MEDICAID DISTRICT OF COLUMBIA (77033) PRE-ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **Provider Conduent EDI Gateway Authorization Form for Billing Agents and Clearinghouses**

WHERE SHOULD I SEND THE FORM(S)?

- Fax the form to (202) 906-8399; OR
- Mail to:

  Conduent
  Technical Support/Enrollment
  PO Box 34734
  Washington DC 20043-4761

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 2 weeks

HOW DO I CHECK STATUS?

- Call Conduent at (866) 407-2005 and ask if you are enrolled and linked to Office Ally's Submitter ID **91168**
- Once the enrollment has been approved, you MUST call Office Ally at (360) 975-7000 Option 1 and notify us of the approval PRIOR to submitting claims electronically

Please return to:
Conduent
Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761
Fax to: (202) 906-8399

Provider Conduent EDI Gateway Authorization Form for Billing Agents and Clearinghouses

Section A. Provider Information.

Please indicate your classification **(required):** ☐ Individual Provider ☐ Group Provider/Practice	
Business Person	
Provider Name (Last, First, MI and Suffix)	
Provider Number (Required for Individuals)	*Group Provider Number (Required for Groups)*
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 retrieving health care responses electronically from Conduent EDI Gateway, Inc. Provider also authorizes the Billing Agent/Cleringhouse's access to the following X12N transaction responses if selected below:

- ☐ 277-Claims Status Response
- ☐ 277CA-Claim Acknowledgement
- ☐ 278-Prior Authorization Response
- ☐ 271-Eligibility Response
- ☐ 835-Healthcare Claims Payment Advice
- ☐ 999-Functional Acknowledgement

____
Provider/Provider Representative name (Please print)

____
Provider/Provider Representative Signature

____
Date