HIPAA 837 Claims EDI Agreement

All New Jersey Medicaid and Charity Care Providers desiring to submit HIPAA formatted electronic claims must complete a HIPAA 837 Claims EDI Agreement as required by HIPAA guidelines. The New Jersey HIPAA 837 Claims EDI Agreement and instructions for their completion are provided later in this section. The EDI Agreement and HIPAA certification received for the specified HIPAA transaction sets must be prior approved and on file with DXC Technology before HIPAA formatted claims may be submitted electronically. DXC Technology will notify the EDI Submitter of New Jersey Medicaid's approval for the submission of HIPAA formatted electronic claims.

Submitters who are currently enrolled with DXC Technology for the submission of HIPAA 4010A1 formatted electronic claims and have completed and returned the Addendum to the existing EDI Agreement along with a 5010 HIPAA Certification do NOT have to complete the EDI Agreements included in this Companion Guide. The Addendum Agreement replaces the previously executed EDI Agreement on file with DXC Technology.

All other providers/submitters who have not been approved to submit claims electronically with DXC Technology must complete one of the following New Jersey Medicaid EDI Agreements.

- If the provider/submitter intends on submitting the claims directly to New Jersey Medicaid, then the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** must be completed and returned to the DXC Technology EDI Unit. In addition, a copy of the HIPAA certification form certifying their capability to produce HIPAA compliant transactions must be included as an attachment to the EDI agreement. Only after the agreement and certification have been received and accepted by the DXC Technology EDI Unit will a Submitter ID be assigned.

- A new agreement must be completed when a provider or billing service changes ownership or name of the company and a new HIPAA Certification is also required to be provided.

- It is the responsibility of each submitter to notify the EDI UNIT if there is a change in address, contact information or email address. Please use the EDI SUBMITTER UPDATE form.

- In addition, a completed **Submitter/Provider Relationship EDI Agreement; (Form EDI–201)** for each New Jersey Medicaid Provider Number under which claims will be submitted needs to be completed and returned either with the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** or subsequent to the assignment of the Submitter ID by DXC Technology.

- New Jersey Medicaid and Charity Care providers who are submitting claims directly to DXC Technology that have already been assigned a Submitter ID must complete a **Submitter/Provider Relationship EDI Agreement (Form EDI–201)** for each Billing/Pay-to New Jersey Medicaid provider number.

- New Jersey Medicaid and Charity Care providers who are submitting claims through Clearing House/Billing Service are required along with the Clearing House/Billing Service to complete a **Submitter/Provider Relationship EDI Agreement (Form EDI–201).** A separate agreement is required for each Billing/Pay-to New Jersey Medicaid provider number.

- New Jersey Medicaid and Charity Care providers wishing to receive their remittance advice information electronically must complete the **Submitter Electronic Remittance EDI Agreement (Form EDI–801).**

Providers must notify DXC Technology in writing when the provider has terminated their agreement with a Clearing House/Billing Service to submit claims to New Jersey Medicaid on behalf of the provider. If the provider elects to contract with a different Clearing House/Billing Service, the provider and new billing service must complete the Submitter/Provider Relationship EDI Agreement and return the completed agreement to the DXC Technology EDI Unit.

HIPAA 837 Claims EDI Agreement

Providers must notify DXC Technology in writing when their use of a software developer's application for the direct submission of electronic claims to DXC Technology has been terminated. When a provider changes to a new software developer's application, the provider must complete a new **New Jersey Submitter/Provider Relationship EDI Agreement (Form EDI–201**) and submit it to DXC Technology along with a copy of the HIPAA certification form. DXC Technology will notify the provider when approval to submit claims electronically has been granted.

All New Jersey Medicaid EDI Agreements **MUST** be submitted to DXC Technology with **ORIGINAL** signatures. Facsimile copies of agreements will **NOT** be accepted. If the agreement is not properly completed, DXC Technology will return it.

HIPAA 837 Claims EDI Agreement (Form EDI–101) – Instructions

WHO SHOULD COMPLETE THIS AGREEMENT?

If you are a provider or a Clearing House/Billing Service for a provider who would like to submit claims directly to DXC Technology, you should complete this form. By completing this form, a submitter number will be assigned to you in order to submit HIPAA 837 formatted claims. Only fill out this form if you currently do not have a submitter number. This agreement MUST be completed and must be accompanied with a HIPAA Certification and the EDI-201 Form (Submitter/Provider Relationship Agreement) in order to link a provider to a submitter.

SECTION 1: SUBMITTER INFORMATION

For the ☐**MEDICAID**, or ☐**CHARITY CARE** check boxes located at the top of the form, indicate the type of claims for which you will be submitting electronically. Check **one** box only.

1. **Submitter Name**: Enter the name of the Provider or Clearing House/Billing Service Name as registered with New Jersey Medicaid/DXC Technology.

2. **Submitter Street Address**: Enter the physical street address of the Provider or Clearing House/Billing Service. This MUST be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

3. **City, State, Zip Code**: Enter the city, state and zip code. This MUST be part of the physical address.

4. **EDI Contact Person:** Enter the name of a person in the event DXC Technology needs to contact someone from your company should there be a problem with your file or transmission of claims.

5. **Phone/Ext:** Enter the phone number along with the extension of a person from your company in the event DXC Technology needs to contact someone should there be a problem with your file or transmission of claims.

6. **FAX:** Enter the FAX number of your place of business.

7. **Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your submitter file profile. This email address will be used to notify you if there is a problem with your file transmission.

8. **2nd EDI Contact Person:** Enter the name of a secondary person in the event DXC Technology needs to contact someone from your company. Preferably the ENROLLMENT DEPARTMENT responsible for handling the EDI AGREEMENT applications.

9. **Phone/Ext:** Enter the secondary phone number along with the extension of a person from your company in the event DXC Technology needs to contact someone.

10. **2nd EDI Contact Person Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your submitter file profile. This email address will be used to send a confirmation to acknowledge the processing of the EDI Agreement and confirm your submitter profile has been updated to allow you to send HIPAA electronic claims.

11. **Submitter Representative's Signature**: This MUST be an original signature of the provider business owner or Billing Service. THIS MAY NOT BE STAMPED. This person should have liability authority of the business.

12. **Date Signed**: Date signature was placed on this form.

13. **Submitter Representative's Name**: PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 11 above).

SECTION 2: HIPAA TRANSACTION SETS & CERTIFICATION

14. **Transaction Sets:** Indicate by placing a check mark in the appropriate boxes that describe the HIPAA transaction set type(s) to be submitted to DXC Technology for the Provider Number above.

15. **Certification Vendor Name:** Enter the name of the organization certifying your ability to produce 837 version 5010 transactions sets to a Level 3 transaction testing. The HIPAA Certification **MUST** have either the Submitter's company name or the Software Vendor's company name on the certification.

16. **Certification Attached**: Indicate by putting a check mark in the appropriate box indicating whether the HIPAA certification document is attached. Certification must be provided before approval for electronic submission is granted. HIPAA Certification is **REQUIRED** individually for each of the transactions sets you will be submitting.

SECTION 3: SOFTWARE VENDOR INFORMATION

NOTE:

- ***If you are a Billing Service and you are using an in house product that was developed by your company, this section is still required.***

- ***If you are a Provider submitting claims directly to DXC Technology this section must be completed.***

17. **SOFTWARE VENDOR NAME:** Enter the BUSINESS name of the software vendor.

18. **STREET ADDRESS:** Enter the physical street address of the software vendor. This MUST be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

19. **CITY, STATE, ZIP CODE:** Enter the city, state and zip code. This **MUST** be part of the physical address.

20. **SOFTWARE CONTACT PERSON:** Enter the name of a person from the software company in the event DXC Technology needs to contact someone at the software company.

21. **PHONE/EXT:** Enter the phone number along with the extension of a person from the software company in the event DXC Technology needs to contact someone at the software company.

22. **SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the email address of a contact person from the software company in the event DXC Technology needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.

23. **2nd SOFTWARE CONTACT PERSON:** Enter the name of a secondary person from the software company in the event DXC Technology needs to contact someone at the software company.

24. **PHONE/EXT:** Enter a secondary phone number along with the extension of a person from the software company in the event DXC Technology needs to contact someone at the software company.

25. **2nd SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the email address of a second contact person from the software company in the event DXC Technology needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.

26. **FAX:** Enter the FAX number of the software company.

27. **SOFTWARE PRODUCT NAME:** If a software company has multiple products, please enter the name of the product you are installing for the submission of the HIPAA transaction sets indicated in Section 2 above.

28. **SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME:** Please enter the release number of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 2 above.

29. **SOFTWARE PRODUCT RELEASE DATE:** Please enter the release date of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 2 above.

Return the completed EDI Agreement to DXC Technology at the following address:

Via U.S. Mail
EDI UNIT
DXC Technology
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
EDI UNIT
DXC Technology
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

For Internal Use Only EMCAGREE				☐ 837-I-D-P
DOCTYPE	*Submitter ID*	*Submitter & Provider Name*		☐ E-RA
				☐ SIGN
				☐ ADD
Update Initials	*Date*	*QA Initials/Date*	*Provider Group Number*	☐ TERM

HIPAA 837 Claims EDI Agreement

☐ **MEDICAID** ☐ **CHARITY CARE**

SECTION 1: SUBMITTER INFORMATION

Every Submitter or their designated Clearing House/Billing Service, as a condition for submitting electronic claim transactions to New Jersey Medicaid, must complete, sign and submit this HIPAA 837 Claims EDI Agreement to the New Jersey Medicaid Program or their designated agent. A submitter is defined as either 1) a third party Clearing House/Billing Service who has entered into a contract with one or more New Jersey Medicaid providers to submit claims to New Jersey Medicaid on behalf of the provider or 2) a New Jersey Medicaid provider that will be submitting their claims directly to New Jersey Medicaid rather than through a third party Clearing House/Billing Service. By signing this agreement you are certifying that the claim transactions you submit will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of software services provided, and to furnish information for such services as the State agency may request.

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.

1) Submitter Name: _____

2) Submitter Street Address: _____
(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

3) City, State, Zip Code: _____

4) EDI Contact Person: _____ 5) Phone/Ext:( ) /

6) FAX: ( ) 7) Email Address: _____

8) 2nd EDI Contact Person: _____ 9) Phone/ Ext:( ) /

10) 2nd EDI Contact Person Email Address: _____

_____ _____
11) Submitter Representative's Signature (must be original) 12) Date Signed

_____
13) (Submitter Representative's Name – Please Print Clearly)

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".

HIPAA 837 Claims EDI Agreement

Submitter Name: _____ Submitter #: _____

SECTION 2: HIPAA TRANSACTION SETS & CERTIFICATION

14) Transaction Sets:

5010	☐	837 Claim Professional 005010X222A1	☐	837 Claim Institutional 005010X223A2	☐	837 Claim Dental 005010X224A2

15) Certification Vendor Name: _____

16) Certification Attached: ☐ Yes ☐ No

FOR EACH BOX CHECKED, THERE MUST BE A HIPAA CERTIFICATION – LEVEL III WITH EITHER THE SUBMITTER'S COMPANY NAME OR THE SOFTWARE VENDOR'S COMPANY NAME ON THE CERTIFICATION.

SECTION 3: SOFTWARE VENDOR INFORMATION

This section is to identify third party software vendor and software product information if you are using a third party software product for the actual creation and submission of transactions to New Jersey Medicaid. If you are using software capabilities that were developed in house, please enter your company name followed by "In House" in the Software Vendor Name field.

17) SOFTWARE VENDOR NAME: _____

18) STREET ADDRESS: _____
(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

19) CITY, STATE, ZIP CODE: _____

20) SOFTWARE CONTACT PERSON: _____ 21) PHONE/EXT:(____) ____/____

22) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

23) 2nd SOFTWARE CONTACT PERSON: _____ 24) PHONE/EXT:(____) ____/____

25) 2nd SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

26) FAX: (____) _____

27) SOFTWARE PRODUCT NAME: _____

28) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: _____

29) SOFTWARE PRODUCT RELEASE DATE: _____

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

Return the completed EDI Agreement to DXC Technology at the following address:

Via U.S. Mail
EDI UNIT
DXC Technology
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
EDI UNIT
DXC Technology
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619