MEDICAID NEVADA (MC008)
PRE-ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Service Center Authorization
  - An original signature is required
  - Check the "Remittance Advice (835)" box if you'd like Office Ally to receive ERA's on your behalf

WHERE SHOULD I SEND THE FORM(S)?

- Mail form to:

  HP Enterprise Services
  Attn: EDI Coordinator
  PO Box 30042
  Reno, NV 89520-3042

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard Processing time is 1 week

HOW DO I CHECK STATUS?

- Approximately 10 business days after you have sent your enrollment, please send an email to support@officeally.com with the following information:
  - Subject line: Checking status on Medicaid enrollment. Attn Anita
  - Provider Tax ID listed on enrollment form.
  - Billing NPI listed on enrollment form.
- If you do not receive a notification from Office Ally, you must follow up with Medicaid at (877) 638-3472. Once you receive confirmation that you've been linked to Office Ally, you must email support@officeally.com with the below information prior to submitting claims electronically.

  Email Subject: Medicaid Nevada (MC008) - EDI Approval

  Body of Email:

  Please log my EDI approval for Medicaid Nevada.

  - Provider Name
  - NPI
  - Tax ID

Hewlett Packard Enterprise • Nevada Medicaid and Nevada Check Up

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.

Mail this form to: Hewlett Packard Enterprise, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.

Service center source: Check one. Enter the business or clearinghouse name as appropriate.

☑ I will submit claims through a clearinghouse.

Clearinghouse name: Office Ally

Hewlett Packard Enterprise Use Only

SC code:

☐ I will submit claims directly from my business to Hewlett Packard Enterprise (direct submitter).

Business name:

Authorize a transaction: Check the box next to each transaction you wish to authorize.

I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies Hewlett Packard Enterprise otherwise by use of this form.

☐ Eligibility Request/Response Batch (270/271)
Connection Method: ☐ SFTP ☐ XEConnect*

☐ Claims Status Request/Response Batch (276/277)
Connection Method: ☐ SFTP ☐ XEConnect*

☑ Professional claim (CMS-1500 claim: 837P)

☐ Institutional claim (UB-04 claim: 8371)

☐ Dental claim (Dental claim: 837D)

☐ Prior Authorization Request/Response (278/278)

☐ Remittance Advice (835)**

Terminate a transaction: Check the box next to each transaction you wish to terminate

I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies Hewlett Packard Enterprise otherwise by use of this form.(Enter the effective date below.)

☐ Eligibility Request/Response Batch (270/271)
Connection Method: ☐ SFTP ☐ XEConnect*

☐ Claims Status Request/Response Batch (276/277)
Connection Method: ☐ SFTP ☐ XEConnect*

☐ Professional claim (CMS-1500 claim: 837P)

☐ Institutional claim (UB-04 claim: 8371)

☐ Dental claim (Dental claim: 837D)

☐ Prior Authorization Request/Response (278/278)

☐ Remittance Advice (835)**

Effective date for termination of this transaction(s):

** XEConnect is an EDIFECS application.*

*** Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.*

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider/entity name: _____ NPI/API (one per form): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? ☐ Yes ☐ No

Authorized Signature: _____