



Empowering Healthcare

ERA Payer Agreement Instructions for New Jersey Medicaid – Payer ID MC087

Important Notes

ERA transactions are available as an additional McKesson contracted service. To add ERAs to your contract please contact your McKesson Sales person or Value Added Reseller. ERAs must be part of your McKesson contract BEFORE requesting ERA service through the McKesson EDI Enrollment Department.

Electronic Funds Transfer (EFT) is an arrangement between the Physician/Provider and the Payer. McKesson does not manage or transmit EFTs. EFT Authorization form is attached to the 835 agreement and must be completed by the provider to be authorized for 835 electronic remittances.

Before receiving ERAs for New Jersey Medicaid the Physician/Provider must:

- Be processing claims electronically with this payer
- Contract with McKesson for All Payer ERA service
- Complete an ERA Enrollment Request Form
- Complete New Jersey Medicaid 's Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form.

Guidelines for completing: New Jersey Medicaid Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form:

- Complete all required fields.
- Complete the Medicaid 835 – Electronic Remittance (ERA) Enrollment Form.
- Complete section B demographics section of the ERA Enrollment Form and be sure to insert your Medicaid provider ID.
- Sign and date the agreement along with the title of person authorized to sign on behalf of the practice.
- Submit one ERA/EFT Payer Agreement for each Physician/Group Tax ID.
- Once the agreement is open in Adobe Reader you can type information onto the form.
- Complete the EFT Authorization Agreement and attach a voided check.
- Forward original ERA agreement along with your McKesson ERA Enrollment Request Form to the Enrollment Team for processing.
- Please allow up to 30 days for approval and receipt of New Jersey Medicaid ERA.

Fax completed New Jersey Medicaid ERA Agreement and McKesson ERA Enrollment Request Form to:

McKesson EDI Enrollment

800-633-4763

835 - ELECTRONIC REMITTANCE

MEDICAID

ENCOUNTER

CHARITY CARE

SECTION A: FISCAL AGENT USE ONLY

PROVIDER #: _____ SUBMITTER NAME: _____ SUBMITTER #: _____

AUTHORIZED FOR HIPAA EDI REMITTANCE ON: _____ MEDICAID SUBMITTER ID: _____

AUTHORIZED BY: _____ **DOCTYPE: EMCAGREE**

SECTION B: PREFERENCES

01) 835 Media Preference (check only one): Internet CD-ROM Cartridge

_____ hereby authorize _____ to receive

02) *(Provider Name print)* _____ 03) *(Submitter Name print)* _____

my electronic remittance information as of _____ . I understand this electronic information
04) (Date)

contains Patient Health Information (PHI) and have taken the necessary steps with the parties named on this document to maintain the confidentiality of all PHI data.

05) _____ 06) _____ 07) _____
(Provider's Signature) (Date) (Medicaid Provider ID)

08) Provider Name: _____

09) Provider Address: _____

10) Provider City, St, Zip Code: _____

11) Submitter Name: _____ 12) Submitter ID: _____

13) Submitter Address: _____

14) Submitter City, St, Zip Code: _____

15) EDI Contact Person: _____ 16) Phone/Ext: (____) _____ / _____

17) E-Mail: _____

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****

Return this completed REMITTANCE EDI Agreement to Unisys at the following address:

Via U.S. Mail

Provider Enrollment

Unisys

P.O. Box 4804

Trenton, New Jersey 08650 - 4804

Other Carriers

Provider Enrollment

Unisys

3705 Quakerbridge Road, Suite 101

Trenton, New Jersey 08619

For detailed instructions on completing this agreement, please refer to the New Jersey Medicaid HIPAA Companion Guide – Section 2.

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS/DEPOSITS

I (we) hereby authorize the Unisys Corporation, acting as Fiscal Agent for the State of New Jersey, Division of Medical Assistance and Health Services, to initiate credit entries to my (our) checking account and the depository bank indicated below, hereinafter called Depository, to credit the same to such account.

DEPOSITORY NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

BANK TRANSIT/ABA NO. _____ ACCOUNT NO. _____

This authority is to remain in effect until the Fiscal Agent has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the Fiscal Agent a reasonable opportunity to act on it.

BANK ACCOUNT NAME _____
(Print account name exactly as it appears on your statement)

PROVIDER NAME _____

PROVIDER NO. _____ TELEPHONE NO. _____

ADDRESS _____

DATE ___ / ___ / ___ SIGNED _____ SIGNED _____

REMARKS _____

NOTES:

1. To insure accuracy of the bank account numbers, it is imperative that you attach a **BLANK, VOIDED CHECK** verifying the above bank ABA and account numbers.
2. If a joint account, both owners must sign request form.
3. Program payments are deposited to your account each Friday at 9:00 a.m.
4. Once Unisys has received a **completed** authorization for payments/deposits, it will take approximately 4 weeks before the first deposit is completed electronically to your account. To verify this information, please call your bank and specifically ask for the **ACH Department**.
5. For those providers who previously had Direct Deposit, you will now receive paper checks until the new information is processed.
6. Please make a copy of this before mailing to Unisys.

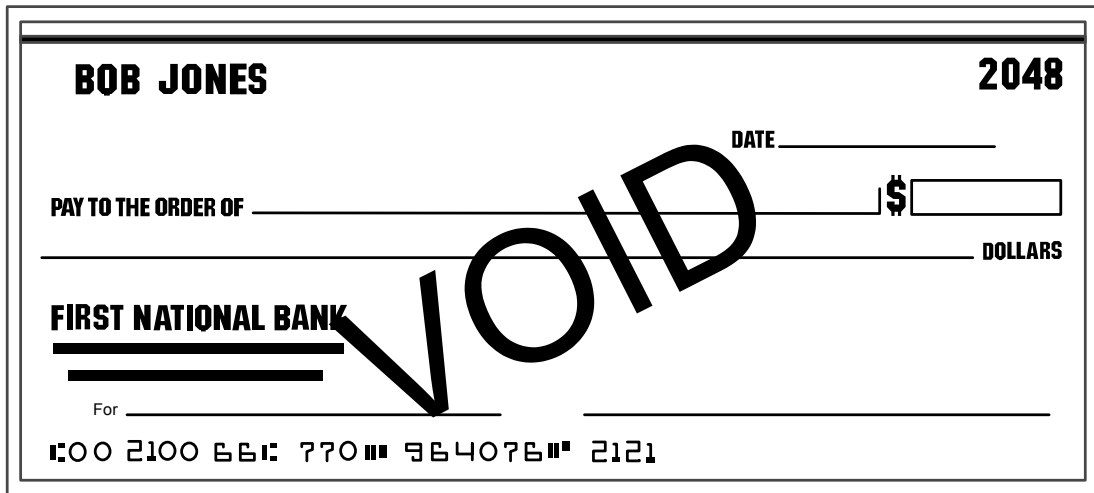
PROVIDER INSTRUCTIONS FOR COMPLETING AUTHORIZATION AGREEMENT FORM

1. DEPOSITORY NAMEName of bank servicing your checking account.
2. BRANCH.....Name of bank branch.
3. CITY.....City or town location of bank branch.
4. STATEState location of bank branch.
5. ZIPZip code of bank branch.
6. BANK TRANSIT/ABA NUMBERBank routing number (see below, voided check example).
7. BANK ACCOUNT NUMBER.....Checking account number (see below, voided check example).
8. BANK ACCOUNT NAMEActual account name per your bank's records.
9. PROVIDER INFORMATIONProvider name, Medicaid/NJ FamilyCare Provider No., telephone No., address, date prepared and signature.

MAIL THE COMPLETED AUTHORIZATION AGREEMENT AND VOIDED CHECK TO:

Provider Enrollment Unit
 Unisys
 P.O. Box 4804
 Trenton, NJ 08650-4804

NOTE: Attach blank, voided check per below sample.



↑
 Bank Transit No.
 (ABA No.)

↑
 Bank Account No.