



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.

10/24/2011 (IE, FE)

<http://www.dhmf.state.md.us>

## Medicaid - MARYLAND (DHMH)

### Enrollment Instructions – Professional Claims & ERA

- ✓ **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.

#### MAIL ORIGINAL, COMPLETED FORMS TO-

Practice Insight  
Attn: Enrollment Department  
1 Greenway Plaza, Suite 350  
Houston, TX 77046

#### 837-CLAIMS and 835-ERAs

#### Initial Provider Enrollment (New) or Re-Enrollment (Change of Service)

To authorize Practice Insight to submit 837 electronic claims and/or receive 835-ERAs (electronic remits) the following form must be completed for each billing provider group or individual, if the individual provider is billing solo.

1. Maryland Medical Care Programs Submitter Identification Form- (2 pages)

Page 1, Section 2- Enter Billing Provider's Information.

Page 1, Section 4- To request 835-ERAs: SEE under Transactions.

Put ✓ in box next to - "**835 Health Care Claim Payment/Advice**".

Page 2- Enter Billing Provider's Name - "The provider, \_\_\_\_\_ hereby authorizes..."

Obtain- Signature of Provider, Printed Name, Telephone Number, Date

### ALLOW 2-4 WEEKS FOR PROCESSING

*If you do not receive confirmation within 30 days after submitting the EDI enrollment request, contact your reseller for assistance or call Medicaid Maryland EDI at 410-767-4682.*



**MARYLAND MEDICAL CARE PROGRAMS  
SUBMITTER IDENTIFICATION FORM**

For Version 004010 HIPAA Transaction Set

The provider, \_\_\_\_\_ hereby authorizes

**PROVIDER NAME**

\_\_\_\_\_, hereafter

**SUBMITTER AGENT**

referred to as Submitter Agent, to transmit our Medicaid claims to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the Submitter Agent the return computer file electronic vouchers of all claims data processed, indicating paid, rejected, denied and pended claims (with error codes). The Submitter Agent agrees to protect the confidentiality of this data as required by law.

\_\_\_\_\_  
**Signature of Provider**

\_\_\_\_\_  
**Signature of Submitter Agent**

\_\_\_\_\_  
**Print Name of Signature**

\_\_\_\_\_  
**Print Name of Signature**

\_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_  
**Date**

**Note:** This form requires completion of all requested information and original signatures to be processed.

**MAIL TO:**

**SYSTEM LIAISON SERVICES  
201 W. PRESTON ST., RM SS-18  
BALTIMORE, MD 21201  
ATTN: HIPAA DESK**

**For Internal Use Only:**

**Systems Liaison Services Signature:** \_\_\_\_\_

**Date Received:** \_\_\_\_\_