Ohio Department of Medicaid
Electronic Remittance Advice Enrollment

Rev. 12.24.2014.1

Overview

Complete this form to enroll with the Ohio Department of Medicaid to receive electronic remittance advice (ERA) files electronically via the Availity Web Portal. **All information on the form is required unless noted otherwise.**

The enrollment process establishes an electronic mailbox where Availity places ERA files received from the Ohio Department of Medicaid. Availity requires the provider's tax ID to establish an ERA receiver mailbox and to parse remittance transactions from the payer. Availity will send you a confirmation e-mail once enrollment is complete

Instructions

1. Complete the Receiver Information fields at the bottom of this page and the fields on the following page.
2. Return both pages of the completed, signed form to Availity via e-mail, fax, or mail. **Do not send this form to the Ohio Department of Medicaid. Availity will complete this step for you.** Allow 10 business days for processing.

E-mail	Fax	Mail
1. Click the **Send Form** button at the bottom of this page. 2. In the Send Email dialog box, click **Default email application**, and then click **Continue**. The form will be attached to an e-mail message that is automatically addressed to: 6415@availity.com 3. Send the e-mail message.	972.383.6415	Availity, LLC P.O. Box 550857 Jacksonville, FL 32255-0857

Who do I contact if I have questions?
If you have questions about your enrollment, contact Availity Client Services at 1.800.AVAILITY (282.4548).

Availity Information

PAYER INFORMATION			
Payer: Medicaid Ohio	Payer ID: MMISODJFS		
RECEIVER INFORMATION	* If different than provider contact information.		
Who will receive your ERA files?	Provider	Clearinghouse	Vendor
Receiver Name:	Availity Customer ID:		
Contact Name*:			
Telephone Number*:	Ext:	E-mail Address*:	
SEND THE FORM VIA:	**E-mail:**	**Fax:** 972.383.6415	**Mail:** Avality LLC P.O. Box 550857 Jacksonville, FL 32255-0857

THIS TRANSMISSION IS A PROPRIETARY AND CONFIDENTIAL COMMUNICATION The documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Ohio Department of Medicaid

DESIGNATION OF AN 835 or 834-820 TRADING PARTNER

By completing and signing this form the provider authorizes the department to transmit member enrollment and remittance advice data in an X12-5010 format through the EDI Trading Partner listed in Section II of this form. *All fields with an (*) are required. Forms missing required information will not be processed. Please include information in other fields if it is available. Current date will be used if the Effective Date is not included.*

SECTION I: PROVIDER INFORMATION

Provider Name:*	Doing Business As Name (DBA):	
Street:*		
City:*	State/Province:*	ZIP Code/Postal Code:*

SECTION II: PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):*	National Provider Identifier (NPI):
Other Identifiers	Assigning Authority: **Ohio Department of Medicaid**	Medicaid Provider ID:*
		Trading Partner ID:*

SECTION III: PROVIDER CONTACT INFORMATION

Provider Contact Name:*		Title:
Telephone Number:* ( ) - ext.	Email Address:*	Fax Number:

SECTION IV: ELECTRONIC REMITTANCE ADVICE INFORMATION

PREFERENCE FOR AGGREGATION OF REMITTANCE DATA *Provider Preference for grouping (bulking) claim payment remittance advice.*	
Provider Tax Identification Number (TIN): Required if NPI is not applicable*	National Provider Identifier (NPI): Required if TIN is not applicable*

SECTION V: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name:*	Clearinghouse Contact Name:*
Telephone Number:	Email Address:

SECTION VI: SUBMISSION INFORMATION

Reason for Submission:* ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	Requested ERA Effective Date:
AUTHORIZED SIGNATURE *The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.*	
Written Signature of Person Submitting Enrollment:*	
Printed Name of Person Submitting Enrollment:*	
Printed Title of Person Submitting Enrollment:	

Send the completed form to:
Ohio Department of Medicaid
P.O. Box 182709
Attn: ITS/EDI
Columbus, Ohio 43218-2709
or eMail: DAS-EDI-Support@das.ohio.gov, or Fax: (614) 644-8989