Medicaid of Mississippi

Attention Providers:

To start receiving ERAs electronically from Medicaid of Mississippi, you will print and review the enrollment form. Please sign the form and submit to EDS using one of the methods below.

Payer:	Medicaid of Mississippi
Payer ID:	CKMS1
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482-3518 or Enrollment@edsedi.com
Payer Enrollment Applications:	**EDI-ERA Provider Agreement and Enrollment Form**
Email or Fax Application to:	Enrollment@edsedi.com Fax (800) 389-9152
Approval Process and Timeframes:	Payer estimates 10-15 business days from the date of submission. EDS will automatically deliver the ERAs to the EDS Portal upon receipt.
Special Instructions:	Once the provider has been approved for ERAs with Medicaid of Mississippi, the provider will no longer receive paper EOBs.

MISSISSIPPI DIVISION OF MEDICAID

xerox

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Please complete the following Mississippi Medicaid EDI ERA Provider Agreement and Enrollment Form. Please print or type. Complete all areas of the form, unless otherwise indicated. Once the form has been completed and signed, please return it to the address above for processing. You may contact the EDI Support Unit at 1.800.884.3222, Monday-Friday 8AM-5PM CST if you have any questions about the EDI ERA Provider Agreement and Enrollment Form or wish to inquire upon the status of a form that has already been submitted. If you wish to receive dual delivery (paper and electronic) of the Remittance Advices for at least 31 days or 3 payments, whichever is greater; please send a written request to the address above.

Instructions for filling out this form are provided at the end. Required fields are denoted with an asterisk(*).

Provider Information

Provider Name*

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)*
or Employer Identification Number (EIN)

National Provider Identifier (NPI)*

Trading Partner ID 6 5 9 4 2

Provider Contact Information

Provider Contact Name

Title

Telephone Number

Telephone Number Extension

Email address

Fax Number

Electronic Remittance Advice Information

Account Number Linkage to Provider Identifier* (**Must Match EFT Preference**)
O Provider Tax Identification Number (EIN/TIN)
O National Provider Identification Number (NPI)

Method of Retrieval*

MISSISSIPPI DIVISION OF MEDICAID

xerox

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Clearinghouse Information

If you have indicated that you plan to use the services of a Billing Agent/Clearinghouse to submit your transactions electronically to Xerox EDI Gateway, please provide the following information regarding the Billing Agent/Clearinghouse. You would need to be able to provide your Billing Agent/Clearinghouse's unique Trading Partner Name and ID. Please contact your Billing Agent/Clearinghouse for this required information. The Trading Partner ID field is located in the Provider Identifiers Information Section of this form.

Clearinghouse Name: EDI Health Group, Inc.

Software Vendor Information

If you have indicated that you plan to use the services of a Software Vendor to submit your transactions electronically to Xerox EDI Gateway, please provide the following information regarding your agent. Your Software Vendor is required to enroll and receive their unique Trading Partner ID to test with Xerox EDI Gateway. Please indicate your Software Vendor's Xerox EDI Gateway Trading Partner ID. Please contact your Software Vendor for this required information. The Trading Partner ID field is located in the Provider Identifiers Information Section of this form.

Vendor Name:

Submission Information

Reason for Submission*

- O New Enrollment
- O Change Enrollment
- O Cancel Enrollment

MISSISSIPPI DIVISION OF MEDICAID

xerox

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

The following constitutes an Electronic Data Interchange Agreement ("EDI Agreement") between the Health Care Provider and the Mississippi Division of Medicaid ("DOM") or its designated Fiscal Agent. This EDI Agreement defines the requirements for Electronic Data Interchange between the Provider and the DOM or its designated Fiscal Agent. Any references in this EDI Agreement to the submission of electronic transactions, refers to electronically submitted transactions as chosen by the Provider.

Terms of Agreement

The Provider agrees to abide by the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Provider and the DOM or its designated Fiscal Agent.

The Provider agrees to abide by the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

The Provider agrees to send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of state and federal laws and regulations.

The Provider agrees that if a Billing Agency or Clearinghouse is used for the submission of electronic transactions, the Billing Agency or Clearinghouse identified in Section III must have a Trading Partner Service Agreement on file with the DOM or its designated Fiscal Agent.

If using a Billing Agency or Clearinghouse, the Provider agrees to report information accurately and completely to the Billing Agency or Clearinghouse as required in the Appropriate DOM Electronic Transactions Submission Manual and agrees to be completely responsible for the electronic transactions generated from the information submitted to the DOM or its Fiscal Agent by the Billing Agency or Clearinghouse.

If using a Billing Agency or Clearinghouse, the Provider agrees to not use any Billing Agency or Clearinghouse except the one listed in Section III of this agreement until this EDI Agreement has been terminated in writing to the DOM or its designated Fiscal Agent.

If using an EDI software vendor for submission of electronic transactions, the Provider agrees to insure that all data meets the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

If any information supplied in this EDI Agreement changes at any time during the Provider's enrollment in the Mississippi Medicaid program, the Provider agrees to notify the DOM or its designated Fiscal Agent immediately in writing. Failure to do so may invalidate this EDI Agreement.

Whenever necessary, this EDI Agreement may be amended by mutual consent of the DOM and the Provider to meet federal or other operational requirements.

The Provider agrees that the EDI Submitter ID is confidential and is not transferable or assignable. This EDI Agreement is not transferable or assignable and may be terminated on thirty (30) days written notice by either party.

This EDI Agreement is automatically terminated in the event the Provider's license is revoked by the Appropriate Board, the Provider is disqualified through a federal administrative action, or as set forth in Miss. Code Ann. Section 43-13-121(l) (1972, as amended

Authorized Signature

Written Signature of Person Submitting Enrollment*

Printed Name of Person Submitting Enrollment

Submission Date

MISSISSIPPI DIVISION OF MEDICAID

xerox

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Provider Information

Provider Name* - If the provider is an individual, enter the provider's name. If the provider is a group, enter the group name.

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)* - Enter the Federal Tax Identification Number (TIN) or the Employer Identification Number (EIN), if available. If the provider is an individual who doesn't have a Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), enter the provider's own Social Security Number.

National Provider Identifier (NPI)* - Enter the provider's National Provider Identifier Number.

Trading Partner ID – Enter the trading partner ID of the billing agent, clearinghouse, or vendor that will be receiving the 835 on behalf of the provider.

Provider Contact Information

Provider Contact Name* - Enter the name of the person to be contacted for questions or clarification.

Title – Enter the title of the Provider Contact person.

Telephone Number – Enter the telephone number, including area code, of the Provider Contact Person.

Telephone Number Extension – Enter the telephone number extension of the Provider Contact Person, if applicable.

Email address – Enter the email address of the Provider Contact Person.

Fax Number – Enter the fax number of the Provider Contact Person.

Electronic Remittance Advice Information

Account Number Linkage to Provider Identifier* - Check the Provider Tax Identification Number (EIN/TIN) radio button if the provider is an atypical provider, otherwise check the National Provider Identification Number (NPI) radio button.

MISSISSIPPI DIVISION OF MEDICAID

xerox

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Method of Retrieval* - Enter one of the following methods for retrieving the electronic remittances advices: EDI Online, MS Envision Web Portal, Hyper Terminal, or Bulletin Board System.

Clearinghouse Information

Clearinghouse Name – Enter the name of the clearinghouse designated to process 835s on behalf of the provider.

Software Vendor Information

Vendor Name - Enter the name of the vendor designated to process 835s on behalf of the provider.

Submission Information

Reason for Submission* - Check the New Enrollment radio button if this application is to enroll a new provider for ERA. Check the Change Enrollment radio button if this application is to make a change to an existing provider's ERA information. Check the Cancel Enrollment radio button if this application is to cancel an existing provider's ERA and change to the paper RA instead.

Authorized Signature

Written Signature of Person Submitting Enrollment* - This application should be signed by the provider or an authorized person.

Printed Name of Person Submitting Enrollment – Enter the name of the person who signed the form to submit enrollment.

Submission Date – Enter the current date.

MISSISSIPPI DIVISION OF MEDICAID

xerox

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Missing ERA Procedures

- The provider will contact the Xerox EDI Support Unit (1-800-884-3222, option 2 then 4) to submit a research request.
- If possible, the electronic remittance advice will be reposted within 3 to 5 business days.

Late ERA Procedures

- The provider will contact the Xerox EDI Support Unit (1-800-884-3222, option 2 then 4) to submit a research request.
- If it was found that the files are late posting, then the files will be made available within 24 to 48 hours.