

**UCARE Of Minnesota – Payer ID SX178**  
**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**

**This Payer does not require an agreement.**

To be set up with this Payer, complete a McKesson Claims Enrollment Form and forward it to our Enrollment Department. Be sure the Claims Enrollment Form includes:

- Your McKesson Client ID.
- Provider Name.
- Provider Tax ID/NPI.
- Provider Site Address.

**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.

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) (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 |
|--------------------|-------------|--------------|-----------------|
|                    |             |              |                 |
|                    |             |              |                 |
|                    |             |              |                 |