



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

MARYLAND MEDICAID
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKMD1
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Dental Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. <p>Maryland Medical Care Programs Submitter Identification Form</p> <ul style="list-style-type: none"> • Please complete section 2 • Insert provider name, signature, telephone number and date. <p>Maryland Medical Care Programs Trading Partner Agreement</p> <ul style="list-style-type: none"> • Please complete all requested information.
SPECIAL NOTES	<p>Providers who wish to continue receiving paper Explanation Of Benefits (EOBs) must call Maryland Medicaid provider enrollment at 410-767-5340 to confirm mailing of EOBs. Currently the program is phasing out the EOBs unless they are contacted.</p>
SEND REGISTRATION FORMS TO	<p>Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment</p>
ENROLLMENT CONFIRMATION	<p>ERA enrollments take approximately 10-15 business days for completion. Once complete, Emdeon Dental will notify the provider or their software vendor to expect to begin receiving ERAs from Maryland Medicaid.</p>
CHANGING ELECTRONIC BILLING AGENTS	<p>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.</p>



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<p>DISCONTINUING ERA</p>	<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 contact Maryland Medicaid Provider Enrollment at 410-767-5340 requesting paper and then contact Emdeon Business Services Provider Enrollment at 888-255-7293 option 1.</p>				
<p>CONTACT PHONE NUMBERS</p>	<table> <tr> <td>Maryland Medicaid Provider Enrollment</td> <td>410-767-5340</td> </tr> <tr> <td>Emdeon Business Services Provider Enrollment</td> <td>888-255-7293</td> </tr> </table>	Maryland Medicaid Provider Enrollment	410-767-5340	Emdeon Business Services Provider Enrollment	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Maryland Medicaid - ERA payer ID CKMD1**

Provider/Organization Name: _____

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

Software Vendor: _____

Billing NPI Number: _____

Group Number: _____
(If applicable)

Name	Rendering Provider Number	NPI
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Date: _____

**MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM**

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

1. This is a Select Media if New Application:
 New Application Electronic Transfer & Paper Voucher
 Change of Submitter Agent Paper Voucher Only
 Submitter Identification Form Update

2. Provider Information

a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	

3. Electronic Submitter Information

a) Submitter Name:	CPS / WebMD Dental dba Emdeon Business Services
b) Submitter Address:	220 Burnham Street, South Windsor, CT 06074
c) Submitter ID(ISA Qualifier and ISA ID):	EC0496

4. EDI Information

Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	004010X092A1
	276/277 Claim Status & Response	004010X093A1
	837 Health Care Claim Institutional	004010X096A1
	837 Health Care Claim Professional	004010X098A1
	837 Health Care Claim Dental	004010X097A1
	820 Premium Payment	004010X061A1
	835 Health Care Claim Payment/Advice 835 GS Receiver ID EC0496 (Required, if Checked) Receiver EDI Information (Required if different from above listed Submitter ID or if you are a Pharmacy Provider or Business Associate requesting an 835): Receiver Name: Receiver Address: ISA Qualifier and ISA ID:	004010X091A1

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM

The provider, _____ hereby authorizes

PROVIDER NAME

CPS / WebMD Dental dba Emdeon Business Services, hereafter

SUBMITTER AGENT

referred to as Submitter Agent, to transmit our Medicaid claims to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the Submitter Agent the return computer file electronic vouchers of all claims data processed, indicating paid, rejected, denied and pended claims (with error codes). The Submitter Agent agrees to protect the confidentiality of this data as required by law.



Signature of Provider

Signature of Submitter Agent

Print Name of Signature

Dawn L Vaughan

Print Name of Signature

Telephone Number

Date

860-289-6090

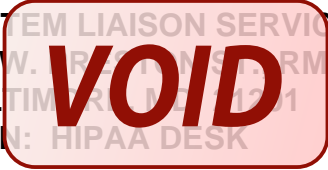
Telephone Number

Date

Note: This form requires completion of all requested information and original signatures to be processed.

MAIL TO:

SYSTEM LIAISON SERVICES
201 W. ... RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK



For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____

TRADING PARTNER AGREEMENT

This Agreement is by and between the Medical Care Program (Medicaid) and

PROVIDER NAME

PROVIDER ADDRESS

_____, hereafter known as the Provider.
CITY, STATE & ZIP CODE

[If applicable] the Provider and Program hereby agree that the Provider may use a certified claims clearinghouse (billing service),

CPS / WebMD Dental dba Emdeon Business Services 220 Burnham Street

BILLING SERVICE NAME

BILLING SERVICE ADDRESS

South Windsor, CT 06074
_____, hereafter known as Billing Service, to
CITY, STATE & ZIP CODE

transmit HIPAA transactions arising from the Provider's treating of Program recipients.

1. Purpose of Agreement- This agreement is intended to facilitate communications between the Program and the Provider in the processing by the Program of electronic transactions filed by or on behalf of the Provider.
2. Provider Submission of transactions- The Provider shall submit all data transmissions pursuant to Program standards. The Provider hereby warrants that all data will be submitted in compliance with the Program's regulations, transmittals, and any provider manual(s) specific to the provider. The Program reserves the right to modify its regulations, transmittals and other manuals at any time and to notify Provider of those changes by electronic communication. The Program reserves the right to reject any transaction which does not conform to its data submission standards.
3. Program Acceptance of Electronic Transactions- The Program agrees to accept valid transactions submitted by the Provider or the billing service agent.
4. Cooperation with Testing- During the testing phase, as designated by the Program, both Program and Provider agree to cooperate with each other, and with entities performing business associate type functions for the contracting parties, for the purpose of striving for accuracy, timeliness, security and completeness of data transmissions.
5. Use of Standard Transactions and Code Set Format- HIPAA regulations, at 45 CFR Part 162 HIPAA Federal Electronic Transactions and Code Sets for Data Exchange, provide for certain transaction standards for transfer of data between trading partners. The Provider must submit and the Program will be prepared to accept, translate, or route HIPAA compliant transactions. As HHS modifies the

standards, the trading partners agree to incorporate by reference any modifications or changes to 45 CFR Part 162.

6. Prohibited Acts- 45CFR § 162.915 specifies that trading partners will not enter into an agreement that would: “change the definition, data condition or use of a data element or segment in a standard; add any data elements or segments to the maximum defined set; use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specifications(s); or change the meaning or intent of the standard’s implementations specification(s)”.
7. Expenses- Each party shall bear its own expenses in implementing this process of transmitting information via this agreement.
8. Confidentiality and Security- Each party shall comply with all HIPAA and State Security and Confidentiality requirements in the handling of protected health information and take reasonable precautions to prevent unauthorized access to any part of the transaction process. In the event that data is improperly sent or received under this agreement, such data shall be highlighted and disposed of or returned in an appropriate manner.
9. Provider Identifiers- The parties shall agree on a unique identifier to be used by Provider. Provider is responsible for disclosing the unique identifier to its agents and only as is prudent to maintain appropriate security for the identifier.
10. This Trading Partner Agreement may be terminated by the Medical Care Program at any time.

All other agreements between the Program and Provider remain in full force and effect.

AGREED:

PROVIDER NAME: _____

PROVIDER NUMBER: _____



AUTHORIZED SIGNATURE

DATE: _____

RETURN VIA MAIL:

Rita Tate
201 W. Preston St., L3
Baltimore, MD 21201
ATTN: HIPAA Billing Agreements

