NEW JERSEY MEDICAID MEDICAL

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**************ATTENTION**************

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THIS PAYER EDI AGREEMENT MUST BE PROCESSED THROUGH EMDEON'S PAYER ENROLLMENT DEPARTMENT.

THIS IS DUE TO PAYER SPECIFIC ENROLLMENT REQUIREMENTS. DO NOT SEND THIS PAYER EDI AGREEMENT DIRECT TO THE PAYER.

THIS APPLIES TO ALL PROVIDERS ENROLLING FOR EDI APPROVAL FOR ELECTRONIC CLAIM SUBMISSIONS TO THIS PAYER THROUGH EMDEON.

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NEW JERSEY MEDICAID MEDICAL

For Initial Enrollment with this payer:

- If you have NOT submitted claims electronically to this payer, the Payer requires Payer Registration forms. Please complete all fields on the following page(s) as well as the attached Payer Registration forms and return to Emdeon for processing.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies accepted.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site http://www.emdeon.com.or by calling our Fax on Demand service at 800-760-2804 (doc# 1084).

For Re-Enrollment (COS Change of Service) with this payer:

- If you have submitted claims electronically to this payer in the past, either directly or through another clearinghouse, and would like to submit through Emdeon, the Payer requires payer registration forms.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies accepted.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site http://www.emdeon.com.or by calling our Fax on Demand service at 800-760-2804 (doc# 1084).

If you are already APPROVED by this payer to submit through Emdeon:

- If you have already received an approval from this payer to submit claims electronically through Emdeon, you must notify Emdeon so that we may process your approval in our enrollment systems. Please submit a **Client Provided Approval Form** to Enrollment for processing.
  - You may obtain the form from our enrollment web site http://www.emdeon.com..or by calling our Fax on Demand service at 1-800-760-2804 (doc# 1450).
  - The Client Provided Approval form must be submitted to: payerregistration@emdeon.com or faxed to 615-885-3713.

Payer Registration Reminders:

- Please keep a copy of all forms for your records.
- Please verify that all pages in the agreement are included when mailing.
- Please ensure that all required fields are completed and legible.
- Please provide a physical address below in case we need to Fed-Ex your agreement back to you.
- Please remember to sign and date all documents. Your software vendor must be certified to send All-Payer claims to Emdeon. Please contact your vendor if you have questions regarding certification.
- To obtain forms or additional payer information, visit our website: http://www.emdeon.com.

NEW JERSEY MEDICAID MEDICAL

Instructions for submitting Payer Registration Forms:

- You must include this page when submitting Payer Registration forms to Emdeon
- Registration forms must be submitted to the address below
- To obtain forms or additional payer information, visit our website: http://www.emdeon.com.

This Registration form is for a: ☐ Provider ☐ Group			
Name*			
Physical Address*			
City, State, Zip*			
Contact Name*			
Contact Phone			
Contact Fax			
Contact Email Address §			
☐ NPI ID*		☐ Group ID* ☐ Provider ID*	
☐ Tax ID* ☐ SSN		Site ID*	
Vendor Submitter ID*		Division ID*	
Vendor Name*			
Additional Info			

* Required Information if applicable. § All Approval Notifications will be sent to this address

Submit Original Payer Registration forms that require original signatures to:

Emdeon Business Services
Attn: Enrollment Dept
Donelson Corporate Ctr Bldg 3
3055 Lebanon Pike Ste 2000
Nashville, TN 37214

Fax: (615) 231-4843
Email: batchenrollment@emdeon.com

To avoid claim rejection, please do not submit electronic claims before receiving Emdeon Approval Notification.

What is needed on the 837 ELECTRONIC CLAIMS INPUT FORM

Medicaid, Encounter or Charity Care. Choose one. Please check only ONE box that applies to the type of claims being submitted.

SECTION 1: Do not complete

SECTION 2: This is specifically **PROVIDER** Information.

This information should currently reside on the NJ Medicaid Provider file. If pertinent information is missing from either the form or the Provider file, the PROVIDER will be asked to update this information before the EDI AGREEMENT is completed.

What is this information used for? State personnel use this information to distribute to patients who are seeking specific services or geographical area. Unisys personnel cross-references information provided on the form to the current NJ Medicaid Provider file insuring information is correct and up-to-date. Therefore this should only be PROVIDER INFORMATION.

01) **MEDICAID PROVIDER NAME**: The name used by the provider to enroll in NJ Medicaid Program. If this information is not current, please contact Provider Enrollment at (609) 588-6036 to make corrections.

02) **MEDICAID PROVIDER NUMBER**: This is the GROUP BILLING NUMBER. In the case of individual practioners, the individual number is used for both the billing and servicing provider numbers.

03) **STREET ADDRESS**: This **MUST BE THE ACTUAL LOCATION SERVICES ARE RENDERED BY THE PROVIDER**. Once again, the State and Unisys personnel rely on current and up-to-date information to service the Medicaid patients. This address information is cross-referenced many ways. There are other addresses available on the NJ Medicaid Provider file to send mail, to send payments, multiple service addresses but this address MUST be where services are rendered. If information on the EDI AGREEMENT does not match, please contact Provider Enrollment at (609) 588-6036 and complete an address change request form which may be downloaded from our website at www.njmmis.com
http://www.njmmis.com/servlet/GetContentServlet?ID=000000000860
Any EDI Agreements received with a Post Office Box will be REJECTED & DISCARDED.

04) **CITY, STATE, ZIP CODE**: Once again, this must be the City, State and Zip Code where services are actually rendered. Please see item 03) above.

05) **EDI CONTACT PERSON**: To insure the State and Unisys has correct information, the name a person where services are rendered is acceptable. This is NOT for billing purposes. Should anyone have questions on the doctor’s certification, office hours, directions it is helpful to have a person’s name but this is not required.

06) **PHONE/EXT:** This is the phone number where SERVICES ARE RENDERED. This phone number is distributed to patients who require Medicaid services. This is the **OFFICE PHONE NUMBER**. This is **NOT** the billing agent’s, or the clearing house’s phone number,

07) **FAX NUMBER**: This is the FAX number where SERVICES ARE RENDERED. This FAX number is given out to patients who require Medicaid services. This is the OFFICE FAX NUMBER. This is NOT the billing agent’s, or the clearing house’s FAX number.

08) **E-MAIL**: This is the e-mail address of the doctor, or place of business where services are rendered. If there is no e-mail address, then please leave blank. This is NOT the billing agent's, or the clearing house's e-mail address.

09) **2nd EDI CONTACT PERSON**: Optional only if this person is located where services are rendered.

10) **PHONE/EXT:** Optional only if this phone number is located where services are rendered.

SECTION 3:

11) **PROVIDER'S SIGNATURE: THIS PERSON SHOULD HAVE LIABILITY AUTHORITY for services authorized by NJ Medicaid.** .

12) **DATE: Enter the date the form is being completed.**

13) **MEDICAID PROVIDER NUMBER**: This is the GROUP BILLING NUMBER. In the case of individual practioners, the individual number is used for both the billing and servicing provider numbers. This seven-digit number was assigned by NJ Medicaid

14) **BILLING AGENT'S SIGNATURE: THIS PERSON SHOULD HAVE LIABILITY AUTHORITY** who represents the commercial software services for submitting HIPAA 837 Electronic claims**.**

15) **DATE: Enter the date the form is being completed.**

16) **SUBMITTER ID**: If you currently have a submitter id, please enter the seven digit number here.

SECTION 4:

17) **TRANSACTION SETS:** Check all that apply assuming the HIPAA CERTIFICATION is attached.

18) **CERTIFICATION VENDOR NAME:**

19) **CERTIFICATION ATTACHED: Any vendor who is NOT listed on the NJ Medicaid Website (www.njmmis.com) as an approved vendor MUST attach a copy or HIPAA CERTIFICATION. CHECK ONLY ONE: YES OR NO**

20) **Requested Effective Date: Optional** NOTE: The system will be updated on the day it receives the request if left blank. If the date is in the future, Unisys will update the file on that day.

21) **Claims Input Media: Optional** NOTE: If Internet is checked and you later want to use BBS or vice versa, you may do so without contacting Unisys.

SECTION 5: SOFTWARE VENDOR: The software package used to enter data to submit claims electronically. Unisys utilizes this information when viewing claims. **i.e.** If several providers consistently have files reject or claims denying due to a programming error the software vendor is contacted directly for suggested updates**.**

In the event a third party vendor that is NOT the provider and NOT the BILLING AGENT is involved in the billing, a second sheet with the company's name and information may be added for supplemental information. Example: If the software package is called CLAIMS DATA and Private Company called FAST CLAIMS submits the information to the billing agent (listed in SECTION 6) a second sheet may be included with FAST CLAIMS information. Please list at the top of the page SUPPLEMENTAL with the following information**:**

22) **COMPANY NAME:** Actual Software Package Name. (In the event this is proprietary software, please indicate –in-house.)

23) **STREET ADDRESS:** Please provide us with a United Parcel Service (UPS) street of a physical location.

24) **CITY, STATE, ZIPCODE:** Please provide us with a United Parcel Service (UPS) city, state and zip code of a physical location.

25) **EDI CONTACT PERSON:** It is helpful to have either a person or a department that Unisys may call if questions arise**.**

26) **PHONE/EXT:** The first phone number should be someone who is in either programming or enrollment**.**

27) **FAX:** The FAX number where Unisys-EDI Unit may send pertinent information regarding problems. This number is only utilized by the EDI Unit.

28) **E-MAIL**: If printed clearly Unisys will send updates such as newsletters or changes to specifications to this e-mail address. A website address may be included here as an additional item.

29) **2ND EDI CONTACT PERSON:** In the event there is a special enrollment department, this person is contacted.

30) **PHONE/EXT:** The **second** phone number should be someone who is in the enrollment department**.**

SECTION 6: BILLING AGENT: A Billing Agent may be an individual or a clearinghouse that ultimately sends NJ MEDICAID claims directly to UNISYS for processing.

31) **COMPANY NAME: Company** who actually sends NJ MEDICAID claims to UNISYS for processing**.**

32) **STREET ADDRESS:** Please provide us with a United Parcel Service (UPS) street of a physical location.

33) **CITY, STATE, ZIPCODE:** Please provide us with a United Parcel Service (UPS) city, state and zip code of a physical location.

34) **EDI CONTACT PERSON:** It is helpful to have either a person or a department that Unisys may call if questions arise**.**

35) **PHONE/EXT:** The first phone number should be a person or department number who is directly responsible for files being sent to Unisys.

36) **FAX:** The FAX number where Unisys-EDI Unit may send pertinent information regarding problems.

37) **E-MAIL**: It is helpful to have either a person or a department that Unisys may contact for problems and/or rejection notices.

38) **2ND EDI CONTACT PERSON:** In the event there is a special enrollment department, this person is contacted.

39) **PHONE/EXT:** The **second** phone number should be someone who is in the enrollment department**.**

Medicaid HIPAA EDI Agreement

837 – ELECTRONIC CLAIMS INPUT

☒ MEDICAID ☐ ENCOUNTER ☐ CHARITY CARE

SECTION 1: FISCAL AGENT USE ONLY

PROVIDER #: ______________ SUBMITTER NAME: ______________________________ SUBMITTER #: ____________

AUTHORIZED BY: ________________________ DATE:_______________ **DOCTYPE: EMCAGREE**

SECTION 2: PROVIDER

01) Medicaid Provider Name: ______________________________________ 02) Medicaid Provider Number: _______________

03) Street Address: ____

04) City, State, Zip Code: ____

05) EDI Contact Person: ____ 06) Phone/Ext: (_____) ___________ / ________

07) Fax: (_____) ___________ 08) E-Mail: ____

09) 2nd EDI Contact Person: ________________________________ 10) Phone/Ext: (_____) ___________ / __________

SECTION 3: AGREEMENT

I certify that the information on these claims will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by these claims and the amounts charged will be in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under these claims has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both

I also certify that for each Medicaid service performed and claim submitted for payment, the patient certification will be on file at the provider's location.

11) ____________________________ (Provider's Signature)
12) ________________ (Date)
13) ____________________ (Medicaid Provider ID)

14) ____________________________ (Billing Agent's Signature)
15) ________________ (Date)
16) 9902201 (Submitter ID)

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

SECTION 4: HIPAA TRANSACTION SETS & CERTIFICATION

17) Transaction Sets:

Version 4010 Addenda**:**

☐ 004010X096A1 837 Institutional
☐ 004010X097A1 837 Dental
☒ 004010X098A1 837 Professional

NCPDP Pharmacy:

☐ Version 1.1 Batch
☐ Version 5.1 Point of Sale (POS)

18) Certification Vendor Name: ______________________________________ 19) Certification Attached: ☐ Yes ☐ No

20) Requested Effective Date: _______________________

21) Claims Input Media: ☒ Internet ☐ BBS via Modem ☐ CD-ROM ☐ Cartridge

837 – ELECTRONIC CLAIMS INPUT - continued

01) Medicaid Provider Name: ______________________ 02) Medicaid Provider Number: __________

SECTION 5: SOFTWARE VENDOR

22) Company Name: ______________________

23) Street Address: ______________________

24) City, State, Zip Code: ______________________

25) EDI Contact Person: ______________________ 26) Phone/Ext: (____) __________ / ________

27) Fax: (____) __________ 28) E-Mail: ______________________

29) 2nd EDI Contact Person: ______________________ 30) Phone/Ext: (____) __________ / ________

(Unisys would like to know the company name/author of the software you are using to submit claims to Unisys)

SECTION 6: BILLING AGENT

31) Submitter Name: Emdeon 32) Medicaid Submitter ID: 9902201

33) Street Address: 3055 Lebanon Rd., Bldg. III, Ste. 2000

34) City, State, Zip Code: Nashville, TN 37214

35) EDI Contact Person: Enrollment Help Desk 36) Phone/Ext: (800) 845-6592 / ________

37) Fax: (615) 231-4843 38) E-Mail: Payerregistration@emdeon.com

39) 2nd EDI Contact Person: ______________________ 40) Phone/Ext: (____) __________ / ________

41) 2nd EDI Contact Person E-Mail: ______________________

(This section should be completed if anyone but the provider is submitting claims to Unisys)

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****

Return the completed EDI Agreement to Unisys at the following address:

Via U.S. Mail
Provider Enrollment
Unisys
P.O. Box 4804
Trenton, New Jersey 08650 - 4804

Other Carriers
Provider Enrollment
Unisys
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

For detailed instructions on completing this agreement, please refer to the New Jersey Medicaid HIPAA Companion Guide – Section 2.