MEDICAID DISTRICT OF COLUMBIA
PRE-ENROLLMENT INSTRUCTIONS – 77033

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 2 weeks.

WHAT FORM(S) SHOULD I COMPLETE?

- Washington, D.C. ACS EDI Provider Enrollment Form

WHERE SHOULD I SEND THE FORMS?

- Fax the forms to (202) 906-8399 Attn: Technical Support/Enrollment, or;
- Mail the forms to:

  ACS
  Attn: Technical Support/Enrollment
  PO Box 34734
  Washington DC 20043-4761

WHAT PROVIDER NUMBER DO I USE?

- NPI Number

WHO CAN SIGN THE FORMS?

- The owner or authorized agent

HOW DO I CHECK STATUS?

- Call ACS at 866-407-2005 and ask if you are enrolled and linked to Office Ally's Submitter ID 91168.
- If you are enrolled and linked you MUST contact My Clients Plus.

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**

Washington, D.C. ACS EDI Provider Enrollment Form

Please return to:
ACS
Attn: Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761
Or fax to: 202-906-8399

Provider ACS EDI Gateway Authorization form for Billing Agents and Clearinghouses.

Section A. Provider Information.	
Please indicate your classification **(required):** ☐ Individual Provider ☐ Group Provider/Practice	
Business Person	
Provider Name (Last, First, MI and Suffix)	
Provider Number (Required for Individuals)	*Group Provider Number (Required for Groups)*
Business Address	
City, State, and Zip	
Telephone Number	*Fax Number*
Contact Name	*E-mail Address*

Section B. Authorization Signature *(required).*

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

Office Ally ______________________________, 91168 ______________________________
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 below:

- ☒ 277-Claims Status Response
- ☐ 271-Eligibility Response
- ☒ 824-Error Report
- ☒ 835-Healthcare Claims Payment Advice
- ☐ 278-Prior Authorization Response

____
Provider/Provider Representative name (Please print)

____
Provider/Provider Representative Signature

____
Date