



Empowering Healthcare

ERA Payer Agreement Instructions for Nevada Medicaid – Payer ID MC008

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.

Before receiving ERAs for Nevada 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 Nevada Medicaid's Electronic Remittance Advice Enrollment Form.

Guidelines for completing: Nevada Medicaid Electronic Remittance Advice Enrollment Form:

- Complete all required fields
- Submit one ERA Payer Agreement for each Physician/Group Tax ID.
- Once the agreement is open in Adobe Reader you can type information onto the form.
- Be sure to list Providers demographics along with the Medicaid group provider number.
- 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 Nevada Medicaid ERA.

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

McKesson EDI Enrollment

800-633-4763

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.



Mail this form to First Health Services, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.

SERVICE CENTER SOURCE: Check one. Enter the business or clearinghouse name as appropriate.	
<input type="checkbox"/> I will submit claims through a clearinghouse. Clearinghouse Name: _____	FIRST HEALTH SERVICES USE ONLY SC Code: _____
<input type="checkbox"/> I will submit claims directly from my business to First Health Services (direct submitter). Business Name: _____	
AUTHORIZE A TRANSACTION: Check the box next to each transaction you wish to authorize.	
<i>I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies First Health Services otherwise by use of this form.</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Electronic Remittance Advice (835)*	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Institutional claim (UB claim: 837I) <input type="checkbox"/> Dental claim (Dental Claim: 837D)
* Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.	
TERMINATE A TRANSACTION: Check the box next to each transaction you wish to terminate.	
<i>I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies First Health Services otherwise by use of this form. (Enter the effective date below.)</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Electronic Remittance Advice (835)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Institutional claim (UB claim: 837I) <input type="checkbox"/> Dental claim (Dental Claim: 837D)
Effective date for termination of this transaction(s): _____	

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider/Entity Name: _____ Phone: _____

NPI/API (one per form): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? Yes No

Authorized Signature: _____ Date: _____ / _____ / _____