

WHICH FORMS SHOULD I COMPLETE?

- **Submitter/Provider Relationship EDI Agreement**
 - o Instructions can be found on pages 3-7
 - o This form must be sent to Office Ally for our **wet signature** and date in Section 1, Items 5 & 6
- If you would like Office Ally to receive your Electronic Remittance Advice on your behalf, also complete the **Electronic Remittance Advice (ERA) EDI Agreement**
 - o Instructions can be found on pages 11-13

WHERE SHOULD I SEND THE FORM(S)?

- 837 Enrollment:
 - o Mail the **original (with wet signature) Submitter/Provider Relationship EDI Agreement** to:
Office Ally
P.O. Box 872020
Vancouver, WA 98687
- 835 Enrollment:
 - o If you are enrolling for 835 at the same time as 837, you may submit the signed ERA Agreement along with your EDI to the address listed above.
 - o If you are **only** enrolling for 835/ERA, mail the **original (with wet signature) Electronic Remittance Advice (ERA) EDI Agreement** to:

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

Other Carriers
EDI UNIT
DXC Technology
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is 10 business days.

HOW DO I CHECK STATUS?

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

- Once you receive confirmation that you have been linked to Office Ally, you **MUST** email payerenrollment@officeally.com with the below information PRIOR to submitting claims electronically.
 - o **Email Subject:** MEDICAID NEW JERSEY (MCDNJ) – EDI Approval
 - o **Body of Email:** Please log my EDI approval for MEDICAID NEW JERSEY.
 - Provider Name:
 - Provider NPI:
 - Provider TIN:

Submitter/Provider Relationship EDI Agreement (Form EDI-201)

All New Jersey Medicaid and Charity Care Providers desiring to submit HIPAA formatted electronic claims must complete a New Jersey Medicaid HIPAA 837 Claims EDI Agreement. The various EDI agreements used by New Jersey Medicaid and the corresponding instructions for their completion are provided later in this section. The EDI Agreement and HIPAA certification received for the specified HIPAA transaction sets must be prior approved and on file with Gainwell Technologies before HIPAA formatted claims may be submitted electronically. Gainwell Technologies will notify the EDI Submitter of New Jersey Medicaid's approval for the submission of HIPAA formatted electronic claims.

Submitters who are currently enrolled with Gainwell Technologies for the submission of HIPAA 4010A1 formatted electronic claims and have completed and returned the Addendum to the existing EDI Agreement along with a 5010 HIPAA Certification do NOT have to complete the EDI Agreements included in this Companion Guide. The Addendum Agreement replaces the previously executed EDI Agreement on file with Gainwell Technologies.

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.

- 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 with the **HIPAA 837 Claims EDI Agreement (Form EDI-101)**.
- 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 they will be billing for.
- New Jersey Medicaid and Charity Care providers who are submitting claims through a 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)**.

Providers using a billing service to submit HIPAA formatted electronic claims must complete the **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** along with the billing service. The billing service is responsible for ensuring that each provider properly completes and submits these agreements to Gainwell Technologies. If the agreement is not properly completed, it will be returned to the submitter/billing service for proper completion.

Providers must notify Gainwell Technologies in writing when the use of a billing service for the submission of electronic claims has been terminated. When a provider changes billing services, the new billing service must ensure that the provider completes a new EDI Agreement form and submits it to Gainwell Technologies along with a copy of the HIPAA certification form. Gainwell Technologies will notify the billing service when approval to submit claims electronically has been granted.

Providers must notify Gainwell Technologies in writing when their use of a software developer's application for the direct submission of electronic claims to Gainwell Technologies has been terminated. When a provider changes to a new software product, the provider must complete a new **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** and submit it to Gainwell Technologies along with a copy of the HIPAA certification form. Gainwell Technologies will notify the provider when approval to submit claims electronically has been granted.

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 for proper completion.

Submitter/Provider Relationship EDI Agreement (Form EDI-201) – Instructions

WHO SHOULD COMPLETE THIS AGREEMENT?

WHAT IF I AM THE PROVIDER AND SUBMIT MY CLAIMS DIRECTLY TO NEW JERSEY MEDICAID?

Providers who are submitting their claims directly to New Jersey Medicaid will need to complete an agreement for each of their New Jersey Medicaid billing/pay-to provider numbers. In this case, the provider is considered to serve as both the submitter and the provider. In most cases a provider submitting their claims directly to New Jersey Medicaid will be submitting claims under a single New Jersey Medicaid billing/pay-to provider number. However, there are cases where the provider may have been issued multiple New Jersey Medicaid billing/pay-to provider numbers. When this occurs, a separate agreement is required for each provider number.

WHAT IF I USE A CLEARINGHOUSE/BILLING SERVICE TO SUBMIT THE CLAIMS TO NEW JERSEY MEDICAID ON MY BEHALF?

Providers who are submitting their claims to New Jersey Medicaid through a Clearing House/Billing Service must also execute a **Submitter/Provider Relationship EDI Agreement (Form EDI-201)** with the Clearing House/Billing Service and the completed agreement must be returned to the Gainwell Technologies EDI Unit for processing. A separate agreement is required for each New Jersey Medicaid billing/pay-to provider number.

In this case, the Submitter (or the Clearing House who owns the NJ Submitter ID completes Section 1 of the agreement and the provider completes Section 2 of the agreement.

Section 3 is to be completed by the provider to identify the software that is being used within the provider's office to capture the claims data and to then send that claims data to the Clearing House/Billing Service.

SECTION 1: SUBMITTER INFORMATION

For the **MEDICAID**, or **CHARITY CARE** check boxes located at the top of the form, indicate the type of claims for which you will be submitting electronic claims. Check **one** box only. A separate New Jersey Medicaid HIPAA EDI Agreement is required for each provider number you will be electronically submitting claims 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.

1. **Submitter Name:** Enter the name of the Provider or Clearing House/Billing Service Name as registered with New Jersey Medicaid/Gainwell Technologies.
2. **Submitter ID:** Enter the Submitter ID as assigned by Gainwell Technologies.
3. **Submitter Street Address:** Enter the physical street address of the Provider or Clearing House/Billing Service. 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.
4. **City, State, Zip Code:** Enter the city, state and zip code. This **MUST** be part of the physical address.
5. **Submitter Representative's Signature:** This **MUST** be an original signature of the Provider or Clearing House/Billing Service. **THIS MAY NOT BE STAMPED.** This person should have liability authority of the business.
6. **Date Signed:** Date signature was placed on this form.
7. **Submitter Representative's Name:** PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 5 above).
8. **Submitter Representative Telephone Number/Ext:** Enter the phone number along with the extension of a person from your company in the event Gainwell Technologies needs to contact someone in reference to their electronic file submission.
9. **FAX:** Enter the FAX number of your place of business.
10. **Submitter Representative 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. This email address will be used to contact someone from your company concerning the electronic file submission or allow you to submit HIPAA electronic claims.
11. **2nd Submitter Contact Person:** Enter the name of a person in the event Gainwell Technologies needs to contact someone from your company. This person's name will be entered as part of your Submitter file profile. This person's name will be used to confirm a provider has been linked to your Submitter ID, preferably someone in the Enrollment Department who handles the EDI Agreement applications.
12. **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.
13. **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. This email address will be entered as part of your Submitter file profile. This email address will be used to confirm a provider has been linked to your Submitter ID, preferably someone in the Enrollment Department who handles the EDI Agreement applications.

SECTION 2: PROVIDER INFORMATION

NOTE: THIS INFORMATION SHOULD ONLY BE THE INFORMATION OF A NEW JERSEY MEDICAID PROVIDER. IF YOU ARE A SECONDARY BILLING SERVICE, PLEASE ADD A SUPPLEMENTARY SECTION 3 AND PLACE BILLING SERVICE INFORMATION ONLY IN SECTION 3.

14. **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.
15. **Provider Name:** Enter the BUSINESS name of the provider as they are registered with Gainwell Technologies.
16. **New Jersey Medicaid Provider Number:** Enter the New Jersey Medicaid 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 his individual number may be used.
17. **NPI Number:** Enter the NPI number of the provider as assigned by NPPES and registered with Gainwell Technologies.
18. **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.
19. **City, State, Zip Code:** Enter the city, state and zip code. This **MUST** be part of the physical address.
20. **Provider EDI 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. (This must be someone at the provider's place of business. If a provider chooses to use a secondary billing service, the billing service information should be placed in Section 5.
21. **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. This phone number is used to verify a current phone number is on file for the provider.
22. **FAX:** Enter the FAX number of the provider's place of business.
23. **Email Address:** PLEASE PRINT CLEARLY. Enter the email address of a contact person from the provider's place of business in the event Gainwell Technologies needs to contact someone.
24. **Provider Representative's Signature:** This **MUST** be an actual signature of the New Jersey provider business owner. **THIS MAY NOT BE STAMPED.** This person should have liability authority of the business.
25. **Date Signed:** Date signature was placed on this form.
26. **Provider Representative's Name:** PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 24 above).

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

27. **SOFTWARE VENDOR NAME:** Enter the BUSINESS name of the Software Vendor.
28. **STREET ADDRESS:** Enter the physical street address of the software vendor. 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.
29. **CITY, STATE, ZIP CODE:** Enter the city, state and zip code. This **MUST** be part of the physical address.

30. **SOFTWARE CONTACT PERSON:** Enter the name of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.
31. **PHONE/EXT:** Enter the phone number along with the extension of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.
32. **SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the email address of a contact person from the software company in the event Gainwell Technologies needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.
33. **2nd SOFTWARE CONTACT PERSON:** Enter the name of a secondary person from the software company in the event Gainwell Technologies needs to contact someone at the software company.
34. **PHONE/EXT:** Enter a secondary phone number along with the extension of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.
35. **2nd SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the email address of a second contact person from the software company in the event Gainwell Technologies needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.
36. **FAX:** Enter the FAX number of the software company.
37. **SOFTWARE PRODUCT NAME:** If a software company has multiple products, please enter the name of the product you are installing for the submission of the HIPAA transaction sets indicated in Section 3 above.
38. **SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME:** Please enter the release number of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 3 above.
39. **SOFTWARE PRODUCT RELEASE DATE:** Please enter the release date of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 3 above.

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

Provider Name: _____ Provider #: _____

SECTION 2: 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.

14) Action Requested: Add New Provider Terminate Existing Provider

15) Provider Name: _____

16) New Jersey Medicaid Provider Number: _____

17) Provider NPI Number: _____

18) Provider Street Address: _____
(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

19) City, State, Zip Code: _____

20) Provider EDI Contact Person: _____ 21) Phone/Ext:(_____) _____ /

22) FAX: (_____) _____ 23) Email Address: _____

24) **Provider Representative's Signature (must be original)** _____ **25) Date Signed** _____26) **Provider Representative's Name – Please Print Clearly** _____

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".

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

This section is to identify the third party software vendor practice management system that the provider is using to exchange information with their third party billing service. This section may also be repeated if a secondary billing service is being used in addition to a clearing house.

27) SOFTWARE VENDOR NAME: Office Ally28) STREET ADDRESS: 1300 SE Cardinal Court, Suite 190
(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the software vendor.)

Provider Name: _____ Provider #: _____

29) CITY, STATE, ZIP CODE: Vancouver, WA 9868330) SOFTWARE CONTACT PERSON: Crystal Cubias 31) PHONE/EXT: (360)975-7000/ Opt 132) SOFTWARE CONTACT PERSON EMAIL ADDRESS: Crystal.Cubias@officeally.com33) 2nd SOFTWARE CONTACT PERSON: Payer Support 34) PHONE/EXT:(360)975-7000/ Opt 135) SOFTWARE CONTACT PERSON EMAIL ADDRESS: PayerSupport@officeally.com36) FAX : (360) 896-215137) SOFTWARE PRODUCT NAME: Proprietary38) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: N/A39) SOFTWARE PRODUCT RELEASE DATE: N/A***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *******Return the completed EDI Amendment 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

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 DXC Technology before an ERA will be made available to the submitter that has been designated by the requesting provider. DXC Technology will notify the EDI Submitter of New Jersey Medicaid's approval for the submitter to receive the ERA.

Submitters who are currently enrolled with DXC Technology 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 DXC Technology 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 DXC Technology 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 DXC Technology 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 DXC Technology.

- New Jersey Medicaid and Charity Care providers who are submitting claims directly to DXC Technology 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 DXC Technology with **ORIGINAL** signatures. Facsimile copies of agreements will **NOT** be accepted. If the agreement is not properly completed, DXC Technology 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 DXC Technology EDI Unit for processing. DXC Technology 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 DXC Technology.
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 DXC Technology. 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 DXC Technology. 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 DXC Technology.
11. **Provider Street Address:** Enter the physical street address of the provider's place of business or service address as it is registered with DXC Technology. 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 DXC Technology 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 DXC Technology 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 DXC Technology. Doing so will notify DXC Technology 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 DXC Technology 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 DXC Technology 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 DXC Technology 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 DXC Technology 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 DXC Technology at the following address:

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

Other Carriers
EDI UNIT
DXC Technology
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: Payer Support 21) Phone/Ext: (360)975-7000 Opt 122) Submitter Email Address: PayerSupport@officeally.com23) 2nd Submitter Contact Person: Cara Trahey 24) Phone/Ext: (360) 975-7000 Opt 125) 2nd Submitter Contact Person Email Address: Cara.Trahey@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 DXC Technology at the following address:

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

Other Carriers
EDI UNIT
DXC Technology
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619