

Medicaid Hawaii 837 and 835

EDI Enrollment Instructions:

- The billing provider must have an EDIinsight customer account.
- SAVE this document to your computer.
- OPEN the file in the Adobe Reader program and type directly onto the form.
- COMPLETE the form using the provider's billing/group information as credentialed with payer.
- PRINT, SIGN and SCAN or SAVE the signed form to your PC so that you may submit the form to the EDIinsight Enrollment Team using EDIinsight Enrollment Manager.
- ERA enrollment processing timeframe is approximately 21 days.
- Payer requires testing before ERA is setup. Before requesting remits for this payer, you must plan on or currently be submitting claims to this payer.
- Payer requires that an enrollment be submitted for the Group and each Individual Provider. The provider number is 10 numeric. All 8-digit provider IDs are to be padded with two leading zeros. NPI can be used to submit enrollment for Claims, but need Provider Number for Remits.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request or contact the payer directly at hi.ecstest@conduent.com.

837 Claims Transactions and 835 Electronic Remittance Advice:

1. Electronic Data Interchange Request (2 pages)

Under the 'Data Exchange Submitter Information' section on Page 1, complete the contact information fields.

On Page 2, the Provider or Authorized Individual must print name, date, and sign where indicated.

Submit to EDIinsight Enrollment Team:

Within EDIinsight - Enrollment Manager:

GO TO or **[ADD Payer Enrollment]** record for this payer.

SELECT record, CLICK **[ATTACH File]** to attach all pages of the completed payer form.

IF prompted, asking if you want to Submit the request, CLICK **[Yes]** -Or- CLICK **[SUBMIT Enrollment]**

ENTER any notes (optional)

CLICK to "**Save and Exit**" notes' window.

ELECTRONIC DATA INTERCHANGE REQUEST

Email completed form to "hi.ecstest@acs-inc.com" or print and fax to: 808-952-5595 Attention: EDI Coordinator

I. Requested Data Exchange Access (Check all that apply)	
Request to:	<input type="checkbox"/> Add User <input type="checkbox"/> Delete User <input type="checkbox"/> Change User
Data Access:	<input type="checkbox"/> Upload <input type="checkbox"/> Download <input type="checkbox"/> Delete <input type="checkbox"/> Rename Date: / /
II. EFT User – Trading Partner User Information (Provider / Clearinghouse / Other)	
Entity Name:	Submitter ID(s):
E-Mail Address:	
Service Account Contact E-Mail Address:	
Street Address:	City, State, Zip:
Telephone:	IP Address:
User First Name:	Phone:
User Last Name:	Last four of SSN:
Note: If this is for an automated <u>service account</u> , you must include a source IP address. A user name and password for the service account will be returned through the EFT server. All <u>individual accounts</u> must <u>also</u> include a first and last name, the last four numbers of the SSN, and an email address. Any request received without this information will not be processed.	
Trading Partner Authorization: (Entity point of contact (<i>Security Liaison</i>) for all Electronic Data Exchange requests)	
Name:	Position: Email Address: Date: / /
Trading Partner Technical Representative: (Entity point of contact for all technical issues)	
Name:	Email Address:
III. Data Exchange Submitter Information (Operates on behalf of one or more Trading Partners)	
Submitter Name:	ID Number:
Street Address:	City, State, Zip:
Phone:	FAX:
E-Mail Address:	
Contact Person:	Phone:
Technical Representative:	Phone:
IV. Data Exchange Information Types (Check all that apply)	
Type of data to exchange:	
<input type="checkbox"/> 270/271 Eligibility Inquiry/Response	<input type="checkbox"/> 835 Fee-for-service Remittance Advice
<input type="checkbox"/> 837 Fee-for-service Claims transaction	<input type="checkbox"/> Other: Reports, etc...
V. User Affirmation Requirement	
Each individual accessing Med-QUEST Division data is required to read and sign an Affirmation Statement. Fax all Affirmation Statements to : 808-952-5595 Attention: EDI Coordinator	
Affirmation Statement:	<input type="checkbox"/> Attached <input type="checkbox"/> On File
Note: Any new individual account requests received without an Affirmation Statement will not be processed.	
Note: All password reset requests should be referred to ACS EDI Coordinator at (808) 952-5583.	
VI. AHCCCS ISD Information (To be completed by AHCCCS personnel)	
User ID: _____	Password: _____ Date: __ / __ / ____ Setup: _____ To Prod: __ / __ / ____
Permissions Granted:	<input type="checkbox"/> Upload <input type="checkbox"/> Download <input type="checkbox"/> Delete <input type="checkbox"/> Rename
Group Name(s): _____	

EXTERNAL USER AFFIRMATION STATEMENT

I understand that all users who have access to Med-QUEST Division (MQD) data are bound by applicable laws, rules and MQD directives.

Use of MQD Data:

- I will share (i.e., verbal, hardcopy, electronic) MQD data only with people who are authorized to receive the data.
- I will only access/add/change/copy/delete MQD data related to my assigned job duties.
- I will never use MQD data for non-work related purposes.

Logon IDs and Passwords:

- I will never use another person's MQD Logon ID and password.
- I will never ask another person to reveal his/her MQD Logon ID and password.
- I will never reveal my MQD Logon ID and password to anyone, at any time.
- I understand that no one else may use my MQD Logon ID and password and that I am responsible for all actions taken with my Logon ID.

Misuse of Data:

- I understand that if I become aware of any misuse of MQD data I must promptly notify MQD Helpdesk 808-692-7953.
- I understand that MQD will take appropriate action to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced.
- I understand that the misuse of MQD data may result in prosecution, or disciplinary action if I am an employee of another state agency.

My signature below confirms that I have read and understood this form. I accept responsibility for adhering to all applicable laws, rules, and MQD directives. Failure to sign this statement will mean that I will be denied access to MQD data.

Print Legal Name of User (Last, First, M.I.)	Signature	Date
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