

WELCOME TO OFFICE ALLY!



MEDICAID OREGON PRE-ENROLLMENT INSTRUCTIONS

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is approximately 7 business days.

WHERE SHOULD I SEND THE FORMS?

- Mail the original forms to Office Ally
 - We request that you mail the forms to Office Ally, so that we can review the forms and make a note of your provider number and the date the form was mailed to Medicaid.
 - FAXED FORMS ARE NOT ACCEPTED.
 - Please complete and submit the entire registration packet.
 - Must be signed in BLUE ink.

WHO CAN SIGN THE FORMS?

- Forms 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).
- Forms can be signed by authorized personnel, but authorized personnel must be listed.

HOW DO I CHECK STATUS?

- Approximately 7 business days after Medicaid receives your form they will notify you of the approval, a letter will be sent directly to you.
- After receiving approval, you MUST notify Office Ally PRIOR to submitting claims.
- To check status, call 888-690-9888
 - Ask if your registration packet has been received.

WHAT PROVIDER NUMBER DO I USE?

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

EDI Registration Packet

How to Complete the DHS EDI Registration Packet

This packet includes three important documents that need to be returned with original signatures in blue ink to DHS as a complete package of information.

For initial registration, you need to sign and return these three forms:

1. Trading Partner Agreement – Pages 10-15
2. Application for Authorization Form (Exhibit A) – Pages 16-19
3. EDI Registration Form (Exhibit B) – Pages 21-24

These forms are also available on the DHS HIPAA/EDI Web site at <www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml>.

If you need further information or assistance on how to complete the DHS EDI Registration forms, or have additional questions about the registration or testing process, contact DHS EDI Support Services (see page 1).

Registration for clinics/group practices

DMAP-enrolled clinics only need to submit one EDI Registration Packet that:

1. Lists the clinic (including the clinic's DHS Provider Number) as the Trading Partner, and
2. Includes a list on clinic letterhead of all providers (*i.e.*, physicians) the clinic bills for. Include all six-digit DHS Provider Number(s) used to bill DMAP, and all National Provider Identifier (NPI) numbers and taxonomy codes. The authorized signer must sign this list.

DHS must be notified if a provider leaves or joins a clinic. Timely claims payment may be impacted without this information (see the TPA, Section A.6).

Changes in information

If any of the submitted information changes from your original registration submission, you may need to complete and submit a new Exhibit or possibly all three registration documents again.

- If changes are needed for either Exhibit A or B, be sure to check the appropriate box indicating the type of change and submit the exhibit to DHS.
- You may also be able to submit the changes using Exhibit C (EDI Registration Change Form). See page 26 for more information.

Instructions for completing the DHS EDI packet

1. Complete the Trading Partner Agreement (page 11)
2. Complete Exhibit A (Application for Authorization Form, page 17) for each EDI submitter associated with the Trading Partner Agreement.
3. Complete Exhibit B (EDI Registration Form, page 23).
4. Make copies, if you have not already done so, of the complete EDI packet (the Trading Partner Agreement, the Application for Authorization, and the EDI Registration Form[s]). Retain these copies for your records.
5. If you have designated an authorized EDI Submitter other than yourself:
 - Send the original Trading Partner Agreement, Application for Authorization (Exhibit A) and the EDI Registration Form (Exhibit B) to your EDI Submitter for completion of Exhibit A.
 - Include a cover letter asking your Authorized EDI Submitter to complete all applicable information in Exhibit A, Section B, sign where indicated and to send the entire packet on to the Department of Human Services as indicated below.

Where to send the completed DHS EDI packet

Send the original copies of the completed Trading Partner Agreement, Application for Authorization, and the EDI Registration Form with original signatures to:

Department of Human Services
Division of Medical Assistance Programs
Encounter and Electronic Data Unit
500 Summer St. NE, E44
Salem, OR 97301-1079

Include ENTIRE address above when mailing. Only send the completed forms; do not send the instructions for how to complete the forms.

Trading Partner Agreement

The Trading Partner Agreement (TPA) is a binding agreement between DHS and a Provider or Trading Partner (OAR 410-001-0110.) DHS requires all of those planning to do electronic business with DHS to sign a Trading Partner Agreement before testing. DHS must have this form on file with original signatures.

You can download additional copies of this form on the EDI Testing and Registration Web page at <www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml>.

How to complete the Trading Partner Agreement

Read and complete all the information requested. If each provider receives their own check they each have to fill out a TPA. If a clinic or group of providers receives the payment then only one TPA is required.

1. Enter your provider number and name on page 1.
2. Sign and date page 5. **Original signature in blue ink is required.**
3. Retain a copy of the TPA for your records and return original to DHS with Exhibits A and B (see page 7 for address information).

Provider 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 _____ (name of Provider, Prepaid Health Plan, Clinic or Allied Agency), 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 OR-DHS EDI rules, OAR 410-001-0100.

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 OR-DHS EDI rules in OAR 410-001-0100 through 410-001-0200, 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 of this TPA is expressly subject to acceptance by OR-DHS, based on criteria established in the OR-DHS EDI rules, OAR 410-001-0100 through 410-001-0200.

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 OR-DHS EDI Rules, OAR 410-001-0100 through 410-001-0200, 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;
 - (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 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:

Ldg:GENE9895
Revised 11/14/03

Exhibit A: Application for Authorization Form

The EDI Registration Packet is designed to identify the two relationships DHS must understand. The TPA identifies who the provider or Trading Partner is, and Exhibit A of the TPA identifies who will be submitting the compliant transaction to DHS for payment or adjudication.

- The Application provides specific identification of and legal authorization from the Trading Partner for the EDI Submitter to conduct EDI Transactions on behalf of the Trading Partner. DHS must have this form on file with original signatures. Each electronic submitter will need to complete, sign, and return it before testing can begin.
- If the relationship between the Trading Partner and EDI Submitter changes, you must notify DHS using Exhibit C (EDI Registration Change Form, page 26).

You can download additional copies of this form on the EDI Testing and Registration Web page at <www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml>.

How to complete the Application for Authorization Form

1. Indicate whether the Authorization Form is a new application or an Updated application and indicate the date that the revisions are effective.
2. Read Section A.
3. Read and complete Section B unless you are acting as your own submitter. If you submit your own electronic billings, then you are the EDI Submitter. If so, complete Section C and go to step 6 to finish Exhibit A. If a clearinghouse or billing service submits your electronic claims on your behalf, then the clearinghouse or billing service is the EDI Submitter; continue to step 4
4. Read and complete Section B, especially the section on EDI Submitter Certification Conditions. Please use the Federal Taxpayer ID or Social Security Number already on file with DMAP.
5. Read, complete, and sign the EDI Submitter Certification section.
6. Retain a copy of this application for your records and return original to DHS with the TPA and Exhibit B (see page 7 for address information).

EXHIBIT A
APPLICATION FOR AUTHORIZATION

New Application **Updated Application (effective date):** _____

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

I, the Trading Partner (Provider/Prepaid Health Plan/Clinic/Allied Agency) signing this Application, by identifying myself in Section C below as the EDI Submitter, hereby request OR-DHS' approval to register my EDI transactions with OR-DHS.

If the Trading Partner will be acting as its own EDI Submitter, stop here and go to Section C. If the Trading Partner will be using an Authorized Agent as its EDI Submitter, each authorized EDI Submitter must sign the following Certification. Failure to include this Certification will result in a rejection of the authorized EDI Submitter's registration.

B. Trading Partner Authorization of EDI Submitter:

I, the Trading Partner (Provider/Prepaid Health Plan/Clinic/Allied Agency) 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.

(Section B is continued on next page).

Section B (continued):

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 OR-DHS EDI rules, OAR 410-001-0100 through 410-001-0200, 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: 949-464-9129

EDI Submitter Signature: _____

Date: _____

OR-DHS EDI Submitter Number (if available): tp000329

EDI Submitter Federal Tax ID Number: 330897513

C. EDI Submitter Information: (Trading Partner information if acting as own submitter)

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): _____

Exhibit B

	DHS–DMAP Encounter and Electronic Data Unit 500 Summer St NE, E44 Salem, OR 97301-1079 (503) 947-5347 (include ENTIRE address above)	Health Insurance Portability and Accountability Act EDI Registration
--	---	---

You are required to sign a Trading Partner Agreement before completing this registration form. Please be sure to 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 with the Trading Partner Agreement and the Application for Authorization Form to the address listed above. Please maintain a copy for your records.

Trading Partner Information				
ONE	THIS REGISTRATION IS: <input type="checkbox"/> A NEW REGISTRATION <input type="checkbox"/> A REVISED REGISTRATION DATE:			
	*Name of Provider, Prepaid Health Plan, Clinic or Allied Agency			
	*Physical Address:			
	Secondary Address:			
	*City, State & ZIP:			
	*Phone Number:		Fax Number:	
TWO	OR-DHS Provider Number:			
	*Provider/Contract # for which the submitter has authorization (see Exhibit A):			
	National Provider Identifier (NPI):			
	Taxonomy Code(s):			
THREE	Contact or Authorized Signer Information (legally authorized signer):			
	*Primary Contact:		*Title:	
	*Phone Number:		*Fax Number:	
	*E-mail Address:			
	Secondary Contact:		Title:	
	Phone Number:		Fax Number:	
	E-mail Address:			
FOUR	Claims Contact Information			
	*Primary Contact:		*Title:	
	*Phone Number:		*Fax Number:	
	*E-mail Address:			
	Secondary Contact:		Title:	
	Phone Number:		Fax Number:	
E-mail Address:				

Complete this page with EDI Submitter information. **You must also include EDI Submitter information for yourself if your company intends to submit its own transactions.**

FIVE	EDI Submitter Information				
	*Company Name:	Office Ally	OR-DHS Submitter ID:	tp000329	
	*Address Line 1:	32356 South Coast Highway			
	Address Line 2:				
	*City, State & ZIP:	Laguna Beach, CA 92651			
*Submitter Type:	<input type="checkbox"/> Billing Provider <input type="checkbox"/> Self <input type="checkbox"/> Clearinghouse/Billing Service <input type="checkbox"/> Managed Care <input type="checkbox"/> TPA <input type="checkbox"/> Other: _____ <i>Check ALL that apply</i> <i>Please Specify</i>				
SIX	EDI Submitter's Contact Information		<input type="checkbox"/> Third Contact on reverse (if needed)		
	*Business Contact:	Eve Du Bry	Title:		
	*Phone Number:	949-464-9129	Fax Number:	949-376-6951	
	*E-mail Address:	Support@officeally.com			
	*Technical Contact:	Virginia Mungia	Title:	Payer Support	
	*Phone Number:	949-464-9129	Fax Number:	(949) 376-6951	
SEVEN	Authorized Transactions for: <input type="checkbox"/> FFS Provider or <input type="checkbox"/> Prepaid Health Plan				
	<p style="text-align: center;">*Check all transactions for which authorization should be registered.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> 837 Professional Claim Submission <input type="checkbox"/> 837 Dental Claim Submission <input type="checkbox"/> 837 Institutional Claim Submission <input type="checkbox"/> 28 Line Roll/Split Report (837I submitters only) <input type="checkbox"/> 835 Health Care Claim Payment/Advice (RA) <input type="checkbox"/> 270 Health Care Eligibility Benefits Inquiry <input type="checkbox"/> 271 Health Care Eligibility Benefits Response <input type="checkbox"/> 278 Health Care Services Review Request (Prior Authorization [PA]) – <i>Currently unavailable</i> <input type="checkbox"/> 278 Health Care Services Review Response (Prior Authorization [PA]) – <i>Currently unavailable</i> </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> 276 Health Care Claims Status Request <input type="checkbox"/> 277 Health Care Claims Status Response <input type="checkbox"/> Status File Health Care Claim Status (PHP only) <input type="checkbox"/> 820 Group Premium Payments (PHP only) <input type="checkbox"/> 834 Benefit Enrollment/Maintenance (PHP only) <input type="checkbox"/> NCPDP Encounter Pharmacy (PHP only) <input type="checkbox"/> NCPDP Response Report (PHP only) <input type="checkbox"/> MMIS Web Portal for Claims/PA – <i>Currently unavailable</i> <input type="checkbox"/> Non-HIPAA Remittance Advice – <i>Currently unavailable</i> </td> </tr> </table> <p style="text-align: center;">NOTE: OR-DHS is currently only accepting ANSI 4010A1 Formats.</p>				<input type="checkbox"/> 837 Professional Claim Submission <input type="checkbox"/> 837 Dental Claim Submission <input type="checkbox"/> 837 Institutional Claim Submission <input type="checkbox"/> 28 Line Roll/Split Report (837I submitters only) <input type="checkbox"/> 835 Health Care Claim Payment/Advice (RA) <input type="checkbox"/> 270 Health Care Eligibility Benefits Inquiry <input type="checkbox"/> 271 Health Care Eligibility Benefits Response <input type="checkbox"/> 278 Health Care Services Review Request (Prior Authorization [PA]) – <i>Currently unavailable</i> <input type="checkbox"/> 278 Health Care Services Review Response (Prior Authorization [PA]) – <i>Currently unavailable</i>
<input type="checkbox"/> 837 Professional Claim Submission <input type="checkbox"/> 837 Dental Claim Submission <input type="checkbox"/> 837 Institutional Claim Submission <input type="checkbox"/> 28 Line Roll/Split Report (837I submitters only) <input type="checkbox"/> 835 Health Care Claim Payment/Advice (RA) <input type="checkbox"/> 270 Health Care Eligibility Benefits Inquiry <input type="checkbox"/> 271 Health Care Eligibility Benefits Response <input type="checkbox"/> 278 Health Care Services Review Request (Prior Authorization [PA]) – <i>Currently unavailable</i> <input type="checkbox"/> 278 Health Care Services Review Response (Prior Authorization [PA]) – <i>Currently unavailable</i>	<input type="checkbox"/> 276 Health Care Claims Status Request <input type="checkbox"/> 277 Health Care Claims Status Response <input type="checkbox"/> Status File Health Care Claim Status (PHP only) <input type="checkbox"/> 820 Group Premium Payments (PHP only) <input type="checkbox"/> 834 Benefit Enrollment/Maintenance (PHP only) <input type="checkbox"/> NCPDP Encounter Pharmacy (PHP only) <input type="checkbox"/> NCPDP Response Report (PHP only) <input type="checkbox"/> MMIS Web Portal for Claims/PA – <i>Currently unavailable</i> <input type="checkbox"/> Non-HIPAA Remittance Advice – <i>Currently unavailable</i>				
EIGHT	Signature				
	*Provider, Prepaid Health Plan, Clinic or Allied Agency Name:		*Phone:		
	*Signature (original only): _____		*Date: _____		
	Please Print Name: _____				