0121

Medicaid Provider ID: _____

or, Application Tracking Number (ATN)

Electronic Data Interchange Agreement

Mark the checkbox to indicate new information.

Important: An authorization letter on official letterhead, signed and dated is required to change any information. Send the authorization letter to the FL EDI Team at flediteam@gainwelltechnologies.com.

☐	Medicaid Provider ID:		☐	NPI:			
☐	Provider Name:						
☐	Address:						
☐	City:		☐	State:		☐	Zip + 4: -
☐	Contact Name:		☐	Contact Phone:	( )		
☐	Email:						
☐	The Medicaid provider listed above is a (check one):		○	Provider		○	Billing Agent/Clearinghouse

Section 1: Transaction Information

Complete this section to indicate how you plan to submit or receive electronic transactions.

If you are currently submitting/receiving electronic transactions directly to/from Medicaid, indicate your current 5-digit or 6-digit Trading Partner ID. _____

If you plan to use a billing agent/clearinghouse to submit directly to/from Medicaid, indicate the billing agent/clearinghouse's Trading Partner ID. _____

Note: To designate a billing agent to submit claims on your behalf, complete Section 2.

Indicate the transaction types you plan to send/receive

☐	820 Premium Payment	☐	835 Remittance Advice
☐	837P Professional	☐	834 Benefit Enrollment (Inbound/Outbound)
☐	837I Institutional	☐	270/271 Eligibility Request/Response
☐	837D Dental	☐	276/277 Claim Status Request/Response

For Fiscal Agent Use: _____

Section 2: Florida Medicaid Billing Agent Agreement

This section must be completed by any provider who wishes to designate or change a billing agent to submit claims form reimbursement by Florida Medicaid.

The following requirements apply to all billing agents/clearinghouses:

1. Any entity, that submits claims to Medicaid on behalf of an enrolled Medicaid provider must be enrolled in the Medicaid program as a billing agent with an active provider number.
2. Claims must be paid in the name of the provider or provider group that renders the services, not in the name of the billing agent.
3. Payment for billing services must be made based upon an administrative fee per claim. Billing agents are prohibited from charging for their services based upon a percentage of the total dollar value of claims billed.
4. If a claim is rejected as inaccurately filed, it cannot be resubmitted unless there has been a change made to the claim form or electronic submission itself.

"The following billing agent is authorized to submit claims to and follow up with Medicaid and the Medicaid fiscal agent on my behalf. I understand that all payments and payment information are in my name and that this agreement does not exempt me from responsibility for claims filed on my behalf or from established claim filing policies. I further understand that the billing agent must be held to the same requirements of confidentiality and access to records as I am, as reflected in my agreement with Medicaid. I will immediately notify the Medicaid fiscal agent of any change in this authorization."

_____ _____

Billing Agent Name | Billing Agent Provider Number

Section 3: Certifications

The provider identified on this Electronic Data Interchange Agreement understands and agrees to the following:

1. Payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws.
2. Providers must safeguard the Medicaid program against abuse in the use of electronic claims submission.
3. Providers must correctly enter the claims data, monitor the data, and certify that the data entered is correct.
4. Providers must assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments by the Agency's fiscal agent that might result from carelessness or fraud.
5. Providers must have on file the applicable source data to substantiate the claim submitted to the Medicaid program.
6. Providers must allow the Agency or any of its designees and representatives of the office of the Auditor General or the Attorney General to review and copy all records, including source documents and data related to information entered through electronic claims submission.
7. Providers must abide by all Federal and State statutes, rules, regulations, and manuals governing the Florida Medicaid program.
8. Providers must sign and adhere to all conditions of the Medicaid Provider Agreement and be officially enrolled in the Medicaid program to participate in electronic claims submission.

_____ _____

Signature | Date

Send completed form by:

Regular Mail
Gainwell Technologies
Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

Overnight or Express Delivery
Gainwell Technologies
Provider Enrollment
2671 Executive Center Circle West Suite 100
Tallahassee, FL 32301

Email
FL EDI Team at
flediteam@gainwelltechnologies.com

(Florida Medicaid Program – Do not write below this line)

Received By:		Date:	
FMMIS Updated By:		Date:	

gainwell