Payor Agreement Cover Sheet

McKesson ERA Setup Form

(Please complete all sections for proper setup)

ERA Processing Days: (Choose either all days or specific day(s) of the week)

___ All days

___ Selected day(s) ___ S ___ M ___ T ___ W ___ T ___ F ___ S

ERA Report Options: (Multiple choices)

___ **Remittance Data Report (CPR401)** (Available for all ERA file formats, contains McKesson's legacy remittance information with limited 835 data content)

___ **Remittance Data Report in Check Number Order (CPR405)** (Available for all ERA file formats, contains McKesson's legacy remittance information with limited 835 data content)

___ **Provider Remittance Data (CPX401)** (Available for ANSI 4010A1 HIPAA Enabled format only, contains listing of 835 ERA data elements)

___ **Remittance Data Report (CPX425)** (Available for all ERA file formats, contains 835 Remittance Notice data similar to Medicare's Standard Paper Remittance (SPR) report)

ERA File Format: (choose one)

___ Proprietary V.1 **(Non-HIPAA)**

___ Proprietary V.2 **(Non-HIPAA)**

___ ANSI 835 Version 3051 **(Pre-HIPAA)**

___ ANSI 835 Version 4010 **(Pre-HIPAA)**

___ ANSI 835 Version 4010A1 **(HIPAA-Enabled)**

ERA Batching Options for ANSI 835 4010A1 HIPAA-Enabled Format: (choose one)

___ Option 1 - One file per payor (May contain multiple checks)

___ Option 2 - Multiple files per payor (Each file may contain multiple checks, combined into one mailbox file)

___ Option 3 - One file per check (Combined into one mailbox file)

___ Option 4 - One file per check (One mailbox file per check)

ERA File Format Options for ANSI 835 4010A1 HIPAA-Enabled Format: (choose one)

___ Wrapped File (Continuous stream of data)

___ Unwrapped File (CR/LF after each segment)

ERA Processing Options: (choose one)

___ Express (Remittance is processed and sent as soon as it is received)

___ Collect (Remittance is processed and sent once per day)

ERA REPORT OPTIONS

McKesson offers the following remittance advice reports:

- The **Provider Remittance Data Report (Report CPR401)** is available to all customers receiving ERA regardless of the electronic output file format. The CPR401 report includes legacy remittance information with limited 835 data content. The payor claim number, claim status, submitted charge amount, amount applied to deductible, amount paid to the provider, and check number are listed on this report. Remittance advice transactions are sorted in CPID, payor run date, provider number, and patient account number order. The **Remittance Report - Claims with Zero Dollars Paid (Report CPR431)** is also generated as part of the CPR401 report options. The CPR431 report identifies all claims that have been processed by the payor which contain zero dollar payments.

- The **Provider Remittance Data Report in Check Number Order (Report CPR405)** is available to all customers receiving ERA regardless of the electronic output file format. The CPR405 report provides the remittance detail information of the CPR401 report as well as check summary information in check number order.

- The **Provider Remittance Data Report for HIPAA-Enabled 4010A1 (Report CPX401)** is only available to customers who receive the 835 4010A1 HIPAA Enabled format from McKesson. The CPX401 report lists all 835 data elements contained within the electronic remittance file with data printed in element heading / text format and transactions listed in the order they are received from the payor.

- The **Remittance Data Report (Report CPX425)** is available to all customers receiving ERA regardless of the electronic output file format. The CPX425 report contains all 835 remittance data similar to Medicare's Standard Paper Remittance (SPR) Notice and is McKesson's preferred remittance advice report.

ERA FILE FORMAT (Explanation of format and batching options)

Proprietary V.1:

- McKesson's Proprietary V.1 remittance file contains various date formats and remark codes are either 4 or 8 characters in length. Proprietary V.1 is not HIPAA compliant and not recommended for use.

Proprietary V.2:

- McKesson's Proprietary V.2 remittance file contains limited 835 data content. All date fields are in CCYYMMDD format. All remark codes are 10 characters in length. Proprietary V.2 is not HIPAA compliant.

ANSI 3051 and ANSI 4010 (Pre-HIPAA):

- The ANSI 3051 and ANSI 4010 (Pre-HIPAA) versions were developed by McKesson prior to the implementation of the HIPAA standards and are not recommended for use. The ANSI 3051 and ANSI 4010 are not HIPAA compliant 835 formats.

ANSI 835 Version 4010A1 (HIPAA- Enabled):

- **Batching Option 1:** Typically this option will produce one file per payor but may vary based upon processing options and multiple checks may be contained within each file. A new interchange (ISA-IEA) file will be created when the value in one of the following fields change: system ID, submitter ID, CPID, or test indicator.

- **Batching Option 2:** Typically this option will produce multiple files per payor but may vary based upon processing options and multiple checks may be contained within each file. In addition to the fields defined in Batching Option 1, a new interchange (ISA-IEA) file will also be created when the value of the receive date, receive time, or interchange control number change within the payor's file.

- **Batching Option 3:** This option will produce a single file (ISA-IEA interchange) for each check produced. These files will be combined into one mailbox file.

- **Batching Option 4:** This option will produce a single file (ISA-IEA interchange) for each check produced. These files will be put into separate mailbox files.

Electronic Funds Transfer Questionnaire
for Health Care Providers
State Farm Insurance
Health Division and Group Health Plan

1. Health Care Provider Name: ____

Federal Tax ID #: ____

Address: ____

City: _____________________ State: ____ Zip_______-________

Contact Name: ____

Phone Number: (___) _____ - ______ Fax Number: (___) ____- _______

Email address: ____

2. Does any other location use this Federal Tax ID #?

☐ Yes ☐ No

3. If you answered "yes" to the question above, do any of the other locations use a different Bank Account?

☐ Yes ☐ No

4. You must be registered for Health Care Claim Payment/Advice (ERA) through a clearinghouse. WebMD Envoy™ is the only option at this time. UHIN will be an option later this year.

Mail to: State Farm Insurance Companies
Three State Farm Plaza
P-4 FSS- CVIT Update
Bloomington, IL 61791-0001

ALL FIELDS ARE REQUIRED

AUTHORIZATION AGREEMENT-U.S.

For direct deposit of payments

Electronic Funds Transfer Information:

Name on Account: ____

Type of Bank Account: ☐ *Checking ☐ **Controlled Disbursement ☐**Savings

*Attach a voided check if this box is marked.

**Attach a deposit slip if this box is marked and provide the ACH Routing/Transit # for this account. ACH Routing /Transit #: ___________________________________

Name and Address
of Financial Institution: ____
____
____

I hereby authorize State Farm Mutual Automobile Insurance Company, its affiliates and subsidiaries ("State Farm") to initiate credit entries into my account as identified by the attached check or deposit slip.

☐ Initial enrollment

☐ Change of bank or account number

This authority is to remain in effect until State Farm has received written notification from us of its termination in such time and in such manner as to afford State Farm and the depository institution a reasonable opportunity to act on it or until we have received written notification of the cancellation of direct deposit offered by State Farm or the depository institution.

Health Care Provider
Name____

Federal Tax ID #____

Date____________________ Business Phone________________________

Provider Representative Signature____

Print name____

Title____

Mail to: State Farm Insurance Companies
Three State Farm Plaza
P-4 FSS- CVIT Update
Bloomington, IL 61791-0001

WebMD

ERA SETUP FORM FIELD DESCRIPTIONS

This ERA setup form can be filled out electronically (via Microsoft Word) and e-mailed (preferred) or faxed back to WebMD. See fax number and email address on form)

FIELD NAME	FIELD TYPE	DESCRIPTION
1) RECEIVER INFORMATION		
Receiver	Alpha	The name of the entity that will retrieve the ERA files from WebMD. Usually the same entity that submits claims to WebMD.
Receiver Contact	Alpha	Name of contact person at entity retrieving ERA files.
Receiver Address, City, State, Zip	Alpha	Address of entity retrieving ERA files.
Receiver Telephone	Numeric	The 10-digit telephone number for the receiver contact
Fax	Numeric	The 10-digit fax number for the receiver contact
Email Address	Alphanumeric	Email address for the receiver contact
Receiver Tax ID	Numeric	The 9-digit Tax ID of the entity retrieving the ERA file.
Login ID	Alphanumeric	ID assigned by WebMD to the entity retrieving the file and used to log in to WebMD's system for ERA file retrieval. Examples are TSO ID, Account ID and User ID.
WebMD ERA Product	Alpha	The name of the WebMD product used to retrieve ERA files and reports from WebMD. Examples include, but are not limited to, Xpedite, Software vendor, WebMD Office, Enline Companion and direct interface.
2) VENDOR INFORMATION		
Vendor	Alpha	The name of the WebMD certified vendor used to retrieve ERA files from WebMD. Usually the same vendor used to submit claims to WebMD.
Vendor Contact	Alpha	The name of contact person at WebMD certified vendor for ERA questions.
Vendor Address, City, State, Zip	Alpha	Address of WebMD certified vendor (contact vendor if unknown)
Vendor Telephone	Numeric	The 10-digit telephone number for the WebMD certified vendor contact (contact vendor if unknown)
Vendor Fax	Numeric	The 10-digit fax number for the WebMD certified vendor contact (contact vendor if unknown)
Vendor/Submitter ID	Alpha	9-digit ID assigned to the WebMD certified vendor (contact vendor if unknown)
3) PROVIDER INFORMATION		
Group/Facility Name	Alpha	The name of the practice or facility for whom ERA's will be generated by the payers.
Provider Name	Alpha	The name of the provider office or group for whom the ERA will be generated by the payer
Provider Contact	Alpha	Name of the contact person at provider site.
Address, City, State, Zip Code	Alphanumeric	Address of provider site
Provider Telephone	Numeric	The 10-digit telephone number for contact at the provider site
Provider Fax	Numeric	The 10-digit fax number for contact at the provider site
SSN/Tax ID	Alphanumeric	The 9-digit Social Security Number or Tax ID sent on claims filed electronically through WebMD's systems
Payers Requested	Alpha	Write the payer name(s), WebMD/ENVOY Payer ID(s), Group ID(s) and Provider ID(s) for all payer(s) from which the provider listed above wishes to receive ERA. Group ID's and Provider ID's are required for non-commercial payers such as Medicare, Blue Cross Blue Shield and Medicaid. Note: Payers requested must indicate ERA is a live service on the WebMD/ENVOY payer list.

ERA Provider Setup Form

Email: batchenrollment@webmd.net
Fax: (615) 885-3713

1	Receiver Information (*Entity retrieving ERA file from WebMD*)				
Receiver			**Contact**		
Address					
City		**State**		**Zip**	
Telephone		**Fax**			
Email Address		**Tax ID**			
WebMD ERA Product (Check only ONE)	☐ **GTEDS TSO**	☐ **OKC Direct Login ID**	☐ **WebMD Office mailto:**	☐ **NDM S Node Name**	☐ **Other Login**
Format requested	☐ **4010** ☐ **4010A**	**NOTE: You can only receive 1 (one) format for your files.**			
Merge Group Required?	☐ **Yes** ☐ **No**	**Merge Group ID/Site ID/PBG#**			

2	Vendor Information (*WebMD certified vendor used to retrieve ERA files from WebMD*)				
Vendor			**Contact**		
Address					
City		**State**		**Zip**	
Telephone		**Fax**			
Email Address		**MM# (for MMNS use only)**			
Vendor/Submitter ID		☐**Clearinghouse** ☐**Direct** ☐**VNS (for WebMD use only)**			

3	Provider Information (*Provider for whom ERA's will be returned to WebMD*)				
Group/Facility Name					
Provider Name			**Provider Contact**		
Provider Address					
City		**State**		**Zip**	
Provider Telephone		**Provider Fax**			
Provider E-mail Address					
Provider SSN or Tax ID (Only 1 ID per form)					

PAYERS REQUESTED (see payer list at http://www.webmdenvoy.com/pages/payers/lists.html)
****GROUP ID/PROVIDER ID NOT REQUIRED FOR COMMERCIAL PAYERS.*** *Payers requested must list ERA as a service on the WebMD/ENVOY Payer List*

	Payer Name	WebMD Payer ID	Provider ID*	Group ID*
1				
2				
3				
4				
5				

Send Setup Notification to: ☐**Do Not Send Notification** ☐**Vendor** ☐**Billing Service/Dealer** ☐**Facility/Provider**
Send Payer Forms (if requested) and Payer Approvals to: ☐**Vendor** ☐**Billing Service/Dealer** ☐**Facility/Provider**

ADDITIONAL WEBMD FORMS

The additional WebMD forms are attached for your convenience. A description of when to use each form follows:

COV (Change of Vendor)

A "change of vendor" (COV) letter is required when an existing WebMD provider/site changes software vendors. The letter is required when the provider/site changes from their existing WebMD certified software vendor (submitter id) to a different WebMD certified software vendor (submitter id). Claims testing may be required in addition to the "change of vendor" letter to ensure the new set up works correctly.

NOTE: A COV may also be required if a provider is currently set up through WebMD sending direct or using a vendor that sends print image claims and would like to submit through McKesson. Current WebMD processes do not allow for both types of submissions.

Any new enrollment or ACD sent to WebMD that requires a Change of Vendor (COV) letter will be considered incomplete without the accompanying letter. WebMD will notify the provider/site if the "change of vendor" letter is required but not received and classify the account as pending until the letter is received.

Following are steps required for a provider/site to change WebMD certified software vendors:

Step #1 Complete a Change of Vendor letter using the template provided (ENV003). **THE LETTER MUST BE ON THE PROVIDER/SITE'S LETTERHEAD AND CONTAIN <u>ALL</u> INFORMATION LISTED IN THE TEMPLATE (ENV003).**

Step #2 Sign the Change of Vendor letter. The letter must be signed by an authorized representative from the provider/site.

WebMD Corporation
Enrollment Department
batchenrollment@webmd.net
Fax: (615) 885-3713

Dear WebMD/ENVOY:

I would like to start receiving my electronic remittance advice through WebMD/ENVOY Corporation using McKesson, effective .

Currently, I am receiving through . I understand that I will NO LONGER be able to receive ERA through the previous vendor after changing.

I understand that this change request will include ALL providers associated with the tax id below.

Please accept this letter as my request to change vendors. Following is specific information regarding my practice:

Name:

Practice:

Address:

Phone #:

Contact:

Email Address:

Tax Id:

Please send acknowledgement of receipt and confirmation of set up to my attention via . I understand testing may be involved for the new set up.

If you have any questions or need additional information, please contact me at .

Sincerely,

ACD (Add, Change, Delete) Form

The ACD form should be used for adds, changes or deletes that are not covered by the COV, such as ACD of a payor, provider or site. If only the vendor is changing, please use the COV form.

To make an Addition:	**Check the Add Box**, indicate the current ID # for claims submission, the current product (the current TID, the current vendor/submitter ID or the current customer ID) and TSO# (if applicable) on the **left side of the form**. Then, complete the information to be added on the **right side** of the form.
To make a Change:	**Check the Change Box**, indicate the current ID # for claims submission, the current product (the current TID, the current vendor/submitter ID, the current customer ID), the current TSO# (if applicable) and **current** information that needs to be changed on the **left side** of the form. Then complete the **new** information on the **right side** of the form.
To make a Deletion:	**Check Delete Box** and complete the information to be deleted on the **left side** of the form.
Effective Date:	Date you want the requested information to go into effect on the WebMD systems.
Form Completed By:	Enter the **full name** and **title** of the person completing the form. This is used in case we have questions on the form.
Phone Number:	Complete the phone number of the person who completed the form. It will be used if WebMD has questions about information on the form.

ERA ACD (ADD/CHANGE/DELETE) FORM

Email: batchenrollment@webmd.net Fax: (615) 885-3713

COLUMN 1: COMPLETE ALL FIELDS

Add ☐ Change ☐ Delete ☐ Effective Date:

Section 1	Existing Receiver Information (Entity retrieving ERA file from WebMD)			
Receiver		Contact		
Address				
City		State		Zip
Telephone				Fax
Email Address				Tax ID
Login ID or TSO		Existing Format ☐ 4010 ☐ 4010A1		
Merge Group ID/Site ID/PBG#				

Section 2	Existing Vendor Information (WebMD certified vendor used to retrieve ERA files from WebMD)			
Vendor		Contact		
Address				
City		State		Zip
Telephone		Fax		
Email Address				
Vendor / Submitter ID				
(For WebMD use only)	*Clearinghouse* ☐	*Direct* ☐	*VNS* ☐	

Section 3	Existing Provider Information (Provider for whom ERA's will be returned to WebMD)			
Group/Facility Name				
Provider Name		Provider Contact		
Provider Address				
City		State		Zip
Provider Telephone		Provider Fax		
Provider E-mail Address				
Provider SSN or Tax ID (Only 1 ID per form)				

COLUMN 2: ENTER ONLY INFORMATION TO BE ADDED, CHANGED, OR DELETED

Form Completed By: Phone:

Section 1	Receiver Information-To Be Added/Changed /Deleted (Entity retrieving ERA file from WebMD)			
Receiver		Contact		
Address				
City		State		Zip
Telephone				Fax
Email Address				Tax ID
Login ID or TSO		Format Requested ☐ 4010 ☐ 4010A1		
Merge Group Required? ☐ Yes ☐ No		Merge Group ID/Site ID/PBG#		

Section 2	Vendor Information-To Be Added/Changed/Deleted (WebMD certified vendor used to retrieve ERA files from WebMD)			
Vendor		Contact		
Address				
City		State		Zip
Telephone		Fax		
Email Address				
Vendor / Submitter ID				
(For WebMD use only)	*Clearinghouse* ☐	*Direct* ☐	*VNS* ☐	

Section 3	Provider Information-To Be Added/Changed/Deleted (Provider for whom ERA's will be returned to WebMD)			
Group/Facility Name				
Provider Name		Provider Contact		
Provider Address				
City		State		Zip
Provider Telephone		Provider Fax		
Provider E-mail address				
Provider SSN or Tax ID (Only 1 ID per form)				

Existing Payer Information (To add new payers please submit an ERA PSF)

**GROUP ID / PROVIDER ID REQUIRED FOR NON-COMMERCIAL PAYERS ONLY

	Payer Name	WebMD Payer ID	Provider ID*	Group ID*
1				
2				
3				
4				
5				

Payer Information to be Changed/Deleted

(see payer list at http://www.webmdenvoy.com/pages/general/lists.html)

	Payer Name	WebMD Payer ID	Provider ID*	Group ID*
1				
2				
3				
4				
5				

Send Setup Notification to: ☐ Do Not Send Setup Notification ☐ Vendor ☐ Billing Service/Dealer ☐ Facility/Provider

Send Payer Forms (if requested above) and Payer Approvals to: ☐ Vendor ☐ Billing Service/Dealer ☐ Facility/Provider

**For Field Descriptions/Help, Select a field and Press F1