
Medicaid – NORTH CAROLINA

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.

For 837- Claims	Mail 5-page (ECS) Agreement- NC Medicaid Provider Enrollment CSC EVC Center PO Box 300020 Raleigh, NC 27622-8020
For 835- ERAs	Fax 1-page Request to- Practice Insight at 713-333-0138

837-CLAIMS Initial Provider Enrollment (New)

If the provider has NOT previously enrolled and/or submitted electronic claims to this payer, the following form must be completed and submitted for the billing provider group or individual provider billing solo. Any individual provider(s) added to the billing provider group subsequent to this edi enrollment, will need to complete this form:

1. **NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT (5 pages)**

IMPORTANT: TYPE or PRINT in black ink. All signatures must be original.

This form requires listing of ALL individual providers in the billing provider group (see pages 5-6).

837- CLAIMS Change to Provider Enrollment (Change of Service)

If the billing provider has previously enrolled to submit electronic claims, no edi enrollment is required.

1. There are no forms to be completed.

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. **EDS 835 Request Or Termination Form (1 page)**

STEP 1 - Action Place ✓ by **“Request 835 Set Up”** for NEW request or

Place ✓ by **“Change 835 setup”** if the provider has previously enrolled for ERAs, and wishes to authorize Practice Insight for retrieval of their 835/ERA files.

STEP 2 - Do not sign here. Practice Insight signs as clearinghouse.

STEP 3 - Enter information specific to the Billing Provider Group or Individual Provider (if billing solo). Provider 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 North Carolina edi dept at 1-800-688-6696.



North Carolina Department of Health and Human Services Division of Medical Assistance **ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT**

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

1. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.
2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.
3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.
4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.
5. The Provider shall notify the CSC EVC Center in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to CSC prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to CSC. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.
6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents.

Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.
8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.
9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.
10. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.
11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.
12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.
13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.
14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

- 15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
- 16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

*Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Medicaid Provider Number National Provider Identifier (NPI)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

Group Practice Member Information:

This portion of the ECS Agreement must be completed if you are billing as a group (for example, dental groups, physician groups, nurse practitioner groups, etc.)

List each individual provider for whom you will submit claims using your group provider number even if there is only one provider in your group practice.

All provider signatures must be original. Signature stamps and copies are not acceptable.

*Provider Name	*Provider Individual Number	*Signature of Provider

(Attach additional sheets if necessary)

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

*Signature of Authorized Agent

*Date

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL

Acceptance Date

by



835 Request Or Termination Form

This form is used by providers, clearinghouses and/or billing services for purposes of establishing or terminating the 835 Electronic Remittance Advice. It is a requirement that the form be completed and signed off by representatives of *both* the provider and the clearinghouse/billing service, if applicable.

Only one Medicaid Provider Number may be identified per form.

STEP 1:

Action (check one) Request 835 set-up Cancel 835 set-up Change 835 set-up
Set-up (check one) 835 Direct to Provider (Continue to STEP 3)
 835 Direct to Clearinghouse or Billing agency (Complete STEPS 2 and 3)

Please print legibly

STEP 2:

To be completed by clearinghouse or billing service, if applicable:

Date: _____ Submitter ID: _____
Clearinghouse Name: _____
Contact Name: _____
Telephone Number: (____) ____-____ EXT: _____ Fax Number: (____) ____-____
Clearinghouse Signature: _____
Printed Name of Clearing House Signature: _____

STEP 3:

To be completed by provider:

Date: _____ Submitter ID: _____ Medicaid Provider Number: _____
Provider Name: _____
Contact Name: _____
Address: _____
Telephone Number: (____) ____-____ EXT: _____ Fax Number: (____) ____-____
Provider Signature: _____
Printed Name of Provider Signature: _____

Return by fax to EDS an HP company Electronic Commerce Services at 919-859-9703.

For ECS Use only:

MB#/Name Verification: _____ Update date: _____ Verification Date: _____
835 TXN Verification: _____ Analyst Initials: _____ Verified By: _____