



1304 Vermillion Street • Hastings, MN 55033
 Pox 800-482-3518 • Fax 651-389-9152

NEVADA MEDICAID DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

| | | | | | |
|--|--|-----------------------------------|--------------|----------------------------|--------------|
| PAYER ID NUMBER | CKNV1 | | | | |
| ELECTRONIC REGISTRATIONS Agreements Required | Electronic Dental Services Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information. Service Center Authorization <ul style="list-style-type: none"> • Please complete all requested information. | | | | |
| SEND REGISTRATION FORMS TO: | EDS 1304 Vermillion Street Hastings, MN 55033 Attn: Provider Enrollment | | | | |
| ENROLLMENT CONFIRMATION | EDS will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete. | | | | |
| CHANGING ELECTRONIC BILLING AGENTS | If the Provider currently submits claims through another Billing Agent other than EDS each Provider must re-enroll following the procedures listed above. | | | | |
| CONTACT PHONE NUMBERS | <table style="width: 100%; border: none;"> <tr> <td style="border: none;">First Health Services Corporation</td> <td style="border: none; text-align: right;">877-638-3472</td> </tr> <tr> <td style="border: none;">Electronic Dental Services</td> <td style="border: none; text-align: right;">800-482-3518</td> </tr> </table> | First Health Services Corporation | 877-638-3472 | Electronic Dental Services | 800-482-3518 |
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PROVIDER ENROLLMENT FORM

Insurance Carrier: **Nevada Medicaid – payer ID CKNV1**

Print/Type the following:

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: _____

Group Type 2 NPI: _____
(if applicable)

| Name | Rendering | NPI – Type 1 |
|-------|-----------|--------------|
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.



~~Mail this form to Magellan Medicaid Administration, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.~~

| | |
|--|--|
| SERVICE CENTER SOURCE: Check one. Enter the business or clearinghouse name as appropriate. | |
| <input type="checkbox"/> I will submit claims through a clearinghouse. Clearinghouse Name: CPS/WebMD Dental | MAGELLAN MEDICAID ADMINISTRATION USE ONLY SC Code: 5147 |
| <input type="checkbox"/> I will submit claims directly from my business to Magellan Medicaid Administration (direct submitter). Business Name: | |
| AUTHORIZE A TRANSACTION: Check the box next to each transaction you wish to authorize. | |
| <i>I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies Magellan Medicaid Administration otherwise by use of this form.</i> | |
| <input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Institutional claim (UB-04 claim: 837I) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Dental claim (Dental Claim: 837D) <input type="checkbox"/> Electronic Remittance Advice (835)* | |
| * Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice. | |
| TERMINATE A TRANSACTION: Check the box next to each transaction you wish to terminate. | |
| <i>I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies Magellan Medicaid Administration otherwise by use of this form. (Enter the effective date below.)</i> | |
| <input type="checkbox"/> Eligibility Request/Response (270/271) <input type="checkbox"/> Professional claim (CMS-1500 claim: 837P) <input type="checkbox"/> Prior Authorization Request/Response (278/278) <input type="checkbox"/> Institutional claim (UB-04 claim: 837I) <input type="checkbox"/> Claims Status Request/Response (276/277) <input type="checkbox"/> Dental claim (Dental Claim: 837D) <input type="checkbox"/> Electronic Remittance Advice (835) | |
| Effective date for termination of this transaction(s): | |

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider/Entity Name: _____ Phone: _____

NPI/API (one per form): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? Yes No

Authorized Signature: _____ Date: _____ / _____ / _____