

MEDICAID OREGON PRE-ENROLLMENT INSTRUCTIONS – MC015



HOW LONG DOES PRE-ENROLLMENT TAKE?

Standard processing time is approximately 7 business days.

WHERE SHOULD I SEND THE FORMS?

- Exhibit C- EDI Registration change Form
 - 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) and 835 Health Care Claim Payment/Advice (RA).

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.
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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.



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: _____

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**