

Nevada Medicaid – Payer ID MC008 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
- Submit one FH-37 form for each Provider Medicaid Number that will be used on Nevada Medicaid claims. For example, if you are a Group Practice with multiple Providers within your Group, you must submit an FH-37 form for the Group ID plus each rendering Provider 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: Nevada Medicaid – Payer ID MC008

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

Mailing Address:

First Services Health Corporation
Attention: EDI Coordinator
P.O. Box 30042
Reno, NV 89520-3042

Service Center Authorization Form for Providers (FH-37 Form)

Section	Instructions
Top Section and Check Boxes	These are pre-filled. Electronic Remittance Advice options are not applicable.
Provider Name, Provider Phone Number:	Complete these entry fields.
Provider Medicaid Number, Group Medicaid Number (if applicable):	Number assigned to Provider or Group Practice by Nevada Medicaid. If your practice has a Group Medicaid ID, then you must complete an agreement for the Group ID plus each rendering Provider ID associated within the Group.
Provider Signature:	This agreement must be signed with the original signature of the provider or authorized agent. Stamped signatures will not be accepted.

Once the Medicaid form(s) has been completed and mailed to the payer, 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>

Practice Name:	
Practice Tax ID:	

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 for Lytec users or at 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:
Medicare	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
Medicaid	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
BCBS	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
TriCare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
RR Medicare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	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

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: _____ / _____ / _____