



emdeon®

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

PAYER ID NUMBER	CKNJ1
SPECIAL NOTES	<p>If you are enrolling as part of a group facility, 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. Only the group number must be enrolled.</p> <p>NJ Medicaid requires ORIGINAL signature to be submitted</p> <p>Effective 1-1-12 all providers will be required to enroll in automatic direct deposit and will no longer be able to receive hardcopy checks. Please see the November 2011 Newsletter following these instruction pages.</p>
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Provider Enrollment Form</p> <ul style="list-style-type: none">• Please complete all requested information. <p>Submitter/Provider Relationship EDI Agreement</p> <ul style="list-style-type: none">• Please complete all requested information.
SEND REGISTRATION FORMS TO	<p>Emdeon 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment</p>
ENROLLMENT CONFIRMATION	<p>Emdeon will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete.</p>
CHANGING ELECTRONIC BILLING AGENTS	<p>If the Provider currently submits claims through another Billing Agent other than Emdeon Dental each Provider must re-enroll following the procedures listed above.</p>
CONTACT PHONE NUMBERS	<p>Molina Customer Service 609-588-6036 Emdeon Dental 888-255-7293</p>



Published by the
N.J. Dept. of Human Services,
Div. of Medical Assistance & Health Services
& the N.J. Dept. of Health & Senior Services

NEWSLETTER

Volume 21 No. 25

November 2011

TO: All Providers

SUBJECT: **New Provider Policies and Requirements - Immediate Action Required**

EFFECTIVE: **January 1, 2012**

Purpose: To notify all providers that the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) and the Department of Health and Senior Services (DHSS) have instructed Molina Medicaid Solutions to implement three important initiatives that will improve and expedite the distribution of Medicaid payments and information to all New Jersey Medicaid providers.

- 1) All providers will be required to enroll in automatic direct deposit and will no longer be able to receive hardcopy checks.
- 2) The production and mailing of the paper remittance advice (RA) statements will be discontinued.
- 3) Individual claims will be required to be submitted electronically, through the submission of a HIPAA transaction or data entered by the provider through the New Jersey Medicaid website, www.njmms.com.

As part of the overall State of New Jersey Go Green Program, DMAHS and DHSS intend to achieve a significant reduction in the amount of paper which had previously been utilized in these past processes.

The regulations that dictate these policies have undergone a thorough review and approval process.

Details follow on each of these soon to be implemented initiatives/requirements:

- 1) All providers will be required to enroll in automatic direct deposit and will no longer be able to receive hardcopy checks. Use of direct deposit is mandatory.**

Background: The New Jersey Division of Medical Assistance and Health Services (DMAHS) in conjunction with Molina, the New Jersey Medicaid fiscal agent, has been making an effort to go green and reduce the use of paper. Over the last few years, efforts have been made to encourage provider's to enroll in Automatic Direct Deposit rather than receiving hard copy checks.

Action: In support of this effort, DMAHS is requiring all new providers applying for enrollment in the NJ FamilyCare/Medicaid Fee-for Service (FFS) programs to sign up for Automatic Direct Deposit. In addition, all existing NJ FamilyCare/Medicaid

Fee-for-Service (FFS) providers are required to enroll in Automatic Direct Deposit by **December 1, 2011**. This will allow time for the processing of the application and the pre-notification steps. Providers should expect to receive hard copy checks while their direct deposit information is being processed which may take up to 4 weeks from receipt of the application.

The Authorization Agreement for Automatic Payments/Deposit form can be obtained online at www.njmmis.com or by contacting Molina Provider Enrollment at 609-588-6036.

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2) The production and mailing of the weekly paper remittance advice (RA) statements will be discontinued.

Background: Currently, many providers (Fee-for-Service, Managed Care and Charity Care) are mailed a paper RA statement which details the status of each claim, associated NJMMIS edit codes and all relevant financial transactions. The secure area of the www.njmmis.com website was made available as an alternative source for the retrieval of the RA statements, and many providers who are registered users routinely download these statements to their own computer systems; the twelve most recent remittance statements have been available on the website. In addition to the ability to retrieve online RA statements, registered users of the secure website have access to other functions, including the download of the HIPAA 835 electronic remit statement and access to the electronic Medicaid Eligibility Verification System (eMEVS), which is a web-enabled information source to verify beneficiary eligibility and associated program enrollment data.

Action: Hardcopy RAs will no longer be distributed and must be accessed via the website; the twelve most recent remittance statements are available on the website. All active billing providers have previously been sent their Username and Password via certified mail. For providers who have never logged on or cannot locate this previous correspondence, access to the secure area of the website must be requested by selecting the Contact Webmaster link on the public www.njmmis.com website. Please reference your Medicaid ID number in the message area. This email sent to the webmaster will result in a new username and password being generated and sent to the provider.

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3) Individual claims will be required to be submitted electronically or directly through the New Jersey Medicaid website, www.njmmis.com.

Background: In September, 2010, in addition to accepting electronically submitted claims via a HIPAA transaction, DMAHS, in conjunction with its fiscal agent, began to accept individual original claims directly through the New Jersey Medicaid website, www.njmmis.com. **(See Newsletter Vol. 20 No. 17 for specific details regarding Claim Submission Process via Direct Data Entry on the website.)** This claim submission process allows providers to enter claim specific data utilizing electronic versions of the paper claim forms. The process supports claims that did not require

attachments or supporting documentation. Medicare Crossover claims that have been previously paid by Medicare are able to be submitted through this function without the

need for Medicare's Explanation of Medicare Benefits (EOMB). Third Party Liability (TPL) claims that have been paid by the TPL vendor can also be submitted through this process without the carrier's Explanation of Benefits (EOB). However, if Medicare or the TPL carrier denied the claim you are still required to submit the claim hardcopy with the appropriate carrier's EOB attached.

Note that the ability to submit long term care crossover claims via the web will be implemented later in 2012 and that, until that capability is implemented, providers will continue to be required to submit their long term care crossover claims on paper.

Action: New Jersey Medicaid claims now must be submitted electronically, either through the submission of a HIPAA transaction or directly via the www.njmmis.com website unless an attachment is required (as outlined above). In addition, voids and adjustments must now be completed either through a HIPAA transaction or directly through the www.njmmis.com website—paper adjusts/voids will no longer be accepted. (A Newsletter providing additional detailed information on the submission of electronic adjustments and voids will be issued in the near future).

Charity Care original claims must continue to be submitted through a HIPAA transaction; however Charity Care voids or adjustments can be submitted either through a HIPAA transaction or through direct data entry via the www.njmmis.com website—Charity Care original claims cannot directly be submitted through the website.

Information on completing the electronic version of the claim forms can be found in the Fiscal Agent Billing Supplements. They can be accessed at www.njmmis.com by clicking on "Billing Supplements" on the left navigator bar and then selecting the applicable provider type from the drop down menu. Additional information is also available in Newsletter Volume 20, No. 17 dated September, 2010. All Newsletters can be accessed by clicking on the link "Newsletters and Alerts" on the left navigator bar on the website homepage.

For more detailed information regarding electronic claim submission via a HIPAA transaction, contact Molina Electronic Data Interchange Unit at (609) 588-6051.

The Molina Medicaid Solutions Provider Services Training Unit can provide comprehensive training to the provider community on each of these initiatives. (Direct Data Entry training documentation is available on the NJMMIS website.)

To request training, contact the Molina Medicaid Solutions Provider Services Call Center at 1-800-776-6334.

If you have any questions regarding any of the initiatives covered in this newsletter please contact Molina Provider Services at 1-800-776-6334.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE



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: _____

For Internal Use Only EMCAGREE			
DOCTYPE	Submitter ID	Submitter & Provider Name	
Update Initials	Date	QA Initials/Date	Provider Group Number

- 837-I-D-P
- E-RA
- SIGN
- ADD
- TERM



Submitter/Provider Relationship EDI Agreement

- MEDICAID
 CHARITY CARE

SECTION 1: SUBMITTER INFORMATION

Every EDI submitter assigned a Submitter ID by New Jersey Medicaid must complete, sign and submit this New Jersey Medicaid Submitter/Provider Relationship Agreement before the submitter is authorized to submit claims for a New Jersey Medicaid Provider.

In some cases the submitter may be a New Jersey Medicaid provider and in other cases the submitter may be a third party Clearing House/Billing Service. Regardless, New Jersey Medicaid cannot process claims submitted with a specific Submitter ID for a specific New Jersey Medicaid provider number unless this agreement has been properly completed and submitted to New Jersey Medicaid or their designated agent. By signing this agreement the New Jersey Medicaid provider is authorizing the submitter to submit claims electronically to New Jersey Medicaid on their behalf.

A separate agreement is required for each New Jersey Medicaid Billing Provider Number.

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.

1) Submitter Name: _____ 2) Submitter ID: _____

3) Submitter Street Address: _____
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the submitter.)

4) City, State, Zip Code: _____

5) Submitter Representative's Signature _____ 6) Date Signed _____

7) Submitter Representative's Name – Please Print Clearly _____

8) Submitter Representative Telephone Number/Ext: (____) _____ / _____ 9) Fax: (____) _____

10) Submitter Representative E-mail Address: _____

11) 2nd Submitter Contact Person: Dawn Bezio 12) Phone/Ext (888) 255-7293

13) 2nd Submitter Contact Person E-mail Address: dentaloperations@emdeon.com

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".



Provider Name: _____ Provider #: _____

SECTION 2: PROVIDER INFORMATION

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.

14) Action Requested: Add New Provider Terminate Existing Provider

15) Provider Name: _____

16) New Jersey Medicaid Provider Number: _____

17) Provider NPI Number: _____

18) Provider Street Address: _____
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the submitter.)

19) City, State, Zip Code: _____

20) Provider EDI Contact Person: _____ 21) Phone/Ext:(_____) _____ /

22) Fax: (_____) _____ 23) E-mail Address: _____

24) Provider Representative's Signature _____

25) Date Signed _____

26) Provider Representative's Name – Please Print Clearly _____

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 3: PROVIDER SOFTWARE VENDOR INFORMATION

This section is to identify the third party software vendor practice management system that the provider is using to exchange information with their third party billing service. This section may also be repeated if a secondary billing service is being used in addition to a clearing house.

27) SOFTWARE VENDOR NAME: _____

28) STREET ADDRESS: _____
(PO Boxes not accepted. Agreement will be rejected and returned if PO Box listed. This must be the physical street address of the software vendor.)

Provider Name: _____ Provider #: _____

29) CITY, STATE, ZIP CODE: _____

30) SOFTWARE CONTACT PERSON: _____ 31) PHONE/EXT: (____) ____ / _____

32) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

33) 2nd SOFTWARE CONTACT PERSON: _____ 34) PHONE/EXT:(____) ____ / _____

35) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

36) FAX: (____) _____

37) SOFTWARE PRODUCT NAME: _____

38) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: _____

39) SOFTWARE PRODUCT RELEASE DATE: _____

***** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. *****
