



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
4/20/2012 (NF, IE)

OKLAHOMA - Medicaid

Enrollment Instructions – Professional / Institutional Claims 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:
Medicaid Oklahoma, EDI Dept
405-416-1426

837 - CLAIMS Initial Provider Enrollment (New) Or Re-Enrollment (Change of Service)

No EDI enrollment required.

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

To authorize Practice Insight to retrieve MCD OK 835 ERA files, the provider must complete the following form:

1. Oklahoma SoonerCare EDI/ERA Application – Providers (1 page)
 - Section I - For Business Name: Enter Billing Provider Name and information, including the Billing Provider's Sooner Care ID/NPI #, e.g, Group ID/NPI #.
 - Section II - Enter individual Provider ID's and Names.
 - Section III - Authorized Signature from the Billing Provider's office 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 MCD OK EDI dept. at 1-800-522-0114.



Oklahoma SoonerCare EDI Application Providers

(Please type or print)

Section I – Provider Information

Provider Type (Check one): Physician Group Facility Other _____

Business Name: _____ Provider ID/NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

1st Contact: _____ Phone: _____ Fax: _____ Email: _____

2nd Contact: _____ Phone: _____ Fax: _____ Email: _____

EDI Software Vendor: _____

Address: _____

Contact Name: _____ Phone: _____ Email: _____

Please indicate EDI transaction type being requested to send/receive:

- | | |
|--|--|
| <input type="checkbox"/> 837 Professional Claim | <input type="checkbox"/> 278 Prior Authorization Request |
| <input type="checkbox"/> 837 Institutional Claim | <input type="checkbox"/> 820 Capitation Payments |
| <input type="checkbox"/> 837 Dental Claim | <input type="checkbox"/> 834 PMP Roster |
| <input type="checkbox"/> 270/271 Eligibility Request/Response | <input type="checkbox"/> 276/277 Claim Status Request/Response |
| <input type="checkbox"/> 835 Remittance Advice <i>**(Complete Section Below)**</i> | |

Section II – Complete Only if Requesting the Electronic Remittance Advice (ERA)

This request is to: (Check One) **Enable 835 Remittance Advice & cease paper RA after 2 week overlap**
 Disable 835 & resume paper RA effective immediately

** Note: The 835 is elected by and generated for the individual provider. The provider has the option to designate a receiver. (See below)*

Provider ID/NPI Number(s) to be Enabled/Disabled:

1. ID: _____ Name: _____ 3. ID: _____ Name: _____

2. ID: _____ Name: _____ 4. ID: _____ Name: _____

Please place additional providers (as needed) on separate page & include as attachment.

Elect a Designated Receiver for All ERA(s):

Receiver's ID: _____ Name: _____ Contact Person: _____

Address: _____ Phone: _____ Email: _____

The 835 Electronic Remittance Advice (ERA) is an X12 transaction that may require special software to process. Paper remittances will cease once the 835 has been enabled. The 835 ERA may be switched back to paper with written notice, and paper copies of your remit may be requested at any time by submitting form HCA-18. As a courtesy, your paper remittances will continue for two weeks after the 835 is enabled. By signing this form you acknowledge that you have read and agree to these terms.

Section III – Signature & Date

*** **Authorized Signature:** _____ **Date:** _____

Please submit form by mail or fax to:
HP Enterprise Services Attn: EDI Department | 2401 NW 23rd St., Suite 11 | Oklahoma City, OK 73107
Fax: 405.416.1426

Questions about this form or EDI procedures, please call the EDI Helpdesk at 1-800-522-0114 *option 2, 2* or email edihelpdesk@okxix.hcg.eds.com