

MEDICAID OREGON PRE-ENROLLMENT INSTRUCTIONS – MC015



HOW LONG DOES PRE-ENROLLMENT TAKE?

Standard processing time is approximately 7 business days.

WHAT FORMS SHOULD I DO?

- Oregon DHS Trading Partner Agreement
 - Exhibit A – Application for Authorization o Note: Leave section B of the EDI Submitter Certification Conditions blank.
 - Exhibit C – EDI Registration Form o If you wish to receive 835 – Health Care Claim Payment/Advice (RA) you must select that under the Authorized Transactions section (section 7).
- The only authorized transactions that can be selected are 837 Professional Claim Submission pre.checked)

WHERE SHOULD I SEND THE FORMS?

Oregon DHS requires original signatures for both the Trading Partner (provider) and the EDI Submitter (Office Ally).

- Mail the form(s) to Office Ally with **original signatures in blue ink to:**
Office Ally
Attn: Anita
PO Box 872020
Vancouver, WA 98687

WHO CAN SIGN THE FORMS?

- Form must be signed by the provider (if the form is for a solo doctor) or the president, CEO, or owner of the group (if the form is for a group).
- Form can be signed by authorized personnel, but the authorized personnel must be listed.

HOW DO I CHECK STATUS?

- Approximately 7 business days after Medicaid receives your form they will notify of the approval via a letter, sent to you directly.
- You may also call 888-690-9888 and ask if your registration packet has been received if you've been approved.
- After receiving approval you MUST contact Office Ally at 866-575-4120 opt. 1 and notify them of the approval BEFORE submitting any claims for electronic transmission.

WHAT PROVIDER NUMBER DO I USE?

- Use one (1) provider number per form.
- Use your Oregon DHS Provider Number
- If you are a group, list only the group name and group number, do one form for each group number you have.

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**



TRADING PARTNER AGREEMENT OREGON DEPARTMENT OF HUMAN SERVICES

This Electronic Trading Partner Agreement (TPA) between the Oregon Department of Human Services (OR-DHS) and _____, provides the terms and conditions which govern the registration and conduct of Electronic Data Interchange (EDI) Transactions, in the performance of obligations under a contract with OR-DHS.

For purposes of this TPA, a Contract means a specific written agreement between OR-DHS and said Provider, Prepaid Health Plan, Clinic or Allied Agency that provides, or manages the provision of, services, goods or supplies to Covered Individuals and in the provision of which OR-DHS and the Provider, Prepaid Health Plan, Clinic or Allied Agency may exchange Data (as defined herein). A Contract specifically includes, without limitation, an OR-DHS Provider Enrollment Agreement, a Fully Capitated Health Plan Managed Care Contract, a Dental Care Organization Managed Care Contract, a Mental Health Organization Managed Care Contract, a Chemical Dependency Organization Managed Care Contract, a County Financial Assistance Agreement, or any other applicable written agreement, interagency agreement, intergovernmental agreement, or grant agreement between OR-DHS and Provider, Prepaid Health Plan, Clinic or Allied Agency.

Capitalized terms used but not defined herein shall have the same meaning as those terms in the DHS Electronic Data Transmission (EDT) rules, OAR 407-120-0100.

For mutual consideration, the parties agree as follows.

A. Provider, Prepaid Health Plan, Clinic or Allied Agency Obligations as a Trading Partner. Providers, Prepaid Health Plans, Clinics or Allied Agencies that wish to register to conduct EDI Transactions with OR-DHS must execute this TPA. A Provider, Prepaid Health Plan, Clinic or Allied Agency that has a TPA with OR-DHS shall be referred to as a Trading Partner when functioning in that capacity. In addition to the obligations of OR-DHS and the Provider, Prepaid Health Plan, Clinic or Allied Agency which are set forth in the Contract, the Provider, Prepaid Health Plan, Clinic or Allied Agency when functioning as a Trading Partner shall comply with DHS Electronic Data Transmission (EDT) rules in OAR 407-120-0100 through 407-120-0200, and other OR-DHS, state and federal rules, policies and procedures applicable to Electronic Data Interchange Transactions.

1. Valid Contract with OR-DHS Required as a Mandatory Condition of Registration. Only Providers, Prepaid Health Plans, Clinics or Allied Agencies with a currently valid Contract with OR-DHS may register as a Trading Partner.
2. Trading Partner as an EDI Submitter. If the Trading Partner wishes to register and conduct its own EDI Transactions directly to OR-DHS, the Trading Partner will be referred to as an EDI Submitter when functioning in that capacity. An EDI Submitter is the entity that establishes the electronic connection with OR-DHS to conduct an EDI Transaction on behalf of a Trading Partner.
3. Trading Partner Agent as an EDI Submitter. A Trading Partner may use, in the performance of this TPA, one or more Agents as the Trading Partner's EDI Submitter. An EDI Submitter is the entity that establishes the electronic connection with OR-DHS to conduct an EDI Transaction on behalf of the Trading Partner. The Trading Partner's authorization and registration of its EDI Submitter(s) for purposes

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of this TPA is expressly subject to acceptance by OR-DHS, based on criteria established in the DHS Electronic Data Transmission (EDT) rules, OAR 407-120-0100 through 407-120-0200.

4. Application for Authorization. A Trading Partner must submit an Application for Authorization (Exhibit A) for Trading Partner to register for EDI Transactions with OR-DHS, and to identify and authorize the EDI Submitter. If Trading Partner will be using an Agent as the EDI Submitter, the Application for Authorization (Exhibit A) shall include a signed EDI Submitter Certification before OR-DHS may accept an electronic transmission from such Agent. The Application for Authorization, when fully executed, shall be incorporated into this TPA by reference and shall be effective on the date of its execution, unless specified otherwise.
5. EDI Registration Information. Trading Partner shall provide, or authorize EDI Submitter to provide, to OR-DHS all the information requested in the EDI Registration Form (Exhibit B). Trading Partner or authorized EDI Submitter must register the name and type of EDI Transactions they are prepared to send or to receive, subject to applicable testing requirements. The Registration Form must be fully completed and signed by Trading Partner or authorized EDI Submitter as a condition of OR-DHS registering and accepting an electronic Data Transmission. The EDI Registration Form, when fully executed, shall be incorporated into this TPA by reference and shall be effective on the date of its execution, unless specified otherwise.
6. Changes in any Material Information. Trading Partner shall submit an updated TPA, Application for Authorization or EDI Registration Form to OR-DHS within ten (10) business days of any material changes in the information. Material changes include but are not limited to changes of address or e-mail address, Contract number or Contract status, identification of authorized individuals of the Trading Partner or EDI Submitter, the addition or deletion of authorized transactions, or any other change that may affect the accuracy of or authority for an EDI Transaction. Only the forms that contain the material change in information must be updated. Trading Partner's signature or the signature of an authorized EDI Submitter is required to ensure that an updated TPA, Application for Authorization or EDI Registration form is valid and authorized. OR-DHS is authorized to act on Data Transmissions submitted by authorized EDI Submitter(s) based on information on file with OR-DHS until an updated form has been received and approved by OR-DHS. Failure to submit an updated form may impact the ability of a Transaction to be processed without errors. Failure to timely submit a signed updated form may result in a rejection of a Data Transmission.
7. Accuracy and Security of Transmissions. Trading Partner and OR-DHS shall take reasonable care to ensure that Data and Data Transmissions are timely, complete, truthful, accurate and secure, and shall take reasonable precautions to prevent unauthorized access to the Information System, the Data Transmission itself or the contents of an Envelope which is transmitted either to or from OR-DHS pursuant to this TPA, and in compliance with 45 CFR Parts 160 and 162, if applicable.
8. Express Warranties Regarding Agents. Trading Partner expressly warrants that its EDI Submitter(s) will take all appropriate measures to maintain the timeliness, accuracy, truthfulness, confidentiality, security and completeness of each Data Transmission. Furthermore, Trading Partner further expressly warrants that its EDI Submitter(s) will be specifically advised of, and will be directed to comply in all respects with, the terms of this TPA.

B. Provider, Prepaid Health Plan, Clinic or Allied Agency Certification.

As a condition for receiving payment from Medicaid and programs for which OR-DHS makes payment, and as a condition of registration of EDI Transactions with OR-DHS, I certify and agree to all the Certifications herein. My signature below signifies agreement to these Certifications.

1. To the best of my knowledge all Data prepared, processed and submitted as claims or encounter data at my direction are true and valid claims or encounter data for healthcare goods or services provided to a Covered Individual under the applicable Contract, and the rules, regulations and policies of OR-DHS.
2. I will maintain Data Transaction information and Source Document information for seven (7) years from the date of the service and be able to reproduce claims or encounters for resubmission or audit upon request by OR-DHS.
3. I will only take such actions that are authorized in the Application or Registration with respect to Registered EDI Transactions, and I will provide updated information within ten (10) business days of a material change in that information.
4. I will allow, upon request and at a reasonable time and place, authorized federal or state government agents to inspect and copy any records I maintain on the services provided or billed under the Contract.
5. I am responsible for the accuracy, truthfulness and completeness of all Data submitted by my Agent(s) to the extent provided by the law.
6. I acknowledge that my Agent will sign Data Transmissions, or may submit Data Transmissions without signature, on my behalf for the purpose of reimbursement from OR-DHS. I acknowledge that I may be liable based on such actions for my participation in the Medicaid or other program to the extent applicable federal or state criminal or civil laws so provide.
7. In conducting EDI Transactions, I will adhere to all DHS Electronic Data Transmission (EDT) rules, OAR 407-120-0100 through 407-120-0200, and other applicable OR-DHS rules, policies and procedures in effect on the date the service or good was provided.
8. If the EDI Transaction relates to payment for Medicaid services or supplies (including Oregon Health Plan and waived services) by OR-DHS to a Provider, Prepaid Health Plan, Clinic or Allied Agency on a fee-for-service basis, the following rule applies to any claim for payment - 42 CFR 447.10:
 - (a) *Who may receive payment.* Payment may be made only -
 - (1) To the provider: or...
 - (2) In accordance with paragraphs ...(b) and (c) of this section.
 - (b) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is -
 - (1) Related to the cost of processing the billing;
 - (2) Not related on a percentage or other basis to the amount that is billed or collected; and
 - (3) Not dependent upon the collection of the payment.
 - (c) *Individual practitioners.* Payment may be made to -
 - (1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;

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- (2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or
 - (3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.
9. I understand that a) payments in relation to my EDI Transactions will be from federal and state funds and b) I may be prosecuted under applicable federal or state criminal or civil laws if I or my Agent submits false claims or documents or if I or my Agent makes misrepresentations, conceals material facts, or conspires to engage in any of the above actions.

C. General Provisions.

1. Federal Tax Certifications. The individual signing below on behalf of Provider, Prepaid Health Plan, Clinic or Allied Agency hereby certifies and swears under penalty of perjury that s/he is authorized to act on behalf of Provider, Prepaid Health Plan, Clinic or Allied Agency, s/he has authority and knowledge regarding Provider's, Prepaid Health Plan's, Clinic's or Allied Agency's payment of taxes, and to the best of her/his knowledge, Provider, Prepaid Health Plan, Clinic or Allied Agency is not in violation of any Oregon tax laws. For purposes of this certification, "Oregon tax laws" means those programs listed in ORS 305.380(4), including without limitation, the state inheritance tax, personal income tax, withholding tax, corporation income and excise taxes, amusement device tax, timber taxes, cigarette tax, other tobacco tax, 9-1-1 emergency communications tax, the elderly rental assistance program, and local taxes administered by the Department of Revenue (Lane Transit District Self-Employment Tax, Lane Transit District Employer Payroll Tax, Tri-Metropolitan Transit District Employer Payroll Tax, and Tri-Metropolitan Transit District Self-Employment Tax).
2. Compliance with Applicable Law. OR-DHS' performance under this Trading Partner Agreement is conditioned upon Trading Partner's compliance with the provisions of ORS 279.312, 279.314, 279.316 and 279.320 which are incorporated by reference herein. In the performance of EDI Transactions under this Agreement, Trading Partner shall use recycled and recyclable products to the maximum extent which is economically feasible in compliance with ORS 279.555.
3. Interpretations; Order of Precedence. Whenever possible, all terms and conditions in this Trading Partner Registration Agreement and any Contract are to be harmonized. Any ambiguity in this TPA shall be resolved to permit the Parties to comply with the HIPAA Transaction Rules, if those rules apply to the EDI transaction. For EDI Transactions governed by the HIPAA Transaction Rules, this TPA should not be interpreted in any manner that would do any of the following:
 - (a) Change the definition, data condition, or use of a data element or segment in a Standard Transaction;
 - (b) Add any data elements or segments to the maximum defined data set;
 - (c) Use any code or data elements that are either marked "not used" in the Standard Transaction' implementation specification or are not in the Standard Transaction's implementation specification(s);
or
 - (d) Change the meaning or intent of the Standard Transaction's implementation specification(s).
4. Term and Termination.
 - (a) Effective Date; Term. This Trading Partner Agreement shall be effective on the date OR-DHS notifies the Trading Partner of the OR-DHS acceptance of the TPA. This TPA shall terminate on the earlier of (i) the date of termination of a Contract that forms the basis for Trading Partner submission of EDI Transactions to OR-DHS, unless said Contract is timely renewed or extended with no lapse of time between Contracts and OR-DHS receives a timely update of EDI Registration, or (ii) the date on which termination of the TPA is effective under section C(4)(b); except that the TPA shall remain in

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effect to the extent necessary for Trading Partner or OR-DHS to complete obligations involving EDI under the Contract for dates of service when the contract was in effect.

- (b) Termination for Cause. Upon OR-DHS knowledge of a material breach by Trading Partner, or any EDI Submitter or other Agent, OR-DHS shall either:
 - (1) Notify Trading Partner of the breach and specify a reasonable opportunity in the notice for Trading Partner to cure the breach, and terminate the TPA if Trading Partner does not cure the breach of the terms of the TPA or end the violation within the time specified by OR-DHS; or
 - (2) Immediately terminate this TPA if Trading Partner has breached a material term of this TPA and cure is not possible in OR-DHS' reasonable judgment.
 - (3) The rights and remedies provided in this TPA are in addition to any rights and remedies provided in a Contract.

Provider/Prepaid Health Plan/Clinic/Allied Agency Name and Title:

Phone number:

Authorized Signature:

Type or Print Name:

Date:



APPLICATION FOR AUTHORIZATION

New Application Updated Application
Effective date: / /

INSTRUCTIONS: If the Trading Partner will be acting as its own EDI Submitter, stop here and only complete Section B. If the Trading Partner will be using an Authorized Agent as its EDI Submitter, the Trading Partner must complete Section A, and each authorized EDI Submitter must sign the following Certification on pages 2 and 3. Failure to include this Certification will result in non-approval of the authorized EDI Submitter’s registration.

A. Trading Partner Application for Authorization of EDI Submitter:

I, the Trading Partner _____ signing this Application For Authorization, by identifying my EDI Submitter in this Section as the EDI Submitter, hereby request OR-DHS’ approval to register my EDI Submitter to prepare, process, submit and receive my EDI Transactions with OR-DHS. I authorize my EDI Submitter to take the following actions on my behalf (mark those that apply):

- Request and participate in business-to-business testing with OR-DHS for my Registered Transactions.
- Submit a request for approval to conduct my Registered Transactions.
- Submit updates of the EDI Submitter information on this Application for Authorization Form.
- Submit updates of the EDI Registration Form.
- Request password and log-on information for my Registered Transactions.
- Conduct my Registered Transactions.

I understand that authorization to act as an EDI Submitter and to register EDI transactions will not be effective until approved by OR-DHS.

Trading Partner Name (print): _____

Trading Partner Phone Number: _____

OR-DHS Contract or Provider Identification Number(s): _____

Federal Taxpayer Identification Number: _____

National Provider Identifier (NPI): _____

Taxonomy Code(s): _____

Date: _____

Trading Partner Signature: _____

EDI Submitter Certification Conditions

I, the authorized EDI Submitter, agree to and certify as follows:

1. All data I submit to OR-DHS on behalf of the Trading Partner is a true and correct representation of the source data I received from the Trading Partner.
2. I understand that I may be prosecuted under applicable federal and state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data system input, other acts of misrepresentation, or conspiracy to engage therein.
3. I will maintain data transaction information for seven years from the date of the service and be able to reproduce claims for resubmission or audit upon request by OR-DHS.
4. I will only take such actions that are authorized in the Application or by change request by the Trading Partner with respect to the Trading Partner's registered EDI transactions.
5. Before billing for any services or conducting a transaction, I will review and fully comply with the DHS Electronic Data Transmission (EDT) rules, OAR 407-120-0100 through 407-120-0200, and other federal and state laws and regulations applicable to the services and to the Registered Transactions.
6. I will allow, upon request, and at a reasonable time and place, authorized federal or state government agents to inspect and copy any records I maintain on the services provided and billed on behalf of Trading Partner, or otherwise related to an EDI Transaction.
7. If the EDI transaction relates to payment for Medicaid services or supplies (including Oregon Health Plan and waived services) by OR-DHS to a Provider, Prepaid Health Plan, Clinic or Allied Agency on a fee-for-service basis, the following rule applies to any claim for payment – 42 CFR 447.10:
 - (d) *Who may receive payment?* Payment may be made only –
 - (1) To the provider; or
 - (3) In accordance with paragraphs (f) and (g) of this section.
 - (f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is –
 - (1) Related to the cost of processing the billing;
 - (2) Not related on a percentage or other basis to the amount that is billed or collected; and
 - (3) Not dependent upon the collection of the payment.
 - (g) *Individual practitioners.* Payment may be made to –
 - (1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;
 - (2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or
 - (3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

Authorized EDI Submitter Certification:

I certify that I am authorized by the Trading Partner identified herein to submit Registered EDI Transactions to OR-DHS. Failure of the authorized EDI Submitter to agree to or to comply with these Certification Conditions shall result in denial or termination of the authorized EDI Submitter's registration by OR-DHS. My signature below signifies agreement to these EDI Submitter Certification Conditions.

EDI Submitter Name and Title: Office Ally
Phone number: 866-575-4120
EDI Submitter Signature: _____
Date: 09-17-2009
OR-DHS EDI Submitter Number (if available): tp000329
EDI Submitter Federal Tax ID Number: 330897513

B. Trading Partner Application for Authorization to Submit EDI Transactions:

I, the Trading Partner _____ signing this Application, by identifying myself below as the EDI Submitter, hereby request OR-DHS' approval to register my EDI transactions with OR-DHS.

EDI Submitter Legal Entity Name: _____
EDI Submitter Contact Individual: _____
Address: _____
Telephone: _____ Fax: _____ E-mail: _____
EDI Submitter Federal Tax ID Number: _____
OR-DHS EDI Submitter Number (if available): _____
Trading Partner Signature: _____



DIVISION OF MEDICAL ASSISTANCE PROGRAMS
 EDI Support Services

Health Insurance Portability and Accountability Act
Exhibit C — EDI Registration Change Form

Please type or print clearly and fill in **all required fields designated with an asterisk (*)**. Incomplete forms will NOT be processed.

Once completed, send this form to the address below.

EDI Support Services, DMAP Operations
 2575 Bittern NE, Building 33, 2nd floor
 Salem, OR 97301-1079

Call 1-888-690-9888

Please maintain a copy for your records.

Change forms must include the signature of the Trading Partner's (Provider/Plan) authorized signer.

Trading partner information

ONE

*Effective date:	*Tax Identification number:
*Name of provider, prepaid health plan, clinic or allied agency:	
*Physical address:	
*Secondary address:	
*City, state and ZIP:	
*Phone number:	*FAX number:

Provider/Plan number (a separate Exhibit C must be completed for each provider number)

TWO

*Provider/Plan number for which the submitter has authorization: (see Exhibit A):	*Number:
*National Provider Identifier (NPI): _____	
*Taxonomy code(s): _____	

Trading partner authorized signer information (cannot be a billing service or clearinghouse)

THREE

*Authorized person at Provider's/Plan's location:	
*Phone number:	*Title:
*E-mail address:	*FAX number:
Secondary contact:	
Phone number:	Title:
E-mail address:	FAX number:

Claims contact information

FOUR

Primary contact:	
Phone number:	*Title:
E-mail address:	*FAX number:
Secondary contact:	
Phone number:	Title:
E-mail address:	FAX number:

Complete this page with EDI submitter information. If you intend to submit your own transactions, provide your information in sections Five and Six.

EDI submitter information

FIVE

*Company name: Office Ally Submitter ID: tp000329
 *Address line 1: 16703 SE McGillivray Blvd.
 Address line 2: Suite 200
 *City, state and ZIP: Vancouver, WA 98683
 *Submitter type: (Check **all** that apply.)
 Self Prepaid Health Plan Clearinghouse Billing service Other: *(Please specify.)*

EDI submitter's contact information

SIX

*Business contact: Customer Service
 *Phone number: 866-575-4120 *Title: Customer Service
 *E-mail address: support@officeally.com *FAX number: 360-896-2151
 *Technical contact: Scott Coppin *Title: Programmer
 *Phone number: 866-575-4120 *FAX number: 360-896-2151
 *E-mail address: support@officeally.com Third contact on reverse *(if needed)*

Authorized transactions

Transactions for: FFS provider or Prepaid health plan

Check all transactions for which authorization should be registered.

SEVEN

HIPAA 5010A1	Transactions
<input checked="" type="checkbox"/> 005010X222A1	837P Professional Claim Submission
<input type="checkbox"/> 005010X224A2	837D Dental Claim Submission
<input type="checkbox"/> 005010223A2	837I Institutional Claim Submission
<input type="checkbox"/> 005010X221A1	835 Health Care Claim Payment/Advice (RA)
<input type="checkbox"/> 005010X279A1	270 and 271 Health Care Eligibility Benefits Inquiry and Response
<input type="checkbox"/> 005010X212	276 and 277 Health Care Claims Status Request and Response
<input type="checkbox"/> 005010X218	820 Group Premium Payments
<input type="checkbox"/> 005010X220A1	834 Benefit Enrollment and Maintenance
<input type="checkbox"/> 005010X231A1	999 Acknowledgement Response
<input type="checkbox"/> D.0/1.2	NCPDP Submission and Response (PHP Only)
<input type="checkbox"/> D.0/1.2	NCPDP Response Report (PHP only)
<input type="checkbox"/>	Status file Health Care Claim Status (PHP only) No change in format

Signature

EIGHT

* Provider, prepaid health plan, clinic or allied agency name: _____ *Phone: _____
 *Authorized trading partner signature *(original signature only)*: _____ *Date: _____
 Please print name: _____