

## Payer Agreement Instructions for District of Columbia Medicaid - MC088

### Important Notes

The provider **must** be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the agreement to submit electronic claims. Please wait until the PIN has been assigned **before** completing these forms requesting submission of electronic claims. Please do not list the PIN as "pending".

To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. Per-Se **cannot** make this request for the provider.

- If making copies include *all* pages of this agreement and be sure they are all legible.
- Submit one agreement for each Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3- 4 weeks. If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from Per-Se or your claims will reject.

### Guidelines for completing: District of Columbia Medicaid - Payer ID MC088

## Provider Billing Agent/ Clearinghouse ACS EDI Gateway, Inc. Authorization Form

### Section A. Provider Information

Field	Instructions
<i>Please indicate your classification (required):</i>	Check if you are a solo practitioner or a group practice with a Group Medicaid ID.
<i>Business Name, Provider Name (Last, First, MI and Suffix), Business Address, City, State, Zip, Telephone Number, Fax Number, Contact name and E-Mail Address:</i>	Complete as indicated.
<i>Provider Number (Required for Individuals) or Group Provider Number (Required for Groups):</i>	Number assigned to provider or group practice by DC Medicaid. If your practice has a Group ID, then you only have to list that number.

### Section B. Authorization Signature (required)

<i>Provider name/ Provider Representative name (please print)</i>	Name of individual signing agreement on behalf of the provider or group practice.
<i>Provider/ Provider Representative name (please print)</i>	Name of individual signing agreement on behalf of the provider or group practice.
<i>Provider/ Provider Representative Signature</i>	This agreement must be signed by the provider or an authorized representative.

*Return the Agreement to the Payer:*

**Fax #**

(850) 385-1705

**Physical address for USPS, FedEx, UPS, etc.**

ACS EDI Gateway, Inc.  
Attention: EDI Enrollment Unit  
2324 Killearn Center Boulevard  
Tallahassee, FL 32309

---

---

**Questions? Contact Per-Se enrollment at:**  
(800) 689-4550, Option 1

Washington, D.C. ACS EDI Submitter Enrollment Form



Please return to:  
Attn: EDI Enrollment Unit  
ACS EDI Gateway, Inc.  
2324 Killearn Center Boulevard  
Tallahassee, Florida 32309  
Or fax to 850-385-1705



Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc. Authorization Form

**Section A. Provider Information.**

Please indicate your classification (required): <input type="checkbox"/> Individual Provider <input type="checkbox"/> Group Provider/Practice	
Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number (Required for Individuals)	Group Provider Number (Required for Groups)
Business Address	
City, State, and Zip	
Telephone Number	Fax Number
Contact Name	E-mail Address

**Section B. Authorization Signature (required).**

Provider, \_\_\_\_\_ hereby appoints

*Provider name /Provider Representative name (please print)*

\_\_\_\_\_  
*Billing Agent/Clearinghouse name (please print)*

\_\_\_\_\_  
*Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 277-Claims Status Response                       271-Eligibility Response                       824-Error Report
- 835-Healthcare Claims Payment Advice                       278-Prior Authorization Response

\_\_\_\_\_  
*Provider/Provider Representative name (Please print)*

\_\_\_\_\_  
*Provider/Provider Representative Signature*

\_\_\_\_\_  
Date