

Medicaid Ohio 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.
- PLEASE NOTE: Completing this enrollment will also enroll the billing provider for payers 35374, 42435, SKOH10, SKOH5, SKOH7, SKOH3, SKOH6, SKOH2, SKOH9, 61103, SKOH8, SKOH4, 88337, 83244, 45221, 83572, SKOH15, SKOH16, SKOH17, SKOH18, SKOH19, SKOH20, and SKOH21 (see list on next page).
- Support Vendors may contact the EDInsight Team to follow up on the ERA setup request or call Medicaid OH at 1 800 686 1516, or send email to omesedisupport@medicaid.ohio.gov

835 Electronic Remittance Advice:

1. DESIGNATION OF AN 835 or 834-820 TRADING PARTNER (1 page)

Under the 'Provider Contact Information' section, complete all fields.

Under the 'Electronic Remittance Advice Information' section, you must choose your preference of data aggregation by entering your NPI or Tax ID.

Under the 'Submission Information' section, check the box next to 'New Enrollment' if you have never received ERAs from this payer. If you have, check 'Change Enrollment.'

Enter the 'Requested ERA Effective Date' where indicated.

Provider or Authorized Individual must print name, title, and sign where indicated on Page 1.

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.

Medicaid Ohio Payer List

Payer Name	Payer ID
Amerihealth Caritas OH	35374
Amerihealth Caritas OH Transportaion ONLY	42435
Anthem BCBS OH	SKOH5
Anthem BCBS OH Vision	SKOH10
Buckeye Health Plan	SKOH3
Buckeye Health Plan Vision	SKOH7
CareSource OH	SKOH2
CareSource OH Vision	SKOH6
Humana Healthy Horizons in Ohio	61103
EyeMed	SKOH9
Molina OH	SKOH4
Molina OH Vision	SKOH8
UHC Medicaid OH Dental	83244
UHC Medicaid OH	88337
UHC Medicaid OH Vision	83572
Aetna Better Health OH	45221
MyCare Anthem (DOS 1/1/2026 and after)	SKOH15
MyCare Buckeye Next Generation (DOS 1/1/2026 and after)	SKOH16
MyCare Molina Duals (DOS 1/1/2026 and after)	SKOH17
MyCare Duals Molina Vision (DOS 1/1/2026 and after)	SKOH18
CareSource OH Vision (EyeMed) (DOS 1/1/2026 and after)	SKOH19
CareSource OH FIDE	SKOH20
CareSource OH Vision FIDE (EyeMed) (DOS 1/1/2026 and after)	SKOH21

DESIGNATION OF AN 835 TRADING PARTNER

By completing and signing this form the provider authorizes the department to transmit remittance advice data in an X12-5010 format through the EDI Trading Partner listed in Section II of this form. **All fields with an (*) are required.** Forms missing required information will not be processed. Please include information in other fields if it is available. **Current date will be used if the Effective Date is not included.**

SECTION I: PROVIDER INFORMATION

Provider Name:*	Doing Business as Name (DBA):	
Street:*		
City:*	State/Province:*	ZIP Code/Postal Code:*

SECTION II: PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers	Provider Federal Tax Identification Number (TIN)	National Provider Identifier (NPI):
	or Employer Identification Number (EIN):*	Medicaid Provider ID:*
Other Identifiers	Assigning Authority: Ohio Department of Medicaid	Trading Partner ID:*

SECTION III: PROVIDER CONTACT INFORMATION

Provider Contact Name:*	Title:		
Telephone Number:*	Extension	Email Address:*	Fax Number:

SECTION IV: ELECTRONIC REMITTANCE ADVICE INFORMATION**PREFERENCE FOR AGGREGATION OF REMITTANCE DATA**

Provider Preference for grouping (bulking) claim payment remittance advice.

Provider Tax Identification Number (TIN): <i>Required if NPI is not applicable*</i>	National Provider Identifier (NPI): <i>Required if TIN is not applicable*</i>
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SECTION V: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name:*	Clearinghouse Contact Name:*
Telephone Number:	Email Address:

SECTION VI: SUBMISSION INFORMATION

Reason for Submission:*	Requested ERA Effective Date:
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment	

AUTHORIZED SIGNATURE

The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.

Written Signature of Person Submitting Enrollment:*
Printed Name of Person Submitting Enrollment:*
Printed Title of Person Submitting Enrollment:

Send the completed form to

Ohio Department of Medicaid
MCD-EDI Support
P.O. Box 182709
Columbus, Ohio 43218-2709

Or eMail: omesedisupport@medicaid.ohio.gov