Electronic Data Interchange

This presentation is intended to be a self-help tool for completing an Oregon DHS Trading Partner Agreement (TPA) and related Exhibits. We hope you find this useful.

~ DHS EDI Support ~

DHS
Oregon Department of Human Services

Overview

- Oregon DHS requires a Trading Partner Agreement (TPA) to be duly executed by any participating provider prior to the exchange of electronic data (*e.g.,* claims for payment).
- This step-by-step presentation will:
  - Explain need for various pieces of information; and
  - Provide instructions for completing each of the forms in the EDI Registration packet.
- You may want to download the EDI packet first and follow this presentation while completing the forms.
  - Packet with forms only: http://dhsforms.hr.state.or.us/Forms/Served/DE2080pkt.pdf
  - Packet with instructions: www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml#reg_tuts

Accepted version

- Not sure if you are using the correct version of this packet?

The bottom right corner should say

(Rev. 6/08) 

- You must use this version.

- DHS may send back your TPA and Exhibits if you use an older version.

Important timelines

- June 30, 2008 – Last day for testing and registration in the current MMIS
- Starting July 1, 2008, DHS will focus on testing and registration in the replacement MMIS.
- Anyone who is not a current DHS Trading Partner by June 30 will need to wait until September 2008 to complete the registration and testing process.

Requirements

- The EDI Registration packet includes three important documents:
  - Trading Partner Agreement (TPA - pages 1-5)
  - Application for Authorization (Exhibit A - pages 6-8)
  - EDI Registration Form (Exhibit B - pages 9-10)
- The TPA, Exhibit A and Exhibit B must be returned to DHS with original BLUE ink signatures as a complete package of information.
  - DHS does not accept stamped or copied signatures.
  - Because DHS requires an original signature, DHS does not accept faxes of the TPA or Exhibits.
- If you are a current Trading Partner and you change to a different clearinghouse, you will need to submit a new Exhibit A and Exhibit B with the different clearinghouse information and signatures.

Mailing instructions

- Read and complete all information required.
- Sign and date in BLUE ink.
- Retain a copy of the TPA and Exhibits for your records.
- Prepare the TPA and Exhibits to be returned to DHS.
- If you choose, you may send your TPA and Exhibits by registered mail.
- Send all signed, original documents to:

  DHS-Division of Medical Assistance Programs
  EDI Support Services
  500 Summer Street NE, E-44
  Salem, OR 97301-1079

Definitions

- Authorized signer:
  - A person responsible for business activities of the named provider and authorized to sign binding agreements.
- Provider number:
  - The six-digit number assigned to Medicaid providers by DHS.
- Submitter number:
  - The number assigned to an EDI submitter by DHS for EDI submissions (may be the billing provider number).

Trading Partner Agreement

The Trading Partner Agreement will be returned if the required fields are not completed, potentially delaying the process.

Trading Partner Agreement

- DHS requires those planning to exchange electronic data (*e.g.,* claims for payment), to sign a TPA before initiating testing.
- The TPA is a binding agreement between DHS and a provider as defined in Oregon Administrative Rule (OAR) 407-120-0100.
- All provider information must be consistent with how the provider is enrolled with DHS.

TPA
page 1

DHS Oregon Department of Human Services

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 Heath 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

TPA page 1

Oregon DHS Trading Partner Agreement

DHS
Oregon Department of Human Services

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.

- Provider Number: Enter the 6-digit number that DHS issued to you when you enrolled as a Medicaid provider. (Note: this cannot be a billing service).

- Name of Provider, Prepaid Health Plan, Clinic or Allied Agency: Enter your (the provider's) name as enrolled with DHS (e.g., name of clinic) .

TPA
page 5

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:

TPA page 5

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

Phone number:

Authorized Signature:

Type or Print Name:

Date:

- Enter your (the provider's):
  - Name as enrolled with DHS (to match page 1 of TPA).
  - Phone number.
- The original BLUE ink signature of the person authorized to sign contracts for your business will sign.
- Type or print the authorized signer's name.
- Enter the date the agreement was signed.

Application for Authorization

Exhibit A required fields

Exhibit A

- The Application for Authorization form has several purposes:
  - It provides DHS information on who will be submitting your electronic transactions.
    - You can authorize another entity (*e.g.,* clearinghouse or billing service) to submit for you, or
    - You can authorize yourself to submit transactions directly to DHS.
  - If you authorize another entity to submit for you, Exhibit A indicates which, if any, actions may be taken by the submitter on your behalf.
  - Exhibit A obligates the EDI submitter (yourself or the authorized entity) to abide by the DHS EDT rules as secured by the required signature.

Exhibit A page 6

DHS Oregon Department of Human Services

APPLICATION FOR AUTHORIZATION

☐ **New Application** ☐ **Updated Application**
Effective date: MM/DD/YYYY

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 (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.

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: _____

Exhibit A - page 6

Exhibit A – Application for Authorization

DHS
Oregon Department of Human Services

APPLICATION FOR AUTHORIZATION

☐ **New Application** ☐ **Updated Application**
Effective date: MM/DD/YYYY

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.

- New Application - Check this box if this is a new application.
- Updated Application - Check this box if updating information (changing or adding a submitter). Indicate the date that the updates are effective.

Exhibit A - page 6 - section A

A. Trading Partner Application for 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.

- You must read and complete this section when you want another entity to submit on your behalf.
- If only you (the provider) are going to submit transactions, then skip to section B.

Exhibit A - page 6 - section A

☐ Request and participate in business-to-business testing with OR-DHS for my Registered Transactions.

- Check this box if you want the submitter to participate in business to business testing with DHS, to test their software's ability to submit your claims.

Exhibit A - page 6 - section A

☐ Submit a request for approval to conduct my Registered Transactions.

- Checking this box gives the submitter permission to request advancement into “production” (*e.g.*, submitting actual claims for payment) from a test mode after going through the testing phase.
  - DHS approval to conduct transactions does not “certify” the HIPAA compliance of electronic transactions exchanged.
  - DHS approval indicates that our internal testing processes have been completed and a “production” status is assigned.

Exhibit A - page 6 - section A

- Check this box if you want to give the submitter permission to send changes or updates to their Exhibit A information directly to DHS.
  - If you leave this box unchecked, DHS will only accept changes to Exhibit A when submitted by you (the provider).

Exhibit A - page 6 - section A

- Check this box if you give the submitter permission to send changes or updates of Exhibit B directly to DHS.
  - If you leave this box unchecked, DHS will only accept changes to Exhibit B when submitted by you (the provider).

Exhibit A - page 6 - section A

- Check this box if you give the submitter permission to request a password and log-on information (if the password should need changing or they are having difficulty logging in).

Exhibit A - page 6 - section A

- Check this box if you are allowing the submitter to submit and/or receive the transactions you will be selecting, such as:
  - 835 Claims Remittance Advice
  - 270 Client Eligibility inquiry
  - 271 Client Eligibility response

Exhibit A - page 6 - section A

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: _____

- Enter your (the provider's):
  - Name (to match page 1 of TPA).
  - Business phone number (to match 5 of TPA).
  - Six-digit DHS provider number (to match page 1 of TPA).
  - Tax ID number (as enrolled with DHS).
  - NPI number(s).
  - Taxonomy code(s).
- Enter the current date.
- The authorized signer must sign here in BLUE ink (to match page 5 of the TPA).

Exhibit A
page 7

- You (the provider) and the entity who will submit on your behalf (the EDI submitter) must read these Conditions.

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 waivered 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.

Exhibit A
page 8

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: _____

Phone number: _____

EDI Submitter Signature: _____

Date: _____

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

EDI Submitter Federal Tax ID Number: _____

B. 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 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: _____

Exhibit A - page 8 – section A

Exhibit A – Application for Authorization

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: _____

Phone number: _____

EDI Submitter Signature: _____

Date: _____

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

EDI Submitter Federal Tax ID Number: _____

- The EDI submitter you have selected must complete all information in this section, including a dated signature.

Exhibit A - page 8 - section B

B. 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 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: _____

- If you (the provider) choose to submit your own transactions, you must complete this section.
- If you only want the EDI submitter that you authorized in section A to submit transactions, then skip this section.

Exhibit A - page 8 - section B

EDI Submitter Legal Entity Name: _____

- This line should match what you entered on page 1 of the TPA.

Exhibit A - page 8 - section B

EDI Submitter Contact Individual: _____

- This line should match the name of the authorized signer from page 5 of the TPA.

Exhibit A - page 8 - section B

Address: _____

- Enter your (the provider's) physical business address.

Exhibit A - page 8 - section B

Telephone: _____ Fax: _____ E-mail: _____

- Enter your (the provider's):
  - Phone number
  - Fax number
  - E-mail address

Exhibit A - page 8 - section B

EDI Submitter Federal Tax ID Number: _____

- The Tax ID information is the your (the provider's) Tax ID as enrolled with DHS.

Exhibit A - page 8 - section B

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

Trading Partner Signature: _____

- Submitter Number: Enter your 6-digit DHS provider number here (to match page 1 of TPA).
  - If your enrollment arrangement with DHS is such that this is different, DHS will notify you.
- Trading Partner Signature: The authorized signer must sign here in BLUE ink (to match page 5 of the TPA).

EDI Registration

Exhibit B required fields

Exhibit B

- The EDI Registration form (Exhibit B) is required by DHS before you or your EDI submitter may submit a transaction(s) for testing.
  - You must complete Exhibit B for each entity you authorize to submit transactions on your behalf (including yourself, if self-submitting).
  - It provides information on the specific transactions you or your EDI submitter will exchange with DHS.
  - It also provides important contact information for DHS to use to resolve any technical or claims inquiries. You can enter up to two contacts for each contact type, and add more contacts on the back of the form if needed.

Exhibit B
page 9

DHS Oregon Department of Human Services	**DHS EDI Support Services** **DMAP Operations** **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.

ONE — Trading Partner Information

THIS REGISTRATION IS: ☐ **A NEW REGISTRATION** ☐ **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 — Authorized Signer Information (legally authorized signer):

*Authorized Signer:		*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:			

Exhibit B - section 1 - page 9

ONE	Trading Partner Information			
	THIS REGISTRATION IS: ☐ A NEW REGISTRATION ☐ 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:	

- Check if new or revised registration and effective date.
- Enter your (the provider's):
  - Name (to match the name entered on page 1 of the TPA).
  - Physical address (actual location).
  - Secondary address if applicable.
  - City, State and ZIP Code (+4).
  - Phone number and fax number.

Exhibit B - section 2 - page 9

TWO	OR-DHS Provider Number:	
	*Provider/Contract # for which the submitter has authorization (see Exhibit A):	#
	*National Provider Identifier (NPI):	
	*Taxonomy Code(s):	

- Enter your (the provider's):
  - Six-digit DHS provider number (to match page 1 of TPA).
  - NPI number(s).
  - Associated taxonomy code(s).
- If you are completing this form for an EDI submitter who will submit on your behalf, then the information in section 2 should match what you entered in section A of Exhibit A (page 7 of packet).

Exhibit B - section 3 - page 9

THREE	Authorized Signer Information (legally authorized signer):			
	*Authorized Signer:		*Title:	
	*Phone Number:		*Fax Number:	
	*E-mail Address:			
	Secondary Contact:		Title:	
	Phone Number:		Fax Number:	
	E-mail Address:			

- This section is the information for the authorized signer. This must be the same as page 5 of the TPA.
- You must complete all fields.
- An authorized signer may designate a secondary contact as having signing authority. Please print secondary signer information, if available.

Exhibit B - section 4 - page 9

FOUR	Claims Contact Information			
	*Primary Contact:		*Title:	
	*Phone Number:		*Fax Number:	
	*E-mail Address:			
	Secondary Contact:		Title:	
	Phone Number:		Fax Number:	
	E-mail Address:			

- Due to HIPAA Privacy rules, DHS will only discuss claims information with the individuals you list in section 4.
- DHS recommends that you list at least one person familiar with claims submissions.

Exhibit B
page 10

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:		OR-DHS Submitter ID:	
*Address Line 1:			
Address Line 2:			
*City, State & ZIP:			

Submitter Type: *Check **ALL** that apply*

☐ Billing Provider ☐ Self ☐ Clearinghouse/Billing Service
☐ Managed Care ☐ TPA ☐ Other: _____ *Please Specify*

SIX — EDI Submitter's Contact Information

☐ **Third Contact on reverse (if needed)**

*Business Contact:		*Title:	
*Phone Number:		*Fax Number:	
*E-mail Address:			
*Technical Contact:		Title:	
*Phone Number:		Fax Number:	
*E-mail Address:			

SEVEN — Authorized Transactions for: ☐ FFS Provider or ☐ Prepaid Health Plan

*Check all transactions for which authorization should be registered.

- ☐ **837** Professional Claim Submission
- ☐ **837** Dental Claim Submission
- ☐ **837** Institutional Claim Submission
- ☐ **835** Health Care Claim Payment/Advice (RA)
- ☐ **270** Health Care Eligibility Benefits Inquiry
- ☐ **271** Health Care Eligibility Benefits Response
- ☐ **278** Health Care Services Review Request (Prior Authorization [PA]) – *Available September 2008*
- ☐ **278** Health Care Services Review Response (Prior Authorization [PA]) – *Available September 2008*
- ☐ **276** Health Care Claims Status Request
- ☐ **277** Health Care Claims Status Response
- ☐ **Status File** Health Care Claim Status (PHP only)
- ☐ **820** Group Premium Payments
- ☐ **834** Benefit Enrollment/Maintenance
- ☐ **NCPDP** Submission (PHP only)
- ☐ **NCPDP** Response Report (PHP only)
- ☐ **NCPDP** Point of Sale Submission/Response – *Available September 2008*

NOTE: OR-DHS is currently only accepting ANSI 4010A1 Formats.

EIGHT — Signature

*Provider, Prepaid Health Plan, Clinic or Allied Agency Name: *Phone:

*Signature (original only): *Date:

Please Print Name:

Exhibit B - sections 5 & 6 - page 10

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.**

	EDI Submitter Information			
FIVE	*Company Name:		OR-DHS Submitter ID:	
	*Address Line 1:			
	Address Line 2:			
	*City, State & ZIP:			
	*Submitter Type: *Check **ALL** that apply*	☐Billing Provider ☐Self ☐Clearinghouse/Billing Service ☐Managed Care ☐TPA ☐Other: _____ *Please Specify*		
SIX	**EDI Submitter's Contact Information**		☐ **Third Contact on reverse (if needed)**	
	*Business Contact:		*Title:	
	*Phone Number:		*Fax Number:	
	*E-mail Address:			
	*Technical Contact:		Title:	
	*Phone Number:		Fax Number:	
	*E-mail Address:			

- The EDI submitter must complete the information in these two sections.
- If you (the provider) are self-submitting, you will complete this information. Select "Self" as the Submitter Type in section 5.

Exhibit B - section 7 - page 10

SEVEN

Authorized Transactions for: ☐ **FFS Provider or** ☐ **Prepaid Health Plan**

*Check all transactions for which authorization should be registered.

- ☐ **837** Professional Claim Submission
- ☐ **837** Dental Claim Submission
- ☐ **837** Institutional Claim Submission
- ☐ **835** Health Care Claim Payment/Advice (RA)
- ☐ **270** Health Care Eligibility Benefits Inquiry
- ☐ **271** Health Care Eligibility Benefits Response
- ☐ **278** Health Care Services Review Request (Prior Authorization [PA]) – *Available September 2008*
- ☐ **278** Health Care Services Review Response (Prior Authorization [PA]) – *Available September 2008*
- ☐ **276** Health Care Claims Status Request
- ☐ **277** Health Care Claims Status Response
- ☐ **Status File** Health Care Claim Status (PHP only)
- ☐ **820** Group Premium Payments
- ☐ **834** Benefit Enrollment/Maintenance
- ☐ **NCPDP** Submission (PHP only)
- ☐ **NCPDP** Response Report (PHP only)
- ☐ **NCPDP** Point of Sale Submission/Response – *Available September 2008*

NOTE: OR-DHS is currently only accepting ANSI 4010A1 Formats.

- Select the transaction(s) you (the provider) wish to exchange with DHS. Not all transactions are available to all providers.
- Only check those that are appropriate for your particular line of business. For example, if you are not a DHS-contracted Prepaid Health Plan, do not check any that state: “PHP only”. If you are a dentist, make sure you check the 837 Dental.

Exhibit B - section 8 - page 10

EIGHT	Signature	
	*Provider, Prepaid Health Plan, Clinic or Allied Agency Name:	*Phone:
	*Signature (original only):	*Date:
	Please Print Name:	

- Sign and date the form using **BLUE** ink.
- The name, phone number, signature and name (of authorized signer) must match page 5 of the TPA.
- Please print your name clearly.

Need help?

- If you have specific EDI registration or testing questions, please contact EDI Support Services at:
  - Phone: 503-947-5347
  - Toll-free: 888-690-9888
  - E-mail: dhs.edisupport@state.or.us

Thank you!