

Payer Agreement Instructions for Georgia Medicaid Payer ID MC020

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: Georgia Medicaid Payer ID MC020

Physical address for USPS, FedEx, UPS, etc.

ACS EDI Gateway, Inc.
Attn: EDI Enrollment Unit
PO Box 4000
McRae, GA 31055

Field	Instructions
Power of attorney	Must be filled out by all providers
EDI Update form	Should ONLY be filled out for providers that are currently enrolled but changing clearinghouses

The Power of Attorney must be notarized.

Once the Medicare form(s) has been completed and mailed to the payer, please complete the **McKesson Ex. B & CAT Form** and fax to:

McKesson EDI Enrollment

800-633-4763

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) 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>

Practice Name:	
Practice Tax ID:	

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 for Lytec users or at 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:
Medicare	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
Medicaid	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
BCBS	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
TriCare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
RR Medicare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	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

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, _____ (*Provider's Name*), with Provider Number(s)
_____ hereby appoints _____

(*Name of Billing Service*), _____ (*Billing Service Trading Partner ID*) as attorney-in-fact
for the benefit of Provider, and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

To act as Provider's authorized agent for purposes of signing, on behalf of Provider, the certification statement herein in connection with each Computer Media Input submission of medical assistance claims:

"I hereby certify that all information contained on and submitted by Computer Media Input is true, accurate, and complete, and that to the best of my knowledge, information and belief, the services for which medical assistance was sought, in fact, have been rendered by Provider as claimed. Furthermore, I understand and acknowledge that the Department will rely on this certification in the payment of medical assistance, which payment will be made from State and Federal funds, and that the submission of any false claims, information, or documents or the concealment of any material facts is a crime under Federal and State laws."

To maintain all original source documents for six (6) years following the month of payment, and to ensure that every electronic entry can be associated and identified with a source document.

Provider agrees that the billing service is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.

Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted by the appointed billing service, and in no way forecloses the application of penalties that may be assessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This _____ day of _____, in the year _____.

Printed Name of Enrolled Provider

By: _____
Signature of Provider or Authorized Representative

Title of Authorized Representative

Sworn to and subscribed before me
this _____ day of _____, in the year _____.

(Notary Public)

My Commission expires: _____



ACS EDI Update Form

ACS EDI Gateway, Inc.

1-800-987-6715

www.acs-gcro.com



A. IDENTIFICATION INFORMATION

Please indicate your Provider/Business name:										
Please indicate your provider ID (if applicable):	**This number consists of 9 numeric digits and 1-2 alpha characters**									
Please indicate your ACS EDI Trading Partner ID (if applicable): <i>(Your trading partner ID was issued to you at the time of enrollment with ACS EDI. You may find this ID on your ACS EDI Logon/Welcome form.)</i>										
A trading partner ID could range from 3-8 digits										

B. CONTACT INFORMATION

Please indicate a contact person for your business. <i>(This should be the person to contact if we have questions concerning this request?)</i>	Contact individual:	First name:	Last name:
	Contact phone #:		Contact fax #:

C. SPECIAL REQUEST

Please select the option that best fits your request and sign below in section D. (Check all that apply)

I am no longer interested in being a trading partner with ACS EDI Gateway, Inc. Please discontinue my trading partner profile. My ACS Gateway logon user name and user ID are as follows:

User name:	User ID:
------------	----------

I wish to change my relationship with my current **Billing Agent/Clearinghouse** as indicated below:

Action	Provider Name	Provider Number	Transaction Types (i.e.: 997, 835, 837, or ALL)	Trading Partner ID
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add				

(You may attach an additional sheet if necessary)

Other:

D. PLEASE SIGN AND DATE BELOW (required)

Requester name (please print): _____

Signature of requester: _____

Date: _____

Please return completed form to:

Fax #: 1-866-309-0935
or mail to:
ACS
Attn: EDI Enrollment Unit
PO BOX 4000
McRae, GA 31055