

MEDICAID GEORGIA PRE-ENROLLMENT INSTRUCTIONS – 77034



HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 30-45 business days.

WHERE SHOULD I SEND THE FORMS?

- Mail the form to:
EDI/Provider Enrollment
PO Box 4000
McRae, Georgia 31055

THE FORM MUST BE NOTARIZED, AND THEREFORE FAXED COPIES ARE NOT ACCEPTABLE

WHO CAN SIGN THE FORMS?

- The owner or authorized personnel

WHAT FORM SHOULD I DO?

- Power of Attorney for Electronic Claims Submission

HOW DO I CHECK STATUS?

- Medicaid Georgia will notify the provider, via mail of the approval; or
- You can call 800-987-6715 and ask if you have been linked to Office Ally.

WHAT PROVIDER NUMBER DO I USE?

- NPI #
- Tax ID

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**

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, _____ (Provider's Name),
with Provider Number _____ (Provider Number)
hereby appoints Office Ally (Name of Billing Service),
140658 (Billing Service Trading Partner ID) as attorney-in-fact for the benefit of Provider,
and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

To act as Provider's authorized agent for purposes of signing, on behalf of Provider, the certification statement herein in connection with each Computer Media Input submission of medical assistance claims:

"I hereby certify that all information contained on and submitted by Computer Media Input is true, accurate, and complete, and that to the best of my knowledge, information and belief, the services for which medical assistance was sought, in fact, have been rendered by Provider as claimed. Furthermore, I understand and acknowledge that the Department will rely on this certification in the payment of medical assistance, which payment will be made from State and Federal funds, and that the submission of any false claims, information, or documents or the concealment of any material facts is a crime under Federal and State laws."

To maintain all original source documents for six (6) years following the month of payment, and to ensure that every electronic entry can be associated and identified with a source document.

Provider agrees that the billing service is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.

Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted by the appointed billing service, and in no way forecloses the application of penalties that may be accessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This _____ day of _____, in the year _____.

Printed Name of Enrolled Provider

By: _____
Signature of Provider or Authorized Representative

Title of Authorized Representative

Sworn to and subscribed before me
this _____ day of _____, in the year _____.

(Notary Public)
My Commission expires: _____