



MEDICAID KENTUCKY (MCDKY) ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Electronic Remittance Advice (ERA)**

WHERE SHOULD I SEND THE FORM(S)?

- Fax the form to (502) 209-3242; OR
- Mail the form to:
 - Electronic Claims Submission
PO Box 2016
Frankfort, KY 40602-2016

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 30 business days

HOW DO I CHECK STATUS?

- Call Medicaid Kentucky's EDI Help Desk at (800) 205-4696 and ask if you have been linked to Office Ally's Submitter ID **9900004139** for ERAs.

Electronic Remittance Advice (ERA)

1. Provider Information

Provider Name:

2. Provider Identifiers

Provider Federal Tax Identification (TIN) or Employer Identification Number (EID):

Provider NPI:

KY Medicaid Provider ID (Assigned Authority):

3. KY Medicaid Trading Partner ID

Enter the Trading Partner ID to be used to retrieve ERA (10 digits beginning with 99):

4. Provider Contact Information

Provider Contact Name:

Title:

Telephone Number (including extension):

Ext:

Email Address:

Fax Number:

5. Clearinghouse Information

Clearinghouse Name:

Clearinghouse Contact Name:

Telephone Number:

Email Address:

6. Reason for Submission

Select the option below for the applicable reason for 835/277U ERA Enrollment submission:

<input type="radio"/> New Enrollment	<input type="radio"/> Change Enrollment	<input type="radio"/> Cancel Enrollment
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7. Submission Date:

8. Effective ERA Date:

I understand that in the event that a different trading partner is selected to retrieve the 835 ERA, I must notify the EDI Helpdesk immediately by completing a new 835 ERA enrollment form. I will not hold the EDI Helpdesk liable for incorrect information submitted on the 835 ERA enrollment form.

If 'Cancel Enrollment' is indicated under 'Reason for Submission', I, the undersigned, hereby cancel the authorization for the Department for Medicaid Services to generate an 835 for the next payment cycle.

9. Title:

10. Electronic Signature: