



## Medicaid of Texas

Attention Providers:

In order to start receiving your ERAs for Medicaid of Texas through EDS, you will need to print and review the enrollment form. Please sign the form and submit to EDS with required documentation noted below.

Payer:	Medicaid of Texas
Payer ID:	CKTX1
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482 -3518 or <a href="mailto:Enrollment@edsedi.com">Enrollment@edsedi.com</a>
Enrollment Application:	Electronic Remittance Advice (ERA) Agreement
Email or Fax Application to:	<a href="mailto:Enrollment@edsedi.com">Enrollment@edsedi.com</a> Fax (800) 389-9152
Approval Process and Timeframes:	Payer estimates 30 business days for processing. EDS will deliver ERAs directly to the EDS Portal upon receipt.
Special Instructions:	Once the provider has been approved for ERAs with Medicaid of Texas, you will no longer receive paper EOBs.

# ERA Agreement — Submission Instructions

**Important:** Submit the completed Electronic Remittance Advice (ERA) Agreement form. Call the **TMHP EDI Help Desk** at 1-888-863-3638 if you need assistance.

Return this form to:

Texas Medicaid & Healthcare Partnership  
Attention: EDI Help Desk MC-B14  
PO Box 204270  
Austin, TX 78720-4270

Fax to:

(512) 514-4228  
OR  
(512) 514-4230

By submitting a signed copy of the ERA Agreement form I agree to the following:

I (we) request to receive Electronic Remittance and Status (R&S) information and authorize the information to be deposited in the electronic mailbox as indicated below. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

I (we) understand that an Adobe PDF version of the paper R&S will continue to be sent to my (our) TexMedConnect account.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

As part of the ERA enrollment process and to comply with the Affordable Care Act CAQH CORE Rule 370, if you are enrolling or have previously enrolled for EFT payments, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements. These data elements will allow you to easily associate your EFT payment with the appropriate ERA remittance advice. You may read more about the CAQH CORE Rule at the CAQH website: <http://caqh.org/>

Only one submitter ID can download the Electronic R&S. Choosing Change Enrollment will cancel any previous Electronic R&S setup. Providers are advised to determine the current recipient of the Electronic R&S before selecting this option. Providers may use the View R&S Reports link on the TexMedConnect portal to allow multiple users to access an Adobe PDF version of the paper R&S.

Complete the required fields on the ERA Agreement form as follows:

Provider Information	
Provider name	Enter the provider's legal name according to the Internal Revenue Service (IRS).
Provider Address	Enter the provider's address including the street, city, state/province and ZIP code/postal code.
Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Enter the provider's TIN or EIN.
National Provider Identifier (NPI)	Enter the provider's NPI.
Other Identifier(s)	The Billing TPI (One request form per TPI is required.)
Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid.
Trading Partner ID	Enter the submitter/production ID.

## ERA Agreement — Submission Instructions

<b>Electronic Remittance Advice Information</b>	
Preference for Aggregation of Remittance Data	Select the provider's preference for grouping (bulking) claim payment Electronic R&S.
Method of Retrieval	Enter the method in which the provider will receive the Electronic R&S from the health plan.
<b>Submission Information</b>	
Reason for Submission	Select the most appropriate reason for submission of the ERA Agreement form.
<b>Authorized Signature</b>	
Written Signature of Person Submitting Enrollment	Signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.
Submission Date	Enter the date the ERA Agreement form was signed.
Printed Name of Person Submitting Enrollment	Enter the printed name of the person signing the ERA Agreement form.
Printed Title of Person Submitting Enrollment	Enter the printed title of the person signing the ERA Agreement form.
Requested EFT Start/Change/Cancel Date	Enter the date on which the requested action is to begin.
<b>Other Data Elements</b>	
<p>The other data elements within this form will allow providers to easily associate Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions.</p> <p>Refer to the Council for Affordable Quality Healthcare (CAQH) website, <a href="http://caqh.org/">http://caqh.org/</a> for more information about CORE Rule 370 and the other data elements on the ERA Agreement form.</p>	

# Electronic Remittance Advice (ERA) Agreement

Provider Information	
<b>Provider Name *</b>	<b>Doing Business As Name (DBA)</b>
<b>Provider Address</b>	
<i>Street *</i>	<i>City * State/Province * ZIP Code/Postal Code * Country Code</i>

Provider Identifiers Information	
<b>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *</b>	<b>National Provider Identifier (NPI) *</b>
<b>Other Identifier(s) *</b>	<b>Assigning Authority *</b>
<b>Trading Partner ID *</b>	
<b>Provider License Number</b>	<b>License Issuer</b>
<b>Provider Type</b>	<b>Provider Taxonomy Code</b>

Provider Contact Information		
<b>Provider Contact Name</b>	<b>Title</b>	
<b>Telephone Number</b>	<b>Telephone Number Extension</b>	<b>Email Address</b>
<b>Fax Number</b>		

\* Required field

# Electronic Remittance Advice (ERA) Agreement

<b>Provider Agent Information</b>				
<b>Provider Agent Name</b>				
<b>Agent Address</b>				
<i>Street</i>	<i>City</i>	<i>State/Province</i>	<i>ZIP Code/Postal Code</i>	<i>Country Code</i>
<b>Provider Agent Contact Name</b>			<b>Title</b>	
<b>Telephone Number</b>	<b>Telephone Number Extension</b>	<b>Email Address</b>		
<b>Fax Number</b>				

<b>Federal Agency Information</b>	
<b>Federal Program Agency Name</b>	
<b>Federal Program Agency Identifier</b>	<b>Federal Agency Location Code</b>

<b>Retail Pharmacy Information</b>	
<b>Pharmacy Name</b>	<b>Chain Number</b>
<b>Parent Organization ID</b>	<b>Payment Center ID</b>
<b>NDCP Provider ID Number</b>	<b>Medicaid Provider Number</b>

<b>Electronic Remittance Advice Information</b>
<b>Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): *</b>
<input type="checkbox"/> Provider Tax Identification Number (TIN): _____ <input type="checkbox"/> National Provider Identifier (NPI): _____
<b>Method of Retrieval</b>

\* Required field



# Electronic Remittance Advice (ERA) Agreement

Electronic Remittance Advice Clearinghouse Information	
<b>Clearinghouse Name</b>	<b>Clearinghouse Contact Name</b>
<b>Telephone Number</b>	<b>Email Address</b>

Electronic Remittance Advice Vendor Information	
<b>Vendor Name</b>	<b>Vendor Contact Name</b>
<b>Telephone Number</b>	<b>Email Address</b>

Reason for Submission*
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment

Authorized Signature	
<b>Written Signature of Person Submitting Enrollment *</b>	
<b>Printed Name of Person Submitting Enrollment *</b>	<b>Printed Title of Person Submitting Enrollment *</b>
<b>Requested ERA Effective Date *</b>	<b>Submission Date *</b>

\* Required field

