

NEW JERSEY MEDICAID PRE-ENROLLMENT INSTRUCTIONS - MCDNJ



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.

ORIGINAL SIGNATURES ARE REQUIRED. FAXED COPIES ARE NOT ACCEPTED.

WHAT FORMS DO I NEED TO COMPLETE?

- **Submitter/Provider Relationship EDI Agreement**
Instructions can be found on pages 1-5 of "Submitter/Provider Relationship EDI Agreement"
- **Electronic Remittance Advice (ERA) EDI Agreement**
Instructions can be found on pages 1-4 of "Electronic Remittance Advice (ERA) EDI Agreement"
ONLY REQUIRED IF YOU WANT OFFICE ALLY TO RECEIVE YOUR ELECTRONIC REMITTANCE ADVICE ON YOUR BEHALF.

WHO CAN SIGN THE FORMS?

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

HOW DO I CHECK STATUS OF PRE-ENROLLMENT?

- Call 609-588-6051 and ask if you are linked to submitter # 9904204.
- You must call Office Ally at 866-575-4120 opt. 1 and inform them you have been approved before you can submit claims.

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**

Submitter/Provider Relationship EDI Agreement

All New Jersey Medicaid and Charity Care Providers desiring to submit HIPAA formatted electronic claims must complete a New Jersey Medicaid HIPAA 837 Claims EDI Agreement. The various EDI agreements used by New Jersey Medicaid and the corresponding instructions for their completion are provided later in this section. The EDI Agreement and HIPAA certification received for the specified HIPAA transaction sets must be prior approved and on file with Molina Medicaid Solutions before HIPAA formatted claims may be submitted electronically. Molina Medicaid Solutions will notify the EDI Submitter of New Jersey Medicaid's approval for the submission of HIPAA formatted electronic claims.

Submitters who are currently enrolled with Molina Medicaid Solutions for the submission of HIPAA 4010A1 formatted electronic claims and have completed and returned the Addendum to the existing EDI Agreement along with a 5010 HIPAA Certification do NOT have to complete the EDI Agreements included in this Companion Guide. The Addendum Agreement replaces the previously executed EDI Agreement on file with Molina Medicaid Solutions.

All other providers/submitters who have not been approved to submit claims electronically with Molina Medicaid Solutions must complete one of the following New Jersey Medicaid EDI Agreements.

If the provider/submitter intends on submitting the claims directly to New Jersey Medicaid, then the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** must be completed and returned to the Molina EDI Unit. In addition, a copy of the HIPAA certification form certifying their capability to produce HIPAA compliant transactions must be included as an attachment to the EDI agreement. Only after the agreement and certification have been received and accepted by the Molina EDI unit will a Submitter ID be assigned.

A new agreement must be completed when a provider or billing service changes ownership or name of the company and a new HIPAA Certification is also required to be provided.

It is the responsibility of each submitter to notify the EDI UNIT if there is a change in address, contact information or e-mail address. Please use the EDI SUBMITTER UPDATE form.

In addition, a completed **Submitter/Provider Relationship EDI Agreement; (Form EDI-201)** for each New Jersey Medicaid Provider Number under which claims will be submitted needs to be completed and returned either with the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** or subsequent to the assignment of the Submitter ID by Molina.

- New Jersey Medicaid and Charity Care providers who are submitting claims directly to Molina Medicaid Solutions that have already been assigned a Submitter ID must complete a **Submitter/Provider Relationship EDI Agreement; (Form EDI-201)** for each Billing/Pay-to New Jersey Medicaid provider number.
- New Jersey Medicaid and Charity Care providers who are submitting claims through Clearing House/Billing Service are required along with the Clearing House/Billing Service to complete a **Submitter/Provider Relationship EDI Agreement; (Form EDI-201)**. A separate agreement is required for each Billing/Pay-to New Jersey Medicaid provider number.
- New Jersey Medicaid and Charity Care providers wishing to receive their remittance advice information electronically must complete the **Submitter Electronic Remittance EDI Agreement; (Form EDI-801)**.

Providers using a billing service to submit HIPAA formatted electronic claims must complete the **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** along with the billing service. The billing service is responsible for ensuring that each provider properly completes and submits these agreements to Molina Medicaid Solutions. If the agreement is not properly completed, it will be returned to the submitter/billing service for proper completion.

Providers must notify Molina Medicaid Solutions in writing when the use of a billing service for the submission of electronic claims has been terminated. When a provider changes billing services, the new billing service must ensure that the provider completes a new EDI Agreement form and submit it to Molina Medicaid Solutions along with a copy of the HIPAA certification form. Molina Medicaid Solutions will notify the billing service when approval to submit claims electronically has been granted.

Providers must notify Molina Medicaid Solutions in writing when their use of a software developer's application for the direct submission of electronic claims to Molina Medicaid Solutions has been terminated. When a provider changes to a new software product, the provider must complete a new **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** and submit it to Molina Medicaid Solutions along with a copy of the HIPAA certification form. Molina Medicaid Solutions will notify the provider when approval to submit claims electronically has been granted.

All New Jersey Medicaid HIPAA EDI Agreements **MUST** be submitted to Molina Medicaid Solutions with **ORIGINAL** signatures. Facsimile copies of agreements will **NOT** be accepted. If the agreement is not properly completed, Molina Medicaid Solutions will return it for proper completion.

Submitter/Provider Relationship EDI Agreement; (Form EDI-201) – Instructions

WHO SHOULD COMPLETE THIS AGREEMENT?

WHAT IF I AM THE PROVIDER AND SUBMIT MY CLAIMS DIRECTLY TO NEW JERSEY MEDICAID?

Providers who are submitting their claims directly to New Jersey Medicaid will need to complete an agreement for each of their New Jersey Medicaid billing/pay-to provider numbers. In this case, the provider is considered to serve as both the submitter and the provider. In most cases a provider submitting their claims directly to New Jersey Medicaid will be submitting claims under a single New Jersey Medicaid billing/pay-to provider number. However, there are cases where the provider may have been issued multiple New Jersey Medicaid billing/pay-to provider numbers. When this occurs, a separate agreement is required for each provider number.

WHAT IF I USE A CLEARINGHOUSE/BILLING SERVICE TO SUBMIT THE CLAIMS TO NEW JERSEY MEDICAID ON MY BEHALF?

Providers who are submitting their claims to New Jersey Medicaid through a Clearing House/Billing Service must also execute a **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** with the Clearing House/Billing Service and the completed agreement must be returned to the Molina EDI Unit for processing. A separate agreement is required for each New Jersey Medicaid billing/pay-to provider number.

In this case, the Submitter (or the Clearing House who owns the NJ Submitter ID completes Section 1 of the agreement and the provider completes Section 2 of the agreement.

Section 3 is to be completed by the provider to identify the software that is being used within the provider's office to capture the claims data and to then send that claims data to the clearing house/billing service.

SECTION 1: SUBMITTER INFORMATION

For the **MEDICAID**, or **CHARITY CARE** check boxes located at the top of the form, indicate the type of claims for which you will be submitting electronic claims. Check **one** box only. A separate New Jersey Medicaid HIPAA EDI Agreement is required for each provider number you will be electronically submitting claims for unless the provider is a group practice and the group is responsible for the billing of the individual providers associated with the provider group.

1. **Submitter Name:** Enter the name of the Provider or Clearing House/Billing Service Name as registered with New Jersey Medicaid/Molina Medicaid Solutions.
2. **Submitter ID:** Enter the Submitter ID as assigned by Molina Medicaid Solutions.
3. **Submitter Street Address:** Enter the physical street address of the Provider or Clearing House/Billing Service. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.
4. **City, State, Zip Code:** Enter the city, state and zip code. This **MUST** be part of the physical address.
5. **Submitter Representative's Signature:** This **MUST** be an actual signature of the Provider or Clearing House/Billing Service. **THIS MAY NOT BE STAMPED.** This person should have liability authority of the business.
6. **Date Signed:** Date signature was placed on this form.
7. **Submitter Representative's Name:** PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 5 above).
8. **Submitter Representative Telephone Number/Ext:** Enter the phone number along with the extension of a person from your company in the event Molina Medicaid Solutions needs to contact someone in reference to their electronic file submission.
9. **Fax:** Enter the FAX number of your place of business.
10. **Submitter Representative E-mail Address:** Enter the e-mail address. **PLEASE PRINT CLEARLY.** This should be a business e-mail address. This e-mail address will be entered as part of your Submitter file profile. This e-mail address will be used to contact someone from your company concerning the electronic file submission or allow you to submit HIPAA electronic claims.
11. **2nd Submitter Contact Person:** Enter the name of a person in the event Molina Medicaid Solutions needs to contact someone from your company. This person's name will be entered as part of your Submitter file profile. This person's name will be used to confirm a provider has been linked to your Submitter ID, preferably someone in the Enrollment Department who handles the EDI Agreement applications.
12. **Phone/Ext:** Enter the secondary phone number along with the extension of a person from your company in the event Molina Medicaid Solutions needs to contact someone.
13. **2nd Submitter Contact Person E-mail Address:** Enter the e-mail address. **PLEASE PRINT CLEARLY.** This should be a business e-mail address. This e-mail address will be entered as part of your Submitter file profile. This e-mail address will be entered as part of your Submitter file profile. This e-mail address will be used to confirm a provider has been linked to your Submitter ID, preferably someone in the Enrollment Department who handles the EDI Agreement applications.

SECTION 2: PROVIDER INFORMATION

NOTE: THIS INFORMATION SHOULD ONLY BE THE INFORMATION OF A NEW JERSEY MEDICAID PROVIDER. IF YOU ARE A SECONDARY BILLING SERVICE, PLEASE ADD A SUPPLEMENTARY SECTION 3 AND PLACE BILLING SERVICE INFORMATION ONLY IN SECTION 3.

14. **Action Requested:** Please check appropriate box if you are either adding a new provider number to be linked to your Submitter ID or terminating an existing provider from your Submitter ID.
15. **Provider Name:** Enter the BUSINESS name of the provider as they are registered with Molina Medicaid Solutions.
16. **New Jersey Medicaid Provider Number:** Enter the New Jersey Medicaid Provider number assigned to the provider by Molina Medicaid Solutions. In the case of a GROUP PRACTICE, the New Jersey Medicaid provider number assigned to the group practice should be used. If a provider practices as a sole practitioner, then his individual number may be used.
17. **NPI Number:** Enter the NPI number of the provider as assigned by NPPES and registered with Molina Medicaid Solutions.
18. **Provider Street Address:** Enter the physical street address of the provider's place of business or service address as it is registered with Molina Medicaid Solutions. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.
19. **City, State, Zip Code:** Enter the city, state and zip code. This **MUST** be part of the physical address.
20. **Provider EDI Contact Person:** Enter the name of a person from the provider's place of business in the event Molina Medicaid Solutions needs to contact someone at the provider level. (This must be someone at the provider's place of business. If a provider chooses to use a secondary billing service, the billing service information should be placed in Section 5.
21. **Phone/Ext:** Enter the phone number along with the extension of a person from the provider's or place of business in the event Molina Medicaid Solutions needs to contact someone. This phone number is used to verify a current phone number is on file for the provider.
22. **Fax:** Enter the FAX number of the provider's place of business.
23. **E-mail Address:** PLEASE PRINT CLEARLY. Enter the e-mail address of a contact person from the provider's place of business in the event Molina Medicaid Solutions needs to contact someone.
24. **Provider Representative's Signature:** This **MUST** be an actual signature of the New Jersey provider business owner. **THIS MAY NOT BE STAMPED.** This person should have liability authority of the business.
25. **Date Signed:** Date signature was placed on this form.
26. **Provider Representative's Name:** PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 24 above).

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

27. **SOFTWARE VENDOR NAME:** Enter the BUSINESS name of the Software Vendor.
28. **STREET ADDRESS:** Enter the physical street address of the software vendor. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.
29. **CITY, STATE, ZIP CODE:** Enter the city, state and zip code. This **MUST** be part of the physical address.

30. **SOFTWARE CONTACT PERSON:** Enter the name of a person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.
31. **PHONE/EXT:** Enter the phone number along with the extension of a person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.
32. **SOFTWARE CONTACT PERSON E-MAIL ADDRESS:** Enter the e-mail address of a contact person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company to correspond with for updates, changes, problems etc. with software.
33. **2nd SOFTWARE CONTACT PERSON:** Enter the name of a secondary person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.
34. **PHONE/EXT:** Enter a secondary phone number along with the extension of a person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.
35. **2nd SOFTWARE CONTACT PERSON E-MAIL ADDRESS:** Enter the e-mail address of a second contact person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company to correspond with for updates, changes, problems etc. with software.
36. **FAX:** Enter the FAX number of the software company.
37. **SOFTWARE PRODUCT NAME:** If a software company has multiple products, please enter the name of the product you are installing for the submission of the HIPAA transaction sets indicated in Section 3 above.
38. **SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME:** Please enter the release number of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 3 above.
39. **SOFTWARE PRODUCT RELEASE DATE:** Please enter the release date of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 3 above.

Return the completed EDI Amendment to Molina Medicaid Solutions at the following address:

Via U.S. Mail
Provider Enrollment
Molina Medicaid Solutions
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
Provider Enrollment
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619



Submitter/Provider Relationship EDI Agreement

Provider Name: _____ Provider Number: _____

SECTION 2: PROVIDER INFORMATION

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.

14) Action Requested: Add New Provider Terminate Existing Provider

15) Provider Name: _____

16) New Jersey Medicaid Provider Number: _____

17) Provider NPI Number: _____

18) Provider Street Address: _____
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the submitter.)

19) City, State, Zip Code: _____

20) Provider EDI Contact Person: _____ 21) Phone/Ext:(____) _____/_____

22) Fax:(____) _____ 23) E-mail Address: _____

24) Provider Representative's Signature _____ 25) Date Signed _____

26) Provider Representative's Name – Please Print Clearly _____

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 3: PROVIDER SOFTWARE VENDOR INFORMATION

This section is to identify the third party software vendor practice management system that the provider is using to exchange information with their third party billing service. This section may also be repeated if a secondary billing service is being used in addition to a clearing house.

31) SOFTWARE VENDOR NAME: Office Ally

32) STREET ADDRESS: 16703 SE McGillivray Blvd. Suite 200
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the software vendor.)



Submitter/Provider Relationship EDI Agreement

Provider Name: _____ Provider Number: _____

33) CITY, STATE, ZIP CODE: Vancouver WA 98683

34) SOFTWARE CONTACT PERSON: customer Service 35) PHONE/EXT: (866) 575-4120 Opt. 1

36) SOFTWARE CONTACT PERSON EMAIL ADDRESS: info@officeally.com

37) 2nd SOFTWARE CONTACT PERSON: Dan Waclawsky 38) PHONE/EXT: (866) 575-4120 x 254

39) SOFTWARE CONTACT PERSON EMAIL ADDRESS: dan.waclawsky@officeally.com

40) FAX: (360) 896-2151

41) SOFTWARE PRODUCT NAME: Proprietary

42) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: NA

43) SOFTWARE PRODUCT RELEASE DATE: NA

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

Return the completed EDI Amendment to Molina Medicaid Solutions at the following address:

Via U.S. Mail
Provider Enrollment
Molina Medicaid Solutions
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
Provider Enrollment
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

Electronic Remittance Advice (ERA) EDI Agreement

All New Jersey Medicaid and Charity Care Providers desiring to receive a HIPAA formatted electronic remittance advice (ERA) must complete a New Jersey Medicaid Electronic Remittance Advice EDI Agreement. The New Jersey Medicaid HIPAA EDI Agreements and instructions for their completion are provided later in this section. The Electronic Remittance Advice EDI Agreement must be prior approved and on file with Molina Medicaid Solutions before an ERA will be made available to the submitter that has been designated by the requesting provider. Molina Medicaid Solutions will notify the EDI Submitter of New Jersey Medicaid's approval for the submitter to receive the ERA.

Submitters who are currently enrolled with Molina Medicaid Solutions and have been approved to receive a HIPAA Version 4010 electronic remittance advice and have completed and returned the Addendum for 5010 to the existing EDI Agreement do NOT have to complete the new Electronic Remittance Advice EDI Agreement.

All other providers/submitters who have not been approved to submit claims electronically with Molina Medicaid Solutions must complete one of the following New Jersey Medicaid EDI Agreements: **HIPAA 837 Claims EDI Agreement (Form EDI-101)** in order to acquire a Submitter ID number. After receiving a Submitter ID number, any New Jersey Medicaid Provider Number who wish to send claims for New Jersey Medicaid claims processing must complete the **Submitter/Provider Relationship EDI Agreement; (Form EDI-201)**.

If the provider/submitter intends on submitting the claims directly to New Jersey Medicaid, then the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** must be completed and returned to the Molina EDI Unit. In addition, a copy of the HIPAA certification form certifying their capability to produce HIPAA compliant transactions must be included as an attachment to the EDI Agreement. Only after the agreement and certification have been received and accepted by the Molina EDI Unit will a Submitter ID be assigned.

A new agreement must be completed when a provider or billing service changes ownership or name of the company and a new HIPAA Certification is also required to be provided

It is the responsibility of each submitter to notify the EDI UNIT if there is a change in address, contact information or e-mail address. Please use the EDI SUBMITTER UPDATE form.

In addition, a completed **Submitter/Provider Relationship EDI Agreement; (Form EDI-201)** for each New Jersey Medicaid Provider Number under which claims will be submitted needs to be completed and returned either with the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** or subsequent to the assignment of the Submitter ID by Molina.

- New Jersey Medicaid and Charity Care providers who are submitting claims directly to Molina Medicaid Solutions that have already been assigned a Submitter ID must complete a **Submitter/Provider Relationship EDI Agreement; (Form EDI-201)** for each Billing/Pay-to New Jersey Medicaid provider number.
- New Jersey Medicaid and Charity Care providers who are submitting claims through Clearing House/Billing Service are required along with the Clearing House/Billing Service to complete a **Submitter/Provider Relationship EDI Agreement; (Form EDI-201)**. A separate agreement is required for each Billing/Pay-to New Jersey Medicaid provider number.
- New Jersey Medicaid and Charity Care providers wishing to receive their remittance advice information electronically must complete the **Submitter Electronic Remittance EDI Agreement; (Form EDI-801)**.

All New Jersey Medicaid HIPAA EDI Agreements **MUST** be submitted to Molina Medicaid Solutions with **ORIGINAL** signatures. Facsimile copies of agreements will **NOT** be accepted. If the agreement is not properly completed, Molina Medicaid Solutions will return it.

Electronic Remittance Advice EDI Agreement: Instructions**WHO SHOULD COMPLETE THIS AGREEMENT?**

If you are a New Jersey Medicaid provider for whom an electronic remittance advice is not already being provided to you and you now wish to receive an electronic remittance advice, you must complete the Electronic Remittance Advice EDI Agreement, including the designation of the Submitter ID under which the electronic remittance advice will be made available. The completed agreement must then be returned to the Molina EDI Unit for processing. Molina Medicaid Solutions will ONLY allow one entity to receive your electronic remittance data.

SECTION 1: MEDIA PREFERENCE

For the **MEDICAID**, or **CHARITY CARE** check boxes located at the top of the form, indicate the Provider Type for which you will receive electronic remittance data for. Check **one** box only. A separate New Jersey Medicaid HIPAA EDI Agreement is required for each provider number you will be electronically receiving claims for unless the provider is a group practice and the group is responsible for the billing of the individual providers associated with the provider group.

1. **Media Preference:** Indicate by putting a check mark in the appropriate box describing the preferred media for receipt of the ERA. Check **one** box only.
 - Web (HIPAA Claims link)** - Indicates the ERA will be picked-up through a secure area of the New Jersey Medicaid Web site. ERA files will remain on the web site for six weeks. "Web" is the preferred method of receiving remittance information.
 - CD-ROM** - Indicates the ERA will be provided on compact disc and mailed. Please note that Molina Medicaid Solutions will only approve the delivery of the ERA on CD-ROM for those submitters who submit more than 1,000 claims per month.

SECTION 2: PROVIDER INFORMATION

2. **Action Requested:** Please check appropriate box if you are either adding a new provider number to be linked to your Submitter ID or terminating an existing provider from your Submitter ID.
3. **Provider Name:** PRINT CLEARLY the BUSINESS name of the provider as they are registered with Molina Medicaid Solutions.
4. **Submitter Name:** PRINT CLEARLY the BUSINESS name of the entity to receive the electronic remittance information.
5. **Date:** Enter the date you wish to begin receiving the electronic remittance information. In a lot of cases it will be a new software product so it may be a date in the future. It is best to install new software after the weekly submission is sent and processed. We recommend a Monday date.
6. **Provider Representative's Signature:** This should be the signature of the provider business owner or someone in the business with liability authority.
7. **Date:** Date signature was placed on form.
8. **Provider Representative's Name:** PRINT CLEARLY the person's name who signed this form (item # 6 above).

9. **Medicaid Provider ID (GROUP ID):** Enter the New Jersey Medicaid Provider Number or Group Provider Number assigned to the provider by Molina Medicaid Solutions. In the case of a GROUP PRACTICE, the New Jersey Medicaid provider number assigned to the group practice should be used. If a provider practices as a sole practitioner, then the provider number assigned to the individual should be used.
10. **NPI Number:** Enter the NPI number of the Provider as assigned by NPES and registered with Molina Medicaid Solutions. Please indicate the GROUP NPI if this is a group practice. If a provider practices as a sole practitioner, then the NPI for the assigned to the individual should be used.
11. **Provider Name:** Enter the BUSINESS name of the provider as they are registered with Molina Medicaid Solutions.
12. **Provider Street Address:** Enter the physical street address of the provider's place of business or service address as it is registered with Molina Medicaid Solutions. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.
13. **City, State, Zip Code:** Enter the city, state and zip code. This **MUST** be part of the physical address.
14. **Provider Contact Person:** Enter the name of a person from the provider's place of business in the event Molina Medicaid Solutions needs to contact someone at the provider level.
15. **Phone/Ext:** Enter the phone number along with the extension of a person from the provider's or place of business in the event Molina Medicaid Solutions needs to contact someone.

SECTION 3: RECEIVER INFORMATION

16. **Submitter Name:** Enter the business name of the Provider/Submitter or Billing Agent/Submitter who will be receiving the 835 Health Care Claim Payment/Advice and 277 Health Care Claim Pending Status Information .
17. **Submitter ID:** Enter the Submitter ID previously assigned by Molina Medicaid Solutions. Doing so will notify Molina Medicaid Solutions that the Provider Number entered above is to be linked for electronic remittance information. If a submitter number has not been assigned, please complete the HIPAA 837 EDI Agreement (EDI-101).
18. **Submitter Address:** Enter the physical street address of the Provider or Billing Agent/Service receiving the electronic remittance information. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction. *Molina Medicaid Solutions will ship all electronic remittance information created on CD-ROM media via Federal Express second day and therefore we must have the physical street address for delivery.* If you have chosen "Web" as the preferred method of receipt of electronic remittance information, Molina Medicaid Solutions will still require a physical street address.
19. **City, St., Zip:** Enter the city, state and zip code. This **MUST** be part of the physical address.
20. **Fax:** Enter the FAX number of your place of business.
21. **Submitter Contact Person:** Enter the name of a person in the event Molina Medicaid Solutions needs to contact someone from your company.
22. **Phone/Ext:** Enter the phone number along with the extension of a person from your company in the event Molina Medicaid Solutions needs to contact someone.
23. **Submitter E-mail Address:** Enter the e-mail address. **PLEASE PRINT CLEARLY.** This should be a business e-mail address. This e-mail address will be entered as part of your Submitter file profile and used to communicate technical problems concerning 835 processing.

24. **2nd Submitter Contact Person:** Enter the name of a person in the event Molina Medicaid Solutions needs to contact someone from your company.
25. **Phone/Ext:** Enter the secondary phone number along with the extension of a person from your company in the event Molina Medicaid Solutions needs to contact someone.
26. **2nd Submitter Contact Person E-mail Address:** Enter the e-mail address. **PLEASE PRINT CLEARLY.** This should be a business e-mail address. This e-mail address will be entered as part of your Submitter file profile and used to acknowledge the processing of the EDI AGREEMENT and confirm your submitter profile has been updated to allow you to receive 835 Electronic Remittance Advice.

SECTION 4: HIPAA TRANSACTION SETS

27. **Transaction Sets:** Indicate by putting a check mark in the appropriate box describing the preferred version of HIPAA transaction sets in which to receive electronic remittance information. Check **one** box only.

Return the completed EDI Amendment to Molina Medicaid Solutions at the following address:

Via U.S. Mail
Provider Enrollment
Molina Medicaid Solutions
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
Provider Enrollment
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

| | | | |
|---|--------------|---------------------------|-----------------------|
| For Internal Use Only EMCAGREE | | | |
| DOCTYPE | Submitter ID | Submitter & Provider Name | |
| | | | |
| Update Initials | Date | QA Initials/Date | Provider Group Number |

- 837-I-D-P
- E-RA
- SIGN
- ADD
- TERM



Electronic Remittance Advice (ERA) EDI Agreement

- MEDICAID**

 CHARITY CARE

SECTION 1: MEDIA PREFERENCE

1) Media Preference: Web (HIPAA Claims link) CD-ROM

SECTION 2: PROVIDER INFORMATION

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.

2) Action Requested: Add New Provider Terminate Existing Provider

3) _____ hereby authorize
(Provider Name – Print Clearly)

4) Office Ally _____ to receive my
(Submitter Name– Print Clearly) (*Entity receiving electronic remittance information*)

Electronic remittance advice as of 5) Date: ____/____/____. I understand this electronic remittance advice contains Patient Health Information (PHI) and have taken the necessary steps with the parties named on this document to maintain the confidentiality of all PHI data.

6) _____ 7) Date: _____
(Provider Representative's Signature)

8) Provider Representative's Name: _____
(Please Print Clearly)

9) Medicaid Provider ID (GROUP ID): _____ 10) NPI (GROUP ID): _____

11) Provider Name: _____

12) Provider Street Address: _____

13) City, State, Zip Code: _____

14) Provider Contact Person: _____ 15) Phone/Ext: (____) _____

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"

Provider Name: _____ Provider Number: _____

SECTION 3: RECEIVER INFORMATION

16) Submitter Name: Office Ally 17) Submitter ID: 9904204
18) Submitter Address: 16703 SE McGillivray Blvd. Suite 200
19) City, St., Zip: Vancouver, WA 98683 20) FAX: (360) 896-2151
21) Submitter Contact Person: Customer Service 22) Phone/Ext: (866) 575-4120 Opt 1
23) Submitter E-mail Address: info@officeally.com
24) 2nd Submitter Contact Person: Dan Waclawsky 25) Phone/Ext: (866) 575-4120 ex 254
26) 2nd Submitter Contact Person E-mail Address: _____

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

27) Transaction Sets: 5010 835 Health Care Claim Payment/Advice & 277 Health Care Claim Pending Status Information 4010A1 835 Health Care Claim Payment/Advice

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

Return the completed EDI Amendment to Molina Medicaid Solutions at the following address:

Via U.S. Mail
Provider Enrollment
Molina Medicaid Solutions
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
Provider Enrollment
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619