

## **Rocky Mountain HMO – Payer ID RMHMO 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: Rocky Mountain HMO**

- Section 1: Options “I would like to:” Select New EDI Enrollment
- Section 2: Office Submitter Profile/Provider / Group Profile “ Complete as requested”
- Section 3-4: Pre-filled
- Section 5: Electronic Claims Transmittal Report Contact and Website Access to Retrieve Report

**Return the 'Request to Transmit Electronic Claims' via Fax to the Payer:**

**ENS Fax:  
(877) 630-2064**

Once the Medicare 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>

<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

## Electronic Data Interchange Transaction Request Form

### Section 1: Options

I would like to:  New EDI Enrollment  
 Change:  Clearinghouse  Billing Service  Billing Office  Direct Submitter

### Section 2: Office/Submitter Profile

Office Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: (     ) \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: (     ) \_\_\_\_\_  
 Contact Name: \_\_\_\_\_  
 Email: \_\_\_\_\_

### Provider / Group Profile

Name of Physician, Degree Hospital, or Group	Tax ID	NPI

**Please attach additional providers if necessary.**

Fax the completed form to 970-244-7880; Attention: IT/EDI.

### Section 3: Electronic Claims Transmittal Report Contact

If data will be submitted to RHMP by a party other than the office, such as a clearinghouse or billing office, please specify below. Failure to specify a clearinghouse or billing office when applicable may result in incorrect EDI set-up and/or delay in EDI transmission to RMHP.

Office Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: (     ) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Contact Name: \_\_\_\_\_

### Section 4: Inbound and Outbound Transmission Information

Please indicate which transaction type(s) you will be submitting:

Inbound                     837P         837I

Please indicate if you wish to receive these outbound transmissions:

Outbound                     835

997 Acknowledgement     Yes         No

