



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
04/19/2012 (FE)

Medicaid - NEW JERSEY 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 COMPLETED FORMS TO-
Practice Insight, EDI Enrollment
1 Greenway Plaza, Suite 350
Houston, TX 77046

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. State of New Jersey Submitter/Provider Relationship EDI Agreement (3 pages)
 - 5) Do Not sign as Submitter Representative. Practice Insight will sign here.
 - 24) Original Provider Representatives signature Required.
- Section 3 – This is optional .

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 the following form:

1. State of New Jersey 835 Electronic Remittance Advice Agreement (2 pages)
 - 6) Original Provider Representatives signature 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 NJ edi dept at 1-609-588-6051.

For Internal Use Only EMCAGREE			
DOCTYPE	Submitter ID	Submitter & Provider Name	
Update Initials	Date	QA Initials/Date	Provider Group Number

- 837-I-D-P
- E-RA
- SIGN
- ADD
- TERM



Submitter/Provider Relationship EDI Agreement

MEDICAID

CHARITY CARE

SECTION 1: SUBMITTER INFORMATION

Every EDI submitter assigned a Submitter ID by New Jersey Medicaid must complete, sign and submit this New Jersey Medicaid Submitter/Provider Relationship Agreement before the submitter is authorized to submit claims for a New Jersey Medicaid Provider.

In some cases the submitter may be a New Jersey Medicaid provider and in other cases the submitter may be a third party Clearing House/Billing Service. Regardless, New Jersey Medicaid cannot process claims submitted with a specific Submitter ID for a specific New Jersey Medicaid provider number unless this agreement has been properly completed and submitted to New Jersey Medicaid or their designated agent. By signing this agreement the New Jersey Medicaid provider is authorizing the submitter to submit claims electronically to New Jersey Medicaid on their behalf.

A separate agreement is required for each New Jersey Medicaid Billing Provider Number.

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

1) Submitter Name: _____ 2) Submitter ID: _____

3) Submitter Street Address: _____
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the submitter.)

4) City, State, Zip Code: _____

5) Submitter Representative's Signature _____

6) Date Signed _____

7) Submitter Representative's Name – Please Print Clearly _____

8) Submitter Representative Telephone Number/Ext: (____) _____ / _____ 9) Fax: (____) _____

10) Submitter Representative E-mail Address: _____

11) 2nd Submitter Contact Person: _____ 12) Phone/Ext: (____) _____ / _____

13) 2nd Submitter Contact Person E-mail Address: _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".



Submitter/Provider Relationship EDI Agreement

Provider Name: _____ Provider Number: _____

SECTION 2: PROVIDER INFORMATION

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

14) Action Requested: Add New Provider Terminate Existing Provider

15) Provider Name: _____

16) New Jersey Medicaid Provider Number: _____

17) Provider NPI Number: _____

18) Provider Street Address: _____
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the submitter.)

19) City, State, Zip Code: _____

20) Provider EDI Contact Person: _____ 21) Phone/Ext:(____) _____/_____

22) Fax:(____) _____ 23) E-mail Address: _____

24) Provider Representative's Signature _____ 25) Date Signed _____

26) Provider Representative's Name – Please Print Clearly _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

This section is to identify the third party software vendor practice management system that the provider is using to exchange information with their third party billing service. This section may also be repeated if a secondary billing service is being used in addition to a clearing house.

31) SOFTWARE VENDOR NAME: _____

32) STREET ADDRESS: _____
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the software vendor.)



Submitter/Provider Relationship EDI Agreement

Provider Name: _____ Provider Number: _____

33) CITY, STATE, ZIP CODE: _____

34) SOFTWARE CONTACT PERSON: _____ 35) PHONE/EXT:(____) ____/_____

36) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

37) 2nd SOFTWARE CONTACT PERSON: _____ 38) PHONE/EXT:(____) ____/_____

39) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

40) FAX:(____) _____

41) SOFTWARE PRODUCT NAME: _____

42) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: _____

43) SOFTWARE PRODUCT RELEASE DATE: _____

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****

Return the completed EDI Amendment to Molina Medicaid Solutions at the following address:

Via U.S. Mail
Provider Enrollment
Molina Medicaid Solutions
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
Provider Enrollment
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

For Internal Use Only EMCAGREE			
DOCTYPE	<i>Submitter ID</i>	<i>Submitter & Provider Name</i>	
<i>Update Initials</i>	<i>Date</i>	<i>QA Initials/Date</i>	<i>Provider Group Number</i>

- 837-I-D-P
- E-RA
- SIGN
- ADD
- TERM



Electronic Remittance Advice (ERA) EDI Agreement

MEDICAID

CHARITY CARE

SECTION 1: MEDIA PREFERENCE

1) Media Preference: Web (HIPAA Claims link) CD-ROM

SECTION 2: PROVIDER INFORMATION

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

2) Action Requested: Add New Provider Terminate Existing Provider

3) _____ hereby authorize
(Provider Name – Print Clearly)

4) _____ to receive my
(Submitter Name– Print Clearly) (*Entity receiving electronic remittance information*)

Electronic remittance advice as of 5) Date: ____/____/____. I understand this electronic remittance advice contains Patient Health Information (PHI) and have taken the necessary steps with the parties named on this document to maintain the confidentiality of all PHI data.

6) _____ 7) Date: _____
(Provider Representative's Signature)

8) Provider Representative's Name: _____
(Please Print Clearly)

9) Medicaid Provider ID (GROUP ID): _____ 10) NPI (GROUP ID): _____

11) Provider Name: _____

12) Provider Street Address: _____

13) City, State, Zip Code: _____

14) Provider Contact Person: _____ 15) Phone/Ext: (____) _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law"



Electronic Remittance Advice (ERA) EDI Agreement

Provider Name: _____ Provider Number: _____

SECTION 3: RECEIVER INFORMATION

16) Submitter Name: _____ 17) Submitter ID: _____

18) Submitter Address: _____

19) City, St., Zip: _____ 20) FAX: (____) _____

21) Submitter Contact Person: _____ 22) Phone/Ext: (____) _____

23) Submitter E-mail Address: _____

24) 2nd Submitter Contact Person: _____ 25) Phone/Ext: (____) _____/_____

26) 2nd Submitter Contact Person E-mail Address: _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law"

SECTION 4: HIPAA TRANSACTION SETS

27) Transaction Sets: 5010 835 Health Care Claim Payment/Advice & 277 Health Care Claim Pending Status Information

4010A1 835 Health Care Claim Payment/Advice

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Via U.S. Mail
Provider Enrollment
Molina Medicaid Solutions
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
Provider Enrollment
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619