



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
07/29/2011 (NEW FORM)

<http://medicaidprovider.hhs.mt.gov/providerpages/electronicbilling.shtm>

**Medicaid - MONTANA (77039)
ACS
Enrollment Instructions—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 FORM TO-
ACS-Inc ATTN: MT EDI
406-442-4402

837-CLAIMS (NEW) or (CHANGE OF SERVICE)

There is no edi enrollment requirement (no paperwork to complete) to submit 837 electronic claims. The provider may begin submitting electronic claims immediately via Practice Insight.

835-ERAs Electronic Remittance (NEW) or (CHANGE OF SERVICE)

1. Montana DPHHS EDI Provider Enrollment Form- Provider Billing Agent/Clearinghouse
ACS EDI Gateway, Inc Authorization Form (1 page)

Section A. Complete with billing provider's information.

Enter group provider number if billing as a group.

Section B. See "Provider, _____ hereby" Enter the Billing Provider's name (group or individual)
Provider/Provider Representative PRINTED NAME and SIGNATURE and DATE required.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 20 days since your request was submitted and the provider has not yet begun receiving ERAS, contact your reseller or software support vendor for assistance or call Medicaid Montana / ACS EDI at 1-800-987-6719.

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM



Please return to:
ACS-Inc
ATTN: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402



Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc Authorization Form

Section A. Provider Information.

Business Name

Provider Name (Last, First, MI and Suffix)

Provider Number

Federal Tax ID Number

Business Address

City, State, and Zip

Telephone Number

Fax Number

Contact Name

E-mail Address

Section B. Authorization Signature (required).

Provider, _____ hereby appoints _____

Provider name /Provider Representative name (please print)

_____, Billing Agent/Clearinghouse name (please print)

_____, Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 277-Claims Status Response, 271-Eligibility Response, 824-Error Report, 835-Healthcare Claims Payment Advice, 278-Prior Authorization Response, Exception Report (Print Image), 997-Functional Acknowledgement

_____, Provider/Provider Representative name (Please print)

_____, Provider/Provider Representative Signature

_____, Date

1.800.987.6719 (phone) 1.406.442.4402 (fax)

www.acs-gcro.com