Texas Medicaid/CHIP Vendor Drug Program
Electronic Remittance Advice (ERA)
Authorization Agreement Form

Access

The Vendor Drug Program Payment File Portal (PFP) is online at http://grabit.acs-shc.com/. The PFP is accessible only through the Microsoft Internet Explorer browser. The browser is available for free from Microsoft.com.

When logged into the PFP you will see a listing of all your new payment files. Pharmacies will receive both a weekly payment register in the Portable Document Format (PDF) and the standard ASC X12N 835 Health Care Payment/Advice. Once posted, the files will remain on the PFP for 30 days.

Passwords

After registering for the PFP, you will receive a user ID and temporary password by email. When a user accesses the PFP for the first time he or she will be prompted to change your password. Users will be prompted by email every 60 days to change their password. If the password expires and the user needs the password reset, please call the Xerox Technical Support & Interfaces Desk. Users will be asked to provide their ID, contact information, and email address.

Downloads

- To download the 835 Advice, select the link that contains "From EDI". Select "Save" and choose the location on your computer where your document will be saved. Locate the downloaded document on your computer and right click on the document. Select "Open With" and choose a text editor/reading application to display your 835 in the ANSI X12 format.
- To download the PDF version, select the link that contains "From RA" and click "Download".

Instructions

Please complete all requested information. Specific field instruction:

- Assigning Authority: Organization that issues and assigns the additional identifier requested on the form (e.g. Medicaid, Medicare)
- Method of Retrieval: The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)

Return the form:

By fax:

866-780-2185

By email:

PharmacyMoveIT@xerox.com

If you choose to send this document via email then be aware you may be sending protected health information (PHI). Please electronically encrypt your information prior to sending.

Please direct all questions to the Xerox Technical Support and Interfaces Desk:

By phone:

888-701-1713

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PHARMACY PROVIDER INFORMATION		
Provider name:		
Doing Business As (DBA) Name:		
Street:		
City:	State/Province:	ZIP Code/Postal Code:

PROVIDER IDENTIFIER INFORMATION
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) :
National Provider Identifier (NPI) (required):
Assigning Authority:

PROVIDER CONTACT INFORMATION			
Provider Contact Name:			
Title:			
Telephone Number:		Email address:	
Fax Number:			

ELECTRONIC REMITTANCE ADVICE INFORMATION
Provider Tax Identification Number (TIN):
National Provider Identifier (NPI):
Method of Retrieval:

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION			
Vendor Name:			
Vendor Contact Name:			
Telephone Number:		Email Address:	

SUBMISSION INFORMATION		
☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment
Electronic Signature of Person Submitting Enrollment:		
Written Signature of Person Submitting Enrollment:		
Printed Name of Person Submitting Enrollment:		
Submission Date:		
Requested ERA Effective Date:		

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