Medicaid of Ohio (CareSource)

Attention Providers:

To start receiving ERAs electronically for Medicaid of Ohio (CareSource) through EDS you will need to follow the instructions below.

Payer:	Medicaid of Ohio (CareSource)
Payer ID:	CKOH1
For Enrollment Questions:	Contact the EDS Enrollment Department at (651) 389-9152 or Enrollment@edsedi.com
Payer Enrollment Application:	**DESIGNATION OF AN 835 or 834-820 TRADING PARTNER**
Upload, Email or Fax Application to:	Sent completed forms to: Enrollment@edseds.com Fax (651)389-9152
Approval Process and Timeframes:	Payer estimates 7-10 business days from the date of submission . EDS will send your ERAs to the EDS Portal as they are received.

4/19/23

OHIO DEPARTMENT OF MEDICAID

DESIGNATION OF AN 835 TRADING PARTNER

By completing and signing this form the provider authorizes the department to transmit remittance advice data in an X12-5010 format through the EDI Trading Partner listed in Section II of this form. **All fields with an (*) are required.** Forms missing required information will not be processed. Please include information in other fields if it is available. ***Current date will be used if the Effective Date is not included.***

SECTION I: PROVIDER INFORMATION

Provider Name:*		Doing Business as Name (DBA):
Street:*		
City:*	State/Province:*	ZIP Code/Postal Code:*

SECTION II: PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers	Provider Federal Tax Identification Number (TIN)	National Provider Identifier (NPI):
	or Employer Identification Number (EIN):*	Medicaid Provider ID:*
Other Identifiers	Assigning Authority: **Ohio Department of Medicaid**	Trading Partner ID:*

SECTION III: PROVIDER CONTACT INFORMATION

Provider Contact Name:*			Title:
Telephone Number:*	Extension	Email Address:*	Fax Number:

SECTION IV: ELECTRONIC REMITTANCE ADVICE INFORMATION

PREFERENCE FOR AGGREGATION OF REMITTANCE DATA *Provider Preference for grouping (bulking) claim payment remittance advice.*	
Provider Tax Identification Number (TIN): *Required if NPI is not applicable**	National Provider Identifier (NPI): *Required if TIN is not applicable**

SECTION V: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name:*	Clearinghouse Contact Name:*
Telephone Number:	Email Address:

SECTION VI: SUBMISSION INFORMATION

Reason for Submission:* ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	Requested ERA Effective Date:

AUTHORIZED SIGNATURE

The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.

Written Signature of Person Submitting Enrollment:*
Printed Name of Person Submitting Enrollment:*
Printed Title of Person Submitting Enrollment:

Send the completed form to

Ohio Department of Medicaid
MCD-EDI Support
P.O. Box 182709
Columbus, Ohio 43218-2709

Or eMail: *omesedisupport@medicaid.ohio.gov*