



# MEDICAID MONTANA (MCDMT) ERA ENROLLMENT INSTRUCTIONS

## WHICH FORM(S) SHOULD I DO?

- Montana DPHHS EDI 835 Request Form

## WHERE SHOULD I SEND THE FORM(S)?

- Fax to (406) 442-4402; OR
- Mail to  
Conduent EDI Solutions, Inc.  
Attn: MT EDI  
PO Box 4936  
Helena, MT 59604

## WHAT IS THE TURNAROUND TIME?

- Standard processing time is 30 business days.

## HOW DO I CHECK STATUS?

- Call Conduent at (800) 987-6719 and ask if you are linked to Office Ally's Submitter ID **7134829**.

MONTANA DPHHS EDI 835 REQUEST FORM



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Provider Billing Agent/Clearinghouse Conduent EDI Solutions, Inc Authorization Form

Section A. Provider Information.

Form with fields: Business Name, Provider Name (Last, First, MI and Suffix), Provider Number, Federal Tax ID Number, 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 submitting health care transactions electronically to Conduent EDI Solutions, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 277-Claim Status Response
271-Eligibility Response
835-Healthcare Claims Payment Advice
278-Prior Authorization Response
Exception Report (Print Image)
999-Implementation Acknowledgement
277CA-Healthcare Claim Acknowledgement

Provider/Provider Representative name (Please print)

Provider/Provider Representative Signature

Date