submission |
| <input type="checkbox"/> Submission Methods              | <input type="checkbox"/> Report Retrieval            |
| <input type="checkbox"/> Contact Information             |  |

### Section 2. Provider/Submitter Information

Legal Name: \_\_\_\_\_  
Business Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email Address: \_\_\_\_\_

### Section 3. Submission method

Please indicate how you plan to submit your electronic transactions.

- Vendor Software (Please complete 1 and 2 below)       Billing Agent       Clearinghouse/Switch Vendor

1. Software Product: \_\_\_\_\_ 2. Vendor trading partner ID: \_\_\_\_\_

State's Provider Web Portal

*Providers changing their submission method from:*

The State's Provider Web Portal **to** a Billing Agent or Clearinghouse/Switch Vendor  
**Must complete and submit the PROVIDER AUTHORIZATION FORM included with this form.**

*Providers changing their submission method from:*

A Billing Agent or Clearinghouse/Switch Vendor **to** the State's Provider Web Portal  
**Do not need to complete and submit the PROVIDER AUTHORIZATION FORM (page 4) with this form.**



# Colorado Medical Assistance Program

## ***Section 4. Contact Information***

### ***Sub-Section 4a. Primary Contact Information***

Contact Individual Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

### ***Sub-Section 4b. Secondary Contact Information***

Contact Individual Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

## ***Section 5. Transactions Available for Transmission***

- |                          |                                 |                          |                                 |
|--------------------------|---------------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | X12N 270 (Eligibility Inquiry)  | <input type="checkbox"/> | X12N 837P (Professional Claim)  |
| <input type="checkbox"/> | X12N 276 (Claim Status Inquiry) | <input type="checkbox"/> | X12N 837D (Dental Claim)        |
| <input type="checkbox"/> | X12N 278 (Prior Authorization)  | <input type="checkbox"/> | X12N 837I (Institutional Claim) |



# Colorado Medical Assistance Program

- I no longer want my clearinghouse/switch vendor/billing agent to retrieve my reports.  
 I want to retrieve my own reports.

## Section 6. Report Transactions

Colorado Medical Assistance Program providers can receive X12N electronic reports. Please select the reports that you want to receive through the State's Provider Web Portal. *Enter only one Trading Partner (TP) ID per report. You may enter a different TP ID for each selected report. Providers can no longer receive/retrieve reports through BBS/MEVSNET.*

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> X12N 824 (Payer Specific Error Report) Will by default be returned to submitting TP ID | <input checked="" type="checkbox"/> X12N 997 (Acknowledgement of a sent transaction) Will by default be returned to submitting TP ID |
| <input checked="" type="checkbox"/> X12N 271 (Eligibility Response) Will by default be returned to submitting TP ID        | <input checked="" type="checkbox"/> X12N 277 (Claim Status Response) Will by default be returned to submitting TP ID                 |

	Receiving TP ID		Receiving TP ID
<input type="checkbox"/> X12N 820 (Client Capitation)	_____	<input type="checkbox"/> X12N 835 (Claim payment/Claim report)	_____
<input checked="" type="checkbox"/> Accept/Reject Report	_____	<input checked="" type="checkbox"/> Provider Claim Report (Previously called the Remittance Advice Report)	_____
<input type="checkbox"/> X12N 834 (Benefit Enrollment and Maintenance)	_____		_____





# Colorado Medical Assistance Program

## PROVIDER AUTHORIZATION PAGE

*This Authorization Form must be completed and signed by any provider who wishes to authorize a billing agent, clearinghouse, or other provider to:*

- Maintain and control their reports*
- Submit and/or retrieve transactions on their behalf.*

*The authorized billing agent, clearinghouse, or provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.*

**Provider,** \_\_\_\_\_ **hereby appoints**  
Provider name (please print)

\_\_\_\_\_,  
Billing Agent/Clearinghouse/Provider name (please print)      Billing Agent/Clearinghouse/Provider Trading Partner/Submitter ID

**to act as an authorized agent for the purpose of submitting health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program. Provider also authorizes the listed agent to retrieve electronic reports/responses on Provider's behalf.**

\_\_\_\_\_  
Provider/Provider Representative name (please print)

\_\_\_\_\_  
Provider/Provider Representative signature      Date

\_\_\_\_\_  
Provider number

**This Authorization can be revoked at any time, in writing. It is considered in effect until terminated.**

Return completed form (or revocation) to:

ACS State Healthcare  
Colorado Medical Assistance Program Provider Services  
P.O. Box 1100  
Denver, CO 80201-1100.





# Colorado Medical Assistance Program

Please return the completed Provider Update Form, Provider Authorization Form (if applicable), and executed Provider Participation Agreement to the following address:

**ACS State Healthcare  
Colorado Medical Assistance Program  
EDI Enrollment  
P.O. Box 1100  
Denver, CO 80201-1100**

Agency ID UHA

State of Colorado  
**AUTHORIZATION AGREEMENT  
FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Check one:  
New  Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called the STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** \_\_\_\_\_

LEGAL NAME \_\_\_\_\_

DBA NAME \_\_\_\_\_

**Complete one of the following (EIN or SSN) but not both**

FEDERAL EIN NUMBER  
(Corporation, partnership, trust, sole proprietor, etc.) \_\_\_\_\_ - \_\_\_\_\_

or

SOCIAL SECURITY NUMBER (Individual or sole proprietor) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

DEPOSITORY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

DEPOSITORY TRANSIT NUMBER \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_

TYPE OF ACCOUNT (CHECK ONE)  CHECKING ATTACH VOIDED CHECK  SAVINGS ATTACH DEPOSIT SLIP

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford the STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date \_\_\_\_\_ Phone number \_\_\_\_\_

Authorized Signature \_\_\_\_\_

Title \_\_\_\_\_

Authorized Signature \_\_\_\_\_

Title \_\_\_\_\_

**For Fiscal Agent Use Only** Initials: \_\_\_\_\_ Date: \_\_\_\_\_

# Completion Instructions

Agency ID UHA

## State of Colorado AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)

Check one:  
New  Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called the STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** Enter your 8 digit provider number  
 LEGAL NAME Enter only the legal name assigned to the Federal EIN or SSN below  
 DBA NAME Optional - you may enter the DBA or trade name for corporation, sole proprietor, etc.

**Complete one of the following (EIN or SSN) but not both**

FEDERAL EIN NUMBER

*(Corporation, partnership, trust, sole proprietor, etc.)*

**or**

SOCIAL SECURITY NUMBER (Individual or Sole Proprietor)

ADDRESS

CITY, STATE, ZIP

DEPOSITORY NAME

ADDRESS

CITY, STATE, ZIP

DEPOSITORY TRANSIT NUMBER

ACCOUNT NUMBER

**Complete for corporations, partnerships, etc. Enter the EIN assigned to the legal name entered above.**

**Complete for individuals or sole proprietors. Enter the SSN assigned to the legal name entered above**

Enter the mailing address for the legal name entered above

Enter the City, State and ZIP for the legal name entered above

Enter the name of the bank or financial institution where the funds will be transferred

Enter the address of the bank or financial institution

Enter the City, State and ZIP for the financial institution

Enter the 9 digit number from your deposit slip or voided check (see illustrations below) or contact your financial institution for information

Enter the account number where the funds will be deposited

Enter a check mark to identify the type of account where funds will be deposited

TYPE OF ACCOUNT (CHECK ONE)  CHECKING *MUST ATTACH VOIDED CHECK*  SAVINGS *MUST ATTACH DEPOSIT SLIP*

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford the STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date Enter the date the form is signed Phone number Enter your telephone number

Authorized Signature This must be the signature of the individual or sole proprietor if an SSN is used or the authorized representative of a corporation, partnership, etc.

Title Enter the title of the authorized representative for a corporation, partnership, etc.

Authorized Signature Optional - Add a second signature only if required by your organization

Title Enter the title of the second authorized representative for a corporation, partnership, etc.

ACCOUNT OWNER NAME  
1234 Main Street  
Anytown, CO 00000

Pay to the Order OF Check number \$             
DOLLARS

ANYTOWN BANK  
Anytown, CO 00000

For  
I: 123456789 123412 1234

### Transit and Account Number Illustrations

DEPOSIT TICKET  
ACCOUNT OWNER NAME  
1234 Main Street 08-73  
Anytown, CO 00000

CASH			
C			
H			
E			
C			
K			
S			
TOTAL FROM OTHER SIDE			
TOTAL			

DATE            19           

ANYTOWN BANK  
Anytown, CO 00000

123456789 00 001 00 15

**Please note: The completed EFT form must be submitted with a completed W-9.**  
**Please allow 30 days to process your paperwork and establish your EFT.**