Medicaid New York 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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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

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INSTRUCTIONS

Payer Specific Instructions:

- Enter your pay-to provider name, Tax ID, NPI, and 8-digit Medicaid provider ID number. If Medicaid pays your group, use the group information. If you are not sure what information to use, please contact Medicaid. INOVALON cannot obtain this information for you.
- Do not alter the pre-completed Trading Partner ID/ETIN.
- Enter the information for the contact person at the provider's office.
- Do not alter any of the pre-completed submitter information on this form.
- If you are enrolling in ERA for the first time, choose New Enrollment. If you are changing vendors or clearinghouses, choose Change Enrollment.
- Enter the printed name and title of the person authorized to sign this form.
- After printing, review all information for accuracy. Obtain the signature of the authorized representative and date the form.

ELECTRONIC OR PDF REMITTANCE ADVICE REQUEST

Pre-Requirements: Prior to submitting this form, providers must:

- Be enrolled in the Medicaid program
- Have an active certification on file for the ETIN submitted in the 'Other Identifiers' section.
- Have a valid and active eMedNY eXchange, Core Web Services, or FTP User ID prior to requesting any electronic remittance advice format.
- To enroll in ePACES/eXchange, contact the eMedNY Call Center at 1-800-343-9000.
- To set up a new FTP account, submit Security Packet B found under Provider Enrollment, Maintenance Forms on eMedNY.org.

THE FORM WILL BE REJECTED IF ANY REQUIRED FIELDS ARE NOT COMPLETED OR ARE ILLEGIBLE.
ALLOW 7 TO 14 BUSINESS DAYS FOR PROCESSING.

Provider Identifiers Information

- **Provider Name:** Enter the name of either the individual provider or organization for which this form is being submitted.
- **Federal Tax Identification Number:** Number being submitted is either Federal Employer identification Number (EIN) or the provider's Social Security Number (TIN).
- **NPI:** Required, unless exempt

Trading Partner IDs

- **MMIS Provider ID:** For atypical providers ONLY, enter your MMIS Provider ID here.
- **ETIN:** Enter the 3 or 4 digit Electronic Transmitter Identification Number. Only one ETIN per form allowed.
  - The Provider ID submitted on this form must be certified to the ETIN.
  - For multiple providers, a separate form must be submitted for each provider who is actively enrolled and currently certified to the ETIN entered.
- **NOTE:** This ETIN will serve as the DEFAULT ETIN for reporting paper claim submissions, state submitted adjustments/voids, and Medicare crossover claims, unless you indicate an alternate ETIN that is set up for electronic/PDF remittances in the field provided.

Provider Contact Information

- Enter the name, phone and email address for the person to be contacted on behalf of the provider with questions regarding this form.

Electronic Remittance Advice Information

Method of Retrieval

- **Remittance Type: Chose one** remittance type for the provider. Only one remittance type is allowed per ETIN/Provider combination.
  Notes:
  - **For 835/820 electronic remittance types, software to interpret HIPAA formatted records is strongly recommended. eMedNY cannot provide remittance interpretation service.**
  - PDF remittance advices can only be delivered to an eMedNY eXchange user account.
- **Remittance Delivery Method: Chose one** remittance delivery method for the provider. Only one remittance delivery method is allowed per ETIN/Provider combination.
- **eXchange user ID, Core Web Services User ID, or FTP User ID:** Enter the user ID of the preferred remittance delivery method.
  - The eXchange, Core Web Services, or FTP user ID submitted on the form must be valid and activated.
  - Only one User ID is allowed per ETIN/Provider combination.

Submission Information

- **Reason for Submission**
  - **New Enrollment check-box:** not applicable to this form**.**
  - **Change Enrollment check-box:** To change the User ID, remittance type, or delivery method for an existing provider ETIN relationship.
- **Authorized Signature**
  - If submitting the form for a practitioner, the practitioner must sign the form.
  - If submitting this form for a group, business or institution, the authorized representative must sign the form.

ELECTRONIC OR PDF REMITTANCE ADVICE REQUEST

To receive the New York Medicaid remittance advice in PDF format through eMedNY eXchange or electronic HIPAA-compliant 835 or 820 format through eMedNY eXchange, FTP or Core WEB Services, complete **all** sections below.
ALLOW 7 to 14 BUSINESS DAYS FOR PROCESSING.

Provider Information

Provider Name _____

Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

☐ TIN ☐ EIN _____

National Provider Identifier (NPI) *(Required, unless exempt):* _____

Other Identifiers – Assigning Authority – New York Medicaid

Trading Partner ID: MMIS Provider ID # *(Required, if NPI exempt)*: _____

Trading Partner ID: ETIN: 0XN_____

NOTE: The ETIN listed on this form above will also serve as the **DEFAULT ETIN** for reporting paper claim submissions, state submitted adjustments/voids, and Medicare crossover claims, unless you indicate an alternate ETIN, which is set up for electronic/PDF remittances, in this field: _____

Provider Contact Information

Provider Contact Name Contact_____

Telephone Number _____ Extension _____

Email Address _____FAX Number _____

Electronic Remittance Advice Information

Method of Retrieval

Remittance Type (**Choose one**): ☑ 835/820 Electronic Remittance ☐ PDF *(eXchange delivery method only)*

Remittance Delivery Method (**Choose one**): ☑ eXchange ☐ FTP ☐ Core WEB Services

eXchange, Core WEB Services **or** FTP User ID: JGRESS1_____

Submission Information

Reason for Submission ☐ New Enrollment ☐ Change Enrollment

Authorized Signature

The person signing this form on behalf of the Provider warrants that s/he has the legal authority to do so.

_____ _____

Written Signature of Person Submitting Enrollment *Submission Date*

_____ _____

Printed Name of Person Submitting Enrollment *Printed Title of Person Submitting Enrollment*

Mail the completed form to:

eMedNY
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, New York 12144-8614
FAX: (518) 257-4632

You can fax the remittance request form if the provider is already certified for the ETIN. Certification forms cannot be faxed. Only originals will be accepted.

This form will be returned if it contains incomplete or illegible information.