

MEDICAID NEVADA (MC008) PRE-ENROLLMENT INSTRUCTIONS



WHAT FORM(S) SHOULD I DO?

- Service Center Authorization
 - An original signature is required
 - Check the “Remittance Advice (835)” box if you’d like Office Ally to receive ERA’s on your behalf

WHERE SHOULD I SEND THE FORM(S)?

- Mail form to:
 - HP Enterprise Services
 - Attn: EDI Coordinator
 - PO Box 30042
 - Reno, NV 89520-3042

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard Processing time is 1 week

HOW DO I CHECK STATUS?

- Approximately 10 business days after you have sent your enrollment, please send an email to support@officeally.com with the following information:
 - Subject line: Checking status on Medicaid enrollment. Attn Anita
 - Provider Tax ID listed on enrollment form.
 - Billing NPI listed on enrollment form.
- If you do not receive a notification from Office Ally, you must follow up with Medicaid at (877) 638-3472. If the approval is confirmed by Medicaid, to complete your enrollment follow instructions on the “Note to My Clients Plus users” page and FAX info requested. We will forward to our clearinghouse and notify you by email when your registration is complete.

Note to My Clients Plus Users:

Once you have confirmed with the Insurance Payer your billing NPI/Provider number is linked to Office Ally, please fax the following information to 888-653-7115.

- **Please label with “My Clients Plus” on top**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my provider ID has been linked to Office Ally with the Insurance Payer”.**
- **Provider email address where you can be notified of setup completion.**
- **For EDISS or Noridian Pre-Enrollments Please Also Include:
Providers Submitter number**

REVISED 9/29/16

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.

Mail this form to: Hewlett Packard Enterprise, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.

Service center source: Check one. Enter the business or clearinghouse name as appropriate.	
<input type="checkbox"/> I will submit claims through a clearinghouse.	Hewlett Packard Enterprise Use Only
Clearinghouse name:	SC code:
<input type="checkbox"/> I will submit claims directly from my business to Hewlett Packard Enterprise (direct submitter).	
Business name:	
Authorize a transaction: Check the box next to each transaction you wish to authorize.	
I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies Hewlett Packard Enterprise otherwise by use of this form.	
<input type="checkbox"/> Eligibility Request/Response Batch (270/271) Connection Method: <input type="checkbox"/> SFTP <input type="checkbox"/> XEConnect*	<input type="checkbox"/> Claims Status Request/Response Batch (276/277) Connection Method: <input type="checkbox"/> SFTP <input type="checkbox"/> XEConnect*
<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)	<input type="checkbox"/> Prior Authorization Request/Response (278/278)
<input type="checkbox"/> Institutional claim (UB-04 claim: 8371)	<input type="checkbox"/> Remittance Advice (835)**
<input type="checkbox"/> Dental claim (Dental claim: 837D)	
Terminate a transaction: Check the box next to each transaction you wish to terminate	
I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies Hewlett Packard Enterprise otherwise by use of this form.(Enter the effective date below.)	
<input type="checkbox"/> Eligibility Request/Response Batch (270/271) Connection Method: <input type="checkbox"/> SFTP <input type="checkbox"/> XEConnect*	<input type="checkbox"/> Claims Status Request/Response Batch (276/277) Connection Method: <input type="checkbox"/> SFTP <input type="checkbox"/> XEConnect*
<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)	<input type="checkbox"/> Prior Authorization Request/Response (278/278)
<input type="checkbox"/> Institutional claim (UB-04 claim: 8371)	<input type="checkbox"/> Remittance Advice (835)**
<input type="checkbox"/> Dental claim (Dental claim: 837D)	
Effective date for termination of this transaction(s):	

* XEConnect is an EDIFECs application.

** Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider/entity name: _____ NPI/API (one per form): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? Yes No

Authorized Signature: _____