MEDICAID MONTANA (MCDMT)
ERA ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Montana DPHHS EDI Provider Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Fax form to: 406-442-4402; or
- Mail form to:

  ACS, A Xerox Company
  Attn: MT EDI
  PO Box 4936
  Helena, MT 59604

WHAT IS THE TURNAROUND TIME FOR ERA ENROLLMENT?

- Standard processing time is 30 days.

HOW DO I CHECK STATUS?

- To check the status, call ACS at 800-987-6719 and ask if you are linked to Office Ally's Submitter ID 7134829.

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

MONTANA
Department of Public Health & Human Services

Please return to:
ACS, A Xerox Company
Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

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Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc Authorization Form

Section A. Provider Information.	
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)

Office Ally _____, 7134829 _____
Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

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

_____
Provider/Provider Representative name (Please print)

_____ _____
Provider/Provider Representative Signature *Date*