eSolutions
Strengthen your revenue health
EDI Insight

Payer ID: MCDNH

Medicaid New Hampshire
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 30 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the ERA setup request or contact the payer directly at 866-291-1674.

837 Claims Transactions and 835 Electronic Remittance Advice:

1. **Billing Agent Agreement (1 page)**

   Provider or Authorized Individual must sign and date where indicated.

2. **Electronic Remittance Advice (ERA) Enrollment Application (2 pages)**

   Under the ‘Provider Identifier Information’ section on Page 2, complete the Provider License Number, License Issuer, Provider Type, and Provider Taxonomy Code fields.

   Under the ‘Provider Contact Information’ section, complete all fields.

   Provider or Authorized Individual must sign and print name where indicated.

3. **NH Title XIX EDI Registration (2 pages)**

   Under the ‘Transactions’ section on Page 1, check the box next to all of the applicable transactions.

   Under the ‘Provider Listing’ section on Page 2, check the box under the applicable transactions.

   Provider or Authorized Individual must 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.

Billing Agent Agreement

All Providers that use a billing agent or clearing house must print and sign the Billing Agent Agreement. Only original signatures will be accepted. Copied or stamped signatures are not acceptable.

* Required Field

If you utilize a Billing Agent or Clearinghouse please verify that you checked 'Yes' in the Third Party Billing segment of Section 4 and correctly completed the Billing Agent/Clearinghouse segment in Section 6, then complete the information below.

Billing Agent/Clearinghouse

Practice Insight NH100693

I authorize the entity identified above to submit claims and/or other electronic transactions on my behalf as specified in Section 6 of this application. This authorization includes conducting any necessary follow-up with the NH Title XIX fiscal agent relative to submitted transactions. I understand that all payments will be made to me; Remittance Advices (RAs) will be delivered via the delivery media I selected in Section 4; and this agreement does not exempt me from the responsibility for claims filed on my behalf in accordance with established NH Title XIX billing policies. I further understand that the billing agent is held accountable to the same requirements of confidentiality and access to records that I am, as reflected in my agreement with the NH Title XIX Program. I will immediately notify the NH Title XIX fiscal agent of any change to this authorization.

Provider Name	Provider/Authorized Representative Signature	Date Signed *

NH Medicaid Provider Relations
P.O. Box 2059
Concord, NH 03302-2059

New Hampshire Title XIX Medicaid Program

ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT APPLICATION

Providers who receive Electronic Remittance Advice from the NH Department of Health and Human Services' (The Department) Title XIX Program must agree to the following terms and conditions:

1. **ERA Information.** Provider will complete ERA information on this form and send in the ERA Signature Page through mail.
2. **CCD+ Format**. Provider will contact its financial institution/bank to arrange for the delivery of the information from the CCD+ EFT that is necessary for successful re-association of the EFT payment with the ERA remittance advice. The information that the bank must return is as follows:

CORE-required Minimum CCD+ Re-association Data Elements		**Corresponding v5010 X12 835 Data Elements**	
CCD+ Record #	**Field #**	Field Name	Data Element Segment Position, Number & Name
5	9	Effective Entry Date	BPR16-373 Date (EFT Effective Date)
6	6	Amount	BPR02-782 Monetary Amount (Total Actual Provider Payment Amount)
7	3	Payment Related Information	TRN Re-association Trace Number Segment

TRN segment consists of Check or EFT trace number/Payer Identifier/optional supplemental code. These pieces of information will match what is received in the ERA (835) transaction for easy re-association. Providers must contact their financial institution to arrange for the delivery of the minimum required fields for re-association. The banks will not automatically supply this detail and it is required that the provider work out how this information will be obtained (email, e-statement, electronically, etc.).

3. **Late/Missing ERA**. In case of a late or missing ERA, the Provider will contact the Provider Relations call center at 866-291-1674. Late or missing is defined as a maximum elapsed time of four (4) business days following the receipt of EFT.
4. **Change/Cancel Enrollment**. If any changes are required to ERA enrollment information, the Provider will contact the Provider Relations call center at 866-291-1674.
5. **TIN/FEIN.** Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) field in the ERA section is equivalent to Social Security Number (SSN) for Individual Providers and Federal Employer Identification # (FEIN) for Group Providers.

1. Provider Information:

*Provider Name

Doing Business As Name (DBA)

Provider Address:

*Street

*City

*State/Province

*Zip Code/Postal Code

2. Provider Identifier Information:

*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI)

Provider License Number

License Issuer

Provider Type

Provider Taxonomy Code

3. Provider Contact Information:

*Provider Contact Name

Title

*Telephone Number

Telephone Number Extension

Email Address

Fax Number

4. Electronic Remittance Advice Information:

* Preference for Aggregation of Remittance Data

☒ Provider Tax Identification Number (TIN)

5. Submission Information:

Reason for Submission

☒ New Enrollment

Authorized Signature

Written Signature of Person Submitting Enrollment

NH Title XIX EDI Registration

EDS INTERNAL USE			
DATE	**APPROVED BY**	**TRADING PARTNER ID**	**WEB LOGON**

Part 1.a. NH Title XIX EDI Registration

Trading Partner Name Practice Insight

Street Address 1 Greenway Plaza

Address 2 Suite 350

City Houston State TX Zip 77046

Enrollment Department	713-333-6000	pi-enrollment@waystar.com
Contact Name	Contact Phone #	Contact Email Address

Part 1.b. PreCertification: Please check one

Method of certification that transactions meet X12N standards & agency/product name:

	Method of Certification	**Agency/Product Name**
	Using Provider Electronic Solutions Software	
	Certified by Independent Agency (Provide name)	
	Translator Compliance Check (Name product)	
X	Utilizing a Certified Vendor/Clearinghouse (Provide name)	Practice Insight
	Other (Describe)	

Transactions: Check all that apply

	837 Institutional Inpatient & Outpatient 997 Functional Acknowledgement Claim Accept/Reject Report		837 Professional 997 Functional Acknowledgement Claim Accept/Reject Report
	837 Institutional Nursing Home 997 Functional Acknowledgement Claim Accept/Reject Report		837 Dental 997 Functional Acknowledgement Claim Accept/Reject Report
	270/271 Eligibility Request/Response		835 Remittance 277 Unsolicited Claim Status
	276/277 Claim Status Inquiry		PDF Remittance Advice

837 Dental is the equivalent of 2006 ADA Dental claim form
837 Professional is the equivalent of CMS 1500 claim form
837 Institutional is the equivalent of UB-04 claim form
837 Institutional Nursing Home includes Swing Beds

TRADING PARTNER ID	NH100693

Part 2. NH Title XIX EDI Registration –Provider Listing

Check each transaction that is authorized by the Provider for this Trading Partner. Only include the "Billing Provider" information. If provider is only a "Rendering Provider", they do not need to be linked to the Trading Partner.

Remittance files (835) and Pended Claim Reports (277 Unsolicited) will be available only to one (1) Trading Partner that a Provider has authorized. If the provider is already receiving 835's through another Trading Partner ID, the provider also needs to send a request on Provider Letterhead to move 835/277 to the new Trading Partner ID.

NH Medicaid Provider ID	Provider Name	837 Dental 997/Claim Acc/Rej	837 Institutional 997/Claim Acc/Rej	837 Professional 997/Claim Acc/Rej	835 RA/277	270/ 271 Eligibility	276/ 277 Claim Status	PDF Remittance Advice	Authorized signature of NH Medicaid Provider, to indicate consent for the described access.
									☒

Please check applicable comment:

✔	Add new provider
	Update existing provider's transactions

Mail completed forms with Original Signatures to:

EDS, Attn: EDI Coordinator, PO Box 2040, Concord, NH 03302-2040