

# MEDICAID SOUTH CAROLINA PRE-ENROLLMENT INSTRUCTIONS - SCXIX



## HOW LONG DOES PRE ENROLLMENT TAKE?

- Standard Processing time is 7 business days.

## WHAT FORM(S) SHOULD I DO?

- Medicaid South Carolina requires that a Trading Partner Agreement must be submitted for both Office Ally and the Provider with every enrollment. Therefore please note that you will be submitting the same form twice, each with different information.
- SC Medicaid Trading Partner Agreement Enrollment Form (FOR PROVIDER) – Page 3 & 4 of this packet.
  - You must complete all fields that are applicable to you. The NPI & Medicaid Provider No. are both required.
- SC Medicaid Trading Partner Agreement Enrollment Form (FOR OFFICE ALLY) Page 5 of this packet
  - Most all fields are completed for you. The only fields that are required for the provider to complete are:
    - Date
    - Start Date

AS OF FEBRUARY 2010 PAPER EOB'S WILL NO LONGER BE AVAILABLE. EOB'S ARE CURRENTLY AVAILABLE ON MEDICAID SOUTH CAROLINA'S WEB SITE. THEY WILL CONTINUE TO BE AVAILABLE AFTER FEBRUARY 2010. CALL MEDICAID IF YOU HAVE ANY QUESTIONS REGARDING THIS.

## WHAT DO I SEND THE FORM(S)?

- Fax the form to 803-870-9021; or
- Mail the form to  
SC Medicaid TPA  
PO Box 17  
Columbia, SC 29202

**IF FAXING THE FORM YOU MUST KEEP THE ORIGINAL ON FILE IN YOUR OFFICE!**

## WHO CAN SIGN THE FORMS?

- Owner or authorized personnel

## HOW DO I CHECK STATUS OF PRE-ENROLLMENT?

- Call 888-289-0709, option 2 and ask if the provider has been enrolled.

## **NOTE TO MY CLIENTS PLUS USERS:**

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally please fax the following information to My Clients Plus at 888-653-7115.

- **My Clients Plus**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my provider ID has been linked to Office Ally with the Insurance Payor”.**
- **Provider email address where you can be notified of setup completion.**

For Noridian Pre-Enrollments Please Also Include:

- **Submitter number**

# SC Medicaid Trading Partner Agreement Enrollment Form Instructions

The purpose of the *Trading Partner Agreement Enrollment Form* is to enroll all EDI trading partners. It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, delaying the enrollment process.

## Completing and Submitting Your Enrollment Request

Once completed please mail to SC Medicaid TPA, P.O. Box 17, Columbia, SC, 29202 or fax\* to (803) 870-9021. The field descriptions in the table below and the form on the next page will aid in completing the form.

Form Field Name	Instructions for Field Completion
Date	Enter today's date.
Action Requested:	Indicate the action to be taken on the enrollment form.
New Trading Partner ID	1. To apply for a new Trading Partner ID, check <b>New Trading Partner ID</b> .
Change	2. To change Trading Partner information, check <b>Change</b> .
Cancel	3. To cancel your enrollment, check <b>Cancel</b> .
Trading Partner Name	Enter the name of the entity that will be submitting/receiving electronic transactions with SCDHHS.
Trading Partner ID	The Trading Partner ID is assigned by SCDHHS to identify trading partners to our system.
NPI & Medicaid Provider ID Number	If the Trading Partner is a Provider, enter the NPI and/or the SCDHHS assigned Medicaid Provider ID Number.
Federal Tax ID #	Enter the trading partner's Federal Tax Identification Number.
Type of Business	Select the type of primary business the trading partner conducts. If you check "Other," indicate the type of business on the line provided.
Start Date	Indicate, in mm/dd/ccyy format, the date the trading partner plans to begin transaction testing with SCDHHS.
End Date	If this form is being used to cancel an account, indicate, in mm/dd/ccyy format, the date the trading partner intends to terminate its trading partner account.
South Carolina Medicaid Web Based Claims Submission Tool	For Trading Partners requesting access to the tool, please check box.
Protocol	Check FTP or ASYNC to specify the communication method. If ASYNC dial up is checked, then specify the product.
Agreement	Please check the appropriate boxes to indicate your agreement with the terms and conditions of the Trading Partner Agreement for Electronic Claims and Related Transactions. <b>Please sign and print your name below.</b>
Software Vendor Or Billing Agent	Indicate the software vendor or billing agent you will be using.
Contact Information	Enter Contact Name, E-mail, Phone Number and Fax Number
Transactions Requested	Mark yes (Y) or no (N) for each transaction.
<b>*When faxing original forms must be kept on file in your office</b>	

# Trading Partner Agreement Enrollment Form

Mail to: SC Medicaid TPA, P.O. Box 17, Columbia, SC 29202 or fax to (803) 870-9021

Date: \_\_\_\_\_

**Action Requested:**  
(Check One)

- New Trading Partner ID
  Change
  Cancel

**Trading Partner Name:** \_\_\_\_\_

**Trading Partner ID:** n/a  
(If Applicable)

**NPI:** \_\_\_\_\_ **Medicaid Provider No:** \_\_\_\_\_

**Type of Business:** (Check One)
  Medicaid Provider
  Clearinghouse
  Software Vendor
  Billing Service
  Other (*indicate*): \_\_\_\_\_

**Start Date:** \_\_\_\_\_ (mm/dd/ccyy)
 **End Date:** \_\_\_\_\_ (mm/dd/ccyy)  
(Required when canceling an account)

**South Carolina Medicaid Web Based Claims Submission Tool:**  # of IDs requested: \_\_\_\_\_

**Protocol:** (Check One)
  SecureFTP
  WS\_FTP Pro
  CD
  Diskette

I have read, understand and agree with the conditions set forth in the South Carolina Medicaid Trading Partner Agreement for Electronic Claims and Related Transactions

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Software Vendor or Billing Agent:** Office Ally Submitter ID M00546WA2

**Software Vendor or Billing Agent:** \_\_\_\_\_

**Contact Information:** \_\_\_\_\_

Contact Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Transactions Requested					
Transmission*	Y/N**		Transmission*	Y/N**	
ASC X12N 820 (004010X061A1)	<input type="checkbox"/>		ASC X12N 834 (004010X095A1)	<input type="checkbox"/>	
ASC X12N 270 (004010X092A1)	<input type="checkbox"/>		ASC X12N 837I(004010X096A1)	<input type="checkbox"/>	
ASC X12N 271 (009010X092A1)	<input type="checkbox"/>		ASC X12N 837P(004010X098A1)	<input checked="" type="checkbox"/>	
ASC X12N 276 (004010X093A1)	<input type="checkbox"/>		ASC X12N 837D (004010X097A1)	<input type="checkbox"/>	
ASC X12N 277 (004010X093A1)	<input type="checkbox"/>		ASC X12N 835 (004010X091A1)	<input checked="" type="checkbox"/>	
ASC X12N 278 (004010X094A1)	<input type="checkbox"/>				

SC Medicaid EDI Help Desk Use Only	
<b>Submitter ID:</b> _____	<b>Date:</b> _____



# Trading Partner Agreement Enrollment Form

Mail to: SC Medicaid TPA, P.O. Box 17, Columbia, SC 29202 or fax to (803) 870-9021

Date: \_\_\_\_\_

**Action Requested:**  
(Check One)

New Trading Partner ID       Change       Cancel

**Trading Partner Name:** OfficeAlly

**Trading Partner ID:** M00546WA2  
(If Applicable)

**NPI:** n/a      **Medicaid Provider No:** n/a

**Type of Business:** (Check One)       Medicaid Provider       Clearinghouse       Software Vendor  
 Billing Service       Other (*indicate*): \_\_\_\_\_

**Start Date:** \_\_\_\_\_ (mm/dd/ccyy)      **End Date:** \_\_\_\_\_ (mm/dd/ccyy)  
*(Required when canceling an account)*

**South Carolina Medicaid Web Based Claims Submission Tool:**  # of IDs requested: \_\_\_\_\_

**Protocol:** (Check One)       SecureFTP       WS\_FTP Pro       CD       Diskette

I have read, understand and agree with the conditions set forth in the South Carolina Medicaid Trading Partner Agreement for Electronic Claims and Related Transactions

**Signature:**  \_\_\_\_\_

**Print Name:** Brian O'Neill

**Software Vendor or Billing Agent:** \_\_\_\_\_

**Software Vendor or Billing Agent:** \_\_\_\_\_

**Contact Information:** \_\_\_\_\_

Contact Name: Customer Service      E-mail: info@officeally.com

Phone: ( 866 ) 575-4120 opt.1      Fax: ( 360 ) 896-2151

Transactions Requested			
Transmission*	Y/N**	Transmission*	Y/N**
ASC X12N 820 (004010X061A1)	<input type="checkbox"/>	ASC X12N 834 (004010X095A1)	<input type="checkbox"/>
ASC X12N 270 (004010X092A1)	<input type="checkbox"/>	ASC X12N 837I(004010X096A1)	<input type="checkbox"/>
ASC X12N 271 (009010X092A1)	<input type="checkbox"/>	ASC X12N 837P(004010X098A1)	<input checked="" type="checkbox"/>
ASC X12N 276 (004010X093A1)	<input type="checkbox"/>	ASC X12N 837D (004010X097A1)	<input type="checkbox"/>
ASC X12N 277 (004010X093A1)	<input checked="" type="checkbox"/>	ASC X12N 835 (004010X091A1)	<input checked="" type="checkbox"/>
ASC X12N 278 (004010X094A1)	<input type="checkbox"/>		

SC Medicaid EDI Help Desk Use Only	
<b>Submitter ID:</b> _____	<b>Date:</b> _____