(Revised 05/23)

DEPARTMENT OF HEALTH AND HOSPITALS
LOUISIANA MEDICAID ELECTRONIC REMITTANCE ADVICE (ERA) AUTHORIZATION AGREEMENT

1. Provider Name _____

2. Provider TIN or EIN (9 digits) | | | | | | | | | |

3. National Provider Identifier (NPI) (10 digits) | | | | | | | | | | |

4. Gainwell Medicaid Trading Partner ID (7 digits) | 4 | 5 | 0 | | | | |

5. Provider Contact Name

6. Provider Contact Telephone Number ( ) -

7. Provider Contact Email Address

8. Account Number Linkage to Provider Identifier (check one) ☐ Provider Tax Identfication Number (TIN) ☐ National Provider Identifier (NPI)

9. Method of Retrieval (check one) ☐ Download 835 From BBS ☐ Download 835 Using CAQH CORE Web Service

10. Reason for Submission (check one) ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

- o I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information, payment information, and bank account information, provided by me and currently on file if enrolled in Electronic Funds Transfer, to the submitter identified in item #4 in the Electronic Remittance Advice Authorization (ERA) Agreement Form. This authorization will remain in effect until discontinued by written request or changed by a future request.
- o I attest that all information supplied in this authorization agreement is true, accurate and complete.
- o Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid on behalf of the provider.
- o I understand this electronic 835 transaction contains Protected Health Information (PHI) and have taken the necessary steps with my submitter to maintain the confidentiality of all PHI data.

11. Written Signature of Person Submitting Enrollment (Authorized Signature) _____

12. Printed Name of Person Submitting Enrollment _____

13. Printed Title of Person Submitting Enrollment _____

14. Submission Date (MM/DD/YYYY) _____