

Medicaid Minnesota 837 and 835

EDI Enrollment Instructions:

- The billing provider must have an EDInsight 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 EDInsight Enrollment Team using EDInsight Enrollment Manager.
- ERA enrollment processing timeframe is approximately 30 days.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request or contact the payer directly at 800-366-5411.

837 Claim Transactions:

Complete and submit this form using the billing provider's group information.

1. Provider Setup Form (1 page)

Complete all applicable fields.

Under the 'MHCP Pay-to-Provider' section, enter the effective date of the enrollment and the contact information.

Provider or Authorized Individual must place check the box next to Claim, ERA, or Both, then print date and sign where indicated.

835 Electronic Remittance Advice:

1. Electronic Remittance Advice (RA) Request Form (1 page)

Complete all applicable fields.

Enter the Contact Person's name and phone number where indicated.

Enter the Requested Start Date where indicated.

Provider or Authorized Individual must print name, phone number, date and sign where indicated at the bottom of the page.

Submit to EDInsight Enrollment Team:

Within EDInsight - 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.



Minnesota Health Care Programs (MHCP) Provider Setup Form

For use by Clearinghouses, [Billing Organizations](#) and providers

Notify MHCP whenever providers/billing organizations are **added or removed** from your list. Copy as needed.

CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID	CLEARINGHOUSE/BILLING ORGANIZATION NAME		
NAME OF PERSON COMPLETING THIS FORM	ADDRESS		
PHONE NUMBER - -	CITY	STATE	ZIP CODE

MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER - -	REMOVE LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER - -	REMOVE LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER - -	REMOVE LINK TO CLEARINGHOUSE/BILLING ORGANIZATION SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both


 Minnesota Department of **Human Services**

Electronic Remittance Advice (RA) Request Form

Complete this form to request the addition or removal of electronic RAs to or from a provider, clearinghouse or billing intermediary, for example, when a provider changes billing intermediaries. Providers may not choose to receive paper RAs (Minnesota Statutes 62J.536 requires electronic only RAs by 12/15/09). **The MHCP provider must authorize, sign and date all changes.** Fax completed form to (651) 431-7462.

MHCP PROVIDER NAME	NPI/UMPI
CONTACT PERSON	CONTACT PHONE NUMBER ()

CLEARINGHOUSE/BILLING INTERMEDIARY NAME (IF APPLICABLE)	UMPI
CONTACT PERSON	CONTACT PHONE NUMBER ()

ADD <input type="checkbox"/> 835 X12 <input type="checkbox"/> 835 PDF	REQUESTED START DATE (MM/DD/YYYY)
REMOVE <input type="checkbox"/> 835 X12 <input type="checkbox"/> 835 PDF	REQUESTED END DATE (MM/DD/YYYY)

ADDITIONAL COMMENTS

NAME (PLEASE PRINT)	PHONE NUMBER ()
MHCP PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)

FOR OFFICE USE ONLY		
EDI REPRESENTATIVE	PHONE NUMBER ()	DATE (MM/DD/YYYY)