MEDICAID ALASKA (MCDAK)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- 835 Authorization form

WHERE SHOULD I SEND THE FORM(S)?

- Fax to: (907) 644-8126; or
- Mail form to:

  Xerox
  HIPAA Provider Support Team
  PO Box 240808
  Anchorage, AK 99524-0808

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard processing time is 5-10 business days.

HOW DO I CHECK STATUS?

- Call (907) 644-6800 or (800) 770-5650 to check on enrollment status.

Provider Electronic Remittance (835) Authorization

Alaska Medical Assistance is capable of sending an 835 transaction to a single entity/organization only. The purpose of this form is to allow providers to designate who should receive their 835. Please complete the following form for this designation and indicate all Alaska Medical Assistance ID(s) and corresponding National Provider Identifier (NPI) number(s) that are applicable.

Send My 835 To:

- ☐ Self (practice management software able to receive)
- ☐ Billing Agent
- ☑ Clearinghouse
- ☐ Other

Organization Name: Office Ally Submitter ID AK03373

Contact Name: Customer Service

Phone Number: 360-975-7000 Option 1

Provider Name: _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

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Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

_____

Telephone #: _____

Attach additional pages if necessary

I authorize the above named entity to receive and process my electronic remittances (835) from Alaska Medical Assistance Programs. I may have multiple entities submitting claims for me and understand that only one entity can be designated by me to accept and process my electronic remittance. I also understand that the entity I have authorized above must have prior approval from Xerox to receive electronic remittances.

_____ _____

Print Authorized Representative Name **Title Authorized Representative**

_____

Signature of Provider* or Authorized Representative**

_____

Date

* ***Individuals and sole proprietors must sign their own enrollment agreement form.***

** ***An authorized representative is an appointed official to whom the provider has granted the legal authority to enroll the provider in the Medicaid program, to make changes and/or updates to the provider's status in the Medicaid program (e.g., new practice locations, changes of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider's organization, or must hold a position of similar status and authority within the provider's organization.***

If you fax this document, please be sure to mail the original.

Mail original or fax to: **Xerox**
HIPAA Provider Support Team
P.O. Box 240808
Anchorage, AK 99524-0808

Fax number: (907) 644-8126