



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 District of Columbia Medicaid (MC088)

You will enroll for ERAs by completing and sending the Payer Agreement directly to the Payer. 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.

EFT enrollment and transmission is an arrangement between the provider and the Payer. If the Payer offers EFT transactions contact them to determine if they:

- Require you to receive EFTs in order to receive their ERAs
- Charge an additional fee for EFTs/ERAs
- Require you to enroll for EFTs on this ERA enrollment form.

Guidelines for Enrolling with this Payer

1. Fax or Mail the **Provider ACS EDI Gateway Authorization Form** to:

ACS EDI Gateway, Inc
Attn: EDI Enrollment Unit
2324 Killlearn Center Blvd
Tallahassee, Florida 32309
Fax: (850) 385-1705

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

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

To obtain the Capario ERA Enrollment Request Form, go to:
www.capario.com/services/resource_center/enrollment_instructions.html

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

Washington, D.C. ACS EDI Submitter Enrollment Form



Please return to:
ACS
Attn: Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761
Or fax to: 202-906-8399



Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc. Authorization Form

Section A. Provider Information.

Please indicate your classification (required): ρ Individual Provider ρ Group Provider/Practice

Business Name

Provider Name (Last, First, MI and Suffix)

Provider Number (Required for Individuals)

Group Provider Number (Required for Groups)

Business Address

City, State, and Zip

Telephone Number

Fax Number

Contact Name

E-mail Address

Section B. Authorization Signature (required).

Provider, _____ hereby appoints

Provider name /Provider Representative name (please print)

Billing Agent/Clearinghouse name (please print)

Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

ρ 277-Claims Status Response

ρ 271-Eligibility Response

ρ 824-Error Report

ρ 835-Healthcare Claims Payment Advice

ρ 278-Prior Authorization Response

Provider/Provider Representative name (Please print)

Provider/Provider Representative Signature

Date