

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM



Please return to:
Conduent EDI Solutions, Inc
Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402



EDI SUBMITTER ENROLLMENT FORM. Please print or type. Complete all areas of the Submitter Enrollment Form, unless otherwise indicated.

Section 1. Classification. Please indicate your classification.

☐ Software Vendor ☐ Billing Agent ☐ Clearinghouse

Section 2. Submission Method. Please indicate how you plan to submit your electronic transactions.

☐ Asynchronous (Direct Submission to EDI) ☐ WINASAP5010

Section 3. Submitter Information.

Business Name (If applicable)

Provider Name (Last, First, MI, and Suffix)

Business Street Address

City, State, and Zip Code

Telephone

Fax

Email Address

Federal Tax ID Number

Section 4. Montana Submitter ID.

If you are currently submitting electronic transactions directly to Montana FAS, please indicate your Montana 7-digit Submitter ID:

NOTE: This is your Montana DPHHS Submitter ID Assigned by FAS.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Section 4a. Submitter/Trading Partner ID Number.

If you are currently submitting electronic transactions directly to EDI Solutions, please indicate your Conduent EDI Solutions 5-digit Submitter ID or 6-digit Trading Partner ID.

NOTE: This is NOT your Montana submitter ID

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Section 5. Software Vendors Only

If you have indicated that you are a Software Vendor in Section 1, please provide the following information:

1.800.987.6719 (phone) 1.406.442.4402 (fax)

www.acs-gcro.com

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Software Name:		Software Version:		Protocol:	
Do you currently have clients submitting to EDI Solutions?				<input type="checkbox"/>	Yes <input type="checkbox"/> No

Section 6. Contact Information. Please indicate contact information.

Contact Name	Contact Title
Business Street Address	
City, State, and Zip Code	
Telephone	Fax
Email Address	

Additional Contact Information. Please indicate additional contact information.

Contact Name	Contact Title
Business Street Address	
City, State, and Zip Code	
Telephone	Fax
Email Address	

Please attach additional sheets if necessary.

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Section 7. Transactions Available for Transmission.

Sub-Section 7a. WINASAP5010 (replacing WINASAP2003).

Request for free WINASAP5010 Software:

☐ I will download a copy from the Conduent website at <http://www.acs-gcro.com/gcro/winasap-software>

<input type="checkbox"/> X12N 837P (Professional Claim)	<input type="checkbox"/> X12N 837D (Dental Claim)	<input type="checkbox"/> X12N 837I (Institutional Claim)
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Sub-Section 7b. Standard Transactions. Check all that apply (Submissions other than WINASAP5010)

<input type="checkbox"/> X12N 837P (Professional Claim)	<input type="checkbox"/> X12N 837D (Dental Claim)	<input type="checkbox"/> X12N 837I (Institutional Claim)
<input type="checkbox"/> X12N 276 (Claim Status Inquiry)	<input type="checkbox"/> X12N 270 (Eligibility Inquiry)	<input type="checkbox"/> X12N 278 (Prior Authorization)

Section 8. Delimiter Information. If you are submitting X12N transactions directly to Conduent, please provide the following information. (This information is not required if you are using WINASAP5010)

Element Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/> Default Delimiter (asterisk) *	Segment Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/> Default Delimiter (tilde) ~	Sub-Element Delimiter to be used: <input style="width: 50px; height: 30px;" type="text"/> Default Delimiter (colon) :
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Section 9. Electronic Response Retrieval. Check all that apply

Montana Submitters can retrieve their electronic responses from the Host Data Exchange (HDE). If you would like to participate in this service, please complete the section below. For more detailed information regarding electronic remittance advices, please see the **835 Companion Guide located on the Conduent website at <http://www.acs-gcro.com/gcro/winasap-software>.**

Responses available for X12N Transactions – check all that apply.

<input type="checkbox"/> X12N 999 (Implementation Acknowledgement)	<input type="checkbox"/> X12N 835 (Healthcare Claim Payment/Advice)
<input type="checkbox"/> X12N 271 (Eligibility Response)	<input type="checkbox"/> X12N 277 (Claims Status Response)
<input type="checkbox"/> X12N 278 (Prior Authorization Responses)	<input type="checkbox"/> X12N 277CA (Healthcare Claim Acknowledgement)

☐ **Exception Report (Print Images) **** If you have selected this option you must complete the Business Associate Agreement (BAA). Please call 1.800.987.6719 to request the BAA be faxed or mailed to you or go to <http://www.acs-gcro.com/gcro> and download the form. You may fax or mail this form to Conduent EDI Solutions, Inc.

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Provider Billing Agent/Clearinghouse Conduent EDI Solutions, Inc Authorization Form

Section A. Provider Information.

Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number	Federal Tax ID Number
Business Address	
City, State, and Zip	
Telephone Number	Fax Number
Contact Name	E-mail Address

Section B. Authorization Signature (required).

Provider, _____ hereby appoints
Provider name /Provider Representative name (please print)

Billing Agent/Clearinghouse name (please print)

Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to Conduent EDI Solutions, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- | | |
|---|---|
| <input type="checkbox"/> 277-Claim Status Response | <input type="checkbox"/> 271-Eligibility Response |
| <input type="checkbox"/> 835-Healthcare Claims Payment Advice | <input type="checkbox"/> 278-Prior Authorization Response |
| <input type="checkbox"/> Exception Report (Print Image) | <input type="checkbox"/> 999-Implementation Acknowledgement |
| <input type="checkbox"/> 277CA-Healthcare Claim Acknowledgement | |

Provider/Provider Representative name (Please print)

Provider/Provider Representative Signature

Date

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