
Medicaid Hawaii ACS Enrollment Instructions – Professional Claims 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 customer account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to make sure provider ID #s are valid. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the submitted paperwork, in case you need to follow up on your request.

FAX COMPLETED FORMS TO-
ACS EDI Enrollment Department
808-952-5595

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

If the provider has NOT submitted electronic claims to this payer before, or if the provider wishes to request a CHANGE of SERVICE to authorize Practice Insight to submit claims and/or retrieve ERAs (electronic remits), the billing provider must complete and submit this form:

1. Electronic Data Interchange - Trading Partner Enrollment Form (2 pages)
 - Section A1-** Enter Billing Provider Information.
 - Section A2-** Enter Contact Information if different than Section A1.
 - Section A3-** Provider signature and date required.

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 Hawaii/ACS EDI at 888-333-5641.



Hawaii Department of Human Services
ELECTRONIC DATA INTERCHANGE
TRADING PARTNER ENROLLMENT FORM

A. SUBMITTER/BILLING AGENT INFORMATION

PLEASE INDICATE YOUR CLASSIFICATION:

Provider Billing Agent

A1.	Submitter/Billing Agent Name:			
	Address:			
	City, State, Zip:			
	Telephone #:		FAX #:	
	Provider Number:		EIN:	
	Group Provider Number:		EMAIL ADDRESS:	

A2.	Please indicate contact information, if different from Submitter/Provider Information in Section A1:		
	Contact name:		
	Contact Title:		
	Address		
	City, State, Zip:		
	Telephone #:		
	Fax #:		
	Email Address		

A3.	If you plan to allow your Billing Agent to submit electronically on your behalf, please indicate the following information and sign below:						
BA Name:				Contact name:			
Address:				Phone Number:			
City:		State:		Zip:		Fax Number:	
_____ Signature				_____ Date			
Note: Your Billing Agent must be equipped with their own uniquely assigned ACS EDI Gateway Trading Partner ID to submit claims on your behalf. Please contact your Billing Agent to confirm their status with ACS EDI Gateway.							
Please indicate your Billing Agent's ACS EDI Gateway Trading Partner ID:							<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>



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B. SUBMISSION METHOD

B1. Please check the appropriate Submitter, Format and Transaction type(s) below:			
Submitter Type		Format and Transaction Type	
<input type="checkbox"/>	I am a provider who will submit and retrieve my response via the WINASAP2003 Software.	<input type="checkbox"/>	X12N 837 Professional
<input type="checkbox"/>	My Billing Agent will submit to ACS and retrieve responses on my behalf using WINASAP2003.	<input type="checkbox"/>	X12N 837 Institutional
		<input type="checkbox"/>	X12N 837 Dental

Please return complete forms via Mail or FAX to: **(808) 952-5595**
ACS EDI ENROLLMENT DEPARTMENT 1440 Kapiolani Blvd. Suite 1400 Honolulu, HI 96814
(Incomplete forms will cause a delay in processing and are subject to return.)