Maryland Medicaid
Dept. of Health and Mental Hygiene (DHMH)
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 this payer.
- EDI enrollment processing timeframe is approximately 25 business days.
- To check status of EDI enrollment, please contact Medicaid at lisa.runk@maryland.gov .

837 Claim Transactions and 835 Electronic Remittance Advice:

Trading Partner Agreement

Complete the form as appropriate, using the information provided below.

Enter the provider group or pay-to name.
Use your Maryland Medicaid legacy provider number containing 9 digits.

Maryland Medical Care Programs Submitter Identification Form

Complete the form as appropriate, using the information provided below.

Section 1. Check appropriate box.
Section 2. Provider Information is obtained from previous form.
Section 3. Electronic Submitter Information: Skip.
Section 4. EDI Information: The boxes are pre-checked.

Submit Completed Documents:

LOGON to EDIinsight-Enrollment Manager
ADD or SELECT payer enrollment record.
CLICK [**Attach File**] to attach the document to the payer enrollment record. **Answer "Yes"** to Submit.
Or, click [**SUBMIT Enrollment**] to submit.

Trading Partner Agreement

This Agreement is by and between the Medical Care Program (Medicaid) and

_____. _____
PROVIDER NAME PROVIDER ADDRESS

_____, hereafter known as the Provider.
CITY, STATE & ZIP CODE

[If applicable] the Provider and Program hereby agree that the Provider may use a certified clearinghouse (Submitter Agent),

Practice Insight. 1 Greenway Plaza, Suite 350
SUBMITTER AGENT NAME SUBMITTER AGENT ADDRESS

Houston, TX 77046, hereafter known as Submitter Agent, to
CITY, STATE & ZIP CODE
transmit HIPAA transactions arising from the Provider's participation in the Program.

1. Purpose of Agreement- This agreement is intended to facilitate communications between the Program and the Provider in the processing by the Program of electronic transactions filed by or on behalf of the Provider.

2. Provider Submission of transactions- The Provider shall submit all data transmissions pursuant to Program standards. The Provider hereby warrants that all data will be submitted in compliance with the Program's regulations, transmittals, and any provider manual(s) specific to the provider. The Program reserves the right to modify its regulations, transmittals and other manuals at any time and to notify Provider of those changes by electronic communication. The Program reserves the right to reject any transaction which does not conform to its data submission standards.

3. Program Acceptance of Electronic Transactions- The Program agrees to accept valid transactions submitted by the Provider or the Submitter Agent.

4. Cooperation with Testing- During the testing phase, as designated by the Program, both Program and Provider agree to cooperate with each other, and with entities performing business associate type functions for the contracting parties, for the purpose of striving for accuracy, timeliness, security and completeness of date transmissions.

5. Use of Standard Transactions and Code Set Format- HIPAA regulations, at 45 CFR Part 162 HIPAA Federal Electronic Transactions and Code Sets for Data Exchange, provide for certain transaction standards for transfer of data between trading partners. The Provider must submit and the Program will be prepared to accept, translate, or route HIPAA compliant transactions. As HHS modifies the standards, the trading partners agree to incorporate by reference any modifications or changes to 45 CFR Part 162.

6. Prohibited Acts- 45CFR § 162.915 specifies that trading partners will not enter into an agreement that would: "change the definition, data condition or use of a data element or segment in a standard; add any data elements or segments to the maximum defined set; use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specifications(s); or change the meaning or intent of the standard's implementations specification(s)".

7. Expenses- Each party shall bear its own expenses in implementing this process of transmitting information via this agreement.

8. Confidentiality and Security- Each party shall comply with all HIPAA and State Security and Confidentiality requirements in the handling of protected health information and take reasonable precautions to prevent unauthorized access to any part of the transaction process. In the event that data is improperly sent or received under this agreement, such data shall be highlighted and disposed of or returned in an appropriate manner.

9. Provider Identifiers- The parties shall agree on a unique identifier to be used by Provider. Provider is responsible for disclosing the unique identifier to its agents and only as is prudent to maintain appropriate security for the identifier.

10. This Trading Partner Agreement may be terminated by the Medical Care Program at any time.

All other agreements between the Program and Provider remain in full force and effect.

AGREED:

PROVIDER NAME: _____

PROVIDER NUMBER: _____

NATIONAL PROVIDER IDENTIFIER (NPI)# _____

_____
AUTHORIZED SIGNATURE

DATE: _____ Phone # _____

RETURN VIA MAIL:

Rita Tate
201 W. Preston St., Rm. LL3
Baltimore, MD 21201
ATTN: HIPAA Billing Agreements

Revised: 3/21/12

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM
For Version 005010 HIPAA Transaction Set

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

1. This is a
   [ ] New Application
   [ ] Change of Submitter Agent
   [ ] Submitter Identification Form Update

Select Media if New Application:
[ ] Electronic Transfer & Paper Voucher
[ ] Paper Voucher Only

2. **Provider Information**

a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	

3. **Electronic Submitter Information**

a) Submitter Name:	Practice Insight
b) Submitter Address:	1 Greenway Plaza, Suite 350 Houston, TX 77046
c) Submitter ID(ISA Qualifier and ISA ID):	161622439

4. **EDI Information**
Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	005010X279A1
	276/277 Claim Status & Response	005010X212
☐	837 Health Care Claim Institutional / 277CA Claim Acknowledgment	005010X223A2 / 005010X214X
☑	837 Health Care Claim Professional / 277CA Claim Acknowledgment	005010X222A1 / 005010X214X
	837 Health Care Claim Dental / 277CA Claim Acknowledgment	005010X224A2 / 005010X214X
	820 Premium Payment	005010X218
☑	835 Health Care Claim Payment/Advice **835 GS Receiver ID** 161622439 (**Required, if Checked**) Receiver EDI Information (Required if different from above listed Submitter ID or if you are a Pharmacy Provider or Business Associate requesting an 835): Receiver Name: Receiver Address**:** ISA Qualifier and ISA ID**:**	005010X221A1

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM
For Version 005010 HIPAA Transaction Set

The provider, _____ hereby authorizes
PROVIDER NAME
Practice Insight
_____, hereafter
SUBMITTER AGENT
referred to as *Submitter Agent*, to transmit HIPAA transactions to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the *Submitter Agent* the return computer electronic files of all data processed. The *Submitter Agent* agrees to protect the confidentiality of this data as required by law.

_____	_____
Signature of Provider	**Signature of Submitter Agent**
_____	Donna Anderson
Print Name of Signature	**Print Name of Signature**
_____ _____	713-333-6000 Opt 2 _____
Telephone Number **Date**	**Telephone Number** **Date**

Note: This form requires completion of all requested information and **original signatures** to be processed.

MAIL TO:

SYSTEMS LIAISON SERVICES
201 W. PRESTON ST., RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK

For Internal Use Only:

Systems Liaison Services Signature: _____
Date Received: _____