

Medicaid New Jersey Institutional 837 and 835

EDI Enrollment Instructions:

- The billing provider must have an EDInsight customer account.
- PRINT this document from your computer.
- **The payer will only accept a handwritten signature.** If an electronic signature is submitted the enrollment will be rejected. The payer will also not accept PO Box addresses for the provider.
- 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 mail the form to the EDInsight Enrollment Team.
- ERA enrollment processing timeframe is approximately **15 days**.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request. The provider may contact e-mail njmmisedi@dxc.com or call EDI: 609-588-6051

837 Electronic Claims:

Complete and submit these form(s) using the billing provider's group information.

1. Submitter/Provider Relationship EDI Agreement (3 pages)

On Page 2, the Provider or Authorized Person must sign where indicated by 'X' in Section 2 of the agreement.

835 Electronic Remittance Advice:

Complete and submit these form(s) using the billing provider's group information.

1. Electronic Remittance Advice (ERA) EDI Agreement (2 pages)

On Page 1, the Provider or Authorized Person must sign where indicated by 'X' in Section 1 of the agreement.

Submit to EDInsight Enrollment Team:

BEFORE mailing the Original, Completed document to Waystar

--SAVE copy of the completed form pages to your PC.

WITHIN EDInsight- 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 Dept.

888 W. Market St.

Suite 400

Louisville, KY 40202

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.)

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

Provider Name: _____ Provider Number: _____

SECTION 2: RECEIVER INFORMATION15) Submitter Name: ZirMed Inc 16) Submitter ID: 990331317) Submitter Address: 888 W Market Street, Ste 40018) City, St., Zip: Louisville, KY 40202 19) FAX: (502) 779-949920) Submitter Contact Person: Enrollment Representative 21) Phone/Ext: (844) 392-978222) Submitter Email Address: enrollment@zirmed.com23) 2nd Submitter Contact Person: _____ 24) Phone/Ext:(_____)25) 2nd Submitter Contact Person Email Address: _____**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. *****

Return the completed EDI Agreement 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