

# MEDICAID SOUTH DAKOTA PRE-ENROLLMENT INSTRUCTIONS – MCDSD



## HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 1 week.

## WHERE SHOULD I SEND THE FORMS?

- Fax the form to (605) 773-5246

## WHO CAN SIGN THE FORMS?

- The owner or authorized personnel

## WHAT FORM SHOULD I DO?

- Hospital, Nursing Home/LTC, HCFA 1500, and Pharmacy Electronic Media Provider Agreement

## HOW DO I CHECK STATUS?

- Call Tracy at (605) 773-3495 and ask if you have been linked to Office Ally's submitter ID 111111337.

## WHAT PROVIDER NUMBER DO I USE?

- NPI #

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

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally, rather than contact Office Ally as directed above, 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**

# HOSPITAL, NURSING HOME/LTC, HCFA 1500, AND PHARMACY ELECTRONIC MEDIA PROVIDER AGREEMENT

Pursuant to Administrative Rule of South Dakota (67:16:35:05) this agreement is made and entered into by and between the Department of Social Services, State of South Dakota, also referred to as the "South Dakota Medical Assistance Program" and \_\_\_\_\_, also referred to as the "Provider". The purpose of this agreement is to enable the Provider to submit claims to the South Dakota Medical Assistance Program Agency with the use of electronic media.

It is hereby agreed as follows:

## **A. GENERAL PROVISIONS**

1. This agreement will be automatically renewed for one year on July 1 if neither party gives notice requesting termination, except that the duration of this agreement may be limited pursuant to action by the South Dakota Medical Assistance Program in excluding a provider for fraud or abuse pursuant to 42 CFR Part 1002. This agreement may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party.
2. This agreement may be modified in writing by mutual consent of the South Dakota Medical Assistance Program and the Provider. Any such modification shall be attached to this agreement and become a part thereof.
3. The Provider must be an authorized medical assistance provider with a signed Standard Provider Agreement on file in order to enter into this agreement.
4. This agreement will in no way supersede the Standard Provider Agreement.

## **B. RESPONSIBILITIES OF THE PROVIDER/BILLING AGENT**

1. Claims submitted by electronic media must comply with the format specifications defined by the South Dakota Medical Assistance Program. Failure to comply with the format specifications will result in the electronic claim being rejected.
2. The provider will notify the South Dakota Medical Assistance Program if the provider changes software providers or billing agents.

## **C. RESPONSIBILITIES OF THE SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM**

If the above mentioned requirements are met the South Dakota Medical Assistance Program shall be responsible for the following:

1. The South Dakota Medical Assistance Program will process and reimburse the Provider in a timely manner for all covered services submitted via electronic media.
2. The South Dakota Medical Assistance Program will notify the Provider/Billing Agent of any changes that may occur in the format specifications.

**PROVIDER**

Provider Type:  HCFA  Hospital  Pharmacy  Nursing Home/LTC

How are you submitting?  POS  Launch Pad/Web Application

\_\_\_\_\_  
Provider Name (Typed)

\_\_\_\_\_  
Provider Number

National Provider Identification (NPI) Number: \_\_\_\_\_

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

\_\_\_\_\_  
Tax ID Number

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Contact Person (Typed)

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Title (Typed)

\_\_\_\_\_  
Date



**BILLING AGENCY**

Office Ally  
Billing Agency

111111337  
Billing Agency Submitter Number

16703 SE McGillivray Blvd Suite 200  
Street Address

Vancouver, WA 98683  
City, State and Zip Code

Dan Waclawsky  
Contact Person (Typed)

866-575-4120  
Telephone Number

dan.waclawsky@officeally.com  
E-Mail Address

**835 Electronic Remit  YES  NO      277 Claim Status Response  YES  NO**



**TO BE COMPLETED BY SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM**

Start Date \_\_\_\_\_

Approved By: \_\_\_\_\_  
Larry Iversen, Division Director

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