



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

MONTANA MEDICAID
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKMT1
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Dental Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. <p>Montana DPHHS EDI Submitter Enrollment Form</p> <ul style="list-style-type: none"> • Please complete section A: Provider Information • Please complete section B: Authorization Signature
SPECIAL NOTES	Montana Medicaid will discontinue sending paper remittance advice statement approximately 2 weeks after approving ERAs.
SEND REGISTRATION FORMS TO	<p>Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055</p>
ENROLLMENT CONFIRMATION	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 Montana 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.



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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>If a provider wishes to discontinue receiving ERAs from Montana Medicaid he needs to mail his request to:</p> <p style="text-align: center;">DPHHS PO Box 202951 Helena, MT 59620-2951</p>				
<p>CONTACT PHONE NUMBERS</p>	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">ACS EDI</td> <td style="border: none; text-align: right;">800-987-6719</td> </tr> <tr> <td style="border: none;">Emdeon Business Services Provider Enrollment</td> <td style="border: none; text-align: right;">888-255-7293</td> </tr> </table>	ACS EDI	800-987-6719	Emdeon Business Services Provider Enrollment	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Montana Medicaid - ERA payer ID CKMT1**

Provider/Organization Name: _____

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

Software Vendor: _____

Billing NPI Number: _____

Billing Taxonomy Code: _____
(If applicable)

Name	Rendering Taxonomy Code	NPI
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Date: _____

MONTANA DPHHS EDI SUBMITTER ENROLLMENT FORM

Please return to:
ACS-Inc
ATTN: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402



Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc Authorization Form

Section A. Provider Information.	
<i>Business Name</i>	
<i>Provider Name (Last, First, MI and Suffix)</i>	
<i>Provider Number</i>	<i>Federal Tax ID Number</i>
<i>Business Address</i>	
<i>City, State, and Zip</i>	
<i>Telephone Number</i>	<i>Fax Number</i>
<i>Contact Name</i>	<i>E-mail Address</i>

Section B. Authorization Signature (required).

Provider, _____ hereby appoints

Provider name /Provider Representative name (please print)

CLAIMS PROCESSING SERVICE, INC dba EMDEON BUSINESS SERVICES - DENTAL 12203-ACS / 7770309-MT Medicaid

Billing Agent/Clearinghouse name (please print)

Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 277-Claims Status Response
- 271-Eligibility Response
- 824-Error Report
- 835-Healthcare Claims Payment Advice
- 278-Prior Authorization Response
- 997 Functional Acknowledgement
- Exception Report

Provider/Provider Representative name (Please print)



Provider/Provider Representative Signature

Date