COLORADO MEDICAID 835 ERA PRE-ENROLLMENT INSTRUCTIONS – 77016

HOW LONG DOES PRE-ENROLLMENT TAKE?

- 5 to 7 business days.

WHERE SHOULD I SEND THE FORMS?

- Mail the **original** form to: (note: faxes are not accepted)

  CO Med Asst Program
  PO Box 1100
  Denver, CO 80201-1100

WHAT FORM SHOULD I DO?

- Existing EDI Submitter form (disregard section 2 & 3)
  - When completing this form please note that you will only receive 835s if you are enrolled for EFTs. (If you are not set up to receive EFTs you should already be receiving Provider Claim Reports via the web portal, effective upon initial pre-enrollment)
    - If you are set up to receive EFTs and wish to receive 835s electronically (via the web portal) Check box X12N835 (claim payment/claim report) and enter your TP ID as the Receiving TP ID.
      - To view the 835 report(s):
        1. Go to: http://www.chcpf.state.co.us/
        2. Select 'Secured Site' on the top menu of options
        3. Log in using your User ID/Password (assigned after submitting Provider Application for EDI Enrollment)
        4. Go to "View and Download Reports"
        5. Enter the date range for the reports you want in order to view your Provider Claim Report or 835 ERA (if applicable).

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Provider EDI Update Form

Provider Trading Partner ID: _____ **Provider ID:** _____

Provider Name: _____ **Provider NPI:** _____

Providers may change/update the following sections to make revisions to the Electronic Data Interchange (EDI) Provider Enrollment & Agreement

***Section 1. I want to update the following information (Changes/ Updates will only be made to items that have been checked below)*:**

☐ Demographic/ Contact Information (Section 2) ☒ Report Retrieval (Section 4)

☐ Submission Method (Section 3)

Section 2. Current Demographic Information:

Legal Name: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____

Contact Information

Primary Contact Information: ☐ Add to existing contact information ☐ Replace current primary contact information

Contact Individual Name: _____ Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____

Secondary Contact Information: ☐ Add to existing contact information ☐ Replace current secondary contact information

Contact Individual Name: _____ Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____

If any of the above is updated information, your information in the MMIS will not be effected. To update your provider information in the MMIS, you must either update your information through the Web Portal or complete and submit the Provider Enrollment Update Form located in the Provider Services Forms Section at: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550.

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Section 3. Submission method

Sub-Section 3a. Submission method – Add

Complete this section if you are adding a Billing Agent, Clearinghouse, or Software Vendor.

You must also complete and submit the Provider Authorization Form (page 4) if you are authorizing a Billing Agent or Clearinghouse.

Please enter the name and Trading Partner ID of the Clearinghouse/Billing Agent/Software Vendor that will submit your electronic transactions.

1. Clearinghouse/Billing Agent/ Software Vendor Name: _____

2. Clearinghouse/Billing Agent/ Software Vendor Trading Partner ID: _____

Sub-Section 3b. Submission method – Remove

Complete this section if you are terminating your affiliation with a Billing Agent, Clearinghouse, or Software Vendor.

If you choose to remove your affiliation with a Clearinghouse, Billing Agent, or Software Vendor, you must update your report retrieval (section 4).

1. Clearinghouse/Billing Agent Name: _____

2. Clearinghouse/Billing Agent Trading Partner ID: _____

Section 4. Report Retrieval

Colorado Medical Assistance Program providers can receive X12N electronic reports. Enter only one Trading Partner ID (TP ID) per report. If you want to retrieve your own reports, please indicate your TP ID on the lines below:

- [x] X12N 824 (Payer Specific Error Report) Will by default be returned to submitting TP ID
- [x] X12N 997 (Acknowledgement of a sent transaction) Will by default be returned to submitting TP ID
- [x] X12N 271 (Eligibility Response) Will by default be returned to submitting TP ID
- [x] X12N 277 (Claim Status Response) Will by default be returned to submitting TP ID
- [x] Accept/Reject Report

Please select the report and enter the corresponding TP ID for each report retrieved through the Web Portal. *Enter only one TP ID per report. You may enter a different TP ID for each selected report.*

	Receiving TP ID		Receiving TP ID
☐ X12N 820 (Client Capitation)		☐ X12N 835 (Claim payment/Claim report)	
☒ Accept/Reject Report	136229	☐ Provider Claim Report (Previously called the Remittance Advice Report)	
☐ X12N 834 (Benefit Enrollment and Maintenance)			

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Provider Authorization

This Authorization must be completed and signed by the provider who wishes to authorize a billing agent, clearinghouse or other provider to:

- *Maintain and control designated reports*
- *Submit and/or retrieve designated transactions*

*The authorized billing agent, clearinghouse, or provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.*

Provider, _____ hereby appoints
Provider Name (please print)

Office Ally, Inc. , 136229
Billing Agent/Clearinghouse/Provider Name (please print) — Billing Agent/Clearinghouse/Provider Trading Partner/Submitter ID

to act as an authorized agent for the purpose of submitting health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program.
Provider must check one box below:

[x] **Provider authorizes the listed agent to retrieve some or all electronic reports/responses on Provider's behalf.**
OR
[ ] **Provider does NOT authorize the listed agent to retrieve electronic reports/responses on Provider's behalf.**

_____
Provider/Provider Representative Name (please print)

_____ _____
Provider/Provider Representative Signature — **Date**

_____
Provider Number

This Authorization may be modified or revoked at any time in writing. It is considered in effect until modified or revoked.

Return completed form (or revocation) to:

ACS State Healthcare
Colorado Medical Assistance Program Provider Services
P.O. Box 1100
Denver, CO 80201-1100