

MEDICAID DISTRICT OF COLUMBIA (77033) PRE-ENROLLMENT INSTRUCTIONS



WHAT FORM(S) SHOULD I DO?

- Provider Conduent EDI Gateway Authorization Form for Billing Agents and Clearinghouses

WHERE SHOULD I SEND THE FORM(S)?

- Fax to: (202) 906-8399; or
- Mail form to:
Conduent
Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard processing time is 2 weeks.

HOW DO I CHECK STATUS?

- Call Conduent at (866) 407-2005 and ask if you are enrolled and linked to Office Ally's Submitter ID 91168.
- 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 District of Columbia (77033) - EDI Approval

Body of Email:

Please log my EDI approval for Medicare District of Columbia.

- Provider Name
- NPI
- Tax ID

Washington, DC Conduent EDI Provider Enrollment Form



Please return to:
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Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761
Fax to: (202) 906-8399



Provider Conduent EDI Gateway Authorization Form for Billing Agents and Clearinghouses

Section A. Provider Information.
Please indicate your classification (required): [] Individual Provider [] Group Provider/Practice
Business Person
Provider Name (Last, First, MI and Suffix)
Provider Number (Required for Individuals) Group Provider Number (Required for Groups)
Business Address
City, State, and Zip
Telephone Number Fax Number
Contact Name E-mail Address

Section B. Authorization Signature (required).

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

_____,
Billing Agent/Clearinghouse name (please print)

_____,
Billing Agent/Clearinghouse Conduent Trading Partner/Submitter ID

to act as the authorized agent for the purpose of retrieving health care responses electronically from Conduent EDI Gateway, Inc. Provider also authorizes the Billing Agent/Cleringhouse's access to the following X12N transaction responses if selected below:

- [] 277-Claims Status Response [] 271-Eligibility Response
[] 277CA-Claim Acknowledgement [] 835-Healthcare Claims Payment Advice
[] 278-Prior Authorization Response [] 999-Functional Acknowledgement

_____,
Provider/Provider Representative name (Please print)

_____,
Provider/Provider Representative Signature

_____,
Date