Medicaid Maryland EDI ERA Enrollment

Submit the completed Payer Request Form to:
Inovalon Enrollment
enrollmentsupport@inovalon.com

INSTRUCTIONS

- Complete all sections of the **Payer Request Form**
- Complete this form using group or individual provider information as listed on file with the payer you wish to set up

Note: Some payers require additional documentation to be completed and signed by the provider in order to complete enrollment. If additional forms are required, the required forms will be sent to you for completion.

IMPORTANT: You must specify the payer(s) with which you wish to enroll. If no payers are specified, enrollment forms WILL BE RETURNED.

If you have more than ten payers to enroll, please make additional copies of this form.

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Inovalon Enrollment
enrollmentsupport@inovalon.com

INSTRUCTIONS

Complete one form per TAX ID.

PROVIDER BILLING INFORMATION

Please type your responses directly into the form.

Please check: ☐ New Request ☐ Change Request

Billing Service Name (if applicable)

TIN or INOVALON ID:

Contact Name:

Phone: ( ) Fax: ( ) Email:

Group/Provider Name:

Please check for designation: ☐ Professional ☐ Institutional

Billing Tax ID: Indicate ☐ TIN/EIN ☐ SSN Billing NPI:

Street Address:

City: State: Zip:

Name of Authorized Signee:

Title of Authorized Signee:

PAYER INFORMATION

List payers with which you wish to enroll below. Please refer to the Inovalon Payer List for enrollment requirements. Check the transaction(s) you want to enroll for each payer.

Payer ID	Payer Name	PTAN, Medicaid ID or Provider ID	Claims	ERA

Inovalon Enrollment
enrollmentsupport@inovalon.com

INSTRUCTIONS

- Do not submit your forms directly to the payer. Submit your forms to INOVALON only. An INOVALON representative must sign these forms before sending to the payer.
- Keep these instructions for reference as you complete the registration process.
- Please type provider information on the form for ease of processing at INOVALON.
- This payer does not accept faxed copies of this form – **EMAIL signed originals to INOVALON at enrollmentsupport@inovalon.com. An INOVALON representative signature is required on this form –do not mail directly to Medicaid.**
- The provider signature should be on the left-hand side of the page ONLY. Do not sign the form on the right-hand side of the page.
- Complete this form with provider information on file with Medicaid. If you are unsure of this information, contact Medicaid – INOVALON cannot obtain this information for you.
- MARYLAND MEDICAL CARE PROGRAMS SUBMITTER IDENTIFICATION FORM
- Page 1:
  - Section 1: This is a:
    - If this is your first time submitting claims electronically to Medicaid select: New Application
    - If you are changing to INOVALON from another submitter, select Change of Submitter Agent
  - Select Media if New Application:
    - Choose Electronic Transfer & Paper Voucher or Paper Voucher Only per your preference, contact Medicaid for more information.
  - Section 2: Provider Information:
    - Complete:
      - Provider Name
      - Provider Address
      - 9-Digit Provider Number (this is NOT your Tax ID number)
      - 10-Digit Billing Provider NPI

- If you do not know the provider information Medicaid has on file, please contact Medicaid. INOVALON cannot obtain this information for you.
- Do not alter the pre-filled submitter information in Section 3.

- Section 4: EDI Information:
  - 837 Health Care Claim has been chosen for you.

    Optional: Choose 835 Health Care Claim Payment/Advice if you want to receive ERA from INOVALON.

- Page 2:
  - Complete the Provider Name as entered on Page 1.
  - On the left-hand side of this form:
    - Complete the name of the person authorized to sign this form.
    - Complete the telephone number of the provider's office and date the form.

- Print the form. **Sign above the printed name on the left side only.**

- **Do not print or sign on the right-hand side of the form.**

Internal Use Only:

Email signed forms to mdh.hipaaeditest@maryland.gov.

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM
For Version 005010 HIPAA Transaction Set

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
   [ ] New Application
   [ ] Change of Submitter Agent
   [ ] Submitter Identification Form Update

Select Media if New Application:
[ ] Electronic Transfer & Paper Voucher
[ ] Paper Voucher Only

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:	Medical Claim Corp
b) Submitter Address:	88 Valley St Bristol, CT 06010
c) Submitter ID(ISA Qualifier and ISA ID):	061306714

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	005010X279A1
	276/277 Claim Status & Response	005010X212
	837 Health Care Claim Institutional / 277CA Claim Acknowledgment	005010X223A2 / 005010X214X
X	837 Health Care Claim Professional / 277CA Claim Acknowledgment	005010X222A1 / 005010X214X
	837 Health Care Claim Dental / 277CA Claim Acknowledgment	005010X224A2 / 005010X214X
	820 Premium Payment	005010X218
	835 Health Care Claim Payment/Advice **835 GS Receiver ID** 061306714 (**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**:**	005010X221A1

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM
For Version 005010 HIPAA Transaction Set

The provider, _____ hereby authorizes
PROVIDER NAME
MEDICAL CLAIM CORP, hereafter
SUBMITTER AGENT
referred to as *Submitter Agent*, to transmit HIPAA transactions to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the *Submitter Agent* the return computer electronic files of all data processed. 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	**Print Name of Signature**
_____ _____	_____ _____
Telephone Number Date	**Telephone Number Date**

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

MAIL TO:

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

For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____