220 Burnham Street ● South Windsor CT 06074
Vox 888-255-7293 ● Fax 860-289-0055

DENTAL COLORADO MEDICAID EDI UPDATE

PAYER ID NUMBER	**CKCO1**
ELECTRONIC REGISTRATIONS Agreements Required	**PROVIDER ENROLLMENT FORM** • Please complete all requested information. **EDI UPDATE FORM** • Please supply the Provider ID and current trading partner ID which are requesting the changes. • Sec. 1 – Check the box(es) for which you are making changes. • Sec 2 – Supply all requested information. • Sec 4 – Supply all requested information. **PROVIDER AUTHORIZATION PAGE** *Only those providers changing their submission method from the state's web port to Emdeon Business Services need complete this form.* • Please complete all requested information.
SPECIAL NOTES	▪ This EDI Update enrollment packet is to be used to submit changes to Provider/Submitter Demographics, Submission Methods, Contact Information, Transaction Submission and Report Retrieval. ▪ Providers who have never submitted an EDI enrollment request should complete the Emdeon Colorado Medicaid Electronic Claims Enrollment Registration packet.
SEND REGISTRATION FORMS TO:	PLEASE MAIL COMPLETED **ORIGINAL** EDI UPDATE PACKET TO: Emdeon Business Services Attn: Provider Registration 220 Burnham Street South Windsor, CT 06074

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ENROLLMENT CONFIRMATION	▪ Updates will be coordinated between Emdeon Business Services and ACS EDI Gateway. ▪ Emdeon Business Services will notify the provider or their software vendor when approval confirmation is received.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll for Electronic Claims Submission using this EDI Update Form.
CONTACT NUMBERS	ACS EDI Gateway Support Unit 800-237-0757 Emdeon Business Services 888-255-7293

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PROVIDER EDI UPDATE FORM

Print/Type the following:

Insurance Carrier: **COLORADO MEDICAID – payer ID CKCO1**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(This is the number that will be used to submit electronic claims)

Software Vendor: _____

Group Number: _____
(if applicable)

Rendering

Name	Number
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Colorado Medical Assistance Program

☐ I no longer want my clearinghouse/switch vendor/billing agent to retrieve my reports.

I want to retrieve my own reports.

Section 6. Report Transactions

Colorado Medical Assistance Program providers can receive X12N electronic reports. Please select the reports that you want to receive through the State's Provider Web Portal. *Enter only one Trading Partner (TP) ID per report. You may enter a different TP ID for each selected report.* **Providers can no longer receive/retrieve reports through BBS/MEVSNET.**

☒ X12N 824 (Payer Specific Error Report) Will by default be returned to submitting TP ID		☒ X12N 997 (Acknowledgement of a sent transaction) Will by default be returned to submitting TP ID	
☒ X12N 271 (Eligibility Response) Will by default be returned to submitting TP ID		☒ X12N 277 (Claim Status Response) Will by default be returned to submitting TP ID	
	Receiving TP ID		**Receiving TP ID**
☐ X12N 820 (Client Capitation)		☐ X12N 835 (Claim payment/Claim report)	SELF
☐ Accept/Reject Report		☐ Provider Claim Report (Previously called the Remittance Advice Report)	SELF
☐ X12N 834 (Benefit Enrollment and Maintenance)		☐ PCP Roster	SELF

Colorado Medical Assistance Program

PROVIDER AUTHORIZATION PAGE

This Authorization Form must be completed and signed by any provider who wishes to authorize a billing agent, clearinghouse, or other provider to:

☐ *Maintain and control their reports*

☐ *Submit and/or retrieve transactions on their behalf.*

*The authorized billing agent, clearinghouse, or provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.*

Provider, _____ hereby appoints
Provider name (please print)

CLAIMS PROCESSING SERVICE dba EMDEON BUSINESS SERVICES ; 12203
Billing Agent/Clearinghouse/Provider name (please print) | Billing Agent/Clearinghouse/Provider Trading Partner/Submitter ID

to act as an authorized agent for the purpose of submitting health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program. Provider also authorizes the listed agent to retrieve electronic reports/responses on Provider's behalf.

_____
Provider/Provider Representative name (please print)

SIGN HERE

_____ _____
Provider/Provider Representative signature **Date**

_____
Provider number

This Authorization can be revoked at any time, in writing. It is considered in effect until terminated.

Return completed form (or revocation) to:

ACS State Healthcare
Colorado Medical Assistance Program Provider Services
P.O. Box 1100
Denver, CO 80201-1100.