



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

Participation in Dental Electronic Remittance Advice (ERA) is limited to those provider's whose practice management software vendor is participating in ERA with Emdeon or to those provider's who have a Dental Provider Services (DPS) account. Please contact your software vendor to verify participation or register for a DPS account at www.emdeondental.com

COLORADO MEDICAID
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKCO1
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Dental Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information. Colorado Medical Assistance Program EDI Update Form <ul style="list-style-type: none"> • Please complete all requested information. Colorado Medical Assistance Program Provider Authorization Page <ul style="list-style-type: none"> • Please complete all requested information. • Original signature required. State of Colorado Authorization Agreement for Automatic Deposits (ACH Credits) <ul style="list-style-type: none"> • Please complete all requested information. • Please include a voided check or deposit slip • Original signature required.
SPECIAL NOTES	Paper Explanation of Payment information will cease to be mailed upon approval of this application. Providers must be currently enrolled with Colorado Medicaid to submit their Dental claims through Emdeon.
SEND REGISTRATION FORMS TO	Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment



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ENROLLMENT CONFIRMATION	ERA enrollments take approximately 2-4 weeks for completion. Once complete, Emdeon Dental will notify the provider or their software vendor to expect to begin receiving ERAs from Colorado Medicaid.				
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives ERAs through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.				
DISCONTINUING ERA	<p>Discontinuing ERA is a 2 step process.</p> <ol style="list-style-type: none"> 1. Deactivation <ol style="list-style-type: none"> a. Providers receiving ERAs via their Practice Management Software need to request deactivation from their software Vendors. Please call your PMS directly. b. Providers receiving their ERAs via an Emdeon DPS account need only ignore the ERA option when logging into the DPS. 2. Payer Un-enrollment <ol style="list-style-type: none"> a. Each payer has their own unique process to discontinue ERAs and return to paper Remittance Advice. Please follow the below steps for this payer. <p>Providers who wish to discontinue receiving ERAs need to complete a new Colorado Medicaid EDI Update form leaving the 835 check box blank. The form than needs to be mailed to Colorado Medicaid at the address indicated on the form.</p>				
CONTACT PHONE NUMBERS	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Colorado Medicaid EDI Help Desk</td> <td style="text-align: right;">800-237-0757 Option 4</td> </tr> <tr> <td>Emdeon Business Services Provider Enrollment</td> <td style="text-align: right;">888-255-7293</td> </tr> </table>	Colorado Medicaid EDI Help Desk	800-237-0757 Option 4	Emdeon Business Services Provider Enrollment	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Colorado Medicaid - ERA payer ID CKCO1**

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: _____

Email Address: _____

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/HCPFH/HCPFH/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) | <u>12203</u> |
| <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.

Agency ID UHA

State of Colorado
**AUTHORIZATION AGREEMENT
FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Check one:
New Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called the STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** _____

LEGAL NAME _____

DBA NAME _____

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER
(Corporation, partnership, trust, sole proprietor, etc.) _____ - _____ - _____

or

SOCIAL SECURITY NUMBER (Individual or sole proprietor) _____ - _____ - _____

ADDRESS _____

CITY, STATE, ZIP _____

DEPOSITORY NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

DEPOSITORY TRANSIT NUMBER _____

ACCOUNT NUMBER _____

TYPE OF ACCOUNT (CHECK ONE) CHECKING ATTACH VOIDED CHECK SAVINGS ATTACH DEPOSIT SLIP

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford the STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date _____ Phone number _____

Authorized Signature _____



Title _____

Authorized Signature _____

Title _____

For Fiscal Agent Use Only Initials: _____ Date: _____

Completion Instructions

Agency ID UHA

State of Colorado AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)

Check one:
New Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called the STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** Enter your 8 digit provider number
 LEGAL NAME Enter only the legal name assigned to the Federal EIN or SSN below
 DBA NAME Optional - you may enter the DBA or trade name for corporation, sole proprietor, etc.

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER

(Corporation, partnership, trust, sole proprietor, etc.)

or

SOCIAL SECURITY NUMBER (Individual or Sole Proprietor)

ADDRESS

CITY, STATE, ZIP

DEPOSITORY NAME

ADDRESS

CITY, STATE, ZIP

DEPOSITORY TRANSIT NUMBER

ACCOUNT NUMBER

Complete for corporations, partnerships, etc. Enter the EIN assigned to the legal name entered above.

Complete for individuals or sole proprietors. Enter the SSN assigned to the legal name entered above

Enter the mailing address for the legal name entered above

Enter the City, State and ZIP for the legal name entered above

Enter the name of the bank or financial institution where the funds will be transferred

Enter the address of the bank or financial institution

Enter the City, State and ZIP for the financial institution

Enter the 9 digit number from your deposit slip or voided check (see illustrations below) or contact your financial institution for information

Enter the account number where the funds will be deposited

Enter a check mark to identify the type of account where funds will be deposited

TYPE OF ACCOUNT (CHECK ONE) CHECKING *MUST ATTACH VOIDED CHECK* SAVINGS *MUST ATTACH DEPOSIT SLIP*

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford the STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date Enter the date the form is signed Phone number Enter your telephone number

Authorized Signature This must be the signature of the individual or sole proprietor if an SSN is used or the authorized representative of a corporation, partnership, etc.

Title Enter the title of the authorized representative for a corporation, partnership, etc.

Authorized Signature Optional - Add a second signature only if required by your organization

Title Enter the title of the second authorized representative for a corporation, partnership, etc.

ACCOUNT OWNER NAME
1234 Main Street
Anytown, CO 00000

Pay to the Order OF Check number \$
DOLLARS

ANYTOWN BANK
Anytown, CO 00000

For I: 123456789 12341234 1234

Transit and Account Number Illustrations

DEPOSIT TICKET
ACCOUNT OWNER NAME
1234 Main Street
Anytown, CO 00000

DATE 19

CASH		
C		
H		
E		
C		
K		
S		
TOTAL FROM OTHER SIDE		
TOTAL		

ANYTOWN BANK
Anytown, CO 00000

123456789 00 001 00 15

Please note: The completed EFT form must be submitted with a completed W-9.
Please allow 30 days to process your paperwork and establish your EFT.