

**Payer Agreement Instructions for Department of Labor- OWCP  
Payer ID 77044**

**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: Department of Labor- OWCP Payer ID 77044**

**Electronic Data Interchange Trading Partner Enrollment Form**

Field	Instructions
Please indicate your classification:	Please check appropriate box
Section A1:	Complete all fields requested
Section A2:	Complete only if applicable
Section A3:	Please indicate contact information if different from Submitter
Section A4:	NA
Section A5:	Pre-filled by MedAvant

**B. Submission Method**

Field	Instructions
Section B1:	Pre-filled by MedAvant
Section B2:	NA

**C. Electronic Report Retrieval**

Field	Instructions
Are you interested I retrieving your transaction reports electronically?	Pre-filled by MedAvant

**Return the Agreement to the Payer:**

**Physical address for USPS, FedEx, UPS, etc.**

ACS EDI Enrollment Department  
PO Box 14600  
Tallahassee, FL 32309

Once the form(s) have 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>

<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



Department of Labor-OWCP  
**ELECTRONIC DATA INTERCHANGE  
 TRADING PARTNER ENROLLMENT FORM**



**A. SUBMITTER / VENDOR INFORMATION**

PLEASE INDICATE YOUR CLASSIFICATION:

Software Vend     Switch Vend     Provider     Clearinghouse     Billing Agent

<b>A1.</b>	Submitter/ Vendor/Provider Name:			
	Address:			
	City, State, Zip:			
	Telephone #:		FAX #:	
	Provider Number:		EIN:	
	Group Provider Number:		EMAIL ADDRESS:	
	Provider Specialty:			

<b>A2.</b>	If you are currently submitting electronic claims directly to ACS EDI for a different plan, please indicate your 5-digit submitter ID: (six-digits for DOL)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<b>A3.</b>	Please indicate contact information, if different from Submitter/Vendor/Provider Information in Section A1:				
Contact Name:		Contact Title:			
Contact Business Address:					
City, State, Zip:					
Phone Number		Fax Number:			
E-Mail Address:					

<b>A4.</b>	If you have indicated that you are a Software Vendor in section A1, please provide the following information:				
Software Name:		Software Version:		Protocol:	
Do you currently have clients submitting to ACS EDI ? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<b>A5.</b>	If you are a submitter and plan to use the services of a Software Vendor, Billing Agent, or Clearinghouse to submit your claims electronically to ACS EDI, please indicate the following information:				
What type of service will you use? <input type="checkbox"/> Software Vendor (SV) <input type="checkbox"/> Billing Agent (BA) <input type="checkbox"/> Clearinghouse (CH)					
SV/CH/ BA Name:		Contact name:			
Address:				Phone Number:	
City:		State:		Zip:	
				Fax Number:	
<b>Note:</b> Your Billing Agent or Clearinghouse must be equipped with their own uniquely assigned ACS EDI Submitter ID or Trading Partner ID to submit claims on your behalf. Please contact your Billing Agent/Clearinghouse to confirm their status with ACS EDI. Software Vendors must complete submitter testing and be issued a Trading Partner ID.					
Please indicate your Clearinghouse or Billing Agent's 5 digit Submitter ID or Trading Partner ID (6 digits for DOL):					<input type="text"/>
If you plan to use the services of a Software Vendor please indicate your vendor's Trading Partner ID (6 digits for DOL):					<input type="text"/>



**B. SUBMISSION METHOD**

**B1. Please check the appropriate Submitter, Format and Transaction type(s) below:**

Submitter Type		Format Type		Transaction Type		Submission Method	
<input type="checkbox"/>	I will submit claims via Vendor's Software.	<input type="checkbox"/>	Proprietary	<input type="checkbox"/>	Professional	<input type="checkbox"/>	ASync
<input type="checkbox"/>	My Clearinghouse will submit to ACS on my behalf.	<input type="checkbox"/>	X-12N 837	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Web
<input type="checkbox"/>	My Billing Agent will submit to ACS on my behalf.	<input type="checkbox"/>	X-12N 835	<input type="checkbox"/>	Institutional	<input type="checkbox"/>	NDM
<input type="checkbox"/>	I am a Clearinghouse submitting on behalf of my clients.			<input type="checkbox"/>	NSF3.1		
<input type="checkbox"/>	I am a Billing Agent submitting on behalf of my clients.			<input type="checkbox"/>	UB92 5.0		
<input type="checkbox"/>	I am a Software Vendor providing services to my clients.						
<input type="checkbox"/>	I am a Switch Vendor providing services to my clients.						

**B2. If you are submitting X12N transactions, please provide the following:**

Element Delimiter to be used:	<input type="text"/>	Segment Delimiter to be used:	<input type="text"/>	Sub-Element Delimiter to be used:	<input type="text"/>
If you do not indicate Delimiter information, your submitter profile will default to the following:					
Element Delimiter:	<input type="text" value="*"/> (asterisk)	Segment Delimiter:	<input type="text" value="~"/> (tilde)	Sub-Element Delimiter:	<input type="text" value=":"/> (colon)

**C. ELECTRONIC REPORT RETRIEVAL**

Are you interested in retrieving your transaction reports electronically?  Yes  No

If yes, you will retrieve reports electronically via the following method:

- DEx Mailbox** (ACS EDI Gateway Mailbox System) Please check box to accept this method  
 If you have chosen to use ACS' DEX Mailbox, please finalize your request below.

Who will retrieve your reports electronically?
<input type="checkbox"/> I will retrieve my reports.
<input type="checkbox"/> My Billing Agent will retrieve reports on my behalf. My Billing Agent's Trading Partner or Submitter ID is: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> My Clearinghouse will retrieve reports on my behalf. My Clearinghouse's Trading Partner or Submitter ID is: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> My agent and I will retrieve my reports. My Billing Agent's/Clearinghouse's Trading Partner or Submitter ID is: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Which reports would you like to access electronically?
<input type="checkbox"/> 997- Functional Acknowledgement
<input type="checkbox"/> 835- Healthcare Claim Payment Advice