Electronic Remittance Advice (ERA) Authorization Agreement

The District of Columbia (DC) Medicaid offers providers claims payment information in an electronic format. The Electronic Remittance Advice (ERA), also known as the 835, is the HIPAA-required X12N transaction set. Medicaid Providers must submit this form prior to receiving the ERA either directly or through a billing service or clearinghouse. When enrolling, please complete a separate Electronic Remittance Advice (ERA) Authorization Agreement Form for each Billing Provider or Tax Identification Number.

In order to enroll, you must complete the following steps:

1. Establish a DC Medicaid Provider ID
2. Obtain a Trading Partner ID
   - If you plan to submit electronic transactions directly, complete a Trading Partner Agreement
   - If you are using a Software Vendor, Clearinghouse or Billing Agent, contact them for their Trading Partner ID

3. Complete the Electronic Remittance Advice (ERA) Authorization Agreement Form.

The completed Electronic Remittance Advice (ERA) Authorization Agreement should be sent directly to:

1. Complete the Supplier/Vendor Information form (new EFT/ACH applicants ONLY).
2. Attach a signed W-9 form (new Medicaid providers ONLY).
3. Complete the Electronic Remittance Advice (ERA) Authorization Agreement Form.

The completed Electronic Remittance Advice (ERA) Authorization Agreement should be sent directly to:

Conduent
Attn: Technical Support/Enrollment
PO Box 34734
Washington, DC 20043-4761
Fax Number: (202) 906-8399

Please allow 7 days to establish your electronic remittance advice account. To check the status of a new, changed or cancelled ERA enrollment, contact the EDI Support Team at 866-407-2005.

Complete **ALL** sections of the form. Required fields are indicated with an asterisk (*). Please review the Electronic Remittance Advice (ERA) Authorization Form Instructions for specific field direction prior to completing this form.

Section 1: PROVIDER SPECIFIC INFORMATION

CLASSIFICATION

***Classification:**

☐ **Individual Provider**	☐ **Group Provider Practice**	
☐ **Individual Pharmacy**	☐ **Branch Pharmacy**	☐ **Corporate Pharmacy**

***Submission Method/Type of Service Used:**

☐ **WINASAP5010** ☐ **Vendor Software** ☐ **Billing Agent** ☐ **Clearinghouse**

If Vendor Software is selected, in addition to completing Section 7, please provide the following:

Software Name:	**Software Version:**	**Protocol:**

Section 2: PROVIDER INFORMATION

*** Provider Name:**

Doing Business As Name (DBA):

PROVIDER ADDRESS

***Street:**

***City:**

***State/Province:**

***ZIP Code/Postal Code:**

Section 3: PROVIDER IDENTIFIERS INFORMATION

PROVIDER IDENTIFIERS

***Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):**

National Provider Identifier (NPI):

OTHER IDENTIFIER(S)

***Assigning Authority:**

Department of Health Care Finance

***Medicaid Provider ID:**

***Trading Partner ID:**

If you are currently submitting electronic transactions directly to Conduent EDI Solutions, please enter your Conduent EDI Solutions 5-digit Submitter ID or 6- digit Trading Partner ID.

If you are submitting electronic transactions through a Software Vendor, Clearinghouse or Billing Agent, please enter their 5-digit Submitter ID or 6- digit Trading Partner ID.

Section 4: PROVIDER CONTACT INFORMATION

***Provider Contact Name:**

***Telephone Number:**	**Telephone Number Extension:**

***Email Address:**

Section 5: ELECTRONIC REMITTANCE ADVICE INFORMATION

*Preference for Aggregation of Remittance Advice Date
Account Number Linkage To Provider Identifier (Select one)

Provider Tax Identification Number (TIN):

National Provider Identifier (NPI):

Method of Retrieval: *(required if not suing an intermediary Billing Agent, Clearinghouse or Software Vendor)*

☐ **EDIONLINE**	☐ **GrabIT**	☐ **WINASAP**	☐ **DC Web Portal**

Section 6: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

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

Section 7: ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

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

Section 8: SUBMISSION INFORMATION

*Reason for Submission:

☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment

AUTHORIZED SIGNATURE

I hereby declare that the information provided is true and accurate in all respects. I hereby appoint the Billing Agent/Clearinghouse identified above to agent as the authorized agent for the purposes of retrieving health care responses electronically from Conduent EDI Solutions. The Billing Agent/Clearing house is also authorized to access the X12N 835 Healthcare Claims Payment Advice.

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