400 Vermillion Street • Hastings, MN 55033
Ph 800-482-3518 • Fax 651-389-9152
www.edsedi.com

FLORIDA MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CKFL1**
ELECTRONIC REGISTRATIONS Agreements Required	**Change Healthcare Provider Enrollment Form** • Please complete all requested information. **Electronic Data Interchange Agreement** • Please complete all request information. **Florida Medicaid Provider Web Portal** • Providers must log into their Florida Medicaid Provider Web Portal account and elect to have their dental claim reports (277U) transactions delivered to Change Healthcare. • Web Portal: http://portal.flmmis.com/FLPublic/Default.aspx Change Healthcare Dental can be found by searching with any of the below. o Username: emdeond o Name: Envoy Corporation o Email: dentaloperations@Change Healthcare.com o Phone: 860-289-6090
SEND REGISTRATION FORMS TO	EDS 400 Vermillion Street Hastings, MN 55033 Attn: Provider Enrollment Or Email to: enrollment@edsedi.com Or Fax to: 651-389-9152
ENROLLMENT CONFIRMATION	EDS will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Electronic Dental Services, each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	EDS EDI Support (FL Medicaid) 800-289-7799 Electronic Dental Services 800-482-3518

400 Vermillion Street ● Hastings, MN 55033
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PROVIDER ENROLLMENT FORM

Insurance Carrier: **Florida Medicaid - payer ID CKFL1**

Print/Type the following:
Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: _____

Group Legacy Number as assigned by the payer:_____
(if applicable)

Group Type 2 NPI: _____
(if applicable)

Group Taxonomy Code: _____
(if applicable)

Rendering Provider Information

Name	Legacy Number	Individual NPI–Type 1	Taxonomy Code
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Medicaid Provider ID: _____
or, Application Tracking Number (ATN)

0 1 2 1

Electronic Data Interchange Agreement

Medicaid Provider ID: _____ NPI: _____

Provider Name: _____

Address: _____

City: _____ State: ____ Zip + 4: _____

Contact Name: _____ Contact Phone: (____) _____

Email: _____

The Medicaid provider listed above is a (check one): ☑ Provider ____ Billing Agent/Clearinghouse

Section 1: Transaction Information

Complete this section to indicate how you plan to submit or receive electronic transactions.

- **If you are currently submitting/receiving electronic transactions directly to/from Medicaid, indicate your current 5-digit or 6-digit Trading Partner ID.**

  _____

- **If you plan to use a software vendor to submit/receive electronic transactions to/from Medicaid, indicate the software vendor's Trading Partner ID.**

  NOTE: If you do not provide the software vendor's Trading Partner ID, you will be required to test.

  N/A

- **If you plan to use a billing agent/ clearinghouse to submit directly to/from Medicaid, indicate the billing agent/clearinghouse's Trading Partner ID.**

  NOTE: To designate a billing agent to submit claims on your behalf, complete Section 2.

  12203

- **Indicate the transaction and version types you plan to send/receive.**

____ 4010 - 820 Premium Payment	____ 4010 - 834 Benefit Enrollment (Inbound/Outbound)
____ 5010 - 820 Premium Payment	____ 5010 - 834 Benefit Enrollment (Inbound/Outbound)
____ 4010 - 837P Professional	____ 4010 - 270/271 Eligibility Request/Response
____ 5010 - 837P Professional	____ 5010 - 270/271 Eligibility Request/Response
____ 4010 - 837I Institutional	____ 4010 - 276/277 Claim Status Request/Response
____ 5010 - 837I Institutional	____ 5010 - 276/277 Claim Status Request/Response
____ 4010 - 837D Dental	
☑ 5010 - 837D Dental	

- **Select the method of submission that you will use to transmit your transactions.**

___ Web Portal/Software Vendor ___ Provider Electronic Solutions (PES)

NOTE: If you are using a Billing Agent or Clearinghouse you may disregard this question.

NOTE: If you selected the Provider Electronic Solutions (PES) submission method, please go to the website http://www.mymedicaid-florida.com to download the software. Should you experience any problems, call the EDI Helpdesk at 1-866-586-0961.

Section 2: Florida Medicaid Billing Agent Agreement

This section must be completed by any provider who wishes to designate or change a billing agent to submit claims for reimbursement by Florida Medicaid.

The following requirements apply to all billing agents/clearinghouses:

1. Any entity, that submits claims to Medicaid on behalf of an enrolled Medicaid provider must be enrolled in the Medicaid program as a billing agent with an active provider number.
2. Claims must be paid in the name of the provider or provider group that renders the services, not in the name of the billing agent.
3. Payment for billing services must be made based upon an administrative fee per claim. Billing agents are prohibited from charging for their services based upon a percentage of the total dollar value of claims billed.
4. If a claim is rejected as inaccurately filed, it cannot be resubmitted unless there has been a change made to the claim form or electronic submission itself.

"The following billing agent is authorized to submit claims to and follow up with Medicaid and the Medicaid fiscal agent on my behalf. I understand that all payments and payment information are in my name and that this agreement does not exempt me from responsibility for claims filed on my behalf or from established claim filing policies. I further understand that the billing agent must be held to the same requirements of confidentiality and access to records as I am, as reflected in my agreement with Medicaid. I will immediately notify the Medicaid fiscal agent of any change in this authorization."

Billing Agent Name: Clams Processing Service dba Emdeon Dental

Billing Agent Provider Number: 990884600

Section 3: Certification

The provider identified on this Electronic Data Interchange Agreement understands and agrees to the following:

1. Payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws.
2. Providers must safeguard the Medicaid program against abuse in the use of electronic claims submission.
3. Providers must correctly enter the claims data, monitor the data and certify that the data entered is correct.
4. Providers must assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments by the Agency's fiscal agent that might result from carelessness or fraud.
5. Providers must have on file the applicable source data to substantiate the claim submitted to the Medicaid program.
6. Providers must allow the Agency or any of its designees and representatives of the office of the Auditor General or the Attorney General to review and copy all records, including source documents and data related to information entered through electronic claims submission.
7. Providers must abide by all Federal and State statutes, rules, regulations, and manuals governing the Florida Medicaid program.
8. Providers must sign and adhere to all conditions of the Medicaid Provider Agreement and be officially enrolled in the Medicaid program to participate in electronic claims submission.

Signature: _____ SIGN HERE Date: _____

~~Fax completed form to: 866-270-1497 (Preferred)~~

~~Or mail completed form to:~~

~~For Regular Mail:~~

~~HP Provider Enrollment~~
~~P.O. Box 7070~~
~~Tallahassee, FL 32314-7070~~

~~For Overnight or Express Delivery:~~

~~HP Provider Enrollment~~
~~2671 Executive Center Circle West~~
~~Suite 100~~
~~Tallahassee, FL 32301~~

(Florida Medicaid Program – Do not write below this line)

Received	By:	Date:
FMMIS Updated	By:	Date: