

## **Nebraska Medicaid – Payer ID NEMCD 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: Nebraska Medicaid- Payer ID NEMCD**

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

**Fax Number:**  
(402) 742-2353

**Mailing address for USPS**  
HHS Finance and Support  
Attention: Medicaid EDI Customer Support  
P. O. Box 95026  
Lincoln, NE 68509-5026

**NEBRASKA MEDICAID TRADING PARTNER AUTHORIZATION**

**Page 1**

Section	Instructions
With this understanding, I .....	Name & Title of person completing agreement.
Representing:	Name of Practice/ Provider.
Authorized for the following NE Medicaid Provider(s) and Provider Number(s):	The NE Medicaid Provider ID and Provider Name of each provider in the practice. If you have a Group ID, list that number here.

**Page 2**

Section	Instructions
Typed or Printed Name:	Name & Title of person completing agreement.
Signature, Title, Date:	This agreement must be signed by the provider or authorized agent.
Title, Date, Provider/Office Name, Provider/Office Address, City, State, Zip, Phone Number, Fax, Email Address:	Complete as indicated.
If you are switching from one clearinghouse to another .....	Previous clearinghouse name, if applicable.

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

<b>McKesson EDI Enrollment</b>
--------------------------------

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>

<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

## NEBRASKA MEDICAID TRADING PARTNER AUTHORIZATION

This Authorization is required of all Nebraska Medicaid Providers who wish to submit or receive electronic transactions directly or through a third party, such as a clearinghouse, to Nebraska Medicaid (hereinafter known as "NE Medicaid"). The submitter of such transactions is hereinafter known as "Trading Partner."

NE Medicaid will only exchange transactions with an approved Trading Partner when an Authorization is on file from a NE Medicaid provider. The Authorization must list the specific provider number(s), transaction(s) and the effective date(s) of the Authorization. For each transaction, the Start Date is the date upon which NE Medicaid can start accepting that transaction, and the End Date is the last date upon which a transaction can be accepted. The End Date is not required until applicable. When a Trading Partner is no longer authorized for any or all of the provider numbers and/or transactions listed, a new Authorization must be completed providing the End Date(s). Only one Trading Partner can be authorized per transaction at a time and the authorized dates may not overlap. NOTE: When authorizing for multiple provider numbers, if the transaction(s) or effective date(s) information varies for provider numbers, please complete separate Authorizations.

**With this understanding, I,** \_\_\_\_\_,  
(Name) (Title)

**representing:** \_\_\_\_\_  
(Provider Name)

**authorize:** \_\_\_\_\_  
(Trading Partner)

**to submit and/or receive the electronic transactions indicated below on behalf of the listed NE Medicaid Provider Numbers for the dates indicated:**

Authorized for the following NE Medicaid Provider(s) and Provider Number(s):

PROVIDER NUMBER (11 digits)	PROVIDER NAME

(Note: Please attach a separate sheet for additional provider numbers, if necessary.)

SUBMIT / RECEIVE WITH NEBRASKA MEDICAID:

	Start Date	End Date
<input type="checkbox"/> 837 Professional Claim*		
<input type="checkbox"/> 837 Institutional Claim*		
<input type="checkbox"/> 837 Dental Claim*		
<input type="checkbox"/> 270/271 Eligibility Inquiry / Response		
<input type="checkbox"/> 276/277 Claim Status Request / Response		
<input type="checkbox"/> 278 Prior Authorization Inquiry / Response		
<input type="checkbox"/> 835 Remittance Advice / Refund Requests Report**		

\*Trading partners will receive an Electronic Claims Activity Report for deleted/rejected claims and 997 Functional Acknowledgements for submitted files.

\*\* Electronic Fund Transfer required. EFT enrollment form is available on web site. When receiving the 835, the Refund Requests Report will only be provided electronically.

# NEBRASKA MEDICAID TRADING PARTNER AUTHORIZATION

## Authorization

On behalf of the Nebraska Medicaid Provider(s) listed above, the undersigned hereby attests and acknowledges that:

- he or she is authorized to complete and sign this Authorization;
- the information provided is accurate and true;
- electronic submission of claims through a trading partner constitutes certification as required by 471 NAC 3-003.02;
- the Trading Partner is responsible to communicate to the Provider any problems or delays in transmission, as well as error/reject information or reports that the provider needs in order to correct, track or complete transactions;
- Nebraska Medicaid will not exchange transactions with a Trading Partner on behalf of a provider without this Trading Partner Authorization;
- the Trading Partner must have an active Trading Partner Agreement with Nebraska Medicaid, or this Authorization is null and void; and,
- this information will be kept current by completing new Authorizations as necessary.

Typed or Printed Name: \_\_\_\_\_ (Required)  
Signature: \_\_\_\_\_ (Required)  
Title: \_\_\_\_\_ (Required)  
Date: \_\_\_\_\_ (Required)  
Provider/Office Name: \_\_\_\_\_ (Required)  
Provider/Office Address: \_\_\_\_\_ (Required)  
City, State, Zip: \_\_\_\_\_ (Required)  
Phone Number: \_\_\_\_\_ (Required)  
FAX: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**If you are switching from one clearinghouse to another, please indicate your previous clearinghouse to discontinue submission of the above transactions.**

**Discontinue Clearinghouse:** \_\_\_\_\_

Please complete and submit this form to Nebraska Medicaid. If using a clearinghouse, you may be requested to return this form to the clearinghouse. If submitting this form directly to Nebraska Medicaid, mail or fax to:

FAX: 402-742-2353

Mail: Department of Health and Human Services  
Attn: Medicaid EDI Help Desk  
PO BOX 95026  
Lincoln, NE 68509-5026

If you have questions, please contact the Nebraska Medicaid EDI Help Desk at:

Email: [medicaid.edi@dhhs.ne.gov](mailto:medicaid.edi@dhhs.ne.gov)

Phone: 402-471-9461 (*In Lincoln*)  
866-498-4357 (*Outside of Lincoln*)