



Empowering Healthcare

ERA Payer Agreement Instructions for Washington DC Medicaid– Payer ID MC088

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 Washington DC 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 Washington DC Medicaid's Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form.

Guidelines for completing: Washington DC Medicaid Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form:

- Complete Provider ACS EDI Gateway Authorization Form.
- Section A
 - Classification
 - Business Contact Name
 - Provider Group or Individual Number (depending if group or sole practitioner)
 - City/ State / Zip
 - Contact Information (Name, phone, fax, email)
- Section B
 - Provider Name
 - Signature
- 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 Washington DC Medicaid ERA.

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

McKesson EDI Enrollment

800-633-4763

Washington, D.C. ACS EDI Provider Enrollment Form



Please return to:
ACS
Attn: Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761
Or fax to: 202-906-8399



Provider ACS EDI Gateway Authorization form for Billing Agents and Clearinghouses.

Section A. Provider Information.

Please indicate your classification (required): Individual Provider Group Provider/Practice

Business Person

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