

# MEDICAID RHODE ISLAND PRE-ENROLLMENT INSTRUCTIONS - MCDRI



## HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard Processing time is 2 weeks from the date Medicaid Rhode Island receives the form.
- Please allow 2 extra business days for Office Ally to receive, sign, and send the forms to Medicaid Rhode Island.

## WHERE SHOULD I SEND THE FORMS?

- Medicaid Rhode Island requires the form to be signed by the provider and clearinghouse. The signatures must be original and therefore the forms must be mailed. Please mail the forms to Office Ally at the address below for us to sign and then send to Medicaid Rhode Island.  
Office Ally  
Attn: Anita  
P.O. Box 872020  
Vancouver, WA 98687
- Do not mail the form to the address on the last page of the agreement. If you do so without a signature from Office Ally the form will be rejected. Once Office Ally has signed the form we will mail the form to the address on the last page of the agreement.

**ORIGINAL SIGNATURES ARE REQUIRED AND FAXES ARE NOT ACCEPTED.**

## WHO CAN SIGN THE FORMS?

- Each individual provider or group included on the agreement must sign and date in his/her respective section.

## WHAT FORMS SHOULD I DO?

- Rhode Island Department of Human Services Trading Partner Agreement ID Change/Add form.

## OBTAINING APPROVALS: HOW DO I CHECK STATUS?

- Medicaid Rhode Island will mail the approvals to Office Ally. You can call Office Ally Customer Service at (866) 575-4120 option 1 to check status of your enrollment. Please allow 16 business days for approval to be noted on your account. Once you have received confirmation of approval you can begin submitting claims electronically.

## WHAT PROVIDER NUMBER DO I USE?

- NPI and/or Medical Assistance Provider Number (can include both)



RHODE ISLAND DEPARTMENT OF HUMAN SERVICES



## Trading Partner Agreement ID Change/Add form

Once a Trading Partner Agreement (TPA) is received and processed, this form may be used to add additional billing providers to the original TPA ID assigned. This form must be received with original signatures. **No facsimile or photocopies will be accepted.**

Trading Partner Name: Office Ally

Assigned Trading Partner ID: 601200580

Before mailing your signed Trading Partner Agreement to EDS for processing please verify that:

- The document is complete
- Signatures are in the appropriate areas
- You have checked the transactions that you will be submitting and receiving (See page 5 of the TPA)

**ARTICLE I. MEDICAL TRANSACTION STANDARDS**

**Rhode Island Medical Assistance Program Transaction Standards**

Selected **ASC X12N Version 4010A** standards include, as applicable, all data dictionaries, segment dictionaries and transmission controls referenced in those standards, but include only the Transaction Sets listed in the section below.

The information provided will be utilized to route transactions to the Medicaid Management Information System and back to Trading Partner directories. Remittance files (835) and Pended Claims Reports (277) will be available only to one trading partner. If authorizing one Trading Partner for claims submission and another for downloads each party must complete a separate TPA.

**Check all that apply:**

<input checked="" type="checkbox"/>	837 Professional	<input checked="" type="checkbox"/>	277 Unsolicited Claim Status
	837 Institutional	<input checked="" type="checkbox"/>	997 Functional Acknowledgement
	837 Dental	<input checked="" type="checkbox"/>	835 Remittance Advice
	270 Eligibility Inquiry		271 Eligibility Response
	276 Claim Status Inquiry		NCPDP 1.1 Batch Pharmacy Claim Response
	NCPDP 5.1 Batch		

**Specify Software:**

	<b>Software</b>	<b>Vendor</b>
	Provider Electronic Solutions	EDS
<input checked="" type="checkbox"/>	Other	Office Ally- Proprietary

**Method of Transmission:** SFTP Preferred

**Guidelines**

HIPAA – Health Insurance Portability and Accountability Act. In the event of any conflict, HIPAA standards and Implementation Guides shall control.

Please list the name(s) and phone number(s) of person(s) authorized to resolve problems regarding electronic transmissions:

\_\_\_\_\_  
Name Phone Number

\_\_\_\_\_  
Name Phone Number

\_\_\_\_\_  
e-mail address

**ARTICLE II. RHODE ISLAND MEDICAL ASSISTANCE PROVIDERS**

Please list the names and the RI Medical Assistance Program provider numbers of those providers for which electronic transactions will be submitted. Each individual provider or group for whom you will be billing must sign and date the agreement below. If additional space is required to identify each provider make copies of Article II and attach.

\* Please list which number (can be both) you would like linked to your Trading Partner Number

1. \_\_\_\_\_  
NPI / Medical Assistance Provider Number

Provider Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

2. \_\_\_\_\_  
NPI / Medical Assistance Provider Number

Provider Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

3. \_\_\_\_\_  
NPI / Medical Assistance Provider Number

Provider Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Trading Partner Execution:  
TRADING PARTNER**

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Signed

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Name

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Title

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**DO NOT FAX**

**Please mail this certification to the  
Following address:**

**EDS  
Attn: EDI Coordinator  
P.O. Box 2010  
Warwick, RI 02887-2010**