# Medi-Cal Rx Electronic Remittance Advice (ERA) Authorization Agreement Form

**Instructions:** Carefully read and complete the Electronic Remittance Advice (ERA) Authorization Agreement. The ERA is the HIPAA-compliant 835-Transaction and is also referred to in this form as the "835-Transaction." The ERA Authorization Agreement must be filled out by an active Medi-Cal Rx provider. Non-providers can receive electronic remittances if designated as a receiver by a provider; however, the authorizing provider must submit the agreement. This authorization remains in effect until Medi-Cal Rx receives written notification from the provider of its termination, or until Medi-Cal Rx or appointing authority deems it necessary to terminate the agreement.

Providers can either submit this form or use the Medi-Cal Rx Web Portal (at https://medi-calrx.dhcs.ca.gov/provider) to provide new or modified ERA account information or to cancel ERA enrollment. A provider must be a registered Medi-Cal Rx Web Portal user to update their ERA information online. Once registered, log in and select **Finance Portal** from the left-hand menu to access the ERA information page.

For providers opting to use this form, print and mail the form per the instructions in the *Form Submission* section below. Explanations regarding form fields are located below the form in the *Explanation of ERA Authorization Agreement Form* section. Complete forms will be processed within 10 business days. Incomplete forms will not be processed and will be returned to the provider.

*** Indicates Required Field**

## * PART 1 – Reason for Submission

- ◯ **New Enrollment:** Select this option if you would like to receive Electronic Remittance Advice from Medi-Cal Rx.
- ◯ **Change Enrollment:** Select this option if you are changing who receives your Electronic Remittance Advice from Medi-Cal Rx.
- ◯ **Cancel Enrollment:** Select this option if you want to cancel receiving Electronic Remittance Advice from Medi-Cal Rx. Any pharmacies not receiving an electronic remittance will be mailed their remittance at the pay-to address on file and will have access to the PDF version via the Medi-Cal Rx Web Portal.

## PART 2 – Provider Information

| | | |
|---|---|---|
| *Provider Name: | | |
| *Street: | | |
| *City: | *State: | *ZIP Code: |

| **PART 3 – Provider Identifiers** | |
|---|---|
| This form accommodates up to three pharmacies to be included in this ERA agreement. To include more than three pharmacies in the ERA agreement or to register an entire chain by NCPDP Chain Code, update ERA information online using the Medi-Cal Rx Web Portal link listed above. | |
| **Provider 1** | |
| *Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN): | |
| *National Provider Identifier (NPI): | |
| *Owner # *(see Explanation of Form Fields below)*: | |
| **Provider 2** | |
| *Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN): | |
| *National Provider Identifier (NPI): | |
| *Owner # *(see Explanation of Form Fields below)*: | |
| **Provider 3** | |
| *Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN): | |
| *National Provider Identifier (NPI): | |
| *Owner # *(see Explanation of Form Fields below)*: | |
| **PART 4 – Provider Contact Information** | |
| *Contact Name: | |
| *Telephone Number: | Telephone Extension: |
| Email Address: | |
| Fax Number: | |

## PART 5 – Receiver Information *(Other than the provider in Part 4)*

A provider can designate an entity to receive an ERA (835-Transaction). The receiver can be an outside party such as a billing service or clearinghouse. The provider must have a business associate agreement, in compliance with *Title 45, Code of Federal Regulations, Section 164.504(e)*, with the outside party designated to receive the 835-Transaction. **If designating one or more entities to receive the 835-Transaction, the provider must fill out each section below in its entirety.** The email address provided will be the designated receiver's user ID. A password and link to the portal will be emailed to the designated receiver. A provider can designate up to two receivers below. To designate more than two receivers, a provider can update ERA information online using the Medi-Cal Rx Web Portal link listed above. If you selected **Change Enrollment** in Part 1, specify whether to **Add** or **Remove** the receiver.

**Receiver 1** ☐ Add ☐ Remove

☐ I hereby attest that I have a business associate agreement with the receiver designated below.

| | | |
|---|---|---|
| Receiver Name *(full legal)*: | | DBA *(if applicable)*: |
| Contact Person: | | |
| Street: | | |
| City: | State: | ZIP Code: |
| Contact Telephone Number: | | Telephone Extension: |
| Email Address: | | |

**Receiver 2** ☐ Add ☐ Remove

☐ I hereby attest that I have a business associate agreement with the receiver designated below.

| | | |
|---|---|---|
| Receiver Name *(full legal)*: | | DBA *(if applicable)*: |
| Contact Person: | | |
| Street: | | |
| City: | State: | ZIP Code: |
| Contact Telephone Number: | | Telephone Extension: |
| Email Address: | | |

**Confidentiality of Record**

The Provider agrees to maintain adequate administrative, technical, and physical safeguards to protect the confidentiality of protected health information (PHI) in accordance with State and Federal statutes and/or regulations. Any breach of security or unlawful disclosure of PHI shall be reported to the Department of Health Care Services (DHCS) within 24 hours of the Provider learning of such breach or disclosure and may be grounds for termination of this Agreement.

**Privacy Statement (Civil Code Section 1798 et seq.)**

The information requested on this form is required by DHCS for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in the Provider's request being delayed or not being processed.

**Provider's Obligations, Termination Rights, and Limitation on Liability**

The Provider is responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment and agrees to seek correction of any claim errors through the appropriate processes as designated by DHCS including, but not limited to, the process set out in *Title 22, California Code of Regulations, Section 51015*, as, from time to time, amended.

Either the Provider or DHCS may terminate this Agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider understands that they have no right to appeal such termination by DHCS. The Provider further agrees that they have no right to appeal termination for cause prior to the effective date of such termination. The Provider may, however, appeal any grievance resulting from the termination in accordance with the procedure established by *Title 22, California Code of Regulations, Section 51015*.

The Provider agrees to hold the State of California harmless for any and all failures to perform by the Receiver services, software, or other features of 835-Transactions, which do not occur with paper (hard copy) Remittance Advice Details. Regardless of whether the Provider employs a third-party Receiver to access the 835-Transaction, the Provider agrees to retain personal responsibility for the receipt of all Health Care payment/advice 835-Transaction information.

The Provider agrees to assume all risks that accompany receiving 835-Transactions, and that the Provider is not relying upon the evaluation the State has made of the electronic Receiver's system or software the Provider is using. The Provider further agrees that neither DHCS nor its agent are responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHCS. The Provider agrees that if the electronic Receiver system, software of Receiver contracted with, is or has been listed as available in Medi-Cal Rx bulletins, that such listing was not an endorsement by the State of California nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

The Provider will not provide the data supplied under this Agreement to any third party except the applicable agents for whom the Provider has authorized to provide billing collection and/or reconciliation

services and which have a business associate agreement in effect with the Provider, in compliance with *Title 45, Code of Federal Regulations*, *Section 164.504(e).* The Provider acknowledges that 835-Transaction data is confidential information owned by the State, the Medi-Cal Rx fiscal intermediary, and/or applicable providers. This provision shall survive the expiration of this Agreement.

The Provider and any authorized Receiver agree to use their Medi-Cal Rx identification number and NPI when accessing the Medi-Cal Rx Web Portal. This information shall serve as the acceptance to the terms and conditions of the *Medi-Cal Rx Telecommunications Provider and Biller Application/Agreement Form* (DHCS 6500).

Upon review of all 835-Transaction data, if the Provider/Receiver finds the data unreadable or incorrect, they are instructed to contact Medi-Cal Rx for resolution. Failure to report any such data inaccuracies shall constitute acceptance thereof.

The Provider understands and agrees that DHCS is not liable to the Provider or to any authorized Receiver for any claim of, or damage or injury suffered by the Provider or any authorized Receiver caused by the DHCS' delay in furnishing the data supplied hereunder. Moreover, neither party shall be liable for any damage amounts representing indirect, consequential (such as loss of business or loss of profits), or punitive damages.

Each party shall be excused from performance under this Agreement for any period and to the extent that it is prevented from performing; in whole or in part, as a result of delays caused by the other party, the State, or an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control.

**Agreement between Provider and Additional Third-Party Receiver (If Other than Provider of Service)**

The Provider stipulates that any agreements with a Receiver to receive Medi-Cal Rx 835-Transactions shall be in conformance with State and/or Federal law governing electronic transactions and shall contain provisions including, but not limited to, the following:

- The Provider shall specifically designate the Receiver as the agent of the Provider for the purpose of receiving 835-Transactions for the Provider. As the Provider's agent, the Receiver agrees to comply with all Medi-Cal requirements on record making and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Section 14124.1 and *Title 22*, *California Code of Regulations, Section 51476*. The Receiver also agrees to comply with State and federal laws on privacy of individually identifiable health information, including *Title 45, Code of Federal Regulations, Parts 160 and 164*.
- The parties shall agree that DHCS will make available 835-Transactions to additional Receivers only as long as the agreement between the Provider and the Receiver including the business associate provisions required by *Title 45, Code of Federal Regulations, Section 164.504(e)*, remains in existence and in effect.

## * PART 6 – Provider Certification

The provider is required to notify DHCS in writing immediately upon any change in or termination of their agreement.

**To be completed by the provider:**

☐ I hereby authorize Medi-Cal Rx to load my 835-Transactions to https://medi-calrx.dhcs.ca.gov/provider and acknowledge that in order to access my 835-Transactions, I must be a registered Web Portal user. I authorize the following individuals to access my 835-Transactions (check all that apply):

- ☐ Myself as the provider.
- ☐ The recipient(s) designated on this form.

☐ I hereby authorize Medi-Cal Rx to update my previous ERA Authorization Agreement with the information on this form.

☐ I hereby cancel my 835-Transaction authorization.

**Signature** *(Original Signature Required; Use Blue Ink)***:**

_____

**Date:** _____

**Print Name:** _____ **Title:** _____

**OFFICE USE ONLY** Date Received: _____ Date Completed: _____
Completed by Name: _____

## Form Submission

Verify that all information is correct, complete, and that the form is signed in blue ink. Print and mail this form to the address below. For assistance in completing the form or to check the status of your form, contact Medi-Cal Rx Customer Service at the phone number below.

Medi-Cal Rx Customer Service Center
ATTN: Financial Inquiries
P.O. Box 610
Rancho Cordova, CA 95741-0610
Phone: 1-800-977-2273 (Select Option 2 for Pharmacy, enter your NPI, and then select Option 2 for Checkwrite)

# Explanation of ERA Authorization Agreement Form

The supplied Provider Information and Provider Identifiers on this form must match the current information on file with the DHCS Provider Enrollment Division (PED). If it does not match, the application will not be approved. If information on file with PED is out of date, update the information through the Provider Application and Validation for Enrollment (PAVE) Portal found at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx prior to submitting this form.

## Explanation of Form Fields

### Provider Information

**Provider Name:** Complete legal name of institution, corporate entity, practice, or individual provider.

**Address fields:** Provider's pay-to address (number, street name, city, state, and ZIP Code).

**Telephone Number:** Telephone number associated with the provider, with no dashes or spaces (e.g., 8888888888).

**Telephone Extension:** Provider's telephone extension, if applicable.

**Email Address:** Electronic mail address at which Medi-Cal Rx staff may reach the provider. This email address will be the User ID to access the provider's 835-Transactions.

### Provider Identifiers

**Federal Tax ID # (TIN) / Employer ID # (EIN) or Social Security # (SSN):** A Federal TIN, also known as an EIN, is used to identify a business entity. This must match the TIN/EIN that is on file with Medi-Cal. Include an SSN if the provider does not have a TIN/EIN.

**National Provider Identifier (NPI):** A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use NPIs (in lieu of legacy provider identifiers) in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

**Owner #:** Enter the owner number associated with the provider. The owner number can be found on the provider's Medi-Cal Rx Remittance Advice Detail or by calling Medi-Cal Rx at 1-800-977-2273 (select Option 2 for Pharmacy, enter your NPI, and then select Option 2 for Checkwrite). Note: If the owner number is updated by PED, the provider must submit a new ERA Authorization Agreement.

## Provider Contact Information

**Contact Name:** Name of a contact in the provider office for handling ERA issues.

**Telephone Number:** Telephone number associated with the contact person, with no dashes or spaces (e.g., 8888888888).

**Telephone Extension:** Contact person's telephone extension, if applicable.

**Email Address:** Electronic mail address at which Medi-Cal Rx staff may reach the contact person.

**Fax Number:** Number at which the provider can be sent facsimiles, with no dashes or spaces (e.g., 8888888888).

## Receiver Information

Complete all of the following fields for *each* receiver that you want to designate.

**Add/Remove:** If you selected **Change Enrollment** in Part 1 of the form, select the appropriate check box to indicate whether you want to add or remove the associated receiver.

**Receiver Name:** Complete legal name of institution, corporate entity, practice, or provider designated as the receiver.

**DBA:** If applicable, enter the "Doing Business As" operating name of the receiver entity.

**Contact Person:** Name of a contact in the receiver office.

**Address fields:** Address (number, street name, city, state, and ZIP Code) for the receiver.

**Contact Telephone Number:** Contact person's telephone number for the receiver.

**Telephone Extension:** Contact person's telephone extension for the receiver, if applicable.

**Email Address:** Contact person's electronic mail address for the receiver. This email address will be the receiver's User ID to access the provider's 835-Transactions.

## Provider Certification

**Authorization:** Select the appropriate check box(es).

**Signature:** The original signature of the authorizing provider, using blue ink.

**Date:** The date on which the authorizing provider signed the form.

**Print Name:** Print the name of the authorizing provider (the person signing the form).

**Title:** Print the title of the authorizing provider.