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## Medicaid Vermont 837 and 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.
- Support Vendors may contact the EDInsight Enrollment Team to follow up on the ERA setup request or contact the payer directly at 802-879-4450.

### 837 Claims Transactions:

#### 1. Part 1a. Vermont Medicaid EDI Registration (2 pages)

Provider or Authorized Individual must sign where indicated on Page 2.

### 835 Electronic Remittance Advice:

#### 1. Gainwell 835 ERA Enrollment Form (1 page)

Complete the '**Provider Contact Information**' section.

In the '**Submission Information**' section, check the **New Enrollment** box if you have never received ERAs from this payer. If you have previously received ERAs, check **Change Enrollment**.

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

### 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.

**Part 1a.**

**Electronic Transactions**

Trading Partner Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Contact Name: \_\_\_\_\_

Primary Contact Phone: \_\_\_\_\_

**Part 1b.**

**Pre-Certification** (please check one)

- Using Provider Electronic Solutions Version 2.XX: Distributed by Gainwell
- Certified by Independent Agency: \_\_\_\_\_
- Translator Compliance Check: \_\_\_\_\_
- Utilizing a Certified Vendor/Clearinghouse: \_\_\_\_\_
- Other (describe): \_\_\_\_\_

Check here to authorize your Billing Service or Clearinghouse to see your weekly Remittance Advice.  
\_\_\_ Enter "R" if you wish to remove authorization.

**Transactions** (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> 837 Institutional Inpatient    | <input type="checkbox"/> **835 Remittance (ERA in X12N format) |
| <input type="checkbox"/> 837 Institutional Outpatient   | <input type="checkbox"/> 999 Functional Acknowledgement        |
| <input type="checkbox"/> 837 Institutional Nursing Home | <input type="checkbox"/> 276/277 Claim Status Inquiry/Response |
| <input type="checkbox"/> 837 Institutional Home Health  | <input type="checkbox"/> 270/271 Eligibility Request/Response  |
| <input type="checkbox"/> 837 Professional               | <input type="checkbox"/> Claim Accept/Reject Report            |
| <input type="checkbox"/> 837 Dental                     |  |

\*\* If you checked this box, it must be accompanied by the 835 Enrollment form.

<https://vtmedicaid.com/#/hipaaTools>

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**\*\*\*Gainwell Internal Use Only\*\*\***

Date: \_\_\_\_\_ Approved By: \_\_\_\_\_

Trading Partner ID: \_\_\_\_\_ Web Log-On: \_\_\_\_\_





## Vermont Medicaid 835 ERA Enrollment Form

### Provider Information (Completion Required)

Provider Name: \_\_\_\_\_ VT Medicaid ID: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 TIN/EIN: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Trading Partner ID: \_\_\_\_\_ Taxonomy Code: \_\_\_\_\_

### Contact Information (Completion Required)

Contact Name: \_\_\_\_\_  
 Telephone Number (w/ Ext): \_\_\_\_\_  
 Email Address: \_\_\_\_\_

### Billing Agent Information (If Applicable)

Name of Provider's Authorized Agent: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Provider Agent Contact Name: \_\_\_\_\_  
 Telephone Number (w/ Ext): \_\_\_\_\_  
 Email Address: \_\_\_\_\_

### Electronic Remittance Advice Clearinghouse Information (If Applicable)

Clearinghouse Name: \_\_\_\_\_

### Electronic Remittance Advice Vender Information (If Applicable)

Vendor Name: \_\_\_\_\_

### Submission Information (Completion Required)

Reason for Submission:  New Enrollment  Change Enrollment  Cancel Enrollment

### Signature

Authorized Signature: \_\_\_\_\_  
 Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

### Electronic Remittance Advice Information

- NPI is the sort field for the Vermont Medicaid 835
- Method of Retrieval: Download from the VT Medicaid Portal at <https://vtmedicaid.com/secure/logon.do>.

Return by E-mail [vtedicoordinator@gainwelltechnologies.com](mailto:vtedicoordinator@gainwelltechnologies.com) or;  
 Mail to Gainwell Technologies, Attn: EDI Coordinator, PO Box 888, Williston, VT 05495.