

Payer Agreement Instructions for Maine Medicaid - MC031

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. McKesson **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 MedAvant or your claims will reject.

Guidelines for completing: Maine Medicaid – Payer ID MC031

MaineCare Electronic Media Claims Rider

Section C

Field	Instructions
<i>By (Provider's Signature), Printed Name and Title:</i>	This agreement must be signed by the provider.
<i>Facility Name, Provider Number, Phone Number:</i>	Complete as indicated.

Return the Agreement to the Payer:

Fax #

(207) 287-1157

McKesson's Claims Enrollment Form

Please complete a McKesson Enrollment Form for each Tax ID and fax it to McKesson at: (800) 633-4763. This form can be used if you are enrolling with one or more new Payer(s) or if you are enrolling a new rendering provider with your existing Payer(s).

**The Claims Enrollment Form, with instructions
is located at:**

<http://www.MedAvanthealth.com/payerlist/default.asp>

Questions? Contact MedAvant Enrollment at:
(800) 792-5256, Option 1

MAINECARE
ELECTRONIC MEDIA CLAIMS RIDER

This Rider permits the electronic generation of claims that will be acceptable to the Department in lieu of written claims. This Rider sets forth requirements under which the provider and the Department will operate:

- Section A: Responsibilities of the Provider
- Section B: Responsibilities of the Department
- Section C: Ratification

Section A

Responsibilities of the Provider

1. The Provider agrees to submit claims to the Department only in the format specified by the Department.
2. The Provider agrees that the Department, Secretary of Health and Human Services or designees have the right to audit and confirm information submitted by the Provider and shall have access to all original source documents, including medical and financial records.
3. The Provider agrees to research and correct any and all, discrepant claims submitted to the Department.
4. The Provider agrees to assume the responsibility to prepare or submit claims and to be solely responsible for errors, omissions and liabilities, regardless of whether claims are submitted by the Provider or by a billing agent.
5. The Provider agrees to assume all costs of hardware and software needed to facilitate the submission of electronic media claims (EMC).
6. The Provider will furnish to the Department the name of the billing agent, the telephone number, and a contact person in the event a billing agent is used for the submission of EMC.
7. The Provider acknowledges that the Provider or the Department may terminate this Rider with a 30-day written notice to the other party.

Section B

Responsibilities of the Department

1. The Department agrees to furnish the Provider with the specifications for submission of electronic media claims.
2. The Department agrees to maintain a phone line to send and receive data and a separate phone line which the Provider may use to address any issues or problems related to claims submission, claims processing and/or remittance information.
3. The Department agrees to produce data on paid/denied claims. Processed claims will be listed on each remittance statement and sent directly to the Provider for purposes of comparison and verification.
4. The Department acknowledges that the Department or the Provider may terminate this Rider with a 30-day written notice to the other party.

Section C

Ratification

In witness whereof, and as consent to this Rider, the parties herein have executed this Rider and ratified it by their signatures found below:

By _____
Provider's Signature Date

Printed Name: _____

Title: _____

Facility Name: _____

Provider Number: _____

Phone Number: _____

If using a billing service, please provide the following:
PLEASE DO NOT LIST YOUR SOFTWARE VENDOR.

Name of billing service: _____

Phone Number: _____

Contact Person: _____

USER ID: _____

By _____
State Department's Signature Date

Printed Name: _____

Title: _____

Please indicate your software:

Hyperterminal: _____

PROCOMMPlus 4.8 _____

Other: _____

Confirmation Report Method: ***If you are billing directly to the state***, then you must choose one of these options.

Callback (phone number of computer to receive call):

Email (email address of person to receive report):

FaxBack (the number to your fax machine)
