ABILITY®

ALABAMA MEDICAID ERA CONTRACT INSTRUCTIONS (SKAL0)

Submit the completed form to:
ABILITY Network, ATTN: Enrollment
FAX: 888.837.2232 | EMAIL: setup@abilitynetwork.com

INSTRUCTIONS

- DO NOT SUBMIT THE FORM DIRECTLY TO THE PAYER.
- Complete the payer agreement with billing provider information as listed on file with the payer. If you're unsure what information to use when completing this form, please contact the payer – ABILITY Network is unable to obtain this information for you.
- Complete and return the Contract Setup Form with your agreement.
- Print these instructions for easy reference during the registration process.
- ELECTRONIC REMITTANCE ADVICE (RA) AGREEMENT
  - Complete the billing NPI number and billing provider name
  - Complete the provider address as listed on file with Medicaid
  - Complete the provider office contact information
  - **Do not alter the pre-filled Trading Partner information**
  - Complete the date, Email address, and title of the person authorized to sign this form
  - **AFTER PRINTING, obtain the signature of the representative authorized to sign this form**
  - **DO NOT COMPLETE THE SECTION LABELED "FOR EDS USE ONLY"**

ELECTRONIC REMITTANCE ADVICE (RA) AGREEMENT

GROUP/BILLING NPI NUMBER: ____________________

GROUP/BILLING NAME: ____________________

ADDRESS: ____________________

CITY: __________ **STATE:** __________ **ZIP:** __________

CONTACT: __________ **PHONE NUMBER:** __________

TRADING PARTNER ID: 300002402

VENDOR NAME: MEDICAL CLAIM CORP

ADDRESS: 88 VALLEY STREET

CITY: BRISTOL **STATE:** CT **ZIP:** 06010

VENDOR PHONE NUMBER: 888-499-5465

VENDOR CONTACT: ENROLLMENT

I (we) request to receive Remittance Advice (RA) information and authorize the information to be deposited in our electronic mailbox. I (we) accept financial responsibility for costs associated with receipt of Electronic RA information.

I (we) understand that paper-formatted RA information will continue to be sent to my (our) mailing address as maintained at EDS until I (we) submit an Electronic RA Certification Request Form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature: ____________________ **Date:** __________

Title: ____________________ **Internet Address:** __________

Mail form to: EDS • Attn: EDI Department • P.O. Box 244035 • Montgomery, AL 36124
FAX form to: 334-215-4272 Attn: EDI Department

FOR EDS USE ONLY

BILLING MODE: __________ **RA MODE:** __________ **PROTOCOL:**

CONTACT DATE: __________ **SOFTWARE MAILED:**

TEST DATE: __________ **AGREEMENT DATE:** __________ **APPROVAL DATE:**

BEGIN DATE: __________ **END DATE:** __________

NOTES: ____________________