Instructions for Completing Florida Medicaid Electronic Data Interchange Agreement

1. Print entire document

    - Complete top portion (all fields must be completed)
    - Skip Section 1: Transaction Information
    - Skip Section 2: Florida Medicaid Billing Agent Agreement
    - Section 3: Sign and date

2. Email (preferred) the completed forms with coversheet as an attachment to csenrollment@experianhealth.com or fax it to 866.921.8415, attention CSEnrollment

3. **Do not fax or mail enrollment form to DXC**

Third Party Agencies: Please have your client(s) follow the steps outlined above and return the completed form(s) to you to return to Experian.

Thank you for your interest in Experian Health!

Payer Enrollment Cover Sheet

To process your payer enrollment correctly, please complete the below before sending in the form.

- Client ID:
- Partner Name (if applicable):
- Facility Name:
- Contact Name:
- Contact Email:
- Contact Phone #:

If you have any questions please email **CSenrollment@experianhealth.com**

Medicaid Provider ID: _____
or, Application Tracking Number (ATN)

0 1 2 1

Electronic Data Interchange Agreement

Medicaid Provider ID: _____ NPI: _____

Provider Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____ Contact Phone: ( ) _____

Email: _____

The Medicaid provider listed above is a (check one): ____ Provider ____ Billing Agent/Clearinghouse

Section 1: Transaction Information

Complete this section to indicate how you plan to submit or receive electronic transactions.

- **If you are currently submitting/receiving electronic transactions directly to/from Medicaid, indicate your current 5-digit or 6-digit Trading Partner ID.** _____

- **If you plan to use a software vendor to submit/receive electronic transactions to/from Medicaid, indicate the software vendor's Trading Partner ID.**

  NOTE: If you do not provide the software vendor's Trading Partner ID, you will be required to test. _____

- **If you plan to use a billing agent/ clearinghouse to submit directly to/from Medicaid, indicate the billing agent/clearinghouse's Trading Partner ID.**

  NOTE: To designate a billing agent to submit claims on your behalf, complete Section 2. 100182

- **Indicate the transaction types you plan to send/receive.**

____	820 Premium Payment	____	835 Remittance Advice
____	837P Professional	____	834 Benefit Enrollment (Inbound/Outbound)
____	837I Institutional	X	270/271 Eligibility Request/Response
____	837D Dental	X	276/277 Claim Status Request/Response

- **Select the method of submission that you will use to transmit your transactions.**

  X Web Portal / Software Vendor ____ Provider Electronic Solutions (PES) (Replaces the Winasap2003)

  NOTE: If you are using a Billing Agent/Clearinghouse, skip this section.

  If you select Provider Electronic Solutions (PES) to submit claims to Medicaid, please go to the website www.mymedicaid-florida.com for a free download of the software. Should you experience any problems, call the EDI Helpdesk at 1-800-289-7799, option 3.

Section 2: Florida Medicaid Billing Agent Agreement

This section must be completed by any provider who wishes to designate or change a billing agent to submit claims for reimbursement by Florida Medicaid.

The following requirements apply to all billing agents/clearinghouses:

1. Any entity, that submits claims to Medicaid on behalf of an enrolled Medicaid provider must be enrolled in the Medicaid program as a billing agent with an active provider number.
2. Claims must be paid in the name of the provider or provider group that renders the services, not in the name of the billing agent.
3. Payment for billing services must be made based upon an administrative fee per claim. Billing agents are prohibited from charging for their services based upon a percentage of the total dollar value of claims billed.
4. If a claim is rejected as inaccurately filed, it cannot be resubmitted unless there has been a change made to the claim form or electronic submission itself.

"The following billing agent is authorized to submit claims to and follow up with Medicaid and the Medicaid fiscal agent on my behalf. I understand that all payments and payment information are in my name and that this agreement does not exempt me from reponsibility for claims filed on my behalf or from established claim filing policies. I further understand that the billing agent must be held to the same requirements of confidentiality and access to records as I am, as reflected in my agreement with Medicaid. I will immediately notify the Medicaid fiscal agent of any change in this authorization."

Billing Agent Name: _____ Billing Agent Provider Number: _____

Section 3: Certification

The provider identified on this Electronic Data Interchange Agreement understands and agrees to the following:

1. Payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws.
2. Providers must safeguard the Medicaid program against abuse in the use of electronic claims submission.
3. Providers must correctly enter the claims data, monitor the data and certify that the data entered is correct.
4. Providers must assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments by the Agency's fiscal agent that might result from carelessness or fraud.
5. Providers must have on file the applicable source data to substantiate the claim submitted to the Medicaid program.
6. Providers must allow the Agency or any of its designees and representatives of the office of the Auditor General or the Attorney General to review and copy all records, including source documents and data related to information entered through electronic claims submission.
7. Providers must abide by all Federal and State statutes, rules, regulations, and manuals governing the Florida Medicaid program.
8. Providers must sign and adhere to all conditions of the Medicaid Provider Agreement and be officially enrolled in the Medicaid program to participate in electronic claims submission.

Signature: _____ Date: _____

Mail completed form to:

For Regular Mail:

EDS Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

For Overnight or Express Delivery:

EDS Provider Enrollment
2671 Executive Center Circle West
Suite 100
Tallahassee, FL 32301

(Florida Medicaid Program – Do not write below this line)

Received	By:	Date:
FMMIS Updated	By:	Date: