



## Louisiana Medicaid Program

# LOUISIANA MEDICAID ELECTRONIC REMITTANCE ADVICE (ERA) AUTHORIZATION AGREEMENT

(Form is subject to change without notice)

# GENERAL INFORMATION FOR THE ELECTRONIC REMITTANCE ADVICE (ERA) AUTHORIZATION AGREEMENT

Complete this form if you are requesting receipt of the Electronic Remittance Advice (HIPAA v5010 221A1 835 transaction) for the first time or wish to change the submitter or clearinghouse authorized to receive the 835 on your behalf.

## **Individual providers:**

Individual providers must sign their own forms.

Original signatures only; no stamps or copied signatures will be accepted. (Blue or colored ink preferred – not black ink).

If the individual provider is doing group billing only, then an ERA form should not be completed for the individual. Instead, an ERA form should be submitted (or already on file) only for the business or entity which the individual is linked to.

## **Business/Entity providers:**

Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.

Original signatures only; no stamps or copied signatures will be accepted. (Blue or colored ink preferred – not black ink).

The provider name on this form must match the provider name associated with the Louisiana Medicaid number, the NPI, or both.

If the entity/business is doing group billing, then an ERA form is required for the group only, and not the individual providers.

## **Send your completed ERA Form to:**

Gainwell EDI Department  
P.O. Box 91025  
Baton Rouge, LA 70821-9025

Call Gainwell EDI Department at (225) 216-6303 if you have questions regarding the completion of this form or the status of your request. You may also go to [lamedicaid.com](http://lamedicaid.com) under the HIPAA Information link for the 5010 EDI General Companion Guide for contact information.

Once you are enrolled for ERA and your electronic remittance is missing or late, call the Gainwell EDI Department at (225) 216-6303 and report the late and/or missing 835 transaction.

***After you are enrolled for ERA contact your financial institution if you wish to arrange for delivery of the CORE-required Minimum CCD+ data elements needed for re-association of your Medicaid payments via electronic funds transfer and the v5010 X12 835 Electronic Remittance Advice.***

# LOUISIANA MEDICAID ELECTRONIC REMITTANCE ADVICE (ERA) AUTHORIZATION AGREEMENT INSTRUCTIONS

1. Provider Name Complete legal name of institution, corporate entity, practice or individual provider.
2. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) A Federal Tax Identification Number, also known as an Employer Identification Number (EIN) is used to identify a business entity (9 digits).
3. National Provider Identifier (NPI) A Health Insurance Portability and Accountability Act (HIPAA) identification number Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
4. Gainwell Medicaid Trading Partner ID (7 digits) The 7-digit Louisiana Medicaid identification number assigned to the **submitter** authorized to receive the 835. (This number always begins with 450.)
5. Provider Contact Name Name of a contact in provider office for handling EFT issues.
6. Provider Contact Telephone Number Associated with contact person.
7. Provider Contact Email Address An electronic mail address at which the health plan might contact the provider.
8. Account Number Linkage to Provider Identifier Check one: Provider Tax Identification Number (TIN), or National Provider Identifier (NPI).
9. Method of Retrieval Check one: Download 835 From BBS, or Download 835 Using CAQH CORE Web Service
10. Reason for submission Check one: New Enrollment, Change Enrollment, or Cancel Enrollment
11. Written Signature of Person Submitting Enrollment (Authorized Signature) A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
12. Printed Name of Person Submitting Enrollment The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
13. Printed Title of Person Submitting Enrollment The printed title of the person signing the form.
14. Submission Date CCYYMMDD

**DEPARTMENT OF HEALTH AND HOSPITALS  
LOUISIANA MEDICAID ELECTRONIC REMITTANCE ADVICE (ERA) AUTHORIZATION AGREEMENT**

1. Provider Name \_\_\_\_\_

2. Provider TIN or EIN (9 digits)

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3. National Provider Identifier (NPI) (10 digits)

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4. Gainwell Medicaid Trading Partner ID (7 digits)

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5. Provider Contact Name \_\_\_\_\_

6. Provider Contact Telephone Number \_\_\_\_\_

7. Provider Contact Email Address \_\_\_\_\_

8. Account Number Linkage to Provider Identifier (check one)     Provider Tax Identification Number (TIN)     National Provider Identifier (NPI)

9. Method of Retrieval (check one)                             Download 835 From BBS     Download 835 Using CAQH CORE Web Service

10. Reason for Submission (check one)                             New Enrollment     Change Enrollment     Cancel Enrollment

- o I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information, payment information, and bank account information, provided by me and currently on file if enrolled in Electronic Funds Transfer, to the submitter identified in item #4 in the Electronic Remittance Advice Authorization (ERA) Agreement Form. This authorization will remain in effect until discontinued by written request or changed by a future request.
- o I attest that all information supplied in this authorization agreement is true, accurate and complete.
- o Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid on behalf of the provider.
- o I understand this electronic 835 transaction contains Protected Health Information (PHI) and have taken the necessary steps with my submitter to maintain the confidentiality of all PHI data.

\_\_\_\_\_  
11. Written Signature of Person Submitting Enrollment  
(Authorized Signature)

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12. Printed Name of Person Submitting  
Enrollment

\_\_\_\_\_  
13. Printed Title of Person  
Submitting Enrollment

\_\_\_\_\_  
14. Submission Date