New Jersey Medicaid HIPAA EDI 835 - ELECTRONIC REMITTANCE – Instructions

Following are instructions for completing the New Jersey Medicaid HIPAA EDI Agreement for the 835 Electronic Remittance. Providers are to complete this form designating the entity you wish to have your 835 Electronic Remittance data sent to. Please understand Molina Medicaid Solutions will ONLY allow **one submitter** to receive your 835 Health Care Claim Payment Advise. This form is ONLY to be used to request the 835 HIPAA EDI format.

By completing this form, you have the option of receiving your 835 Health Care Claim Payment Advise or having another entity receive it for you.

For the ☐ **MEDICAID**, ☐ **ENCOUNTER** or ☐ **CHARITY CARE** check boxes located at the top of the form, indicate the Provider Type for which you would like to receive electronic remittance in the 835 HIPAA format. 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.

DOCTYPE: EMCAGREE

Who should complete this section? ONLY AUTHORIZED MOLINA MEDICAID SOLUTIONS PERSONNEL. This is for internal use only.

SECTION A: MEDIA PREFERENCE

Who should complete this section? Any PROVIDER wishing to receive 835 HIPAA Formatted claims or designating a specific entity to receive your 835 HIPAA Claims Payment Remittance.

01) 835 Media Preference: Indicate by putting a check mark in the appropriate box describing the preferred media for receipt of 835 Health Care Claim Payment/Advise information. A check mark indicating your choice of: Check **one** box only.

- ☐ Internet - Indicates the 835 information will be picked-up through a secure area of the New Jersey Medicaid Web site. Remittance Information will remain on the website for six weeks. INTERNET is the preferred method of receiving Remittance Information.
- ☐ CD-ROM - Indicates the 835 information will provided on compact disc and mailed. Before checking this box, there is a minimum number of claim submissions (1,000) per month in order to request a CD.
- ☐ Cartridge - Indicates the 835 information will be provided on tape cartridge and mailed. Before checking this box, there is a minimum number of claim submissions (1,000) per month in order to request a cartridge. **In addition, the cartridges are the property of Molina Medicaid Solutions Corporation. The cartridges may not be reused for any reason. The cartridges must also be returned in 30 days. Failure to comply with these standards will be at the discretion of Molina Medicaid Solutions personnel to eliminate the use.**

SECTION B: PROVIDER INFORMATION

02) Provider Name: Enter the name of the Provider or Provider's Group name as registered with New Jersey Medicaid. PLEASE PRINT.

03) Submitter Name: Enter the Submitter's Name who you authorize to receive the 835 Health Care Claim Payment information. This could be your computer company or some other entity. It could be in the case of a provider who maintains their own computer department, the Provider's name. If you are using the Provider's name, please use the group name as registered with Provider Enrollment.

04) Date: Enter the date you wish to begin the 835 Health Care Claim Payment 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 approved. We recommend a Monday date.

05) Provider's Signature: This field is for the signature of the New Jersey Medicaid Provider. In the case of a group practice, the person that has signature authority for the group as a whole. THIS PERSON SHOULD HAVE LIABILITY AUTHORITY.

06) Date: Enter the date the form is being completed.

07) Medicaid Provider ID: Enter the number of the Provider or Provider's Group that was assigned by Molina Medicaid Solutions.

08) NPI: Enter the Provider or Provider's Group NPI (National Provider Identification) number.

09) Provider Name: Enter the name of the Provider or Provider's Group name as registered with New Jersey Medicaid. PLEASE PRINT.

10) Provider Address: Enter the physical **street** address of the Provider or Provider's Group. PO Box addresses will not be accepted.

11) Provider City, State, Zip Code: Enter the city, state and zip code of the physical address the 835 Health Care Claim Payment/Advise information is to be delivered to. If you have chosen INTERNET, a physical **street** address is still required.

SECTION C: 835 RECEIVER INFORMATION

12) Submitter Name: Enter the incorporated name of the billing service/software vendor or computer firm who will be receiving your 835 Health Care Claim Payment/Advise.

13) Submitter ID: Enter the Electronic Submitter ID previously assigned by Molina Medicaid Solutions if one exists. Doing so will notify Molina Medicaid Solutions that the Provider Number entered at the top of this EDI Agreement is to be linked only to the 835 Health Care Claim Payment/Advise. If one has not been assigned or you do not wish the Provider Number entered above to be linked to the previously assigned Electronic Submitter ID leave this blank.

14) Submitter Address: Enter the physical **street** address of the entity receiving the 835 Health Care Claim Payment/Advise. PO Box addresses will not be accepted. If you have chosen INTERNET as the preferred method of receipt of Remittance information, Molina Medicaid Solutions will still require a physical street address. *Molina Medicaid Solutions will ship all 835 information created on CD-ROM or tape cartridge media via Federal Express second day and therefore we must have the physical street address for delivery.*

15) Submitter City, State, Zip Code: Enter the city, state and zip code of the entity receiving the 835 Health Care Claim Payment/Advise.

16) EDI Contact Person: Enter the name of the person to be contacted by Molina Medicaid Solutions regarding the 835 Health Care Claim Payment/Advise.

17) Phone/Ext: Enter the area code, telephone number, and extension of the EDI Contact Person regarding the 835 Health Care Claim Payment/Advise.

18) E-Mail: Enter the e-mail address of the EDI Contact Person if one exists.

Return the completed EDI Agreement 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			
Submitter Id		*Submitter & Provider Name*	
Update Initials	*Date*	*QA Initials/Date*	*Provider Group Number*

state of newjersey 835 Electronic Remittance Agreement

835 - ELECTRONIC REMITTANCE

☐ **MEDICAID** ☐ **ENCOUNTER** ☐ **CHARITY CARE**

SECTION A: MEDIA PREFERENCE

01) 835 Media Preference (check only one): ☐ Internet ☐ CD-ROM ☐ Cartridge

SECTION B: PROVIDER INFORMATION

02) _____ hereby authorize
(*Provider Name print*)

03) _____ to receive my
(*Submitter Name print*)

electronic remittance information as of 04) Date: _____. I understand this electronic information 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.

05) _____ 06) Date: _____
(Provider's Signature)

07) Medicaid Provider ID (*GROUP ID*): _____ 08) NPI (*GROUP ID*):_____

09) Provider Name: _____

10) Provider Address: _____

11) Provider City, St, Zip Code: _____

SECTION C: 835 RECEIVER INFORMATION

12) Submitter Name: _____ 13) Submitter ID: _____

14) Submitter Address: _____

15) Submitter City, St, Zip Code: _____

16) EDI Contact Person: _____ 17) Phone/Ext: (_____) _____

18) E-Mail: _____

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

Return this completed REMITTANCE EDI Agreement 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 detailed instructions on completing this agreement, please refer to the 835 Electronic Remittance Agreement Instructions.