



FACSIMILE TRANSMITTAL SHEET

TO:	FROM: Ivertex Enrollment Team
COMPANY:	E-MAIL ADDRESS: ENROLLMENT@SOLACE-EMC.COM
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
DATE: 8/30/2010	SENDER'S PHONE NUMBER: 602-439-2525
RE: AK Medicaid: ACS	SENDER'S FAX NUMBER: 602-439-0808

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

NOTES/COMMENTS:

The following pages contain important information in regards to your EDI Enrollment for:

AK Medicaid: ACS

Included in this fax are the forms you need to complete in order to enroll in EDI. To obtain additional copies of the forms, please refer to the download link(s) provided in the Enrollment Instructions page.

Comments:



AK Medicaid: ACS

Enrollment Instructions

Thank you for your interest in Electronic Data Interchange (EDI).

Required Documents

The following documents are **required** enrollment documents that must be completed, signed and returned to the ACS office prior to initiation of electronic claims submission or inquiry.

Providers, please print out this form:

1. Provider Submission Agreement
2. Electronic Remittance (835) Authorization Form

Billing Services, please print out these forms:

1. Billing Agent Submission Agreement

To obtain the forms above, please download them from:

<http://medicaidalaska.com/providers/hipaa/agreements.shtml>

If you have any questions regarding any of the documents in this package, please phone the ACS EDI Technology Support Center at 907-644-6800.

Required Information

We recommend that you have the following information ready before filling out your forms:

Your Submitter Information	Software Vendor Information
<ul style="list-style-type: none"> • Name 	<ul style="list-style-type: none"> • Vendor Name – Ivertex
<ul style="list-style-type: none"> • Address 	<ul style="list-style-type: none"> • Contact – EDI Team
<ul style="list-style-type: none"> • Phone and Fax Numbers 	<ul style="list-style-type: none"> • Vendor Code – n/a
<ul style="list-style-type: none"> • E-mail Address (if any) 	<ul style="list-style-type: none"> • Phone – 602-439-2525
<ul style="list-style-type: none"> • Contact Name (if other than name above) 	<ul style="list-style-type: none"> • Fax – 602-439-0808
<ul style="list-style-type: none"> • Provider PIN numbers for this payer 	<ul style="list-style-type: none"> • Address – PO Box 86609 Phoenix, AZ 85080
<ul style="list-style-type: none"> • Organization or Group PINs for this payer 	<ul style="list-style-type: none"> • Software Name– SolAce EMC
	<ul style="list-style-type: none"> • E-mail – Support@Ivertex.com

Filling out your forms

Providers

Provider Submission Agreement

Section Header:

- Fill in the Provider's name in the first paragraph

Section 16:

- Please select "HIPAA-Compliant Information"

Section 17:

- Please select "Electronic" for both questions

Section 18:

- Please select the following:
 - 835 Remittance Advice
 - 837 Institutional
 - 837 Professional

Section 19:

- If you will be sending claims through SolAce from your office please select Option A. "Directly from my office system to the state"
- If you will be using a Billing Service please select Option D "Through a Billing Agent or Clearinghouse to the state" and skip to question #21.

Section 20:

- Please enter the Software Vendor information provided on the first page of this document for Ivertex.

Section 21:

- If you are using a Billing Agency please enter the Billing Agency's information here

Section 22:

- Enter the information for the main contact person for your office

Section 23:

- Please complete this section with the Provider's information and signature.

Provider Electronic Remittance (835) Authorization

Section 1:

- Please Select "Self" if you will be using SolAce to submit claims directly from your office
- Please Select "Billing Agent" if you will be using a Billing Service and would like your Billing Service to receive your Electronic EOB's.

Section 2:

- Please enter your Business or Practice Name

Section 3:

- Please enter the Provider's name and PIN number as well as his/her telephone number.

Section 4:

- Please have an Authorized Representative for your office or the Provider sign and date this section

Billing Services

Billing Agent Submission Agreement

Section Header:

- Fill in the Billing Service name in the first paragraph

Section 14:

- Please select “HIPAA-Compliant Information”

Section 15:

- Please select “Electronic” for both questions

Section 16:

- If you will be sending claims through SolAce from your office please select Option A. “Directly from my *Billing Agent office system* to the State.”

Section 17:

- Please select the following:
 - 835 Remittance Advice
 - 837 Institutional
 - 837 Professional

Section 18:

- Please enter the Software Vendor information provided on the first page of this document for Ivertex.

Section 20:

- Please complete this section with your Business Information and signature.

NOTE: Each of the Providers you will be billing for must complete a **Provider Submission Agreement** and **Provider Electronic Remittance (835) Authorization**. Instructions on how to fill out these forms are above under the “Providers” section.

Submitting your forms

It is recommended that you keep a copy of all the forms you will be submitting for your records. Mail the enrollment forms reflecting **original** signatures to:

Affiliated Computer Services, Inc
HIPAA Provider Support Team
P.O. Box 240808
Anchorage, Alaska 99524-0808

It is very important that you complete and return the entire enrollment packet as described above. ***Incomplete packets will not be processed and will be returned to the submitter.***

Waiting for a response

Once the complete provider enrollment packet has been received, the documents will be processed. Processing will take approximately two weeks from the date of receipt. (Remember that mailing time can take as much as five days.)

After processing, a confirmation will be faxed to you as notification to begin filing claims electronically. If neither confirmation nor a returned packet is received after two weeks, contact the Technology Support Center toll-free at 907-644-6800.

Testing

Once you have received your Submitter ID and password from ACS Health, please call the Ivertex Support Team and set an appointment for a Mailbox setup and Test Transmission to ACS Health.

Please have 25 test claims ready for testing. Test files should consist of a variety of claims that represent the type of claims you will be submitting once production status is achieved. Test claims will not be processed for payment but will be validated against production files; therefore, they must contain valid patient procedure, diagnosis, and provider information.