

Payer Agreement Instructions for Vermont Medicaid - Payer ID MC081**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: Vermont Medicaid - Payer ID MC081

On Page 3 (Part 2) - List all Providers with Provider ID and services requested. For each Provider listed the entry must be signed with the ***original*** signature of the provider or authorized agent. Stamped signatures will not be accepted.

Mail the EDI Registration form to the Payer. Address listed below.
Fax a MedAvant Claims Enrollment Form to MedAvant. See below.

Return the Agreement to the Payer:

Mailing address for USPS

VT Medicaid/EDS
P.O. Box 888
Willston, VT. 05495-0088

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) 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

Vermont Medicaid EDI Registration

Purpose:

Registration of Vermont Medicaid Trading Partners to allow access to the Vermont Medicaid Web Portal for test and production claim transaction uploads, and downloads of functional acknowledgements, submitted claim reports, claim status reports and remittance files.

Who must register:

Any entity that will utilize the Vermont Medicaid Web Portal or diskette submission must complete the EDI Registration.

Requirements:

A completed Trading Partner Agreement with Vermont Medicaid.

Identification of the Entity or Process utilized to certify that the Trading Partner is producing standard X12N transactions.

Utilization of the Vermont Medicaid Companion Guide to ensure that the transactions meet the requirements of Vermont Medicaid.

Accurate identification of all of the Vermont Medicaid Providers, by provider ID, served by the Trading Partner, and identification of transactions used by each. Timely notification to advise EDS of changes to the provider and transaction lists.

Instructions:

Part 1a. Provide the name, address, and contact information for the entity that will utilize the Vermont Medicaid Web Portal to send or receive electronic transactions. This entity may or may not be a Vermont Medicaid service provider, but will be required to complete a Trading Partner Agreement with Vermont Medicaid.

Part 1b. Identify the method of certification that transactions meet X12N standards, and indicate all of the electronic transactions that the Trading Partner will utilize, either now or in the future when they are implemented.

Part 2. Complete the Medicaid Provider list to identify each Vermont Medicaid Provider that has authorized the Trading Partner to send or receive its transactions. Identify all of the transactions that are authorized for each provider. List only the providers who will be identified in the claims as the “Billing Provider” or the “Pay-To Provider”. Make additional copies if needed.

Mark only the transactions that this Trading Partner will process for the Vermont Medicaid Provider. This information will be used to route transactions to the Claims Processing System and back to Trading Partner directories.

Part 1a. Vermont Medicaid EDI Registration

Trading Partner Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Primary Contact Name: _____

Primary Contact Phone: _____

Part 1b. Pre-Certification: Please check one.

Agency or Product name:

<input type="checkbox"/>	Using Provider Electronic Solutions Version 2.x	Distributed by EDS
<input type="checkbox"/>	Certified by Independent Agency	
<input type="checkbox"/>	Translator Compliance Check	
<input type="checkbox"/>	Utilizing a Certified Vendor/Clearinghouse	
<input type="checkbox"/>	Other (Describe)	

Transactions: Check all that apply

<input type="checkbox"/>	837 Institutional Inpatient	<input type="checkbox"/>	835 Remittance
<input type="checkbox"/>	837 Institutional Outpatient	<input type="checkbox"/>	277 Unsolicited Claim Status
<input type="checkbox"/>	837 Institutional Nursing Home	<input type="checkbox"/>	997 Functional Acknowledgement
<input type="checkbox"/>	837 Institutional Home Health	<input type="checkbox"/>	276/277 Claim Status Inquiry/Response
<input type="checkbox"/>	837 Professional	<input type="checkbox"/>	270/271 Eligibility Request/Response
<input type="checkbox"/>	837 Dental	<input type="checkbox"/>	Claim Accept/Reject Report

EDS INTERNAL USE			
DATE	APPROVED BY	TRADING PARTNER ID	WEB LOGON

