



Enrollment Department  
 MedAvant  
 1854 Shackelford Court,  
 Suite 200  
 Norcross, GA. 30093

**Phone:** (800) 792-5256 Option 1  
**Fax:** (770) 885-4559  
 provider.enrollment@MedAvanthealth.com

## Payer Agreement Instructions for Wyoming Medicaid

### Important Notes

The provider **must** be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the agreement to submit electronic claims. Please wait until the PIN has been assigned **before** completing these forms requesting submission of electronic claims. Please do not list the PIN as "pending".

To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. MedAvant **cannot** make this request for the provider.

- If making copies include *all* pages of this agreement and be sure they are all legible.
- Submit one agreement for each Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3- 4 weeks. If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from MedAvant or your claims will reject.

### Guidelines for completing: Wyoming Medicaid - Payer ID MC042

## Provider ACS EDI Gateway Authorization Form For Billing Agents/ Clearinghouses

### Section A. Provider Information

Field	Instructions
<i>Please indicate your classification (required):</i>	Check if you are a solo practitioner or a group practice with a Group Medicaid ID.
<i>Business Name, Provider Name (Last, First, MI and Suffix), Business Address, City, State, Zip, Telephone Number, Fax Number, Contact name and E-Mail Address:</i>	Complete as indicated.
<i>Provider Number (Required for Individuals) or Group Provider Number (Required for Groups):</i>	Number assigned to provider or group practice by Wyoming Medicaid. If your practice has a Group ID, then you only have to list that number.

### Section B. Reports and Responses Available

<i>Pre-Filled</i>	
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### Section C. Authorization Signature (required)

<i>Provider name/ Provider Representative name (please print)</i>	Name of individual signing agreement on behalf of the provider or group practice.
<i>Provider/ Provider Representative name (please print)</i>	Name of individual signing agreement on behalf of the provider or group practice.
<i>Provider/ Provider Representative Signature, Date</i>	This agreement must be signed by the provider or an authorized representative.



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**ACS Provider Enrollment Form**

Section 1. Classification:	Please indicate your classification
Section 2. Submission Method:	Pre-Filled by MedAvant
Section 3. Provider Information:	Complete all fields requested
Section 4&5. Submitter/Trading Partner ID Number:	Complete this section <b>only</b> if you were previously submitting claims directly to ACS. Be sure to include your 5 digit submitter or 6 digit Trading Partner ID
Section 6. Provider Using a Software Vendor, Billing Agent, or a Clearinghouse:	Pre-Filled by MedAvant
Section 7. Transactions Available for Transmission:	Pre-Filled by MedAvant
Section 8. Delimiter Information:	NA
Section 9. Electronic Reports and Response Retrieval:	NA
Section 10. Additional Pay to Provider List:	List any additional pay to providers and their assigned provider id.

**Return the Agreement to the Payer:**

**Fax #**

(307) 772-8405

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

ACS EDI Gateway  
 Attention: EDI Enrollment Unit  
 P.O. Box 667  
 Cheyenne, WY 82003

**MedAvant's Claims Enrollment Form**

*Please complete a MedAvant Claims Enrollment Form for each Tax ID and fax it to MedAvant at: (770) 885-4559. This form can be used if you are enrolling with one or more new Payer(s) or if you are enrolling a new rendering provider with your existing Payer(s)*

**The Claims Enrollment Form, with instructions  
 is located at:**

<http://www.MedAvanthealth.com/payerlist/default.asp>

**Questions? Contact MedAvant enrollment at:**

(800) 792-5256, Option 1

## Wyoming ACS EDI Provider Enrollment Form



Please return to:  
**Attn: EDI Enrollment Unit**  
**PO Box 667**  
**Cheyenne, WY 82003**  
**Or fax to 307.772.8405**



### Provider ACS EDI Gateway Authorization Form for Billing Agents/Clearinghouses

<b>Section A. Provider Information</b>	
Please indicate your classification ( <b>required</b> ): <input type="checkbox"/> Individual Provider <input type="checkbox"/> Group Provider/Practice	
<i>Business Name</i>	
<i>Provider Name (Last, First, MI and Suffix)</i>	
<i>Provider Number (Required for Individuals)</i>	<i>Group Provider Number (Required for Groups)</i>
<i>Business Address</i>	
<i>City, State, and Zip</i>	
<i>Telephone Number</i>	<i>Fax Number</i>
<i>Contact Name</i>	<i>E-mail Address</i>
<b>Section B. Reports and Responses Available</b>	
<input type="checkbox"/> X12N 997 Functional Acknowledgement	<input type="checkbox"/> X12N 271 Eligibility Response
<input type="checkbox"/> X12N 277 Claims Status Response	<input type="checkbox"/> X12N 824 Error Report
<input type="checkbox"/> X12N 278 Response	<input type="checkbox"/> X12N 835 Remittance Advice
<b>Section C. Authorization Signature (<i>required</i>)</b>	

**Provider,** \_\_\_\_\_ **hereby appoints**  
*Provider name /Provider Representative name (please print)*

\_\_\_\_\_  
*Billing Agent/Clearinghouse name (please print)*

\_\_\_\_\_  
*Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

**to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected above:**

\_\_\_\_\_  
*Provider/Provider Representative Name (Please print)*

\_\_\_\_\_  
*Provider/Provider Representative Signature*

\_\_\_\_\_  
*Date*

1.800.672.4959 (phone) 1.307.772.8405 (fax)

[www.acs-gcro.com](http://www.acs-gcro.com)

# Wyoming ACS EDI Provider Enrollment Form



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## ACS EDI PROVIDER ENROLLMENT FORM

Please print or type. Complete all areas of the ACS Provider Enrollment Form, unless otherwise indicated.

### Section 1. Classification Please indicate your classification.

Individual  Group

### Section 2. Submission Method Please indicate how you plan to submit your electronic transactions.

WINASAP2003  Vendor Software  Billing Agent  Clearinghouse  Web Portal

### Section 3. Provider Information

*Business Name (If applicable)*

*Provider Name (Last, First, MI, and Suffix)*

*Business Street Address*

*City, State, and Zip Code*

*Telephone*

*Fax*

*Provider Number (Required for Individuals)*

*Group Provider Number (Required for Groups)*

*Email Address (If applicable)*

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<b>Section 4. Submitter/Trading Partner ID Number</b>	
If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your ACS EDI Gateway 5-digit Submitter ID or 6-digit Trading Partner ID:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

<b>Section 5. Contact Information</b> Please indicate contact individual information.	
Contact Name (Individual)	Contact Title
Business Street Address	
City, State, and Zip Code	
Telephone	Fax
Email Address	

<b>Additional Contact Information</b> Please indicate additional contact information.	
Contact Name	Contact Title
Business Street Address	
City, State, and Zip Code	
Telephone	Fax
Email Address	

Please attach additional sheets if necessary.

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**Section 6. Provider Using a Software Vendor, Billing Agent, or a Clearinghouse**

If you have indicated that you plan to use the services of a Software Vendor, a Billing Agent, or a Clearinghouse to submit your transactions electronically to ACS EDI Gateway, please provide the following information.  
**(If you plan on using WINASAP2003 or the Web Portal, you do not need to complete this section)**

**Sub-section 6a. Type of Service that you use**

Please indicate the type of service that you use to submit electronic transactions.

<input type="checkbox"/> Software Vendor (SV)	<input type="checkbox"/> Clearinghouse (CH)	<input type="checkbox"/> Billing Agent (BA)
SV/CH/BA Name		
Contact Name	Contact Title	
Business Address		
City, State, and Zip Code		
Telephone Number	Fax Number	
Email Address		

**Sub-section 6b. Software Vendor, Billing Agent or Clearinghouse Submitter ID or Trading Partner ID**

**Note: Your Software Vendor, Billing Agent or Clearinghouse must be equipped with their own uniquely assigned ACS EDI Gateway Submitter ID or Trading Partner ID to act on your behalf. Please contact your Software Vendor, Billing Agent/Clearinghouse to confirm their status with ACS EDI Gateway.**

Please indicate your Software Vendor/Clearinghouse/Billing Agent's 5-digit Submitter ID or 6-digit Trading Partner ID:

□	□	□	□	□	□
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**Sub-section 6c. Provider Using a Software Vendor**

If you plan to use Vendor Software, please complete the following information related to your software.

Software Name:	Software Version:	Protocol:
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<b>Section 7. Transactions Available for Transmission</b>	
<b>Sub-Section 7a. WINASAP2003 (replacing ACE\$ software)</b>	
<b>Request for free WINASAP2003 Software:</b>	
<input type="checkbox"/> I will download a copy from the ACS EDI Gateway website at <a href="http://www.acs-gcro.com">www.acs-gcro.com</a>	
<input type="checkbox"/> Please mail me a CD-ROM of the WINASAP2003 software	
<input type="checkbox"/> X12N 837P (Professional Claim)	<input type="checkbox"/> X12N 837D (Dental Claim)
<input type="checkbox"/> X12N 837I (Institutional Claim)	
<b>Sub-Section 7b. Standard Transactions (Submissions other than WINASAP2003 and Web Portal)</b>	
<input type="checkbox"/> X12N 837P (Professional Claim)	<input type="checkbox"/> X12N 278 (Prior Authorization)
<input type="checkbox"/> X12N 837D (Dental Claim)	<input type="checkbox"/> X12N 270 (Eligibility Inquiry)
<input type="checkbox"/> X12N 837I (Institutional Claim)	<input type="checkbox"/> X12N 276 (Claim Status Inquiry)
<b>Sub-Section 7c. Standard Transactions (Batch Submissions through Web Portal)</b>	
<input type="checkbox"/> X12N 837P (Professional Claim)	
<input type="checkbox"/> X12N 837D (Dental Claim)	
<input type="checkbox"/> X12N 837I (Institutional Claim)	

<b>Section 8. Delimiter Information</b>		
If you are submitting X12N transactions directly to ACS, please provide an alternate delimiter. If nothing is entered, the default will be used.		
<b>This information is not required if you are using WINASAP2003.</b>		
Element Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/>  <i>Default Delimiter (asterisk) *</i>	Segment Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/>  <i>Default Delimiter (tilde) ~</i>	Sub-Element Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/>  <i>Default Delimiter (colon) :</i>

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## Section 9. Electronic Reports and Response Retrieval

Wyoming EqualityCare providers can retrieve their electronic reports and/or responses from the ACS EDI Gateway Internet Data Exchange (iDEx). If you would like to participate in this service, please complete the section below.

### Reports and/or Responses available for X12N Transactions

<input type="checkbox"/> X12N 997 (Functional Acknowledgement)	<input type="checkbox"/> X12N 835 (Healthcare Claim Payment/Advice)
<input type="checkbox"/> X12N 271 (Eligibility Response)	<input type="checkbox"/> 835 (Print Image)
<input type="checkbox"/> X12N 277 (Claims Status Response)	<input type="checkbox"/> X12N 824 (Error Response)
<input type="checkbox"/> X12N 278 (Prior Authorization Response)	<input type="checkbox"/> 824 (Print Image)

