



Capario Enrollment  
1901 E. Alton Ave. #100  
Santa Ana, CA. 92705  
Phone: (800) 792-5256 Option 1  
Fax: (404) 877- 3324  
provider.enrollment@Capario.com

## ERA Payer Agreement Instructions for Colorado Medicaid (MC004)

To enroll with Colorado Medicaid for ERAs complete and send the payers agreements and requested information directly to ACS. In addition, please complete and send the Capario ERA Enrollment Request Form to our EDI Team. Specific instructions for this Payer are shown below.

ERA Transactions are available as an additional Capario contracted service. To add ERAs to your contract please contact your Capario Sales person or Account Manager. ERAs must be part of your contract and you must be enrolled with this Payer BEFORE submitting this ERA Payer Agreement.

**\*\*NOTE\*\*** EFT enrollment and transmission is an arrangement between the provider and the Payer. Colorado Medicaid requires EFT in order to receive ERAs electronically. You must submit the Authorization Agreement for Automatic Deposits and a current W-9 Form and a voided check.

### Guidelines for Enrolling with this Payer

**1. Mail the completed Provider EDI Update Form, the Authorization Agreement for Automatic Deposits, a current W-9 and a voided check to:**

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

**2. Fax or mail the Capario ERA Enrollment Request Form to:**

Capario  
EDI Team  
1901 E. Alton Ave. Suite 100  
Santa Ana, CA. 92705  
Fax: (404) 877-3324

To obtain the Capario ERA Enrollment Request Form, go to:  
[www.capario.com/services/resource\\_center/enrollment\\_instructions.html](http://www.capario.com/services/resource_center/enrollment_instructions.html)

*Questions? Contact Capario Enrollment at: (800) 792-5256 Option 1*

**For Portal Users: Enroll using the Capario Portal Enrollment Tool.  
The ERA Enrollment Request Form is not needed.**



# Colorado Medical Assistance Program

## Provider EDI Update Form

Provider Trading Partner ID: \_\_\_\_\_ Provider ID: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

**Providers may change/update the following sections to make revisions to the Electronic Data Interchange Provider Enrollment & Agreement**

**Section 1. I want to update the following information (Changes/ Updates will only be made to items that have been checked below):**

- Demographic/ Contact Information (Section 2)
- Report Retrieval (Section 4)
- Submission Method (Section 3)

### Section 2. Demographic/ Contact information:

Legal Name: \_\_\_\_\_

Mail to Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Contact Information** –  Add to existing contact information  Replace current contact information

#### Primary Contact Information

Contact Individual Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

#### Secondary Contact Information

Contact Individual Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

*If the any above is updated information, your information in the MMIS will not be updated. To update your provider information in the MMIS, you must either update the information through the Web Portal or complete and submit the Provider Enrollment Update Form located in [Providers already enrolled in the Colorado Medical Assistance Program](#) of the Provider Services Enrollment section.*



# Colorado Medical Assistance Program

## Section 3. Submission method

### Sub-Section 3 a. Submission method – Add

Complete this section if you are adding a Billing Agent, Clearinghouse, or Software Vendor

**You must also complete and submit the Provider Authorization Form (page 4) if you are authorizing a Billing Agent or Clearinghouse.**

Please enter the name and TP ID of the Clearinghouse/Billing Agent or Software Vendor Name that will submit your electronic transactions.

1. Clearinghouse/Billing Agent/ Software Vendor Name: \_\_\_\_\_
2. Clearinghouse/Billing Agent/ Software Vendor Trading Partner ID (TP ID): \_\_\_\_\_

### Sub-Section 3b. Submission method – Remove (If you choose to Remove your affiliation with a Clearinghouse or Billing Agent, you must update your report retrieval (section 4))

Complete this section if you are terminating your affiliation with a Billing Agent or Clearinghouse,

1. Clearinghouse/Billing Agent/ Name: \_\_\_\_\_
2. Clearinghouse/Billing Agent/ Trading Partner ID (TP ID): \_\_\_\_\_

## Section 4. Report Retrieval

Colorado Medical Assistance Program providers can receive X12N electronic reports. Enter only one Trading Partner (TP) ID per report. If you want to retrieval your own reports please indicate your TP ID on the lines below)

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> X12N 824 (Payer Specific Error Report) Will by default be returned to submitting TP ID | <input checked="" type="checkbox"/> X12N 997 (Acknowledgement of a sent transaction) Will by default be returned to submitting TP ID |
| <input checked="" type="checkbox"/> X12N 271 (Eligibility Response) Will by default be returned to submitting TP ID        | <input checked="" type="checkbox"/> X12N 277 (Claim Status Response) Will by default be returned to submitting TP ID                 |

Please select the report and enter the corresponding TP ID for each report retrieved 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.*

	Receiving TP ID		Receiving TP ID
<input type="checkbox"/> X12N 820 (Client Capitation)	_____	<input type="checkbox"/> X12N 835 (Claim payment/Claim report)	_____
<input type="checkbox"/> X12N 834 (Benefit Enrollment and Maintenance)	_____	<input checked="" type="checkbox"/> Provider Claim Report (Previously called the Remittance Advice Report)	_____
<input checked="" type="checkbox"/> Accept/Reject Report	_____	<input checked="" type="checkbox"/> PAR Letters	_____
<input type="checkbox"/> ACC Roster Report	_____		



# 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 designated reports*
- *Submit and/or retrieve designated transactions*

*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)

\_\_\_\_\_  
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)

\_\_\_\_\_  
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.



# Colorado Medical Assistance Program

Please return the completed Provider Update Form, Provider Authorization Form (if applicable), and executed Provider Participation Agreement to the following address:

**ACS State Healthcare  
Colorado Medical Assistance Program  
EDI Enrollment  
P.O. Box 1100  
Denver, CO 80201-1100**

Agency ID UHA

State of Colorado  
**AUTHORIZATION AGREEMENT  
FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Check one:

New  Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** \_\_\_\_\_

LEGAL NAME \_\_\_\_\_

DBA NAME \_\_\_\_\_

**Complete one of the following (EIN or SSN) but not both**

FEDERAL EIN NUMBER

(Corporation, partnership, trust, sole proprietor, etc.)

\_\_\_\_\_ - \_\_\_\_\_

or

SOCIAL SECURITY NUMBER

(Individual or sole proprietor)

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

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**DEPOSITORY INFORMATION**

BANK NAME \_\_\_\_\_

BANK ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

BANK DEPOSITORY TRANSIT NUMBER \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_

TYPE OF BANK ACCOUNT (CHECK ONE)  CHECKING

*Attach voided check or bank letter*

SAVINGS

*Attach bank letter*

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This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date \_\_\_\_\_ Phone number \_\_\_\_\_

Authorized Signature \_\_\_\_\_

Title \_\_\_\_\_

Authorized Signature \_\_\_\_\_

Title \_\_\_\_\_

**For Fiscal Agent Use Only**      *Initials:* \_\_\_\_\_      *Date:* \_\_\_\_\_

# Completion Instructions

Agency ID UHA

State of Colorado  
**AUTHORIZATION AGREEMENT  
 FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Check one:  
 New  Change

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type)      **MEDICAID TYPE (34)**      **MEDICAID PROVIDER #** Enter your 8-digit provider #  
 LEGAL NAME      Enter the legal name assigned to the Federal EIN or SSN below  
 DBA NAME      Optional - You may enter the DBA or trade name for corporation, sole proprietor, etc.

**Complete one of the following (EIN or SSN) but not both**

FEDERAL EIN NUMBER      Complete for corporations, partnerships, etc. Enter the EIN assigned to the legal name entered above.  
(Corporation, partnership, trust, sole proprietor, etc.)

or  
 SOCIAL SECURITY NUMBER (Individual or sole proprietor)      Complete for individuals or sole proprietors. Enter the SSN assigned to the legal name entered above.

ADDRESS      Enter the mailing address for the legal name entered above

CITY, STATE, ZIP      Enter the City, State and ZIP for the legal name entered above

**DEPOSITORY INFORMATION**

BANK NAME      Enter the name of the bank or financial institution where the funds will be transferred

BANK ADDRESS      Enter the address of the bank or financial institution

CITY, STATE, ZIP      Enter the City, State and ZIP for the bank or financial institution

BANK DEPOSITORY TRANSIT NUMBER      Enter the 9-digit number from your voided check (see illustration below) or contact your financial institution for information

ACCOUNT NUMBER      Enter the account number where the funds will be deposited

TYPE OF BANK ACCOUNT (CHECK ONE)  CHECKING       SAVINGS  
    **Attach voided check or bank letter**      **Attach bank letter**

Enter a check mark to identify the type of account where the funds will be deposited.

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it. It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date Enter the date the form is signed      Phone number Enter your telephone number

Authorized Signature      This must be the signature of the individual or sole proprietor if an SSN is used or the authorized representative of a corporation, partnership, etc.

Title Enter the title of the authorized representative of a corporation, partnership, etc.

Authorized Signature      Optional - Add a second signature only if required for a corporation, partnership, etc.

Title Enter the title of the second authorized representative of a corporation, partnership, etc.

**For Fiscal Agent Use Only**      Initials: \_\_\_\_\_      Date: \_\_\_\_\_

Revised: March 2009

ACCOUNT OWNER NAME  
 1234 Main Street  
 Anytown, CO 00000

Pay to the Order OF \_\_\_\_\_ \$ \_\_\_\_\_  
DOLLARS

ANYTOWN BANK  
 Anytown, CO 00000

For \$ 123456789 123412 1234

**Transit number**      **Account number**

**Account Number Illustration**