



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms  
7/25/2011 (IE,FE)  
<http://www.dhs.state.mn.us>

---

---

## **Medicaid MINNESOTA Minnesota Health Care Programs (MHCP) Enrollment Instructions – Professional Claims and 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.

**Fax Completed Forms To-  
MHCP Provider Enrollment  
651-431-7462**

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

If the provider has NOT submitted claims electronically to this payer or if the provider HAS SUBMITTED electronic claims to this payer VIA ANOTHER CLEARINGHOUSE, and they now want to submit via Practice Insight, the provider must complete this form:

**1. Minnesota Health Care Programs (MHCP) Provider Setup Form (1 page)**

MHCP Pay-To Provider - Enter Billing Provider(s) Information.  
Enter Effective date to be linked to submitter.  
Signature Required.  
CHOOSE ONE: Put ✓ for either: Claim, ERA, or Both

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

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

**1. Electronic Remittance Advice (RA) Request Form (1 page)**

Enter Billing Provider Information and Requested Start Date.  
Billing Provider Signature is Required.

---

---

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

*If it has been more than 30 business days since request was submitted and you have not received confirmation of enrollment, contact your reseller or software support vendor for assistance, or call Medicaid Minnesota at 800-366-5411*


 Minnesota Department of **Human Services**
*Minnesota Health Care Programs (MHCP)*

# Provider Setup Form

**For use by Billing Intermediaries and Clearinghouses only.**

Use this form to notify DHS whenever providers are **added or removed** from your list. Copy as needed.

SUBMITTER ID (UMPI)		SUBMITTER NAME	
NAME OF PERSON COMPLETING THIS FORM		ADDRESS	
PHONE (     )	CITY	STATE	ZIP CODE

## MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER (     )	REMOVE LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

## MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER (     )	REMOVE LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

## MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER (     )	REMOVE LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

**Fax this form to MHCP Provider Enrollment at (651) 431-7462 or mail to  
 DHS Provider Enrollment  
 PO Box 64987  
 St. Paul, MN 55164-0987**


 Minnesota Department of **Human Services**

# Electronic Remittance Advice (RA) Request Form

Complete this form to request the addition or removal of electronic RAs to or from a provider, clearinghouse or billing intermediary, for example, when a provider changes billing intermediaries. Providers may not choose to receive paper RAs (Minnesota Statutes 62J.536 requires electronic only RAs by 12/15/09). **The MHCP provider must authorize, sign and date all changes.** Fax completed form to (651) 431-7462.

MHCP PROVIDER NAME	NPI/UMPI
CONTACT PERSON	CONTACT PHONE NUMBER (     )

CLEARINGHOUSE/BILLING INTERMEDIARY NAME (IF APPLICABLE)	UMPI
CONTACT PERSON	CONTACT PHONE NUMBER (     )

<b>ADD</b> <input type="checkbox"/> 835 X12 <input type="checkbox"/> 835 PDF	REQUESTED START DATE (MM/DD/YYYY)
<b>REMOVE</b> <input type="checkbox"/> 835 X12 <input type="checkbox"/> 835 PDF	REQUESTED END DATE (MM/DD/YYYY)

ADDITIONAL COMMENTS

---



---



---



---



---



---

NAME (PLEASE PRINT)	PHONE NUMBER (     )
MHCP PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)

FOR OFFICE USE ONLY		
EDI REPRESENTATIVE	PHONE NUMBER (     )	DATE (MM/DD/YYYY)