

## South Carolina Medicaid 837- Prof Claims and 835- ERAs

### 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 14 days.
- South Carolina Medicaid requires a separate Trading Partner Agreement for each SC Medicaid Provider ID.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the EDI setup request. Or, the provider may contact the payer at (888) 289-0709.

### 837 and 835 Transactions:

Complete and submit this form using the billing provider's group information.

#### 1. SC Trading Partner Agreement/Remittance Advice Agreement (1 page)

Select the '**Reason for Submission**' by checking the box next to '**New Enrollment**' or '**Change Enrollment**.'

Complete the Provider Contact Information section.

Under the '**TPA Authorization Agreement**' section, the Provider or Authorized Individual must print name, dates, and 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.

# SC Trading Partner Agreement/Remittance Advice Enrollment

Fax to (803)870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Reason for Submission:  New Enrollment  Change Enrollment  Cancel Enrollment

## Trading Partner Information

Provider Name: \_\_\_\_\_

Doing Business As Name (DBA): \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code/Postal Code: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_ Provider Federal Tax Identification Number (TIN): \_\_\_\_\_

Trading Partner ID: \_\_\_\_\_ SC Medicaid Provider ID: \_\_\_\_\_

Type of Business:  Medicaid Provider  Billing Service  Clearinghouse  Software Vendor

Other (please specify): \_\_\_\_\_

## Provider Contact Information

Provider Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Telephone Number Extension: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Preference for Aggregation of Remittance Data (e.g., Account number linkage to provider identifier):  Provider Tax Identification Number (TIN): \_\_\_\_\_  
 National Provider Identifier (NPI): \_\_\_\_\_

## Claims Submission/Retrieval Information

Are you using a clearinghouse, billing agent, or vendor to submit your claims?  Yes  No

If Yes, please enter the name of the clearinghouse, billing agent, or vendor here: \_\_\_\_\_

If No, please indicate below which protocol(s) is/are used: (multiple selections are allowed)

Secure FTP  WS\_FTP Pro  CD  Diskette

South Carolina Medicaid Web-Based Claims Submission Tool (Select One)

Requesting Access: Number of IDs Requested \_\_\_\_\_  No Access Needed

Link to Existing IDs: \_\_\_\_\_

(If you submit X12 claims directly to SC Medicaid, you must complete the "linked" Submitter ID Information found on the second page of this application)

## Transactions Requested

Yes  No 270 – Eligibility IN  Yes  No 820 – Premium Payments  Yes  No 837P – Professional Claims  
 Yes  No 271 – Eligibility OUT  Yes  No 834 – Benefit Enrollment  Yes  No 837D – Dental Claims  
 Yes  No 276 – Claim Status IN  Yes  No 835 – Electronic Remittance Advice\*  
 Yes  No 277 – Claim Status OUT  Yes  No 837I – Institutional Claims

## TPA Authorization Agreement

I have read, understand, and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Authorized Signature: \_\_\_\_\_

Printed Name of Person Submitting Enrollment: \_\_\_\_\_

Submission Date: \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_

\*Please contact the Provider Service Center at 1-888-289-0709 for any questions regarding the electronic remittance advice enrollment process or the status of your enrollment.

\*Please refer to the "Your Remittance Advice" area in the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider Web Page for instructions on how to complete updates to your Electronic Remittance Advice.

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.