

Medicaid Montana 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 30 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request or contact the payer directly at 800-987-6719.

835 Electronic Remittance Advice:

1. MONTANA DPHHS EDI 835 REQUEST FORM (1 page)

Complete all applicable fields.

Under the 'Section A. Provider Information' section, enter the Contact Person's name and email address where indicated.

Under the 'Section B. Authorization Signature' section, the person completing the agreement must print their name.

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

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.

MONTANA DPHHS EDI 835 REQUEST FORM



Please return to:
Conduent EDI Solutions, Inc.
Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402



Provider Billing Agent/Clearinghouse Conduent EDI Solutions, Inc Authorization Form

Section A. Provider Information.

Form with fields: Business Name, Provider Name (Last, First, MI and Suffix), Provider Number, Federal Tax ID Number, Business Address, City, State, and Zip, Telephone Number, Fax Number, Contact Name, E-mail Address

Section B. Authorization Signature (required).

Provider, _____ hereby appoints
Provider name /Provider Representative name (please print)

_____, _____
Billing Agent/Clearinghouse name (please print) Billing Agent/Clearinghouse Conduent Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to Conduent EDI Solutions, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 277-Claim Status Response
835-Healthcare Claims Payment Advice
Exception Report (Print Image)
277CA-Healthcare Claim Acknowledgement
271-Eligibility Response
278-Prior Authorization Response
999-Implementation Acknowledgement

Provider/Provider Representative name (Please print)

Provider/Provider Representative Signature

Date