

Trading Partner Agreement Enrollment Instructions for Providers

The Trading Partner Agreement Enrollment (TPA) form may be found online at

<http://www.dhhs.state.sc.us/dhhsnew/hipaa/webfiles/TradingPartnerEnrollmentForm.pdf>

Please use the instructions below to fill out the TPA. Incomplete or incorrect TPAs will not be processed.

FIELD	INSTRUCTIONS
Date	Enter today's date.
Action Requested	Leave Blank
Trading Partner Name	Provider or Group Organization name. Some providers have both. In this case, you will complete a separate TPA for each provider or group SC Medicaid Provider Number.
Trading Partner ID	Leave blank, unless you have an X12 Submitter ID.
NPI	Enter the 10-digit NPI for the provider indicated on Trading Partner Name.
SC Medicaid Provider ID	Enter the 6-digit alphanumeric SC Medicaid Provider number here. If you are submitting this form as a part of your SC Medicaid Provider Enrollment packet, leave this field blank. If you wish to become a SC Medicaid Provider, contact Provider Enrollment at 888 289 0709 for an enrollment packet.
Type of Business	Select "Medicaid Provider"
South Carolina Medicaid Web Based Claims Submission Tool	<p>If you would like access to the SC Medicaid Web Tool, check the box. Indicate the number of IDs you require. Each person needs his own ID for access.</p> <p>If you bill as part of a group and the group already has access, you may leave this section blank. If you have an existing Web Tool ID and you would like the NPI on this TPA linked, you may request the link on this form. Write the Web Tool User ID in the space provided.</p> <p>The SC Medicaid Web Tool provides access to remittance advice, recipient eligibility, claims status and claims entry. Remittance Advice information is only available electronically; we no longer mail Remittance Advice information to providers.</p>
Protocol	Leave blank, unless you plan to submit your claim in X12 format directly to SC Medicaid.
Check Box	Read the 4 page EDI Agreement at http://www.scdhhs.gov/dhhsnew/hipaa/webfiles/TradingPartnerAgreement3.pdf and check the box.
Signature/Print Name	Signature of the provider or an authorized representative is required. A signature or name from the clearinghouse or software vendor is not valid.
Contact Information	Enter the contact information for the person in the provider's office who completed this form. <i>Do not use contact information for your vendor or clearinghouse.</i> We will contact this person if we need additional information to complete processing or if the form was not completed properly and cannot be processed. This information must be complete and accurate.
Software Vendor/Billing Agent	List your clearinghouse here. If you will only use the Web Tool, write "Web Tool" here. You may use both a clearinghouse and the Web Tool concurrently.
Transactions Requested	Leave blank, unless you have an X12 Submitter ID.
Page 2	Leave blank, unless you have an X12 Submitter ID. Do not list group members on this page. A separate TPA is required for providers belonging to a group.

Trading Partner Agreement Enrollment

Fax to (803) 870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Date	_____		
Trading Partner Name	_____		
Trading Partner ID (if applicable)	_____		
NPI	_____	SC Medicaid Provider ID	_____
Type of Business:	<input type="checkbox"/> Medicaid Provider	<input type="checkbox"/> Clearinghouse	<input type="checkbox"/> Software Vendor
	<input type="checkbox"/> Billing Service	<input type="checkbox"/> Other (please specify)	_____

South Carolina Medicaid Web-Based Claims Submission Tool

Select one

<input type="checkbox"/> Requesting access	Number of IDs requested	_____
<input type="checkbox"/> No access needed		
<input type="checkbox"/> Link to existing IDs		_____

Protocol

<input type="checkbox"/> Secure FTP	<input type="checkbox"/> WS_FTP Pro	<i>Only use this section if you are filing X12 claims directly to SC Medicaid. DO NOT USE if you submit through a vendor or clearinghouse.</i>
<input type="checkbox"/> CD	<input type="checkbox"/> Diskette	

I have read, understand, and agree with the conditions set forth in the South Carolina Medicaid Trading Partner Agreement for Electronic Claims and Related Transactions.

Signature _____

Print Name _____

Contact information

Name _____ Email _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Software Vendor or Billing Agent _____

Transactions Requested

Only use this section if you are filing X12 claims directly to SC Medicaid. DO NOT USE if you submit through a vendor or clearinghouse.

Y <input type="checkbox"/> N <input type="checkbox"/> 270 - Eligibility IN	Y <input type="checkbox"/> N <input type="checkbox"/> 835 - Electronic Remittance	Y <input type="checkbox"/> N <input type="checkbox"/> 820 - Premium Payments
Y <input type="checkbox"/> N <input type="checkbox"/> 271 - Eligibility OUT	Y <input type="checkbox"/> N <input type="checkbox"/> 837I - Institutional Claims	Y <input type="checkbox"/> N <input type="checkbox"/> 278 - Authorization
Y <input type="checkbox"/> N <input type="checkbox"/> 276 - Claims Status IN	Y <input type="checkbox"/> N <input type="checkbox"/> 837P - Professional Claims	Y <input type="checkbox"/> N <input type="checkbox"/> 834 - Benefit Enrollment
Y <input type="checkbox"/> N <input type="checkbox"/> 277 - Claims Status OUT	Y <input type="checkbox"/> N <input type="checkbox"/> 837D - Dental Claims	

