

How long does pre-enrollment take?

- 8-10 Business Days

Where should I send the forms?

- Mail the original forms to:
Office Ally
P.O. Box 872020
Vancouver, WA 98687
Attn: Anita
- Office Ally will sign the forms and then mail to Medicaid New Jersey.

What forms are required?

- 837- Electronic Claims Input Form
- Form Instructions
 - Section 1 - leave blank
 - Section 2 - enter provider information
 - Section 3 - provider to complete lines 11-13, Office Ally will complete lines 14-15
 - Section 4 - enter effective date on line 20
 - Section 5 - prefilled with Office Ally information
 - Section 6 - prefilled with Office Ally information

Who can sign the forms?

- Provider for a solo practice
- If group practice, the person that has signature and liability authority must sign.

How does user check status or pre-enrollment?

- Call 609-588-6051 and ask if you are linked to submitter # 9904204.

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**



837 – ELECTRONIC CLAIMS INPUT

MEDICAID

ENCOUNTER

CHARITY CARE

SECTION 1: FISCAL AGENT USE ONLY

PROVIDER #: _____ SUBMITTER NAME: _____ SUBMITTER #: _____

AUTHORIZED BY: _____ DATE: _____ DOCTYPE: **EMCAGREE**

SECTION 2: PROVIDER

01) Medicaid Provider Name: _____ 02) Medicaid Provider Number: _____

03) Street Address: _____

04) City, State, Zip Code: _____

05) EDI Contact Person: _____ 06) Phone/Ext: (____) _____ / _____

07) Fax: (____) _____ 08) E-Mail: _____

09) 2nd EDI Contact Person: _____ 10) Phone/Ext: (____) _____ / _____

SECTION 3: AGREEMENT

I certify that the information on these claims will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by these claims and the amounts charged will be in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under these claims has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both

I also certify that for each Medicaid service performed and claim submitted for payment, the patient certification will be on file at the provider's location.

11) _____ 12) _____ 13) _____
(Provider's Signature) (Date) (Medicaid Provider ID)

14) _____ 15) _____ 16) 9904204
(Billing Agent's Signature) (Date) (Submitter ID)

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

SECTION 4: HIPAA TRANSACTION SETS & CERTIFICATION

17) Transaction Sets: Version 4010 Addenda: NCPDP Pharmacy:
 004010X096A1 004010X097A1 004010X098A1 Version 1.1 Batch
837 Institutional 837 Dental 837 Professional Version 5.1 Point of Sale (POS)

18) Certification Vendor Name: EDIFECS 19) Certification Attached: Yes No

20) Requested Effective Date: 7/17/08

21) Claims Input Media: Internet BBS via Modem CD-ROM Cartridge



837 – ELECTRONIC CLAIMS INPUT - continued

01) Medicaid Provider Name: _____ 02) Medicaid Provider Number: _____

SECTION 5: SOFTWARE VENDOR

22) Company Name: Office Ally

23) Street Address: P.O. Box 872020

24) City, State, Zip Code: Vancouver, WA 98687

25) EDI Contact Person: Customer Service 26) Phone/Ext: (866) 575-4120 / opt. 1

27) Fax: (360) 896-2151 28) E-Mail: info@officeally.com

29) 2nd EDI Contact Person: Karen Forden 30) Phone/Ext: (949) 464-9129 / 241

(Unisys would like to know the company name/author of the software you are using to submit claims to Unisys)

SECTION 6: BILLING AGENT

31) Submitter Name: Office Ally, LLC 32) Medicaid Submitter ID: 9904204

33) Street Address: P.O. Box 872020

34) City, State, Zip Code: Vancouver, WA 98687

35) EDI Contact Person: Customer Service 36) Phone/Ext: (866) 575-4120 / opt. 1

37) Fax: (360) 896-2151 38) E-Mail: info@officeally.com

39) 2nd EDI Contact Person: Karen Forden 40) Phone/Ext: (949) 464-9129 / 241

41) 2nd EDI Contact Person E-Mail: karen.forden@officeally.com

(This section should be completed if anyone but the provider is submitting claims to Unisys)

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****

Return the completed EDI Agreement to Unisys at the following address:

Via U.S. Mail

**Provider Enrollment
Unisys
P.O. Box 4804
Trenton, New Jersey 08650 - 4804**

Other Carriers

**Provider Enrollment
Unisys
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619**

For detailed instructions on completing this agreement, please refer to the New Jersey Medicaid HIPAA Companion Guide – Section 2.