
Medicaid - Pennsylvania Enrollment Instructions Professional / Institutional 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.

MAIL COMPLETED FORMS TO-

Practice Insight, LLC
Enrollment Dept.
1 Greenway Plaza, Suite 350
Houston, TX 77046

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

No edi enrollment required to submit electronic claims.

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. Data Release Agreement (4 pages)
Provider Signature required on page 4. Leave Agent and Department blank.
2. Provider Authorization Letter.
Please include Practice Insight Submitter #, Provider Name, 13 Digit Provider #, and Provider Signature. See Sample 1-page letter.
3. Nondisclosure Agreement – do not sign! (2 pages)
The provider should only print the name on the first page in the 2nd paragraph. The provider should not sign the Nondisclosure Agreement - leave blank.

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 Pennsylvania at 1-800-248-2152

DATA RELEASE AGREEMENT

I. PARTIES

This Agreement is made between the Pennsylvania Department of Public Welfare (hereinafter "Department") and _____ (hereinafter "Provider") and the Provider's Agent, _____ (hereinafter "Agent").

II. INTRODUCTION

Federal and state laws allow the release of information concerning recipients of Medical Assistance but place strict guidelines on the release of this information. 42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300; 62 P.S. § 404 and 55 Pa. Code Chapter 105; and 45 CFR Parts 160, 162 and 164.

III. PURPOSE

The Department, the Provider, and the Agent enter this agreement regarding the disclosure and use of information regarding the eligibility status of certain individuals, claims processing and/or the receipt of the 835. The information received is such as would normally be available to Medical Assistance providers in relation to the administration of the Medical Assistance Program. This information is subject to federal and state law restrictions regarding confidentiality. The purpose of this document is to set forth the scope of the responsibilities of the Provider and the Agent in order to permit claims processing and receiving the 835 and/or the disclosure of eligibility information to the Provider and Agent.

IV. RESPONSIBILITIES OF THE DEPARTMENT

1. **Designation of Staff Contact** – The Department shall designate one liaison to serve as the single point of contact for the Provider and its Agent.
2. The Department will allow the Provider and its Agent access to information, which will allow the Provider to verify Medical Assistance eligibility, process claims and/or receive the 835 for individuals from the date specified in the contract with the Medicaid Provider until the contract is terminated.

V. RESPONSIBILITIES OF PROVIDER AND AGENT

1. The Provider and Agent shall designate one liaison to serve as a single point of contact for the Department.
2. The Provider attests that it has a contractual arrangement with Agent in which Agent has agreed to assist the Provider. The Agent agrees to supply the Department with copies of the agreements it has with any Provider for which it accesses information.
3. The Provider gives the Agent permission to work on its behalf with the Department to verify Medical Assistance eligibility, process claims and /or receive the 835.
4. The Provider and Agent agree that all information disclosed by the Department is confidential and agree that they shall safeguard and maintain the confidentiality of all information received under this Agreement in accordance with federal and state law. The Provider and Agent agree that the use or disclosure of information for research or purposes other than as intended by the Agreement is strictly prohibited by federal and state law. Further, the Provider and Agent agree not to disclose any information obtained from the Department unless they have obtained express prior written approval from the Department.
5. The Provider, the Agent, and their employees will use the information only to verify an individual's eligibility for the Medical Assistance Program, process claims and/or receive the 835.
6. The Provider and Agent agree that they will instruct any person having access to this information as to the security requirements, and obligations and will inform such persons that they are bound by the confidentiality provisions of this Agreement.
7. The Provider and Agent agree that any person having access to this information will execute a Non-Disclosure Agreement (see Appendix I, Nondisclosure Agreement). No other persons shall be permitted access to this information.
8. The Provider and Agent agree to inform all employees that the violation of this Agreement may result in disciplinary action, including discharge or criminal prosecution if warranted.
9. The Provider and Agent agree that they are responsible for compliance with the terms of this Agreement of their employees and/or Agents.

VI. CONFIDENTIALITY

The Department, the Provider and Agent must protect client confidentiality while sharing the information necessary for verifying an individual's eligibility for Medical Assistance, claims processing and/or receiving the 835. The Provider and Agent agree that only those employees who have a "need to know" will have access to this information and the information will be used only for the purpose contemplated by this Agreement.

VII. GENERAL PROVISIONS

1. The Department may immediately terminate this Agreement with the Provider and/or its Agent upon any breach of the terms of this Agreement.
2. The Provider and Agent agree to indemnify and hold harmless the Department, the Commonwealth of Pennsylvania and their employees and officials for any loss, damage, judgements and costs of liability arising from the release or use of the information provided by the Department.
3. The Provider and its Agent may not use this information for any commercial or political purpose.
4. This Agreement can be canceled for no cause by either the Department or the Provider with thirty days notice.
5. The Agreement is not assignable, nor may the Provider or Agent delegate duties described herein.
6. Each of the signatories to this Agreement represent that he/she has full power and authority (without further approvals or consents) to enter into this Agreement and perform the obligations set forth herein.

VIII. CONTACT PERSON

The contact person for the Eligibility Verification System and the 835 Provider/Agent relationship is:

Name: Ruth Johns	Address:	EDS BDCM-PAMMIS
Title: Human Service Program Specialist		225 Grandview Ave
Telephone: 717-705-9717		Camp Hill, PA 17011

The contact person for the Provider/Agent is:

Name
Title
Office

Address
Telephone

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed as of the dates indicated below.

PROVIDER: _____ Date: _____
Sign: _____
Title: _____

AGENT: _____ Date: _____
Sign: _____
Title: _____

DEPARTMENT: _____ Date: _____
Sign: _____
Title _____

_____ Date: _____
Sign: _____
Title: _____
Office of Legal Counsel

(Type on Provider's Letterhead)

Date

EDS BDCM-PAMMIS
225 Grandview Ave
Camp Hill PA 17011

Dear EDI Enrollment:

The following Pennsylvania providers authorize clearinghouse submitter,

Practice Insight, LLC, ID# 945928152,

to receive 835 ERA reports on their behalf:

(provider name)

(provider's Medicaid ID#)

Thank you for your attention to this matter.

Sincerely,

(provider's signature)

(provider name)

Appendix I

NONDISCLOSURE AGREEMENT

Introduction

State and Federal law place stringent restrictions on the disclosure of information concerning applicants and recipients of assistance. 42 U.S.C. §1396a(a)(7); 42 C.F.R. 431.300; 62 P.S. §404 and 55 Pa. Code Chapter 105; and 45 CFR Parts 160, 162 and 164. Any person knowingly violating these restrictions may be sentenced to pay a fine or imprisonment, or both.

Agreement

I, _____, understand that all information obtained from the Department of Public Welfare and/or on the Department of Public Welfare's data base, directly or indirectly, is confidential. I agree not to disclose any information regarding persons who have applied for, have received, or who are receiving public assistance benefits (including Medical Assistance) to any unauthorized persons.

I understand that I may use the information only in my capacity as an employee or Agent of _____ for verifying eligibility for Medical Assistance, claims processing and/or receiving the 835. I understand that the use of disclosure of any information concerning an applicant or recipient of assistance or service for any other purpose is prohibited.

I understand that I am prohibited from disclosing to any person or entity (e.g., legislative body, committee) any information that identifies by name, address, recipient number or Social Security number of an applicant or recipient of public assistance, including Medical Assistance unless required by law or pursuant to valid authorization.

I have read this entire nondisclosure agreement and agree to abide by it. I also understand that any violation of this agreement may result in disciplinary action, which may include withdrawal of the right to use the information or discharge. Furthermore, I understand that criminal prosecution will be undertaken if I knowingly and intentionally disclose the information to anyone who is unauthorized, or use the data for fraudulent purposes.

Respectfully submitted,

Execution Date

SIGNATURE

NAME/TITLE (PRINTED)

WITNESS SIGNATURE

WITNESS NAME/TITLE (PRINTED)