

**NEW JERSEY MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKNJ1				
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Business Services Provider Enrollment form</p> <ul style="list-style-type: none"> Please complete all requested information <p>Medicaid HIPAA EDI Agreement</p> <ul style="list-style-type: none"> Section 2: Please complete all requested information. Section 3: Provider (or for a group practice authorized signer) must sign, date and supply Medicaid Provider ID. 				
SPECIAL NOTES	<ul style="list-style-type: none"> If you are enrolling as part of a <u>group facility</u>, please only supply the group information on your enrollment paperwork. As long as an individual provider number is associated with the group, the individual provider does not have to enroll to do ECS. <u>Only the group number must be enrolled.</u> NJ Medicaid requires <u>ORIGINAL</u> signature to be submitted. 				
SEND REGISTRATION FORMS TO:	<p>Please mail completed <u>ORIGINAL</u> forms to:</p> <p align="center">Emdeon Business Services Attn: Provider Registration 220 Burnham Street South Windsor, CT 06074</p>				
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Emdeon Business Services and Unisys. Once approval is received Emdeon will contact the provider or their software vendor.				
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 above.				
CONTACT PHONE NUMBERS	<table> <tr> <td>Unisys Customer Service</td> <td align="right">609-588-6036</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table>	Unisys Customer Service	609-588-6036	Emdeon Business Services	888-255-7293
Unisys Customer Service	609-588-6036				
Emdeon Business Services	888-255-7293				



PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **New Jersey Medicaid – payer ID CKNJ1**

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: _____
(if applicable)

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

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

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) _____  12) _____ 13) _____
(Provider's Signature) (Date) (Medicaid Provider ID)

14) _____ 15) _____ 16) _____ 9901493
(Billing Agent's Signature) (Date) (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: NCPDP Pharmacy:
 004010X096A1 004010X097A1 004010X098A1 Version 1.1 Batch
 837 Institutional 837 Dental 837 Professional Version 5.1 Point of Sale (POS)

18) Certification Vendor Name: _____ Claredi 19) Certification Attached: Yes No

20) Requested Effective Date: _____ 12-11-2003

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: _____

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: Claims Processing Service dba Emdeon Dental 32) Medicaid Submitter ID: 9901493

33) Street Address: 220 Burnham Street

34) City, State, Zip Code: South Windsor, CT 06078

35) EDI Contact Person: Dawn Bezio 36) Phone/Ext: (860) 289-6090 / _____

37) Fax: (860) 289-0055 38) E-Mail: _____

39) 2nd EDI Contact Person: Dawn L Vaughan 40) Phone/Ext: (860) 289-6090 / _____

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.