



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms  
04/19/2012 (IE)  
<http://www.medicaid.state.al.us/>

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## Medicaid Alabama (75254) Enrollment Instructions - Professional ERA only

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

**FAX COMPLETED FORMS TO-**  
EDI Enrollment  
334-215-4272

### **837 - CLAIMS Provider Enrollment (New) or (Change of Service)**

This payer DOES NOT require provider enrollment for claims' submission through a clearinghouse.

### **835 - ERAs Electronic Remits (New) or (Change of Service)**

If the provider wishes to authorize Practice Insight to retrieve 835 ERA files, the provider must complete the following form:

1. Electronic Explanation of Payment (EOP) Agreement

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## **ALLOW 2-4 WEEKS FOR PROCESSING**

*If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller or software support vendor for assistance or call Medicaid Alabama edi dept at 1-800-456-1242.*

***ELECTRONIC EXPLANATION OF PAYMENT (EOP) AGREEMENT***

**GROUP/BILLING PROVIDER NUMBER:** \_\_\_\_\_

**GROUP/BILLING NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**CONTACT:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**SUBMITTER ID:** \_\_\_\_\_

**VENDOR NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**VENDOR PHONE NUMBER:** \_\_\_\_\_

**VENDOR CONTACT:** \_\_\_\_\_

**I (we) request to receive Electronic Explanation of Payment (EOP) information and authorize the information to be deposited in our electronic mailbox. I (we) accept financial responsibility for costs associated with receipt of Electronic EOP information.**

**I (we) understand that paper-formatted EOP information will continue to be sent to my (our) mailing address as maintained at EDS until I (we) submit an Electronic EOP Certification Request Form.**

**I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.**

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Internet Address:** \_\_\_\_\_

**Mail form to: EDS • Attn: ECS Department • P.O. Box 244035 • Montgomery, AL 36124**

**FAX form to: 334-215-4272 Attn: ECS Department**

***FOR EDS USE ONLY***

**BILLING MODE:** \_\_\_\_\_ **EOP MODE:** \_\_\_\_\_ **PROTOCOL:** \_\_\_\_\_

**CONTACT DATE:** \_\_\_\_\_ **SOFTWARE MAILED:** \_\_\_\_\_

**TEST DATE:** \_\_\_\_\_ **AGREEMENT DATE:** \_\_\_\_\_ **APPROVAL DATE:** \_\_\_\_\_

**BEGIN DATE:** \_\_\_\_\_ **END DATE:** \_\_\_\_\_

**NOTES:** \_\_\_\_\_

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