



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

**FLORIDA MEDICAID
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKFL1				
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Business Services Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. <p>Electronic Data Interchange Agreement</p> <ul style="list-style-type: none"> • Please complete all requested information. 				
SEND REGISTRATION FORMS TO:	<p>Please MAIL completed ORIGINAL form to:</p> <p align="center">Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attention Provider Enrollment</p>				
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Emdeon Business Services and EDS. Emdeon Business Services will notify either the provider or their software vendor when approval has been received.				
CHANGING ELECTRONIC BILLING AGENTS	If the provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed in this document.				
CONTACT PHONE NUMBERS	<table> <tr> <td>EDS EDI Support</td> <td align="right">800-289-7799</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table>	EDS EDI Support	800-289-7799	Emdeon Business Services	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Florida Medicaid – payer ID CKFL1**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: _____

Group Number: _____
(if applicable)

Group NPI Number: _____

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

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____



0 1 2 1

Electronic Data Interchange Agreement

Medicaid Provider ID: _____ NPI: _____

Provider Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____ Contact Phone: () _____

Email: _____

The Medicaid provider listed above is a (check one): _____ Provider _____ Billing Agent/Clearinghouse

Section 1: Transaction Information

Complete this section to indicate how you plan to submit or receive electronic transactions.

- If you are currently submitting/receiving electronic transactions directly to/from Medicaid, indicate your current 5-digit or 6-digit Trading Partner ID.

- If you plan to use a software vendor to submit/receive electronic transactions to/from Medicaid, indicate the software vendor's Trading Partner ID.

NOTE: If you do not provide the software vendor's Trading Partner ID, you will be required to test.

N/A

- If you plan to use a billing agent/ clearinghouse to submit directly to/from Medicaid, indicate the billing agent/clearinghouse's Trading Partner ID.

NOTE: To designate a billing agent to submit claims on your behalf, complete Section 2.

12203

- Indicate the transaction types you plan to send/receive.

- | | |
|---|--|
| <input type="checkbox"/> 820 Premium Payment | <input type="checkbox"/> 837D Dental (Encounter) |
| <input type="checkbox"/> 837P Professional | <input type="checkbox"/> 835 Remittance Advice |
| <input type="checkbox"/> 837P Professional (Encounter) | <input type="checkbox"/> 834 Benefit Enrollment (Inbound/Outbound) |
| <input type="checkbox"/> 837I Institutional | <input type="checkbox"/> 270/271 Eligibility Request/Response |
| <input type="checkbox"/> 837I Institutional (Encounter) | <input type="checkbox"/> 276/277 Claim Status Request/Response |
| <input type="checkbox"/> 837D Dental | |

- Select the method of submission that you will use to transmit your transactions.

- | | |
|---|--|
| <input type="checkbox"/> Web Portal / Software Vendor | <input type="checkbox"/> Provider Electronic Solutions (PES)
(Replaces the Winasap2003) |
|---|--|

NOTE: **If you are using a Billing Agent/Clearinghouse, skip this section.**

If you select Provider Electronic Solutions (PES) to submit claims to Medicaid, please go to the website www.mymedicaid-florida.com for a free download of the software. Should you experience any problems, call the EDI Helpdesk at 1-800-289-7799, option 3.



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This section must be completed by any provider who wishes to designate or change a billing agent to submit claims for reimbursement by Florida Medicaid.

The following requirements apply to all billing agents/clearinghouses:

1. Any entity, that submits claims to Medicaid on behalf of an enrolled Medicaid provider must be enrolled in the Medicaid program as a billing agent with an active provider number.
2. Claims must be paid in the name of the provider or provider group that renders the services, not in the name of the billing agent.
3. Payment for billing services must be made based upon an administrative fee per claim. Billing agents are prohibited from charging for their services based upon a percentage of the total dollar value of claims billed.
4. If a claim is rejected as inaccurately filed, it cannot be resubmitted unless there has been a change made to the claim form or electronic submission itself.

"The following billing agent is authorized to submit claims to and follow up with Medicaid and the Medicaid fiscal agent on my behalf. I understand that all payments and payment information are in my name and that this agreement does not exempt me from responsibility for claims filed on my behalf or from established claim filing policies. I further understand that the billing agent must be held to the same requirements of confidentiality and access to records as I am, as reflected in my agreement with Medicaid. I will immediately notify the Medicaid fiscal agent of any change in this authorization."

Claims Processing Service

Billing Agent Name: dba Emdeon Business Services Billing Agent Provider Number: 990884600

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The provider identified on this Electronic Data Interchange Agreement understands and agrees to the following:

1. Payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws.
2. Providers must safeguard the Medicaid program against abuse in the use of electronic claims submission.
3. Providers must correctly enter the claims data, monitor the data and certify that the data entered is correct.
4. Providers must assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments by the Agency's fiscal agent that might result from carelessness or fraud.
5. Providers must have on file the applicable source data to substantiate the claim submitted to the Medicaid program.
6. Providers must allow the Agency or any of its designees and representatives of the office of the Auditor General or the Attorney General to review and copy all records, including source documents and data related to information entered through electronic claims submission.
7. Providers must abide by all Federal and State statutes, rules, regulations, and manuals governing the Florida Medicaid program.
8. Providers must sign and adhere to all conditions of the Medicaid Provider Agreement and be officially enrolled in the Medicaid program to participate in electronic claims submission.

Signature: _____ Date: _____



(Florida Medicaid Program – Do not write below this line)

Received	By:	Date:
FMMIS Updated	By:	Date: