
MEDICAID – WYOMING (ACS) 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.

FAX COMPLETED FORMS TO-
EDI Enrollment Unit, 307-772-8405

837-Claims and/or 835-ERAs Initial Provider Enrollment (New)

If the provider has NOT submitted claims electronically to, and/or NOT authorized the retrieval of electronic remits from this payer, the billing provider must complete this form:

1. Wyoming ACS EDI Provider Enrollment Form (6 pages)

COMPLETE Sections 1, 3 and 5 with Billing/Group Provider information.

COMPLETE Section 4 ONLY-- if you are currently submitting transactions DIRECT to MCD WY.

OPTIONAL - ERAs (to authorize Practice Insight to retrieve electronic remits for this provider):

SEE Page 6, Section 9: PUT ✓ - "X12N 835 (Healthcare Claim Payment/Advice)"

COMPLETE Section 10 to add any additional individual "pay to" providers.

837-Claims and/or 835-ERAs Provider Re-Enrollment (Change of Service)

If the provider is currently submitting electronic claims and/or retrieving electronic remits directly or through another service company, and would like to submit claims and/or retrieve remits via Practice Insight, the billing provider must complete this form:

1. Provider ACS EDI Gateway Authorization Form for Billing Agents/Clearinghouses (1 page)

COMPLETE Section A with Billing Provider/Group Provider information.

OPTIONAL - ERAs (to authorize Practice Insight to retrieve electronic remits for this provider):

SEE Page 1, Section B: PUT ✓ - "X12N 835 Remittance Request"

COMPLETE Section C to include Provider/Representative Name, Signature and Date.

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 ACS EDI Gateway at 1-800-672-4959.

Wyoming ACS EDI Provider Enrollment Form



Please return to:
Attn: EDI Enrollment Unit
PO Box 667
Cheyenne, WY 82003
Or fax to 307.772.8405



ACS EDI PROVIDER ENROLLMENT FORM

Please print or type. Complete all areas of the ACS Provider Enrollment Form, unless otherwise indicated.

Section 1. Classification Please indicate your classification.

Individual Group

Section 2. Submission Method Please indicate how you plan to submit your electronic transactions.

WINASAP2003 Vendor Software Billing Agent Clearinghouse Web Portal

Section 3. Provider Information

Business Name (If applicable)

Provider Name (Last, First, MI, and Suffix)

Business Street Address

City, State, and Zip Code

Telephone

Fax

Provider Number (Required for Individuals)

Group Provider Number (Required for Groups)

Email Address (If applicable)

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Section 4. Submitter/Trading Partner ID Number	
If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your ACS EDI Gateway 5-digit Submitter ID or 6-digit Trading Partner ID:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Section 5. Contact Information Please indicate contact individual information.	
<i>Contact Name (Individual)</i>	<i>Contact Title</i>
<i>Business Street Address</i>	
<i>City, State, and Zip Code</i>	
<i>Telephone</i>	<i>Fax</i>
<i>Email Address</i>	

Additional Contact Information Please indicate additional contact information.	
<i>Contact Name</i>	<i>Contact Title</i>
<i>Business Street Address</i>	
<i>City, State, and Zip Code</i>	
<i>Telephone</i>	<i>Fax</i>
<i>Email Address</i>	

Please attach additional sheets if necessary.

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Section 6. Provider Using a Software Vendor, Billing Agent, or a Clearinghouse

If you have indicated that you plan to use the services of a Software Vendor, a Billing Agent, or a Clearinghouse to submit your transactions electronically to ACS EDI Gateway, please provide the following information.

(If you plan on using WINASAP2003 or the Web Portal, you do not need to complete this section)

Sub-section 6a. Type of Service that you use

Please indicate the type of service that you use to submit electronic transactions.

<input type="checkbox"/> Software Vendor (SV)	<input type="checkbox"/> Clearinghouse (CH)	<input type="checkbox"/> Billing Agent (BA)
SV/CH/BA Name		
Contact Name	Contact Title	
Business Address		
City, State, and Zip Code		
Telephone Number	Fax Number	
Email Address		

Sub-section 6b. Software Vendor, Billing Agent or Clearinghouse Submitter ID or Trading Partner ID

Note: Your Software Vendor, Billing Agent or Clearinghouse must be equipped with their own uniquely assigned ACS EDI Gateway Submitter ID or Trading Partner ID to act on your behalf. Please contact your Software Vendor, Billing Agent/Clearinghouse to confirm their status with ACS EDI Gateway.

Please indicate your Software Vendor/Clearinghouse/Billing Agent's 5-digit Submitter ID or 6-digit Trading Partner ID:

□	□	□	□	□	□
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Sub-section 6c. Provider Using a Software Vendor

If you plan to use Vendor Software, please complete the following information related to your software.

Software Name:	Software Version:	Protocol:
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Section 7. Transactions Available for Transmission	
Sub-Section 7a. WINASAP2003 (replacing ACE\$ software)	
Request for free WINASAP2003 Software:	
<input type="checkbox"/> I will download a copy from the ACS EDI Gateway website at www.acs-gcro.com	
<input type="checkbox"/> Please mail me a CD-ROM of the WINASAP2003 software	
<input type="checkbox"/> X12N 837P (Professional Claim)	<input type="checkbox"/> X12N 837D (Dental Claim)
<input type="checkbox"/> X12N 837I (Institutional Claim)	
Sub-Section 7b. Standard Transactions (Submissions other than WINASAP2003 and Web Portal)	
<input type="checkbox"/> X12N 837P (Professional Claim)	<input type="checkbox"/> X12N 278 (Prior Authorization)
<input type="checkbox"/> X12N 837D (Dental Claim)	<input type="checkbox"/> X12N 270 (Eligibility Inquiry)
<input type="checkbox"/> X12N 837I (Institutional Claim)	<input type="checkbox"/> X12N 276 (Claim Status Inquiry)
Sub-Section 7c. Standard Transactions (Batch Submissions through Web Portal)	
<input type="checkbox"/> X12N 837P (Professional Claim)	
<input type="checkbox"/> X12N 837D (Dental Claim)	
<input type="checkbox"/> X12N 837I (Institutional Claim)	

Section 8. Delimiter Information		
If you are submitting X12N transactions directly to ACS, please provide an alternate delimiter. If nothing is entered, the default will be used.		
This information is not required if you are using WINASAP2003.		
Element Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/> <i>Default Delimiter (asterisk) *</i>	Segment Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/> <i>Default Delimiter (tilde) ~</i>	Sub-Element Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/> <i>Default Delimiter (colon) :</i>

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Section 9. Electronic Reports and Response Retrieval

Wyoming EqualityCare providers can retrieve their electronic reports and/or responses from the ACS EDI Gateway Internet Data Exchange (iDEx). If you would like to participate in this service, please complete the section below.

Reports and/or Responses available for X12N Transactions

<input type="checkbox"/> X12N 997 (Functional Acknowledgement)	<input type="checkbox"/> X12N 835 (Healthcare Claim Payment/Advice)
<input type="checkbox"/> X12N 271 (Eligibility Response)	<input type="checkbox"/> 835 (Print Image)
<input type="checkbox"/> X12N 277 (Claims Status Response)	<input type="checkbox"/> X12N 824 (Error Response)
<input type="checkbox"/> X12N 278 (Prior Authorization Response)	<input type="checkbox"/> 824 (Print Image)

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Provider ACS EDI Gateway Authorization Form for Billing Agents/Clearinghouses

Section A. Provider Information	
Please indicate your classification (required): <input type="checkbox"/> Individual Provider <input type="checkbox"/> Group Provider/Practice	
<i>Business Name</i>	
<i>Provider Name (Last, First, MI and Suffix)</i>	
<i>Provider Number (Required for Individuals)</i>	<i>Group Provider Number (Required for Groups)</i>
<i>Business Address</i>	
<i>City, State, and Zip</i>	
<i>Telephone Number</i>	<i>Fax Number</i>
<i>Contact Name</i>	<i>E-mail Address</i>
Section B. Reports and Responses Available	
<input type="checkbox"/> X12N 997 Functional Acknowledgement	<input type="checkbox"/> X12N 271 Eligibility Response
<input type="checkbox"/> X12N 277 Claims Status Response	<input type="checkbox"/> X12N 824 Error Report
<input type="checkbox"/> X12N 278 Response	<input type="checkbox"/> X12N 835 Remittance Advice
Section C. Authorization Signature (<i>required</i>)	

Provider, _____ **hereby appoints**
Provider name /Provider Representative name (please print)

_____,
Billing Agent/Clearinghouse name (please print)

Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected above:

Provider/Provider Representative Name (Please print)

Provider/Provider Representative Signature

Date

1.800.672.4959 (phone) 1.307.772.8405 (fax)

www.acs-gcro.com