

MEDICAID NEVADA PRE-ENROLLMENT INSTRUCTIONS – MC008



HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 1 week

WHERE SHOULD I SEND THE FORMS?

- We request that you mail the Original form to Office Ally so that we can review the forms and make a note of your provider number and the date the form was mailed to Medicaid.

Office Ally

Attn: Anita

PO Box 872020

Vancouver, WA 98687

- You may also mail the forms directly to Medicaid:

First Health Services

Attn: EDI Coordinator

PO Box 30042

Reno, NV 89520-3042

WHO CAN SIGN THE FORMS?

- The form must be signed by the provider if for a solo doctor, or the president, CEO, or owner of group if the form is for a group.

ORIGINAL SIGNATURE IS REQUIRED. FAXED FORMS NOT ACCEPTED.

WHAT FORM SHOULD I DO?

- Service Center Authorization Form

HOW DO I CHECK STATUS?

- Approximately one week after Medicaid receives your application they will notify Office Ally of the approval. When office Ally receives the approval we will enter it in our system and notify you via email. After you are notified you may begin submitting claims for electronic transmission.
- If you DO NOT receive notification from Office Ally you must follow up with Medicaid at 877-638-3472 option 2, option 5.

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**

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.



Mail this form to First Health Services, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.

SERVICE CENTER SOURCE: Check one. Enter the business or clearinghouse name as appropriate.	
<input type="checkbox"/> I will submit claims through a clearinghouse. Clearinghouse Name: _____	FIRST HEALTH SERVICES USE ONLY SC Code: _____
<input type="checkbox"/> I will submit claims directly from my business to First Health Services (direct submitter). Business Name: _____	
AUTHORIZE A TRANSACTION: Check the box next to each transaction you wish to authorize.	
<i>I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies First Health Services otherwise by use of this form.</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Electronic Remittance Advice (835)*	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Institutional claim (UB claim: 837I) <input type="checkbox"/> Dental claim (Dental Claim: 837D)
* Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.	
TERMINATE A TRANSACTION: Check the box next to each transaction you wish to terminate.	
<i>I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies First Health Services otherwise by use of this form. (Enter the effective date below.)</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Electronic Remittance Advice (835)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Institutional claim (UB claim: 837I) <input type="checkbox"/> Dental claim (Dental Claim: 837D)
Effective date for termination of this transaction(s): _____	

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider/Entity Name: _____ Phone: _____

NPI/API (one per form): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? Yes No

Authorized Signature: _____ Date: _____ / _____ / _____