

Medicaid- Texas 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 this payer.
- Taxonomy Code and ZIP + 4 Code/Postal Code are required.
- 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.
- EDI enrollment processing timeframe is approximately 30 business days.
- To check status of ERA enrollment, please contact Medicaid TX at 1-888-863-3638.

835 Electronic Remittance Advice:

Electronic Remittance Advice (ERA) Agreement (3 pages)

Provider Information section, ENTER billing provider's zip code along with the 4-digit postal code.

Provider Identifiers Information section, ENTER billing provider's Tax ID #, NPI #, and Taxonomy Code.

Provider Contact Information section, COMPLETE all fields in this section.

Electronic Remittance Advice Information section, SELECT **TIN** or **NPI** based on your preference for aggregation. ENTER **TIN #** or **NPI #** based on what was selected above.

Reason for Submission section, CHOOSE '**New Enrollment**' if you have never received ERAs from this payer. CHOOSE '**Change Enrollment**' if you have received ERAs before.

Authorized Signature section, SIGN, ENTER Name, Title, Requested ERA Effective Date, and Submission Date.

NOTE: Medicaid TX completes ERA setup based on the NPI / Address / Taxonomy information on the request form. If the billing provider uses same NPI to bill for multiple address locations and/or taxonomies, a separate ERA Agreement must be submitted for each NPI /Address / Taxonomy combination.

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.

Electronic Remittance Advice (ERA) Agreement

Provider Information			
Provider Name *	Doing Business As Name (DBA)		
Provider Address <i>Street *</i>	<i>City *</i>	<i>State/Province *</i>	<i>ZIP + 4 Code/Postal Code *</i> <i>Country Code</i>

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *	National Provider Identifier (NPI) *
Billing Taxonomy Code *	Assigning Authority *
Trading Partner ID *	Provider Benefit Code (if applicable)
Provider License Number	License Issuer

Provider Contact Information		
Provider Contact Name	Title	
Telephone Number	Telephone Number Extension	Email Address
Fax Number		

* Required field

Electronic Remittance Advice (ERA) Agreement

Provider Agent Information					
Provider Agent Name					
Agent Address <i>Street</i>		<i>City</i>	<i>State/Province</i>	<i>ZIP Code/Postal Code</i>	<i>Country Code</i>
Provider Agent Contact Name			Title		
Telephone Number	Telephone Number Extension	Email Address			
Fax Number					

Federal Agency Information	
Federal Program Agency Name	
Federal Program Agency Identifier	Federal Agency Location Code

Retail Pharmacy Information	
Pharmacy Name	Chain Number
Parent Organization ID	Payment Center ID
NDCP Provider ID Number	Medicaid Provider Number

Electronic Remittance Advice Information
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): *
<input type="checkbox"/> Provider Tax Identification Number (TIN): _____ <input type="checkbox"/> National Provider Identifier (NPI): _____
Method of Retrieval

* Required field

Electronic Remittance Advice (ERA) Agreement

Electronic Remittance Advice Clearinghouse Information	
Clearinghouse Name	Clearinghouse Contact Name
Telephone Number	Email Address

Electronic Remittance Advice Vendor Information	
Vendor Name	Vendor Contact Name
Telephone Number	Email Address

Reason for Submission*
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment

Authorized Signature	
Written Signature of Person Submitting Enrollment *	
Printed Name of Person Submitting Enrollment *	Printed Title of Person Submitting Enrollment *
Requested ERA Effective Date *	Submission Date *

* Required field