

Payer Agreement Instructions for Rhode Island Medicaid - MC097

Important Notes

The provider **must** be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the agreement to submit electronic claims. Please wait until the PIN has been assigned **before** completing these forms requesting submission of electronic claims. Please do not list the PIN as "pending".

To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. Per-Se **cannot** make this request for the provider.

- If making copies include *all* pages of this agreement and be sure they are all legible.
- Submit one agreement for each Provider ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3- 4 weeks. If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from Per-Se or your claims will reject.

Guidelines for completing: Rhode Island Medicaid – Payer ID MC097

Trading Partner Agreement ID Change/Add Form

Field	Instructions
<i>Trading Partner Name:</i>	Pre-filled
<i>Assigned Trading Partner ID</i>	Pre-filled

Article I Medical Transaction Standards

<i>Pre-filled</i>	Pre-filled.
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Article II Rhode Island Medical Assistance Providers

<i>Medical Assistance Provider Number & Name Authorized Signature & Date:</i>	Please list the provider name & RI Medicaid numbers of those providers for which electronic transactions will be submitted. Sign & Date
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Trading Partner Execution: Trading Partner

<i>Signed, Name, Title:</i>	This agreement must be signed with the <u>original</u> signature of the provider or authorized agent. Stamped signatures will not be accepted.
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RHODE ISLAND DEPARTMENT OF HUMAN SERVICES



Trading Partner Agreement ID Change/Add form

Once a Trading Partner Agreement (TPA) is received and processed, this form may be used to add additional billing providers to the original TPA ID assigned. This form must be received with original signatures. **No facsimile or photocopies will be accepted.**

Trading Partner Name: _____

Assigned Trading Partner ID: _____

Before mailing your signed Trading Partner Agreement to EDS for processing please verify that:

- The document is complete
- Signatures are in the appropriate areas
- You have checked the transactions that you will be submitting and receiving (See page 5 of the TPA)

ARTICLE I. MEDICAL TRANSACTION STANDARDS

Rhode Island Medical Assistance Program Transaction Standards

Selected **ASC X12N Version 4010A** standards include, as applicable, all data dictionaries, segment dictionaries and transmission controls referenced in those standards, but include only the Transaction Sets listed in the section below. The information provided will be utilized to route transactions to the Medicaid Management Information System and back to Trading Partner directories. Remittance files (835) and Pended Claims Reports (277) will be available only to one trading partner. If authorizing one Trading Partner for claims submission and another for downloads each party must complete a separate TPA.

Check all that apply:

837 Professional	277 Unsolicited Claim Status
837 Institutional	997 Functional Acknowledgement
837 Dental	835 Remittance Advice
270 Eligibility Inquiry	271 Eligibility Response
276 Claim Status Inquiry	NCPDP 1.1 Batch Pharmacy Claim Response
NCPDP 5.1 Batch	

Specify Software:

Software	Vendor
Provider Electronic Solutions	EDS
Other	

Method of Transmission: _____

Guidelines

HIPAA – Health Insurance Portability and Accountability Act. In the event of any conflict, HIPAA standards and Implementation Guides shall control.

Please list the name(s) and phone number(s) of person(s) authorized to resolve problems regarding electronic transmissions:

Name Phone Number

Name Phone Number

e-mail address

ARTICLE II. RHODE ISLAND MEDICAL ASSISTANCE PROVIDERS

Please list the names and the RI Medical Assistance Program provider numbers of those providers for which electronic transactions will be submitted. Each individual provider or group for whom you will be billing must sign and date the agreement below. If additional space is required to identify each provider make copies of Article II and attach.

1. _____
Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

2. _____
Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

3. _____
Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

**Trading Partner Execution:
TRADING PARTNER**

Signed

Name

Title

DO NOT FAX

**Please mail this certification to the
Following address:**

**EDS
Attn: EDI Coordinator
P.O. Box 2010
Warwick, RI 02887-2010**