ERA Payer Agreement Instructions for TN Medicare Payer ID MR034

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 Medicare 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

Guidelines for completing: Tennessee Medicare MR034

- Submit one ERA Payer Agreement for each Physician/Group Tax ID.
- Complete sections (2) & (9). (Read and understand the terms of the agreement before signing.)
- The provider must sign this form. Other signatures may result in a delay in processing this agreement.
- Forward original ERA agreement and ERA request form to MedAvant Enrollment Team for processing. Please allow (30) days turn around time prior to submitting for this service.

Fax completed Medicare ERA Agreement and McKesson ERA Enrollment Request Form to:

McKesson EDI Enrollment

800-633-4763

ERA Enrollment Request Form

Client Information: ☐ Existing Phoenix Customer ☐ New Phoenix Customer			
Client Name:			
Client ID: If new Customer leave this field blank		**Date of Request:**	
Phone Number:		**Fax Number:**	

Provider Information: **Complete one form for each Tax ID**				**Individual NPI:** **Group NPI:**	
Provider/Group Name:					
Address:				**Tax ID:**	
City:		**State:**		**Zip:**	

ERA Payer Information:
Refer to Instruction sheet attached for location of the Phoenix Payer List and Carrier Agreement Map.

Provider #	Payer ID	Payer Name	Date Sent to Payer	Service Used (ie: FedEx, UPS, USPS)	Tracking # (if applicable)

Return to McKesson Support Services – Fax # 800-633-4763

Part B EDI Customer Profile Instructions

IMPORTANT: Read the instructions before completing your applications.
Incomplete or incorrect applications will be returned.
The entity performing the billing must complete this form.

The purpose of the EDI Customer Profile is to enroll providers, billing services, clearinghouses and software vendors as electronic submitters and recipients of electronic claims data. **The entity (provider, billing service, clearinghouse, or software vendor) that will be billing directly to CIGNA Government Services must complete the EDI Customer Profile.**

In order to enroll a provider that is not already setup with CIGNA Government Services for electronic billing, all three (3) pages of the Customer Profile must be sent with all three (3) pages of the EDI Enrollment Form. You may access the EDI Enrollment Form at http://www.cignagovernmentservices.com/partb/forms/pdf/EDI_enrollment_form.pdf **.** Existing EDI billers may change or add information to their submitter profile by using the Part B EDI Customer Profile only.

Incomplete or incorrect applications will be returned. In order to complete the EDI application, both the provider PTAN number and NPI number are required. All complete applications are processed within 21 business days from the date the application is received. A letter containing the Submitter ID, EDI ID with initial password, and software (if applicable) will be mailed upon completion of the application.

The EDI ID and password act as an electronic signature, therefore the submitter would be liable if any entity performed an illegal action while using that EDI ID and password. Likewise, an EDI ID and password is not transferable, meaning that it may not be given to a new owner of the submitter's operation. New owners must obtain their own EDI ID and password.

The application tips and field descriptions listed below will aid in completing the form properly. For any additional questions, contact the EDI Helpdesk at 866.352.1608.

Application Tips - (Sections 1, 2 and 9 must be completed for all applications.)

New EDI Submitter Tips

Complete Section 1, 2, 3, 4 and 9. If applicable, complete sections 5, 6, 7 and 8.

Existing EDI Submitter Tips

If you are changing, adding or removing information from your existing profile-
Change

- Customer information, complete sections 1, 2 and 9.
- Claim transmission information, complete sections 1, 2, 4 and 9.
- Software vendor/trading partner information, complete sections 1, 2, 4, 5 and 9.

Add or Remove

- Provider number, complete sections 1, 2, 3 and 9
- Additional Features (ERNs, PPTN and CSI), complete sections 1, 2, 3, 6 and 9. If applicable, complete sections 7 and 8.

Field Descriptions

Form Section	Form Field Name	Instructions for Field Completion
Section 1	Type of Request	Check the appropriate box for the entity that will be directly billing CIGNA Government Services.
	Effective Date	Indicate the date you would like the change to be effective.
	Activate/Deactivate Features	Check the appropriate box for the activations or deactivations (if applicable) to be taken.
Section 2	Submitter ID #	The Submitter ID is used by the submitter to communicate with CIGNA Government Services electronically. For new EDI billers, leave this field blank, CIGNA Government Services will assign this ID. For existing EDI billers, enter the Submitter ID.
	Company Name	Enter the name of the entity (provider, billing service, clearinghouse, software vendor) that will actually be communicating electronically with CIGNA Government Services.
	Mailing Address	The mailing address of the submitter.
	City, State, Zip	The city, state, and zip code of the submitter.
	Contact Name	The name of the submitter's primary EDI contact. This is the person the EDI department will contact if there are questions regarding the application or future questions about their communications.
	Phone #	The area code and phone number for the Contact Person listed.
	E-mail	The e-mail address for the Contact Person listed.
	Fax #	The fax number for the Contact Person listed.
Section 3	Provider #s	Provide the Medicare group and individual provider PTAN issued by Medicare for each provider listed.
	NPI #s	Provide the 10 digit NPI Number issued by the NPI Enumerator for each provider listed.
Section 4	Connection Method	Indicate the connection method. Check only one method. If other is selected IVANS, VisionShare or NDM must be indicated. DSL and Cable connections are not valid methods of connection.
	Format	Indicate which electronic format will be sent.
	Billing Software	Indicate which software will be used. If Vendor Software is selected, you must complete section 5.
Section 5	Company Name	Enter the name of the software vendor/trading partner you are using.
	Mailing Address	The mailing address for the software vendor/trading partner.
	Contact Name	The name of the software vendor's/trading partner's contact.
	Phone#	The software vendor's/trading partner's phone number.
	E-mail	The software vendor's/trading partner's e-mail address.
	Fax #	The software vendor's/trading partner's fax number.
Section 6	ERN	Indicate the mailbox number ERNs will be returned to or request a mailbox number be assigned to retrieve ERNs. To cancel ERNs shade in the 3rd circle.
	PPTN	Indicate the vendor with IVANS or VisionShare.
	CSI	Indicate the trading partner you will be using to submit the batch 276 file.
Section 7	Third Party Authorization	This section should only be completed if a Third-Party (billing service or clearinghouse) is applying for additional features (ERNs, PPTN, CSI). This section is to be completed by the provider.
Section 8	Additional Instructions	Indicate any additional instructions that are needed for your setup.
Section 9	Form Submission Instructions	Instructions for mailing the completed applications.

Part B EDI Customer Profile

CIGNA Government Services

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Important Note: The entity performing the billing must complete this form.

Incomplete or incorrect application **will be** returned.

1. General Information

I am requesting to:	☐ Start billing electronically ☒ Add Electronic Remits Notice (ERN) (835 Report) ☐ Delete ERN ☐ Change existing Trading Partner
Effective Date:	☐ Provider Professional Transaction Network (PPTN) ○ Activate ○ Deactivate ☐ Claim Status Inquiry (CSI) ○ Activate ○ Deactivate ☐ Other (Complete Section 8)

2. Provider Information

Submitter ID# (If known for existing EDI Billers):			
Practice Name:			
Mailing Address:			
City, State, Zip:			
Contact Name:		Phone #:	
E-mail:		Fax #:	

3. PTAN & NPI Numbers

(Please list the Group PTAN and NPI numbers below. If a Group PTAN does not apply, list the Individual PTAN and NPI numbers. In order to complete the EDI application, both the PTAN and NPI numbers are required.)

Group PTAN #:		Individual PTAN #:		NPI #:	

4. Claim Transmission Information (Mark all applicable boxes below.)

Connection Method (If nothing is selected, Stratus will be the default.):	☐ Stratus (dial-up connection to CIGNA) ☐ Other (Please be specific): ______________________	
Format:	☒ ANSI X12N 837 v. 4010A1	
Billing Software (Shade in circle of selection):	☐ Program In-House ☐ Vendor Software ☐ Billing Service ☐ Clearinghouse	Medicare Claims Express (MCE): ☐ MCE for Primary Billing (You will automatically be set-up to receive ERL & ERN files). ☐ MCE for Medicare Secondary Payer (MSP)

5. Trading Partner & Third-Party Information

(Include information pertaining to the selected bililng service, clearinghouse, and/or software vendor.)

	Software Vendor:	Billing Service:	Clearinghouse:
Name:			MedAvant Healthcare Solutions
Address:			1901 E. Alton Ave., Suite 100
City, State, Zip:			Santa Ana, CA 92705
Phone #:			(800) 792-5256 Opt. 1
Fax #:			(404) 877-3324
Contact:			Enrollment Department
Submitter ID (If one assigned for all Providers):			H329

Continued on the next page . . .

6. Additional Features (If this section is not filled out you will automatically default to a mailbox **without** ERNs.)

Electronic Remittance Notice (ERN): Format ANSI X12N 835 v. 4010A1

If you are currently an electronic submitter receiving paper EOB and elect to receive ERNs, paper remittance notices will be discontinued after 45 days.

Note: Electronic Receipt Listings (ERL) are downloaded to the same mailbox as the Electronic Remittance Notice (ERN).

This section must be filled out. If you have been assigned a stratus mailbox number, it must be listed below, or the profile will be returned to the entity performing the billing!

Please choose one of the following:

- ❑ I elect to have Electronic Remittance Notice (ERN) downloaded using mailbox number: _______________
- ❑ Please assign me a Stratus mailbox number for ERN download.

- ❑ I do not wish to receive Electronic Remittance (ERN) downloaded to mailbox number: ________________
- ❑ Please assign me a Stratus mailbox. I do not wish to download ERNs at this time.

Provider Professional Transaction Network (PPTN)*:

Please choose one of the following: ❑ Direct Data Entry (DDE) ❑ IVANS ❑ VISION SHARE

Claim Status Inquiry (CSI)*:

Please choose one of the following:

❑ Format: ANSI X12N 276/277 v. 4010A1 (Software not provided by CIGNA Government Services.)
Trading Partner: ____

7. Provider Acknowledgement & Signature (To be completed by Provider.)

Provider Acknowledgement:

The following is acknowledged and hereby agreed to, once the profile has been signed:

- **Electronic Remittance Notices (ERN):** I understand that this transaction contains payment information concerning my processed claims.
- **Beneficiary Eligibility (PPTN):** I understand that this allows access to information regarding patient eligibility.
- **Claims Status Inquiry (PPTN or batch mode):** I understand that this transaction allows access to information on both pending and processed claims.
- **Electronic Receipt Listings (ERL):** I understand that this transaction contains batch detail of submitted claims.

Effective immediately, I hereby authorize CIGNA Government Services to release the aforementioned data (which contains confidential information), make all changes indicated within this profile. I certify that all information provided is accurate, to the best of my knowledge. I acknowledge that in signing this form, I bind this company or unincorporated organization to notify the Medicare contractor, in advance and in writing, if changes occur or if it is necessary to revoke this authorization.

The provider or an authorized official must sign this section, or the application will be returned to the requested Trading Partner.

____________________________________ ____________________
Signature Date

____________________________________ ____________________
Name (printed) Title

8. Additional Instructions

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9. Form Submission (Return the completed Medicare Part B EDI Customer Profile to the address below.)

CIGNA Government Services
Attn: EDI Department
PO Box 690, Nashville, TN 37202

Fax #: 1.615.782.4653
Phone #: 1.866.352.1608

* Additional information located at: http://www.cignagovernmentservices.com/partb/claims/edi/services.html