
Medicaid – Rhode Island EDS

Enrollment Instructions – Professional Claims and 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 customer account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to make sure provider ID #s are valid. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the submitted paperwork, in case you need to follow up on your request.

MAIL COMPLETED FORMS TO
Practice Insight, Enrollment Department
1 Greenway Plaza, Suite 350
Houston, TX 77046

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

If the provider has NOT submitted electronic claims to this payer before, or if the provider wishes to request a CHANGE of SERVICE to authorize Practice Insight to submit claims and/or retrieve ERAs (electronic remits), the billing provider must complete and submit this form:

1. Trading Partner Agreement ID Change/Add Form (4 page form)
 - Complete page 3 with names, identification numbers, and signatures of all providers desiring to submit claims electronically.

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

If the provider has never registered for ERA files -Or if the provider currently receives 835 ERA files and wishes to authorize Practice Insight to retrieve their 835 ERA files, the provider must complete this form:

1. Trading Partner Agreement ID Change/Add Form – Article I.
 - Check box next to “835 Remittance Advice” on page 2 of form.

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.



RHODE ISLAND DEPARTMENT OF HUMAN SERVICES



Trading Partner Agreement ID Change/Add form

Once a Trading Partner Agreement (TPA) is received and processed, this form may be used to add additional billing providers to the original TPA ID assigned. This form must be received with original signatures. **No facsimile or photocopies will be accepted.**

Trading Partner Name: _____

Assigned Trading Partner ID: _____

Before mailing your signed Trading Partner Agreement to EDS for processing please verify that:

- The document is complete
- Signatures are in the appropriate areas
- You have checked the transactions that you will be submitting and receiving (See page 5 of the TPA)

ARTICLE I. MEDICAL TRANSACTION STANDARDS

Rhode Island Medical Assistance Program Transaction Standards

Selected **ASC X12N Version 4010A** standards include, as applicable, all data dictionaries, segment dictionaries and transmission controls referenced in those standards, but include only the Transaction Sets listed in the section below. The information provided will be utilized to route transactions to the Medicaid Management Information System and back to Trading Partner directories. Remittance files (835) and Pended Claims Reports (277) will be available only to one trading partner. If authorizing one Trading Partner for claims submission and another for downloads each party must complete a separate TPA.

Check all that apply:

837 Professional	277 Unsolicited Claim Status
837 Institutional	997 Functional Acknowledgement
837 Dental	835 Remittance Advice
270 Eligibility Inquiry	271 Eligibility Response
276 Claim Status Inquiry	NCPDP 1.1 Batch Pharmacy Claim Response
NCPDP 5.1 Batch	

Specify Software:

Software	Vendor
Provider Electronic Solutions	EDS
Other	

Method of Transmission: _____

Guidelines

HIPAA – Health Insurance Portability and Accountability Act. In the event of any conflict, HIPAA standards and Implementation Guides shall control.

Please list the name(s) and phone number(s) of person(s) authorized to resolve problems regarding electronic transmissions:

Name Phone Number

Name Phone Number

e-mail address

ARTICLE II. RHODE ISLAND MEDICAL ASSISTANCE PROVIDERS

Please list the names and the RI Medical Assistance Program provider numbers of those providers for which electronic transactions will be submitted. Each individual provider or group for whom you will be billing must sign and date the agreement below. If additional space is required to identify each provider make copies of Article II and attach.

* Please list which number (can be both) you would like linked to your Trading Partner Number

1. _____
NPI / Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

2. _____
NPI / Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

3. _____
NPI / Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

**Trading Partner Execution:
TRADING PARTNER**

Signed

Name

Title

DO NOT FAX

**Please mail this certification to the
Following address:**

**EDS
Attn: EDI Coordinator
P.O. Box 2010
Warwick, RI 02887-2010**