

## **Florida Medicaid – Payer ID MC010 Payer Agreement Instructions**

### **Are you set up with the Payer?**

This enrollment form is for submitters who have completed all necessary arrangements with this payer. Although payer requirements vary, please be sure to:

- Register your NPI with this Payer
- Contract with this Payer, if needed. You must have a valid Provider Identification Number (PIN).

In addition there may be other EDI payer requirements. For more specific information please contact the Payer's Provider Relations Department.

### **McKesson Requirements**

Complete the Exhibit B & Carrier Agreement Tracking Form (CAT Form) and fax to the McKesson EDI Enrollment Department at: 800-633-4763. These forms are included in the next two pages.

- This form is used to update the provider/practice profile with the correct information so that approval can be obtained from the payer for electronic submission.
- This form can also be used if you are making changes to an existing setup for this payer, i.e. change to Provider PIN or NPI.
- Please ensure that any tracking information is included. This is used when contacting the payer for approvals.
- Failure to complete this form and submit to McKesson may delay the processing of this payer with the clearinghouse.
- The Exhibit B & CAT Form does not go to the payer, only to McKesson EDI Enrollment.

### **Payer Enrollment**

- Some payers require original forms.
- If the payer accepts copies, be sure to include all pages of the agreement and verify that they are legible.
- Submit one agreement per Provider Group ID
- Incomplete or incorrect agreements may be denied or returned by the payer and may require the enrollment process be started from the beginning.
- Approvals can take 3 – 4 weeks.

### **Payer Approvals**

- In some cases the payer will send the approval to the provider/practice instead of notifying the clearinghouse. If you receive payer approval please let us know by faxing a copy to EDI Enrollment at: 800-633-4763.
- DO NOT transmit claims to this payer until you have verified with the Enrollment Department that the clearinghouse has received and updated the approval in their system.

**Guidelines for completing: Florida Medicaid**

When you have completed this agreement please mail to the payer at:

**Mailing Address:**

EDS  
Provider Enrollment  
P.O. Box 7070  
Tallahassee, FL 32314-7070

**Florida EDI Information Sheet**

Section	Instructions
Indicate if Group Practice or Individual Provider, Business Name, Contact Name, Phone & Fax Number	Complete all fields. This is the person that EDS would call if they need to contact your organization.
FL Medicaid Provider I.D. (required):	9 digit assigned Medicaid Provider I.D.
Clearinghouse Company Name, Trading Partner ID:	Pre-filled
Additional Information:	No additional information required

**Electronic Claims Submission Agreement**

Section	Instructions
Provider Name & Representative's Name	Print Provider Name & Representative's Name
Provider/Representative Signature & Date	Signature of Provider or Representative who has authorization to sign on behalf of the provider & Date Agreement. Please sign with <b>Blue ink</b>
Medicaid Provider ID Number	9 digit assigned Medicaid Provider I.D.
Telephone Number for Receiving Call & Claims Submission	Self Explanatory
Address, City, State, Zip Code:	Complete as requested

**Florida Medicaid Provider Billing Agent Agreement**

Section	Instructions
Billing Agent Name, Billing Agent Provider Number, Billing Agent Address, City, State, Zip, Phone:	Pre-filled
Signature, Print Name & Title, Date:	Complete as indicated

Please complete the **McKesson Ex. B & CAT Form** and fax to:

<b>McKesson EDI Enrollment</b> 800-633-4763
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**FAX TO 1-800-633-4763**

Each provider in the practice planning to submit health care transactions electronically must be included in this enrollment form. If a provider has more than one office, please complete a separate form for each office.

**PLEASE CHECK ONE OF THE BELOW CHOICES**

- Add on Provider (Adding Provider to existing McKesson Account)\*
- Add on Payer ( Adding Payer to a Provider with an existing McKesson account)\*\*
- Update or Change to a Provider's PIN or Group Number for requested payers.\*\*

\*Adding a provider to an account may result in a pricing increase depending on the pricing plan you are currently on. If you are not sure what pricing plan you are on, please contact your Value Added Reseller or the EDI Enrollment Department at 1-800-689-4550

\*\* If adding or changing information regarding an Insurance Carrier/Payer for an existing provider you must also complete the Carrier Agreement Tracking Form (CAT Form) which is page 2 of this document.

Client ID: \_\_\_\_\_ Practice Tax-ID: \_\_\_\_\_

Practice Name: \_\_\_\_\_

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

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

E-Mail Address: \_\_\_\_\_ VAR # \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

Billing service name: \_\_\_\_\_ Billing Service Tax  
 ID: \_\_\_\_\_ (If applicable) (If  
 applicable)

<i>First Name</i>	<i>Last Name</i>	<i>Credential</i>	<i>Specialty</i>	<i>Individual NPI</i>	<i>Group NPI</i>

<b>Practice Name:</b>	
<b>Practice Tax ID:</b>	

Please include this form with the Exhibit B. Complete this form for each provider in the practice after all agreements have been forwarded to the respective carriers. You may wish to retain a copy of this form for your records.

In the grid below, please enter **ALL** of the requested information for each carrier/payer to enroll. **This is critical information that is required to complete your enrollment process. The clearinghouse cannot contact payers to confirm your approval for electronic transmission without first knowing the date agreements were mailed to them.**

\*Please indicate the appropriate Payer ID Number below each payer as indicated in the payer directory. The Phoenix Payer Directory can be found online at [http://www.lytec.com/download/Phoenix\\_Payer\\_List.pdf](http://www.lytec.com/download/Phoenix_Payer_List.pdf) for Lytec users or at [http://www.medisoft.com/download/Phoenix\\_Payer\\_List.pdf](http://www.medisoft.com/download/Phoenix_Payer_List.pdf) for Medisoft users

Payer	Provider #1	Provider #2	Provider #3
	Name:	Name:	Name:
	Ind NPI:	Ind NPI:	Ind NPI:
	Group NPI:	Group NPI:	Group NPI:
<b>Medicare</b>	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
<b>Medicaid</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>BCBS</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>TriCare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>RR Medicare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #

Please note the date on which you sent each carrier agreement to the carrier and the service used to send it (i.e., UPS, FedEx, Airborne Express, etc.) as well as a package tracking number, if applicable.

Carrier/Payer Name	Date Mailed	Service Used	Tracking Number



0 1 2 1

# Electronic Data Interchange Agreement

Medicaid Provider ID: \_\_\_\_\_ NPI: \_\_\_\_\_

Provider Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_\_

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

The Medicaid provider listed above is a (check one): \_\_\_\_\_ Provider \_\_\_\_\_ Billing Agent/Clearinghouse

## Section 1: Transaction Information

Complete this section to indicate how you plan to submit or receive electronic transactions.

- If you are currently submitting/receiving electronic transactions directly to/from Medicaid, indicate your current 5-digit or 6-digit Trading Partner ID. \_\_\_\_\_

- If you plan to use a software vendor to submit/receive electronic transactions to/from Medicaid, indicate the software vendor's Trading Partner ID. \_\_\_\_\_

NOTE: If you do not provide the software vendor's Trading Partner ID, you will be required to test. \_\_\_\_\_

- If you plan to use a billing agent/ clearinghouse to submit directly to/from Medicaid, indicate the billing agent/clearinghouse's Trading Partner ID. \_\_\_\_\_

NOTE: To designate a billing agent to submit claims on your behalf, complete Section 2. \_\_\_\_\_

- Indicate the transaction types you plan to send/receive.

- |                                      |   |
|--------------------------------------|---|
| _____ 820 Premium Payment            | _____ 837D Dental (Encounter)                   |
| _____ 837P Professional              | _____ 835 Remittance Advice                     |
| _____ 837P Professional (Encounter)  | _____ 834 Benefit Enrollment (Inbound/Outbound) |
| _____ 837I Institutional             | _____ 270/271 Eligibility Request/Response      |
| _____ 837I Institutional (Encounter) | _____ 276/277 Claim Status Request/Response     |
| _____ 837D Dental                    |   |

- Select the method of submission that you will use to transmit your transactions.

- |                                    |   |
|------------------------------------|---|
| _____ Web Portal / Software Vendor | _____ Provider Electronic Solutions (PES)<br>(Replaces the Winasap2003) |
|------------------------------------|---|

NOTE: If you are using a Billing Agent/Clearinghouse, skip this section.

If you select Provider Electronic Solutions (PES) to submit claims to Medicaid, please go to the website [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com) for a free download of the software. Should you experience any problems, call the EDI Helpdesk at 1-800-289-7799, option 3.



**Section 2: Florida Medicaid Billing Agent Agreement**

**This section must be completed by any provider who wishes to designate or change a billing agent to submit claims for reimbursement by Florida Medicaid.**

**The following requirements apply to all billing agents/clearinghouses:**

1. Any entity, that submits claims to Medicaid on behalf of an enrolled Medicaid provider must be enrolled in the Medicaid program as a billing agent with an active provider number.
2. Claims must be paid in the name of the provider or provider group that renders the services, not in the name of the billing agent.
3. Payment for billing services must be made based upon an administrative fee per claim. Billing agents are prohibited from charging for their services based upon a percentage of the total dollar value of claims billed.
4. If a claim is rejected as inaccurately filed, it cannot be resubmitted unless there has been a change made to the claim form or electronic submission itself.

“The following billing agent is authorized to submit claims to and follow up with Medicaid and the Medicaid fiscal agent on my behalf. I understand that all payments and payment information are in my name and that this agreement does not exempt me from responsibility for claims filed on my behalf or from established claim filing policies. I further understand that the billing agent must be held to the same requirements of confidentiality and access to records as I am, as reflected in my agreement with Medicaid. I will immediately notify the Medicaid fiscal agent of any change in this authorization.”

Billing Agent Name: \_\_\_\_\_ Billing Agent Provider Number: \_\_\_\_\_

**Section 3: Certification**

**The provider identified on this Electronic Data Interchange Agreement understands and agrees to the following:**

1. Payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws.
2. Providers must safeguard the Medicaid program against abuse in the use of electronic claims submission.
3. Providers must correctly enter the claims data, monitor the data and certify that the data entered is correct.
4. Providers must assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments by the Agency's fiscal agent that might result from carelessness or fraud.
5. Providers must have on file the applicable source data to substantiate the claim submitted to the Medicaid program.
6. Providers must allow the Agency or any of its designees and representatives of the office of the Auditor General or the Attorney General to review and copy all records, including source documents and data related to information entered through electronic claims submission.
7. Providers must abide by all Federal and State statutes, rules, regulations, and manuals governing the Florida Medicaid program.
8. Providers must sign and adhere to all conditions of the Medicaid Provider Agreement and be officially enrolled in the Medicaid program to participate in electronic claims submission.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail completed form to:**

**For Regular Mail:**

**EDS Provider Enrollment**  
P.O. Box 7070  
Tallahassee, FL 32314-7070

**For Overnight or Express Delivery:**

**EDS Provider Enrollment**  
2671 Executive Center Circle West  
Suite 100  
Tallahassee, FL 32301

(Florida Medicaid Program – Do not write below this line)

Received	By:	Date:	
FMMIS Updated	By:	Date:	