



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: 5/7/2007	SENDER'S PHONE NUMBER: 602-439-2525
RE: MI Medicaid	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:

MI Medicaid

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:



MI Medicaid

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 Medicaid office prior to initiation of electronic claims submission or inquiry.

1. Billing Agent ID Request Form
2. Billing Agent Authorization
3. 835/277U Request

To obtain the forms above, please download them from:

http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-103476--00.html#Submitting_Claims_Electronically

If you have any questions regarding any of the documents in this package, please phone the Medicaid EDI Technology Support Center at 1-517-373-3500.

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

Billing Agent ID Request Form

This form must be completed and faxed to 1-517-335-5570

Please answer the questions on the *Billing Agent ID Request* form as indicated below:

1. Yes
2. Yes
3. Yes
4. Yes
5. Yes
6. Write in "837P" for Professional Claims and "837I" for Institutional Claims
7. Please enter the specialty type codes (a.k.a. Provider Type Codes) that you will be billing.
8. To submit electronic claims to Medicaid
9. Please enter the name of your Billing Clerk who will be submitting your electronic claims.
10. Enter your office Address
11. Enter your office phone number
12. Enter the name of the main contact person for your office
13. Enter the name of the backup contact person for your office
14. Enter your office fax number

Medical Billing Agent Authorization

This form is to be completed after your Billing Clerk receives his/her Billing Agent ID. (If you are billing for multiple providers in your office please make additional copies of this form for each one of your providers.)

Please answer the questions on the *Billing Agent Authorization Form* as indicated below:

1. Enter the name of the Billing Clerk who applied for an ID
2. Enter the Billing Agent ID number that was assigned to the Billing Clerk.
3. Enter the Medicaid Number of the Provider your Biller will be billing for.
4. Have the provider sign the Provider Certification section.
5. The Billing Clerk who was assigned an ID must complete the Billing Agent Certification section.

This form must be mailed with Original Signatures to:

Provider Enrollment
Michigan Department of Community Health
PO Box 30238
Lansing, MI 48909

835/277U – Electronic Remittance Advice Request

If you would like to receive your EOBs electronically in SolAce, please complete this form. (If you are billing for multiple providers, please make additional copies of this form for each one of your providers.)

Please answer the questions on the form as indicated below:

1. Enter the Provider Tax ID for whom you would like to receive electronic EOBs.
2. Enter the Billing Agent ID Number that was assigned to your Biller.
3. Enter the Name and Title of your Biller.
4. Enter your Biller's E-mail address
5. Enter your Biller's Fax number
6. Please have your Biller sign the signature line.

Please Fax this form to: 1-517-335-5570

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 1-517-373-3500.

Testing

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

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.