



Empowering Healthcare

ERA Payer Agreement Instructions for Virginia Medicaid Payer ID MC017

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 Medicaid the Physician/Provider must:

- Be enrolled with the payer and have a valid Provider Identification Number (PIN).
- Contract with McKesson for All Payer ERA service
- Complete an ERA Enrollment Request Form
- Complete Medicaid's required form included in this packet - "Provider Service Center Authorization Form".

Guidelines for completing: Virginia Medicaid Form

- Be sure to print, sign, and date this form with provider information.
- Be sure to list Provider Number (PIN) assigned by VA Medicaid.
- Fax the completed Medicaid Form (listed as First Health) to the payer at (804) 273-6797.
- Fax copy of the completed form along with the McKesson ERA Enrollment Request Form (last page in packet) to McKesson EDI Enrollment at (800) 633-4763.

VA Medicaid Enrollment Fax:

804-273-6797

McKesson EDI Enrollment

800-633-4763

Provider Service Center Authorization

Please review and check the block(s) which pertain to you:

SERVICE CENTER AUTHORIZATION:

I certify that I have authorized the following service center(s) to submit electronic transactions to the Department of Medical Assistance Services until such time as I notify First Health Services otherwise:

NAME OF SERVICE CENTER PREPARING ELECTRONIC TRANSMISSION	
<i>If Adding a New Service Center or a New Transaction:</i>	
SERVICE CENTER NUMBER:	BEGIN DATE:
ELECTRONIC TRANSACTION TYPES SUBMITTED:	
<input type="checkbox"/> Eligibility Req/Resp (270/271)	<input type="checkbox"/> Claims Status Req/Resp (276/277)
<input type="checkbox"/> Prior Authorization Req/Resp (278/278)	<input type="checkbox"/> Dental (837 D)
<input type="checkbox"/> Institutional (837 I)	<input type="checkbox"/> Professional (837 P)
<input type="checkbox"/> Pharmacy (NCPDP – batch)	
<i>If Terminating a Service Center or a Transaction:</i>	
SERVICE CENTER NUMBER:	END DATE:
TERMINATED ELECTRONIC TRANSACTION TYPES:	
<input type="checkbox"/> Eligibility Req/Resp (270/271)	<input type="checkbox"/> Claims Status Req/Resp (276/277)
<input type="checkbox"/> Prior Authorization Req/Resp (278/278)	<input type="checkbox"/> Remittance Advice (835)
<input type="checkbox"/> Dental (837 D)	<input type="checkbox"/> Institutional (837 I)
<input type="checkbox"/> Professional (837 P)	<input type="checkbox"/> Pharmacy (NCPDP – batch)

Please select A or B for an 835 Electronic Remittance Request:

- A** I desire to have Service Center _____ receive my electronic remittances (835) and I understand that I will continue to receive paper remittances only for 30 days after the electronic remittances start. **Refer to Terms and Conditions on Page 2, Item A.**
- B** I desire to have Service Center _____ receive my electronic remittances (835) and I would like my paper remittances to continue for the period selected below. **Refer to Terms and Conditions on Page 2, Item B.**

Please extend my remittance for:

- 60 Days 90 Days 120 Days

PROVIDER SERVICE CENTER AUTHORIZATION:

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these 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. This agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

_____ PROVIDER NAME		_____ PROVIDER NUMBER
_____ SIGNATURE	_____ DATE	_____ TELEPHONE NUMBER

TERMS AND CONDITIONS:

A. Electronic Remittance Request (835) and Paper Remittances for 30 Days after Production Approval.

I certify that I have authorized the Service Center identified on Page 1 to receive and process my electronic remittances. Although I can have multiple service centers submitting claims for me, I understand that only one service center can accept and process my electronic remittances and that service center must have prior approval from First Health Services to receive electronic remittances. I am also aware that 30 days after I start getting electronic remittances, all paper remittances will cease.

B. Electronic Remittance Request (835) and Paper Remittances Extended for 60 Days, 90 Days, or 120 Days after Production Approval.

I certify that I have authorized the Service Center identified on Page 1 to receive and process my electronic remittances. Although I can have multiple service centers submitting claims for me, I understand that only one service center can accept and process my electronic remittances and that service center must have prior approval from First Health Services to receive electronic remittances. I am also aware that after I start getting electronic remittances, all paper remittances will cease after the delay I selected on Page 1.