DATA-DRIVEN HEALTHCARE SOLUTIONS

COLORADO MEDICAID EDI CONTRACT INSTRUCTIONS (SKCO0)

Please MAIL the completed and signed agreement to:
ABILITY
Butler Square
100 North 6th St Ste 900A
Minneapolis, MN 55403
Do not fax the agreement to MD On-Line. Do not mail the agreement directly to Medicaid.

Please type provider information on the form for ease of processing at MD On-Line.

Do not mail the document to the address on Page 4 of this agreement.
Mail the document to MD On-Line at the New Jersey address below ONLY.

Please MAIL all pages of the completed and signed agreement to:
ABILITY
Butler Square
100 North 6th St Ste 900A
Minneapolis, MN 55403

Do not fax the agreement to MD On-Line. Do not mail the agreement directly to Medicaid.

Have questions or need assistance? Contact the MD On-Line Enrollment Department at 888-499-5465 x3506 or setup@mdol.com

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Department of Health Care Policy & Financing

Colorado Medical Assistance Program

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 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. Demographic/ Contact information:

Legal Name: _____

Mail to Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____

Contact Information – ☐ Add to existing contact information ☐ Replace current contact information

Primary Contact Information

Contact Individual Name: _____ Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____

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 updated. To update your provider information in the MMIS, you must either update the information through the Web Portal or complete and submit the Provider Enrollment Update Form located in the Forms section of the Department's website (colorado.gov/hcpf)→Provider Services→Forms→Update Forms section.

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Section 3. Submission Method

Please indicate how you plan to submit your electronic transactions

Electronic Transactions

☒ State's Provider Web Portal

Check appropriate box if utilizing:

☐ Vendor Software
☐ Billing Agent
☐ Clearinghouse/Switch Vendor

Transactions available for transmission

☒ X12N 270 (Eligibility Inquiry)
☒ X12N 276 (Claim Status Inquiry)
☒ X12N 278 (Prior Authorization)
☒ X12N 837P (Professional Claim)
☒ X12N 837D (Dental Claim)
☒ X12N 837I (Institutional Claim)

Section 3a. Submission Method- Add

Complete this section if your 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 TP ID of the Clearinghouse/Billing Agent or Software Vendor Name that will submit your electronic transactions.

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

2. Clearinghouse/Billing Agent/ Trading Partner ID (TP ID): _____

Sub-Section 3b. Submission method – Remove (If you choose to Remove your affiliation with a Clearinghouse or Billing Agent, you must update your report retrieval (section 4)

Complete this section if your are terminating your affiliation with a Billing Agent or Clearinghouse,

1. Clearinghouse/Billing Agent/ Name: _____

2. Clearinghouse/Billing Agent/ Trading Partner ID (TP ID): _____

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Section 4. Electronic Report/ Response Retrieval

All software vendors must have their own uniquely assigned Submitter or Trading Partner ID to act on a provider's behalf. Obtain your software vendor's ID and confirm the ID is active and functioning. Enter the software vendor's 5-digit Submitter ID or 6-digit Trading Partner ID and the software product name.

☐☐☐☐☐☐

Software Product Name _____

Transactions available for Receiving Reports

Colorado Medical Assistance Program providers can receive X12N electronic reports. Enter only one Trading Partner (TP) ID per report. You may enter a different TP ID for each selected report. If you want to retrieve your own reports please indicate your TP ID on the lines below.

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

Optional Reports

If the Receiving TPID field is left blank, it will by default be returned to submitting provider's TPID

	Receiving TP ID		Receiving TP ID
☐ X12N 820 (Client Capitation)	_____	☐ X12N 835 (Claim payment/Claim report)	_____
☐ X12N 834 (Benefit Enrollment and Maintenance)	_____	☒ Provider Claim Report (Previously called the Remittance Advice Report)	
☒ Accept/Reject Report	_____	☒ PAR Letters	
☐ PCP Roster	_____	☐ Managed Care Transactions	
		☐ ACC Roster Report	_____

Section 5. Delimiter (Complete if appropriate)

Element Delimiter to be used: ☐	Sub-element Delimiter to be used: ☐	Segment Delimiter to be used: ☐
Default Delimiter (asterisk) *	Default Delimiter (colon) :	Default Delimiter (tilde) ~

The Department will provide you with more information at a later date, including a User ID and Password, under separate cover.

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Provider Authorization Page

This must be completed by the billing provider <u>not</u> a rendering provider.

This authorization must be completed and signed by the billing provider who wishes to authorize a billing agent, clearinghouse, or other provider to maintain, control, submit and/or retrieve designated reports/transactions.

The billing agent, clearinghouse, or other 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)

_____ _____
Billing Agent/Clearinghouse/Other Provider Name (please print) Billing Agent/Clearinghouse/Other Provider Trading Partner or 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 also check one box below:

☐ Provider authorizes the agent listed above to **retrieve** some or all electronic reports/responses on Provider's behalf

OR

☐ Provider does NOT authorize the agent listed above 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:
Colorado Medical Assistance Program Provider Services
P.O. Box 1100
Denver, CO 80201-1100