



Empowering Healthcare

ERA Payer Agreement Instructions for Florida Medicare – Payer ID MR025

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 Florida Medicare 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 Florida Medicare's Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form.

Guidelines for completing: Florida Medicare Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form:

- Section E- Sign and enter your Medicare A or B Provider Name and Number
- Complete all other required fields
- 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 directly to Medicare.
- Fax your McKesson ERA Enrollment Request Form to the Enrollment Team for processing.
- Please allow up to 30 days for approval and receipt of Florida Medicare ERA.

Fax or Mail the Florida Medicare ERA Agreement to:

Fax number: (904) 791-6692

Physical address for FedEx, UPS, etc.

Florida Medicare EDI- FL Enrollment Team
532 Riverside Ave. 4C
Jacksonville, FL. 32202-4918

P.O. Box for USPS

Florida Medicare EDI- FL Enrollment Team
P.O. Box 44071- 4C
Jacksonville, FL. 32231-4071

Fax completed Florida Medicare ERA Agreement and McKesson ERA
Enrollment Request Form to:

McKesson EDI Enrollment

800-633-4763



**MEDICARE
Electronic Data Interchange**

ELECTRONIC DATA REQUEST (EDR) FORM

SECTION A: REQUEST TYPE. Please Check One. This section is required.

New Sender/Submitter: (New Installation/Change of Vendor Form is required to accompany this request.)

- ADD ELECTRONIC REMITTANCE ADVICE ASC X12N 835 version 4010A1
- ADD ELECTRONIC CLAIMS STATUS REQUEST AND RESPONSE ASC X12N 276/277 version 4010A1 (Not supported by PC-ACE Pro32® software)

Existing Sender/Submitter: (A sender/submitter number has already been issued.)

- ADD ELECTRONIC REMITTANCE ADVICE ASC X12N 835 version 4010A1
- DELETE ELECTRONIC REMITTANCE ADVICE ASC X12N 835 version 4010A1
- ADD ELECTRONIC CLAIMS STATUS REQUEST AND RESPONSE ASC X12N 276/277 version 4010A1 (Not supported by PC-ACE Pro32® software)
- DELETE ELECTRONIC CLAIMS STATUS REQUEST AND RESPONSE ASC X12N 276/277 version 4010A1

NOTE: *The provider is required to have a signed EDI Enrollment Form on file. Failure to have an EDI Enrollment form on file will result in the EDR form being returned.*

SECTION B: SENDER/SUBMITTER INFORMATION. All fields in this section are required unless otherwise indicated as optional or conditional.

Sender/Submitter Number (Conditional): _____
(Required when adding or deleting a transaction to an existing sender/submitter)

Sender/Submitter Name: _____

Mailing Address: _____

City/State/Zip: _____

Contact Name: _____ Position/Title: _____

Telephone: _____ EXT. _____

Fax (Optional): _____ Email Address (Optional): _____

SECTION C: VENDOR INFORMATION. The software support vendor can assist with this section. **All fields in this section are required unless otherwise indicated as optional.**

Vendor Name: _____

Vendor Address (Optional): _____

City/State/Zip (Optional): _____

Contact Name (Optional): _____ Position/Title (Optional): _____

Telephone Number (Optional): _____ Fax Number (Optional): _____

SECTION D (Optional): DEFAULT DELIMITERS. Contact your software support vendor for assistance with this section. If you are using the PC-ACE Pro32® software, leave blank. If your software supports the default delimiters, please leave blank.

The default delimiters returned on electronic remittance advice are:

- * (2A hex value) for element delimiter;
- > (3E hex value) for sub-element delimiter; and
- Line Feed (0A hex value) for segment delimiter.

If alternate values are required, please indicate below:

Element _____ Sub-element _____ Segment _____

SECTION E: PROVIDER SIGNATURE, TITLE, MEDICARE BILLING PROVIDER NAME, MEDICARE PROVIDER NUMBER (IF KNOWN) EFFECTIVE DATE, NPI, PROVIDER'S TAX IDENTIFICATION / SOCIAL SECURITY NUMBER: This section is required. Please copy and complete this page for each additional provider.

“By signing below, I authorize the indicated electronic data request addition or deletion.

X _____ / _____
 (Signature) (Title)

MEDICARE PART “A” PROVIDER: _____ / _____
 (FL ONLY) Name of Provider Medicare Provider Number
 (If known)

MEDICARE PART “B” PROVIDER: _____ / _____
 Name of Provider Medicare Provider Number
 (If known)

EFFECTIVE DATE: _____ NPI: _____
 (National Provider Identifier)

BILLING PROVIDER'S TAX IDENTIFICATION NUMBER / SSN: _____

****Attention: The provider is required to notify Medicare EDI, in writing, in advance of any changes impacting their use of EDI and the effective date of such changes. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party. The form necessary to notify us of such changes is the EMC Change of Information form that can be downloaded from the Web site www.fcso.com. Select Medicare Electronic Services-Using EDI-Forms.**

If you have questions about the completion of this form, please refer to the "General Completion Instructions" of the EDR form.

Mailing Address:

Medicare EDI
PO Box 44071 – 14T
Jacksonville, FL 32231-4071

Telephone and Fax Numbers:

FL (904) 791-8767, option 2
CT (203) 639-3160, option 1
Fax (904) 791-6692

Physical Address:

Medicare EDI
532 Riverside Ave. 14T
Jacksonville, FL 32202-4918

