WHICH FORMS SHOULD I COMPLETE?

Complete the following forms:
- **SC Medicaid Trading Partner Agreement/Remittance Advice** Enrollment (Page 2)
  - o You MUST complete all fields that are applicable to you
- **SC Medicaid Trading Partner Agreement Enrollment Form** (Page 3)
  - o Most all fields are completed for you. The only fields the provider needs to complete are:
    - ▪ Provider Billing NPI
    - ▪ SC Medicaid Provider ID
    - ▪ Authorized Signature and name of Person Submitting Enrollment
    - ▪ Submission Date and Requested Effective Date

WHERE SHOULD I SEND THE FORM(S)?

- Fax the forms to (803) 970-9021
  OR
- Mail the forms to:
  > SC Medicaid TPA
  > PO Box 17
  > Columbia, SC 29202

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 7 business days

HOW DO I CHECK STATUS?

- Call (888) 289-0709 opt 2 and ask if the provider has been enrolled
- Once you receive confirmation that you have been enrolled, you **MUST** email
  payerenrollment@officeally.com with the below information **BEFORE** submitting claims electronically:
  - o **Email Subject:** Medicaid South Carolina (03202) – EDI Approval NPI (Insert NPI)
  - o **Body of Email:**
    - ▪ Please log my EDI approval for Medicaid South Carolina
      - • Provider Name:
      - • NPI:
      - • TIN:

SC Trading Partner Agreement/Remittance Advice Enrollment

Fax to (803)870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Reason for Submission: ☐ New Enrollment   ☐ Change Enrollment   ☐ Cancel Enrollment

Trading Partner Information

Provider Name: _____

Doing Business As Name (DBA): _____

Street: _____

City: _____   **State/Province:** _____   **Zip Code/Postal Code:** _____

National Provider Identifier (NPI): _____   **Provider Federal Tax Identification Number (TIN):** _____

Trading Partner ID: _____   **SC Medicaid Provider ID:** _____

Type of Business: ☐ Medicaid Provider   ☐ Billing Service   ☐ Clearinghouse   ☐ Software Vendor

☐ Other (please specify): _____

Provider Contact Information

Provider Contact Name: _____

Telephone Number: _____   **Telephone Number Extension:** _____

Fax Number: _____   **Email Address:** _____

Preference for Aggregation of Remittance Data   ☐ Provider Tax Identification Number (TIN): _____
(e.g., Account number linkage to provider identifier):   ☐ National Provider Identifier (NPI): _____

Claims Submission/Retrieval Information

Are you using a clearinghouse, billing agent, or vendor to submit your claims?   ☐ Yes   ☐ No

If Yes, please enter the name of the clearinghouse, billing agent, or vendor here: _____

If No, please indicate below which protocol(s) is/are used: (multiple selections are allowed)

☐ Secure FTP   ☐ WS_FTP Pro   ☐ CD   ☐ Diskette

South Carolina Medicaid Web-Based Claims Submission Tool (Select One)

☐ Requesting Access: Number of IDs Requested _____   ☐ No Access Needed

☐ Link to Existing IDs: _____
(If you submit X12 claims directly to SC Medicaid, you must complete the "linked" Submitter ID Information found on the second page of this application)

Transactions Requested

☐ Yes ☒ No 270 – Eligibility IN	☐ Yes ☒ No 820 – Premium Payments	☒ Yes ☐ No 837P – Professional Claims
☐ Yes ☒ No 271 – Eligibility OUT	☐ Yes ☒ No 834 – Benefit Enrollment	☐ Yes ☒ No 837D – Dental Claims
☐ Yes ☒ No 276 – Claim Status IN	☐ Yes ☐ No 835 – Electronic Remittance Advice*	
☐ Yes ☒ No 277 – Claim Status OUT	☐ Yes ☒ No 837I – Institutional Claims	

TPA Authorization Agreement

☐ I have read, understand, and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____   **Requested Effective Date:** _____

*Please contact the Provider Service Center at 1-888-289-0709 for any questions regarding the electronic remittance advice enrollment process or the status of your enrollment.

*Please refer to the "Your Remittance Advice" area in the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider Web Page for instructions on how to complete updates to your Electronic Remittance Advice.

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

Revised January 1, 2014

SC Trading Partner Agreement Enrollment

Fax to (803)870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Reason for Submission: ☐ New Enrollment   ☐ Change Enrollment   ☐ Cancel Enrollment

Trading Partner Information

Trading Partner Name: _____

Doing Business As Name (DBA): _____

Street: _____

City: _____ **State/Province:** _____ **Zip Code/Postal Code:** _____

National Provider Identifier (NPI): _____ **Provider Federal Tax Identification Number (TIN):** _____

Trading Partner ID: _____ **SC Medicaid Provider ID:** _____

Type of Business: ☐ Billing Service   ☐ Clearinghouse   ☐ Software Vendor

☐ Other (please specify): _____

Trading Partner Contact Information

Trading Partner Contact Name: _____

Telephone Number: _____ **Telephone Number Extension:** _____

Fax Number: _____ **Email Address:** _____

Claims Submission/Retrieval Information

Indicate below which protocol(s) is/are used: (Multiple selections are allowed)

☐ Secure FTP   ☐ WS_FTP Pro   ☐ CD   ☐ Diskette

South Carolina Medicaid Web-Based Claims Submission Tool (Select One)

☐ Requesting Access: Number of IDs Requested _____   ☐ No Access Needed

☐ Link to Existing IDs: _____

(If you submit X12 claims directly to SC Medicaid, you must complete the "linked" Submitter ID Information found on the second page

of this application)

Transactions Requested

☐ Yes ☐ No 270 – Eligibility IN	☐ Yes ☐ No 820 – Premium Payments	☐ Yes ☐ No 837P – Professional Claims
☐ Yes ☐ No 271 – Eligibility OUT	☐ Yes ☐ No 834 – Benefit Enrollment	☐ Yes ☐ No 837D – Dental Clams
☐ Yes ☐ No 276 – Claim Status IN	☐ Yes ☐ No 835 – Electronic Remittance Advice	
☐ Yes ☐ No 277 – Claim Status OUT	☐ Yes ☐ No 837I – Institutional Claims	

TPA Authorization Agreement

☐ I have read, understand, and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____ **Requested Effective Date:** _____

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

Revised January 1, 2014