Payer ID: MCDNJ

# New Jersey Medicaid
# 837 and 835

**EDI Enrollment Instructions:**

- Please 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 **10-20 business days**.
- An enrollment confirmation notice will be sent to the email address of the contact person.
- To check status of EDI enrollment, please contact **Medicaid at 609-588-6051**.

**837 Claim Transactions:**

**State of New Jersey – Submitter/Provider Relationship EDI Agreement**
SKIP Page 1, Section 1 DO NOT SIGN. PI will sign under "Submitter Representative"
SEE Page 2, Section 2 ENTER Billing Provider Group Name, New Jersey Medicaid Provider Number, Provider NPI Number, Provider Street Address, and Provider EDI Contact Person.
SEE "Provider Representative's Signature". OBTAIN ORIGINAL SIGNATURE.
Include Date Signed and Printed Name of Provider Representative
SKIP Section 3 (this data is optional)

**835 Electronic Remittance Advice:**

**State of New Jersey – Electronic Remittance Advice (ERA) EDI Agreement**
SEE Page 1, Section 2 ENTER Provider Name (Group Name)
OBTAIN SIGNATURE under "Provider Representative's Signature".
Include Date Signed and Printed Name of Provider Representative
SEE Page, 1, Section 2, 9-15 ENTER Medicaid Provider ID (Group ID):, NPI (Group ID), Provider Name, Provider Street Address, Provider Contact Person, etc.
SEE Top of Page 2 ENTER Provider Name (Billing Group), Provider Number (Medicaid Group No)

**Submit Completed Documents:**

BEFORE mailing the Original, Completed document to Waystar
--SAVE copy of the completed form pages to your PC.
WITHIN EDIinsight- Enrollment Manager-
--ADD or LOCATE Payer Enrollment Record
--SELECT record, CLICK **[ATTACH File]** to attach copy of completed document (payer enrollment form) to the record.
CLICK **[ADD Action Taken]**, SELECT- Enrollment Forms Mailed to Enrollment

Mail all pages of completed documents containing original signatures to the clearinghouse for our signature:

**Waystar Enrollment Department**
**888 W. Market St.**
**Suite 400**
**Louisville, KY 40202**

| For Internal Use Only<br>EMCAGREE | | | | ☐ 837-I-D-P |
|---|---|---|---|---|
| **DOCTYPE** | *Submitter ID* | *Submitter & Provider Name* | | ☐ E-RA |
| | | | | ☐ SIGN<br>☐ ADD |
| *Update Initials* | *Date* | *QA Initials/Date* | *Provider Group Number* | ☐ TERM |

# Submitter/Provider Relationship EDI Agreement

☑ **MEDICAID** ☐ **CHARITY CARE**

## SECTION 1: SUBMITTER INFORMATION

***Every EDI submitter assigned a Submitter ID by New Jersey Medicaid must complete, sign and submit this New Jersey Medicaid Submitter/Provider Relationship Agreement before the submitter is authorized to submit claims for a New Jersey Medicaid Provider.***

In some cases the submitter may be a New Jersey Medicaid provider and in other cases the submitter may be a third party Clearing House/Billing Service. Regardless, New Jersey Medicaid cannot process claims submitted with a specific Submitter ID for a specific New Jersey Medicaid provider number unless this agreement has been properly completed and submitted to New Jersey Medicaid or their designated agent. By signing this agreement the New Jersey Medicaid provider is authorizing the submitter to submit claims electronically to New Jersey Medicaid on their behalf.

**A separate agreement is required for each New Jersey Medicaid Billing Provider Number.**

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

1) Submitter Name: Practice Insight, LLC 2) Submitter ID: 9903496

3) Submitter Street Address: 1 Greenway Plaza, Suite 350

***(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)***

4) City, State, Zip Code: Houston TX, 77046

B. Mesik

5) Submitter Representative's Signature (must be original) 6) Date Signed

Barb Mesik

7) Submitter Representative's Name – Please Print Clearly

8) Submitter Representative Telephone Number/Ext: 713 333-6000 Opt 2 9)FAX : 713 333-0138

10) Submitter Representative Email Address: pi-enrollment@waystar.com

11) 2nd Submitter Contact Person: Nicole Olivares 12) Phone/Ext ( 713 ) 333-6000 / ext 7200

13) 2nd Submitter Contact Person Email Address: nicole.olivares@waystar.com

**NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".**

# Submitter/Provider Relationship EDI Agreement

Provider Name: _____ Provider #: _____

## SECTION 2: PROVIDER INFORMATION

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

14) Action Requested: ☑ Add New Provider ☐ Terminate Existing Provider

15) Provider Name: _____

16) New Jersey Medicaid Provider Number: _____

17) Provider NPI Number: _____

18) Provider Street Address: _____
***(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)***

19) City, State, Zip Code: _____

20) Provider EDI Contact Person: _____ 21) Phone/Ext: _____

22) FAX: _____ 23) Email Address: _____

_____ _____
24) Provider Representative's Signature (must be original) 25) Date Signed

_____
26) Provider Representative's Name – Please Print Clearly

**NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".**

## SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

This section is to identify the third party software vendor practice management system that the provider is using to exchange information with their third party billing service. This section may also be repeated if a secondary billing service is being used in addition to a clearing house.

27) SOFTWARE VENDOR NAME: _____

28) STREET ADDRESS: _____
***(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the software vendor.)***

# Submitter/Provider Relationship EDI Agreement

Provider Name: _____ Provider #: _____

29) CITY, STATE, ZIP CODE: _____

30) SOFTWARE CONTACT PERSON: _____ 31) PHONE/EXT: (____) _____ / _____

32) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

33) 2nd SOFTWARE CONTACT PERSON: _____ 34) PHONE/EXT:(____) _____ / _____

35) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

36) FAX : (____) _____

37) SOFTWARE PRODUCT NAME: _____

38) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: _____

39) SOFTWARE PRODUCT RELEASE DATE: _____

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****

**Return the completed EDI Amendment to Gainwell Technologies at the following address:**

**Via U.S. Mail**
**EDI UNIT**
**Gainwell Technologies**
**P.O.Box 4804**
**Trenton, New Jersey 08650 – 4804**

**Other Carriers**
**EDI UNIT**
**Gainwell Technologies**
**3705 Quakerbridge Road, Suite 101**
**Trenton, New Jersey 08619**

| For Internal Use Only<br>EMCAGREE | | | |
|---|---|---|---|
| **DOCTYPE** | *Submitter ID* | *Submitter & Provider Name* | |
| | | | |
| *Update Initials* | *Date* | *QA Initials/Date* | *Provider Group Number* |

☐ 837-I-D-P
☐ E-RA
☐ SIGN
☐ ADD
☐ TERM

# Electronic Remittance Advice (ERA) EDI Agreement

☑ **MEDICAID** ☐ **CHARITY CARE**

## SECTION 1: PROVIDER INFORMATION

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

1) Action Requested: ☑ Add New Provider ☐ Terminate Existing Provider

2) _____ hereby authorize
(Provider Name – Print Clearly)

3) Practice Insight, LLC #9903496 to receive my
(Submitter Name– Print Clearly) (*Entity receiving electronic remittance information*)

Electronic remittance advice as of 4) Date: ___/___/2022 I understand this electronic remittance advice contains Patient Health Information (PHI) and have taken the necessary steps with the parties named on this document to maintain the confidentiality of all PHI data.

5) _____ 6) Date: _____
(Provider Representative's Signature) Must be original

7) Provider Representative's Name _____
(Please Print Clearly)

8) Medicaid Provider ID (*GROUP ID*): _____ 9) NPI (*GROUP ID*) _____

10) Provider Name: _____

11) Provider Street Address: _____

12) City, State, Zip Code: _____

13) Provider Contact Person: _____ 14) Phone/Ext: (_____

**NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".**

# Electronic Remittance Advice (ERA) EDI Agreement

Provider Name: _____ Provider Number: _____

**SECTION 2: RECEIVER INFORMATION**

15) Submitter Name: Practice Insight, LLC 16) Submitter ID: 9903496

17) Submitter Address: 1 Greenway Plaza, Suite 350

18) City, St., Zip: Houston, TX 77046 19) FAX: 713 333-0138

20) Submitter Contact Person: Enrollment Department 21) Phone/Ext: 713 333-6000 Opt 2

22) Submitter Email Address: pi-enrollment@waystar.com

23) 2nd Submitter Contact Person: Martha Johnson 24) Phone/Ext: ( 713 ) 333-6000 ext 7200

25) 2nd Submitter Contact Person Email Address: mjohnson@practiceinsight.net

**NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law"**

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****

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**P.O. Box 4804**
**Trenton, New Jersey 08650 – 4804**

**Other Carriers**
**EDI UNIT**
**Gainwell Technologies**
**3705 Quakerbridge Road, Suite 101**
**Trenton, New Jersey 08619**