



MEDICAID NEW JERSEY (MCDNJ) ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- Electronic Remittance Advice (ERA) EDI Agreement
 - Instructions can be found on pages 1-3

WHERE SHOULD I SEND THE FORM(S)?

- Mail the original Electronic Remittance Advice (ERA) EDI Agreement to:

Molina Medicaid Solutions
PO Box 4804
Trenton, NJ 08650-4804
Attn: EDI Unit

- Original signature is required. Faxed copies are not accepted

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 8-10 business days

HOW DO I CHECK STATUS?

- Call (609) 588-6051 and ask if you are linked to Office Ally's Submitter ID **9904204** for ERA retrieval.

Electronic Remittance Advice (ERA) EDI Agreement (Form EDI-801)

All New Jersey Medicaid and Charity Care Providers desiring to receive a HIPAA formatted electronic remittance advice (ERA) must complete a New Jersey Medicaid Electronic Remittance Advice EDI Agreement. The New Jersey Medicaid HIPAA EDI Agreements and instructions for their completion are provided later in this section. The Electronic Remittance Advice EDI Agreement must be prior approved and on file with Gainwell Technologies before an ERA will be made available to the submitter that has been designated by the requesting provider. Gainwell Technologies will notify the EDI Submitter of New Jersey Medicaid's approval for the submitter to receive the ERA.

Submitters who are currently enrolled with Gainwell Technologies and have been approved to receive a HIPAA Version 4010 electronic remittance advice and have completed and returned the Addendum for 5010 to the existing EDI Agreement do NOT have to complete the new Electronic Remittance Advice EDI Agreement.

All other providers/submitters who have not been approved to submit claims electronically with Gainwell Technologies must complete one of the following New Jersey Medicaid EDI Agreements: **HIPAA 837 Claims EDI Agreement (Form EDI-101)** in order to acquire a Submitter ID number. Any New Jersey Medicaid Provider Number who wishes to send claims for New Jersey Medicaid must complete the **Submitter/Provider Relationship EDI Agreement (Form EDI-201)**.

If the provider/submitter intends on submitting the claims directly to New Jersey Medicaid, then the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** must be completed and returned to the Gainwell Technologies EDI Unit. In addition, a copy of the HIPAA certification form certifying their capability to produce HIPAA compliant transactions must be included as an attachment to the EDI Agreement. Only after the agreement and certification have been received and accepted by the Gainwell Technologies EDI Unit will a Submitter ID be assigned.

A new agreement must be completed when a provider or billing service changes ownership or name of the company and a new HIPAA Certification is also required to be provided

It is the responsibility of each submitter to notify the EDI UNIT if there is a change in address, contact information or email address. Please use the EDI SUBMITTER UPDATE form.

In addition, a completed **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** for each New Jersey Medicaid Provider Number under which claims will be submitted needs to be completed and returned either with the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** or subsequent to the assignment of the Submitter ID by Gainwell Technologies.

- New Jersey Medicaid and Charity Care providers who are submitting claims directly to Gainwell Technologies that have already been assigned a Submitter ID must complete a **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** for each Billing/Pay-to New Jersey Medicaid provider number.
- New Jersey Medicaid and Charity Care providers who are submitting claims through Clearing House/Billing Service are required along with the Clearing House/Billing Service to complete a **Submitter/Provider Relationship EDI Agreement (Form EDI-201)**. A separate agreement is required for each Billing/Pay-to New Jersey Medicaid provider number.
- New Jersey Medicaid and Charity Care providers wishing to receive their remittance advice information electronically must complete the **Submitter Electronic Remittance EDI Agreement (Form EDI-801)**.

All New Jersey Medicaid HIPAA EDI Agreements **MUST** be submitted to Gainwell Technologies with **ORIGINAL** signatures. Facsimile copies of agreements will **NOT** be accepted. If the agreement is not properly completed, Gainwell Technologies will return it.

Electronic Remittance Advice EDI Agreement: Instructions**WHO SHOULD COMPLETE THIS AGREEMENT?**

If you are a New Jersey Medicaid provider who is not already being provided electronic remittance advice (ERA) and you now wish to receive electronic remittance advice, you must complete the Electronic Remittance Advice EDI Agreement (Form EDI-801). You must include the designation of the Submitter ID under which the electronic remittance advice will be made available. The completed agreement must then be returned to the Gainwell Technologies EDI Unit for processing. Gainwell Technologies will ONLY allow one entity to receive your electronic remittance data.

For the **MEDICAID**, or **CHARITY CARE** check boxes located at the top of the form, indicate the Provider Type for which you will receive electronic remittance data for. Check **one** box only. A separate New Jersey Medicaid Electronic Remittance Advice EDI Agreement is required for each provider number you will be electronically receiving remittance advice for unless the provider is a group practice and the group is responsible for the billing of the individual providers associated with the provider group.

SECTION 1: PROVIDER INFORMATION

1. **Action Requested:** Please check appropriate box if you are either adding a new provider number to be linked to your Submitter ID or terminating an existing provider from your Submitter ID.
2. **Provider Name:** PRINT CLEARLY the BUSINESS name of the provider as they are registered with Gainwell Technologies.
3. **Submitter Name:** PRINT CLEARLY the BUSINESS name of the entity to receive the electronic remittance information.
4. **Date:** Enter the date you wish to begin receiving the electronic remittance information. NOTE: In many cases it will be a new software product to be installed, so it may be a date in the future. It is best to install new software after the weekly submission is sent and processed. We recommend a Monday date.
5. **Provider Representative's Signature:** This should be the signature of the provider business owner or someone in the business with liability authority.
6. **Date:** Date signature was placed on form.
7. **Provider Representative's Name:** PRINT CLEARLY the person's name who signed this form (item # 6 above).
8. **Medicaid Provider ID (GROUP ID):** Enter the New Jersey Medicaid Provider Number or Group Provider Number assigned to the provider by Gainwell Technologies. In the case of a GROUP PRACTICE, the New Jersey Medicaid provider number assigned to the group practice should be used. If a provider practices as a sole practitioner, then the provider number assigned to the individual should be used.
9. **NPI Number:** Enter the NPI number of the Provider as assigned by NPPES and registered with Gainwell Technologies. Please indicate the GROUP NPI if this is a group practice. If a provider practices as a sole practitioner, then the NPI for the assigned to the individual should be used.
10. **Provider Name:** Enter the BUSINESS name of the provider as they are registered with Gainwell Technologies.
11. **Provider Street Address:** Enter the physical street address of the provider's place of business or service address as it is registered with Gainwell Technologies. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

12. **City, State, Zip Code:** Enter the city, state and zip code. This **MUST** be part of the physical address.
13. **Provider Contact Person:** Enter the name of a person from the provider's place of business in the event Gainwell Technologies needs to contact someone at the provider level.
14. **Phone/Ext:** Enter the phone number along with the extension of a person from the provider's or place of business in the event Gainwell Technologies needs to contact someone.

SECTION 2: RECEIVER INFORMATION

15. **Submitter Name:** Enter the business name of the Provider/Submitter or Billing Service/Submitter who will be receiving the 835 Health Care Claim Payment/Advice and 277 Health Care Claim Pending Status Information .
16. **Submitter ID:** Enter the Submitter ID previously assigned by Gainwell Technologies. Doing so will notify Gainwell Technologies that the Provider Number entered above is to be linked for electronic remittance information. If a submitter number has not been assigned, please complete the HIPAA 837 EDI Agreement (EDI-101).
17. **Submitter Address:** Enter the physical street address of the Provider or Billing Agent/Service receiving the electronic remittance information. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.
18. **City, St., Zip:** Enter the city, state and zip code. This **MUST** be part of the physical address.
19. **FAX:** Enter the FAX number of your place of business.
20. **Submitter Contact Person:** Enter the name of a person in the event Gainwell Technologies needs to contact someone from your company.
21. **Phone/Ext:** Enter the phone number along with the extension of a person from your company in the event Gainwell Technologies needs to contact someone.
22. **Submitter Email Address:** Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your Submitter file profile and used to communicate technical problems concerning 835 processing.
23. **2nd Submitter Contact Person:** Enter the name of a person in the event Gainwell Technologies needs to contact someone from your company.
24. **Phone/Ext:** Enter the secondary phone number along with the extension of a person from your company in the event Gainwell Technologies needs to contact someone.
25. **2nd Submitter Contact Person Email Address:** Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your Submitter file profile and used to acknowledge the processing of the EDI AGREEMENT and confirm your submitter profile has been updated to allow you to receive 835 Electronic Remittance Advice.

Return the completed EDI Agreement to Gainwell Technologies at the following address:

Via U.S. Mail
EDI UNIT
Gainwell Technologies
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
EDI UNIT
Gainwell Technologies
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

For Internal Use Only EMCAGREE			
DOCTYPE	<i>Submitter ID</i>	<i>Submitter & Provider Name</i>	
<i>Update Initials</i>	<i>Date</i>	<i>QA Initials/Date</i>	<i>Provider Group Number</i>

- 837-I-D-P
- E-RA
- SIGN
- ADD
- TERM



Electronic Remittance Advice (ERA) EDI Agreement

- MEDICAID**

 CHARITY CARE

SECTION 1: PROVIDER INFORMATION

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

1) Action Requested: Add New Provider Terminate Existing Provider

2) _____ hereby authorize
(Provider Name – Print Clearly)

3) _____ to receive my
(Submitter Name– Print Clearly) *(Entity receiving electronic remittance information)*

Electronic remittance advice as of 4) Date: ___/___/___ I understand this electronic remittance advice contains Patient Health Information (PHI) and have taken the necessary steps with the parties named on this document to maintain the confidentiality of all PHI data.

5) _____ 6) Date: _____
(Provider Representative's Signature) Must be original

7) Provider Representative's Name _____
(Please Print Clearly)

8) Medicaid Provider ID (GROUP ID): _____ 9) NPI (GROUP ID) _____

10) Provider Name: _____

11) Provider Street Address: _____

12) City, State, Zip Code: _____

13) Provider Contact Person: _____ 14) Phone/Ext: (____) _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

Provider Name: _____ Provider Number: _____

SECTION 2: RECEIVER INFORMATION15) Submitter Name: Office Ally 16) Submitter ID: 990420417) Submitter Address: 1300 SE Cardinal Court Ste 19018) City, St., Zip: Vancouver, WA 98683 19) FAX: (360) 896-215120) Submitter Contact Person: Customer Service 21) Phone/Ext: (360)-975-7000 Option 122) Submitter Email Address: info@officeally.com23) 2nd Submitter Contact Person: Dan Waclawsky 24) Phone/Ext: (360) 975-7000 x725425) 2nd Submitter Contact Person Email Address: dan.waclawsky@officeally.com

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law"

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****

Return the completed EDI Agreement to Gainwell Technologies at the following address:

Via U.S. Mail
EDI UNIT Gainwell
Technologies P.O. Box
4804
Trenton, New Jersey 08650 – 4804

Other Carriers
EDI UNIT Gainwell
Technologies
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619