
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.

Questions or need assistance?

Contact Inovalon Enrollment Department at 888.499.5465 or enrollmentsupport@inovalon.com

Submit the completed Payer Request Form to:
 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

Questions or need assistance?

Contact Inovalon Enrollment Department at 888.499.5465 or enrollmentsupport@inovalon.com

Inovalon Enrollment
enrollmentsupport@inovalon.com

INSTRUCTIONS

- Print these instructions. Refer to them as you complete the registration process.
- Please read the following information carefully before completing and submitting EDI enrollment forms.
- Contact MassHealth at 800-841-2900 to make sure you have a current Trading Partner Agreement on file.
Inovalon cannot complete this step for you.
- **IMPORTANT** >> The MassHealth 837/835 EDI enrollment request template following these instructions must be **Printed on Provider's Letterhead**, then signed and submitted to Inovalon's enrollment team.
- Completing the MassHealth 837/835 EDI Enrollment request:
 - Please be sure to include ALL following information when requesting EDI/ERA enrollment:
 - Group/provider name
 - MassHealth Provider ID and NPI (contact MassHealth if you do not know this information; Inovalon cannot obtain this information for you)
 - Typed or hand-printed name of the person signing the form, just as if you were signing a formal letter
 - A legible signature
- None of the above information should be omitted; none of the information on the template is optional.
- After printing the forms, sign and date them. **MassHealth/Medicaid requires the signature to be legible.**
- Fax or Email Inovalon's setup form and the MassHealth 837/835 EDI Enrollment request to Inovalon Enrollment only.
- Do not submit the setup form or the MassHealth 837/835 EDI Enrollment request directly to MassHealth.
- **Optional:** If you want to receive ERA from MassHealth : Requirements are as follows: Providers Must enroll in EFT prior to ERA enrollment. **Please note:** ERA receipt for this payer is not required. The required EFT form and completion instructions are attached. Contact MassHealth at (800) 841-2900 or email EDI@mahealth.net to coordinate the necessary setup for receipt of the 835 transaction. Depending on whether you are a provider using a clearinghouse or billing intermediary, a provider submitting your own claims, or an organization managing multiple providers, there are unique sets of information that are required to complete the registration process.
- **IMPORTANT** >> Submit ONLY the EFT form directly to MassHealth.
 - Do not submit the EFT form to Inovalon.
 - Do not submit the MassHealth 837/835 EDI enrollment request to MassHealth.
 - MassHealth requires providers requesting EFT enrollment to obtain pre-notification status before requesting ERA enrollment.
 - Providers should contact MassHealth to confirm pre-notification status before requesting ERA enrollment.
 - EFT and ERA enrollment do not affect 837 claims enrollment; providers can enroll in 837 claims with MassHealth at any time.
- Submit the MassHealth EFT Enrollment form directly to MassHealth. Do not submit the MassHealth EFT Enrollment form to Inovalon.

Questions or need assistance?

Contact Inovalon Enrollment Department at 888.499.5465 or enrollmentsupport@inovalon.com

MassHealth Enrollment Instructions

- Please type or copy & paste the following letter onto your provider letterhead.
 - This letter is necessary for us to begin sending claims to Massachusetts Medicaid on your behalf.

To Whom It May Concern:

We would like to request 837 claim submission (insert "and 835 Remittance Advice" ONLY IF you would like Inovalon to receive your EOB's electronically) under Inovalon Provider Inc., submitter number 11C0207631A.

Provider name Provider Number NPI

- *(Please list all provider names and their corresponding Medicaid provider number and NPI.*
- *If you have a group number, list the group name and Medicaid group number.)*

If you have any questions, please contact (insert contact name) at (phone number) or E- mail (insert E-mail address). Thank you,

(Signature)

(typed name)

Questions or need assistance?

Contact Inovalon Enrollment Department at 888.499.5465 or enrollmentsupport@inovalon.com



Electronic Funds Transfer (EFT) Enrollment/Modification Form

Complete this form to enroll in electronic funds transfer (EFT) with MassHealth or to terminate or modify an existing electronic funds agreement. Additional terms of agreement on page 2 of this form must be completed.

PROVIDER INFORMATION

Provider legal name		DBA name	
Street	City	State	Zip

PROVIDER IDENTIFIERS INFORMATION

Provider TIN or EIN	NPI
---------------------	-----

PROVIDER CONTACT INFORMATION

Provider contact name		
Tel.	Tel. Ext.	Email

FEDERAL AGENCY INFORMATION

Federal program agency identifier

FINANCIAL INSTITUTION INFORMATION

Financial institution name			
Street	City	State	Zip
Financial institution routing number	Type of account at financial institution		
Provider's account number with financial institution			
Provider TIN	NPI		

SUBMISSION INFORMATION

Reason for Submission	<input type="checkbox"/> New enrollment	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Cancel enrollment	Included	<input type="checkbox"/> Voided check	<input type="checkbox"/> Bank letter
Signature of person submitting enrollment						
Printed name of person submitting enrollment					Submission date	

If you are modifying or changing your bank account information, you must include your old bank account information on page 2 of this form or your request will be incomplete.

Please complete page 2 in its entirety.

If you are modifying your bank account information, please provide the old bank account information directly below.

Provider old bank account number _____ Account type Checking Savings

CERTIFICATION

I, _____, hereby certify that the account(s) indicated on this form is under my direct control and access; therefore, I authorize the state treasurer as fiscal agent for the Commonwealth of Massachusetts to initiate, change, or cancel credit entries to that account/s as indicated on this form. (For ACH debits consistent with the International ACH Transaction (IAT) rules, check one of the following.)

- I affirm that payments authorized hereunder are not to an account that is subject to being transferred to a foreign bank account.
- I affirm that payments authorized hereunder are to an account that is subject to being transferred to a foreign bank account.

This authority is to remain in full force and effect until the Office of Comptroller (CTR) has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford CTR a reasonable opportunity to act upon it.

This authorization will remain in effect until it is canceled in writing or until an updated form changing information is sent to the department you currently do business with.

Signature of authorized representative _____
(For signature requirements please see instructions.)

- Please contact your financial institution to arrange for the delivery of the CORE (Committee on Operating Rules for Information Exchange)-required Minimum CCD+(Corporate Credit or Debit entry) data elements needed for reassociation of the payment and the Electronic Remittance Advice (ERA).
- The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.
- Instructions to complete the EFT Enrollment/Modification form can be found at www.mass.gov/how-to/tips-for-completing-the-electronic-funds-transfer-eft-form. You may also confirm the status of your EFT enrollment by contacting MassHealth at (800) 841-2900, TDD/TTY: 711.
- The EFT user job aid that explains how providers can match the EFT payment to the remittance advice can be found at <https://massfinance.state.ma.us/VendorWeb/JobAidTraining/MassHealth.pdf>.
- The EFT Enrollment/Modification form can be completed manually or electronically. Electronic submissions must be printed, signed, faxed or mailed in the following ways.

Fax:
(617) 988-8974

Mail:
MassHealth Provider Enrollment and Credentialing
PO Box 278
Quincy, MA 02171-0278