



220 Burnham Street • South Windsor CT 06074  
 Vox 888-255-7293 • Fax 860-289-0055

## COLORADO MEDICAID PROVIDER EDI UPDATE

<b>PAYER ID NUMBER</b>	<p style="text-align: center;"><b>CKCO1</b></p>
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>Emdeon Provider Enrollment Form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> <b>Provider EDI Update form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information</li> </ul>
<b>SPECIAL NOTES</b>	<ul style="list-style-type: none"> <li>▪ This EDI Update enrollment packet is to be used to submit changes to Provider/Submitter Demographics, Submission Methods, Contact Information, Transaction Submission and Report Retrieval.</li> <li>▪ <b>Providers who have never submitted an EDI enrollment request should complete the Emdeon Colorado Medicaid Electronic Claims Enrollment Registration packet.</b></li> </ul>
<b>SEND REGISTRATION FORMS TO:</b>	<p style="text-align: center;">PLEASE MAIL COMPLETED <b>ORIGINAL</b> EDI UPDATE          PACKET TO:</p> <p style="text-align: center;">Emdeon Business Services          Attn: Provider Registration          220 Burnham Street          South Windsor, CT 06074</p>
<b>ENROLLMENT CONFIRMATION</b>	<ul style="list-style-type: none"> <li>▪ Updates will be coordinated between Emdeon Business Services and ACS EDI Gateway.</li> <li>▪ Emdeon Business Services will notify the provider or their software vendor when approval confirmation is received.</li> </ul>



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<b>CHANGING ELECTRONIC BILLING AGENTS</b>	If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll for Electronic Claims Submission using this EDI Update Form.
<b>CONTACT PHONE NUMBERS</b>	Emdeon 888-255-7293 ACS EDI Gateway Support Unit 800-237-0757



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**PROVIDER EDI UPDATE FORM**

Print/Type the following:

Insurance Carrier: **COLORADO MEDICAID – payer ID CKCO1**

Provider/Organization Name: \_\_\_\_\_

Tax Identification or Social Security Number: \_\_\_\_\_  
*(This is the number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group Number: \_\_\_\_\_  
*(if applicable)*

Group NPI Number: \_\_\_\_\_  
*(if applicable)*

Name	Number	Rendering	NPI
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date: \_\_\_\_\_



# Colorado Medical Assistance Program

## Provider EDI Update Form

Provider Trading Partner ID: \_\_\_\_\_ Provider ID: \_\_\_\_\_

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

**Providers may change/update the following sections to make revisions to the Electronic Data Interchange (EDI) Provider Enrollment & Agreement**

**Section 1. I want to update the following information (Changes/ Updates will only be made to items that have been checked below):**

- Demographic/ Contact Information (Section 2)       Report Retrieval (Section 4)  
 Submission Method (Section 3)

### Section 2. Current Demographic Information:

Legal Name: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

### Contact Information

**Primary Contact Information:**  Add to existing contact information     Replace current primary contact information

Contact Individual Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**Secondary Contact Information:**  Add to existing contact information     Replace current secondary contact information

Contact Individual Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

*If any of the above is updated information, your information in the MMIS will not be effected. To update your provider information in the MMIS, you must either update your information through the Web Portal or complete and submit the Provider Enrollment Update Form located in the Provider Services Forms Section at:*

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550>.



# Colorado Medical Assistance Program

## Section 3. Submission method

### Sub-Section 3a. Submission method – Add

Complete this section if you are adding a Billing Agent, Clearinghouse, or Software Vendor.

**You must also complete and submit the Provider Authorization Form (page 4) if you are authorizing a Billing Agent or Clearinghouse.**

Please enter the name and Trading Partner ID of the Clearinghouse/Billing Agent/Software Vendor that will submit your electronic transactions.

1. Clearinghouse/Billing Agent/ Software Vendor Name: Claims Processing Service dba Emdeon
2. Clearinghouse/Billing Agent/ Software Vendor Trading Partner ID: 12203

### Sub-Section 3b. Submission method – Remove

Complete this section if you are terminating your affiliation with a Billing Agent, Clearinghouse, or Software Vendor.

**If you choose to remove your affiliation with a Clearinghouse, Billing Agent, or Software Vendor, you must update your report retrieval (section 4).**

1. Clearinghouse/Billing Agent Name: \_\_\_\_\_
2. Clearinghouse/Billing Agent Trading Partner ID: \_\_\_\_\_

## Section 4. Report Retrieval

Colorado Medical Assistance Program providers can receive X12N electronic reports. Enter only one Trading Partner ID (TP ID) per report. If you want to retrieve your own reports, please indicate your TP ID on the lines below:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> X12N 824 (Payer Specific Error Report) Will by default be returned to submitting TP ID | <input checked="" type="checkbox"/> X12N 997 (Acknowledgement of a sent transaction) Will by default be returned to submitting TP ID |
| <input checked="" type="checkbox"/> X12N 271 (Eligibility Response) Will by default be returned to submitting TP ID        | <input checked="" type="checkbox"/> X12N 277 (Claim Status Response) Will by default be returned to submitting TP ID                 |
| <input checked="" type="checkbox"/> Accept/Reject Report   |  |

Please select the report and enter the corresponding TP ID for each report retrieved through the Web Portal. Enter only one TP ID per report. You may enter a different TP ID for each selected report.

- |  | Receiving TP ID |   | Receiving TP ID |
|--|-----------------|---|-----------------|
| <input type="checkbox"/> X12N 820 (Client Capitation)                  | _____           | <input type="checkbox"/> X12N 835 (Claim payment/Claim report)                                  | _____           |
| <input type="checkbox"/> Accept/Reject Report                          | <u>12203</u>    | <input type="checkbox"/> Provider Claim Report (Previously called the Remittance Advice Report) | _____           |
| <input type="checkbox"/> X12N 834 (Benefit Enrollment and Maintenance) | _____           |   |                 |



# Colorado Medical Assistance Program

## Provider Authorization

This Authorization must be completed and signed by the provider who wishes to authorize a billing agent, clearinghouse or other provider to:

- Maintain and control designated reports
- Submit and/or retrieve designated transactions

The authorized billing agent, clearinghouse, or provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.

Provider, \_\_\_\_\_ hereby appoints  
Provider Name (please print)

Claims Processing Service dba Emdeon, 12203  
Billing Agent/Clearinghouse/Provider Name (please print) Billing Agent/Clearinghouse/Provider Trading Partner/Submitter ID

to act as an authorized agent for the purpose of submitting health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program.

Provider must check one box below:

Provider authorizes the listed agent to retrieve **some** or all electronic reports/responses on Provider's behalf.

OR

Provider does NOT authorize the listed agent to retrieve electronic reports/responses on Provider's behalf.

\_\_\_\_\_  
Provider/Provider Representative Name (please print)

**SIGN HERE**

\_\_\_\_\_  
Provider/Provider Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Number

**This Authorization may be modified or revoked at any time in writing. It is considered in effect until modified or revoked.**