

**837 ELECTRONIC CLAIMS INPUT**

MEDICAID

ENCOUNTER

CHARITY CARE

**SECTION 1: FISCAL AGENT USE ONLY**

PROVIDER #: \_\_\_\_\_ SUBMITTER NAME: \_\_\_\_\_ SUBMITTER #: \_\_\_\_\_

Authorized by : \_\_\_\_\_ DATE: \_\_\_\_\_ **DOCTYPE: EMCAGREE**

**SECTION 2: PROVIDER**

01) Medicaid Provider Name: \_\_\_\_\_ 02) Medicaid Provider Number: \_\_\_\_\_

03) Street Address: \_\_\_\_\_

04) City, State, Zip Code: \_\_\_\_\_

05) EDI Contact Person: Adam Trimeloni 06) Phone/Ext: ( 949 ) 255-2600 / \_\_\_\_\_

07) Fax: ( 949 ) 255-2601 08) Email: ATrimeloni@qsii.com

09) 2nd EDI Contact Person: \_\_\_\_\_ 10) Phone/Ext: ( \_\_\_\_\_ ) \_\_\_\_\_ / \_\_\_\_\_

**SECTION 3: AGREEMENT**

I certify that the information on these claims will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by these claims and the amounts charged will be in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under these claims has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both

I also certify that for each Medicaid service performed and claim submitted for payment, the patient certification will be on file at the provider's location.

11) \_\_\_\_\_ 12) \_\_\_\_\_ 13) \_\_\_\_\_  
(Provider's Signature) (Date) (Medicaid Provider ID)

14) \_\_\_\_\_ 15) \_\_\_\_\_ 16) \_\_\_\_\_  
(Billing Agent's Signature) (Date) (Submitter ID)

**NOTICE:** Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

**SECTION 4: HIPAA TRANSACTION SETS & CERTIFICATION**

17) Version 4010 Addenda:  004010X096A1  004010X097A1  004010X098A1  Version 1.1 Batch  
837 Institutional 837 Dental 837 Professional NCPDP: Pharmacy

18) Certification Vendor Name: \_\_\_\_\_ 19) Certification Attached:  Yes  No

20) Requested Effective Date: \_\_\_\_\_

21) Claims Input Media:  Internet  BBS via Modem  CD-ROM  Cartridge

01) Medicaid Provider Name: \_\_\_\_\_ 02) Medicaid Provider Number: \_\_\_\_\_

**SECTION 5: SOFTWARE VENDOR**

22) Company Name: Quality Systems, INC

23) Street Address: 18191 Von Karman Ave. Suite 450

24) City, State, Zip Code: Irvine, CA 92612

25) EDI Contact Person: Adam Trimeloni 26) Phone/Ext: ( 949 ) 255-2600 / \_\_\_\_\_

27) Fax: ( 949 ) 255-2601 28) Email: ATrimeloni@qsii.com

29) 2nd EDI Contact Person: David Razin 30) Phone/Ext: ( 949 ) 255-2600 / \_\_\_\_\_

(Unisys would like to know the company name/author of the software you are using to track, submit claims to Unisys)

**SECTION 6: BILLING AGENT**

31) Submitter Name: Quality Systems INC 32) Medicaid Submitter ID: 9900641

33) Street Address: 18191 Von Karman Ave Suite 450

34) City, State, Zip Code: Irvine, CA 92612

35) EDI Contact Person: Adam Trimeloni 36) Phone/Ext: ( 949 ) 255-2600 / \_\_\_\_\_

37) Fax: ( 949 ) 255-2601 38) Email: ATrimeloni@qsii.com

39) 2nd EDI Contact Person: David Razin 40) Phone/Ext: ( 949 ) 255-2600 / \_\_\_\_\_

41) 2nd EDI Contact Person E-mail: DRazin@qsii.com

*(This section should be completed if anyone but the provider is submitting claims to Unisys)*

**\*\*\* PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. \*\*\***

**Return the completed EDI Agreement to Unisys at the following address:**

**Via U.S. Mail**

**Provider Enrollment**

**Unisys**

**P.O. Box 4804**

**101**

**Trenton, New Jersey 08650 - 4804**

**Other Carriers**

**Provider Enrollment**

**Unisys**

**3705 Quakerbridge Road, Suite**

**Trenton, New Jersey 08619**

**For detailed instructions, please refer to the NJMMIS COMPANION GUIDE – SECTION 2**