

# MEDICAID KENTUCKY PRE ENROLLMENT INSTRUCTIONS - MCDKY



## HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 1 week

## WHERE SHOULD I SEND THE FORMS?

- You can fax the forms to (502) 209-3242; or
- Mail the forms to:
  - Electronic Claims Submission
  - PO Box 2016
  - Frankfort, KY 40602-2016

## WHAT FORMS SHOULD I DO?

- You need to complete the following two forms:
  - Agreement between the KY Medicaid Program and Electronic Billing Agency
  - Provider Agreement Electronic Media Addendum
    - Form is titled as Cabinet for Health and Family Services Department for Medicaid Services Kentucky Medical Assistance Program.

## WHO CAN SIGN THE FORMS?

- The owner or authorized personnel

## HOW DO I CHECK STATUS?

- Call Medicaid Kentucky's EDI Help Desk at 1-800-205-4696 and ask if you have been linked to Office Ally's submitter number 9900004139.

OFFICE ALLY IS NOT NOTIFIED OF APPROVALS BY MEDICAID KENTUCKY. IF YOU DO NOT NOTIFY OFFICE ALLY OF YOUR APPROVAL YOU RISK YOUR CLAIMS BEING PRINTED AND MAILED OR REJECTED.

## **NOTE TO MY CLIENTS PLUS USERS:**

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally, please fax the following information to My Clients Plus at 888-653-7115.

- **My Clients Plus**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my provider ID has been linked to Office Ally with the Insurance Payor”.**
- **Provider email address where you can be notified of setup completion.**

For Noridian Pre-Enrollments Please Also Include:

- **Submitter number**

Agreement Between the Kentucky Department for Medicaid Services  
And  
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The Office Ally has entered into a contract with  
(Name of Billing Agency)

\_\_\_\_\_, \_\_\_\_\_,  
(Name of Provider) (Provider Number)

\_\_\_\_\_ to submit claims via electronic media for service provided to KMP recipients.  
(National Provider Identifier [NPI])

The billing agency agrees:

1. Billing Agency also agrees to maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with the HIPAA Security Standards once finalized.
2. To maintain or have access to a record of all claims submitted for payment for a period of at least six (6) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider and in compliance with the HIPAA transaction and code set regulations by the appropriate due date, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to commit fraud or deceive, makes or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.
5. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations with their provider's business associate agreement. Billing agency agrees to take "reasonable steps" to cure the breach or to end any uncovered violations of confidentiality or security of data under their control.

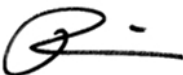
The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.
3. To maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with HIPAA Security Standards once finalized.
4. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations.

This agreement may be terminated upon written notice by either party without cause.

**This is to certify that the foregoing information is true, accurate, and complete.**

**I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.**



Brian O'Neill, President and CEO

**SIGNATURE, AUTHORIZED AGENT OF BILLING AGENCY**

August 13, 2009

**DATE**

Dan Waclawsky

**CONTACT PERSON (FIRST AND LAST NAME)**

866-575-4120 ex. 254

**TELEPHONE NUMBER**

**MEDIA:**  POS  PC to PC  CD

**Please return form to:  
Electronic Claims Submission,  
P.O. Box 2016  
Frankfort, KY 40602-2016**

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
KENTUCKY MEDICAL ASSISTANCE PROGRAM**

This addendum to the Provider Agreement is made and entered into as of the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by and between the Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services, hereinafter referred to as the Cabinet, and

\_\_\_\_\_, \_\_\_\_\_,  
(Provider Name) (Provider Address)  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
(City) (State) (Zip Code)

hereinafter referred to as the provider.

**WITNESSETH, THAT:**

Whereas, the Cabinet fro Health and Family Services, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
(Type of provider) (Provider Number) NPI (National Provider Identifier)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

- A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP
- B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent
- C. Acknowledges that the Provider’s signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media”  
  
“This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may by prosecuted under applicable Federal and State Law.”
- D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet
- E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately
- F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
KENTUCKY MEDICAL ASSISTANCE PROGRAM**

2. The Cabinet:

- A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies
- B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

Either party shall have the right to terminate this Addendum upon written notice without cause.

**This is to certify that the foregoing information is true, accurate, and complete.**

**I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.**

\_\_\_\_\_  
(Provider)

\_\_\_\_\_  
(Provider Signature)

\_\_\_\_\_, \_\_\_\_\_  
(Contact Person) (First and Last Name) (Title)

\_\_\_\_\_, \_\_\_\_\_  
(Date) (Telephone Number)

Office Ally, Electronic  
\_\_\_\_\_, \_\_\_\_\_  
(Software Vendor and/or Billing Agency) (Media)

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Frankfort, KY 40602-2016**