MEDI-CAL (MC051)
PRE-ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- Medi-Cal Telecommunications Provider and Biller Application/Agreement (for electronic claim submission)
    - Use one NPI number per form
    - If you are a group, list only your group information

WHERE SHOULD I SEND THE FORM(S)?

- Mail the original forms to:

  Office Ally
  PO Box 872020
  Vancouver, WA 98687

- **PLEASE NOTE:** Faxed copies are **NOT** accepted, originals must be sent to Office Ally

WHO CAN SIGN THE FORM(S)?

- Medi-Cal enrollment requires the provider's signature or president, CEO, or owner of a group in **BLUE INK**!
    - Signature must be ORIGINAL
    - Signature must be in **BLUE INK**
    - Signature must be by provider or owner on file at Medi-Cal as authorized to sign
    - Medi-Cal will not accept signatures in black ink or signatures from office managers or billers
    - DO NOT use white out

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is approximately 4 to 6 weeks.

HOW DO I CHECK STATUS?

- To check status call Medi-Cal at 916.636.1200, option 1, 4, 2, 2, 1 for CMC/EDI. Ask if your provider number has been linked to Submitter ID **JQR**.
- Once you receive confirmation that you've been linked to Office Ally, follow the instructions on the "Note to My Clients Plus Users" page and FAX info requested. We will forward to our clearinghouse and notify you by email when your registration is complete.

Note to My Clients Plus Users:

Once you have confirmed with the Insurance Payer your Billing NPI/ Provider Number is linked to Office Ally, please fax the following information to 888-653-7115.

- **Please label with "My Clients Plus" on top**
- **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 Payer".**
- **Provider email address where you can be notified of setup completion.**
- **For EDISS or Noridian Pre-Enrollments Please Also Include: Providers Submitter Number**

REVISED 9/29/16

MEDI-CAL TELECOMMUNICATIONS PROVIDER AND BILLER APPLICATION/AGREEMENT
(For electronic claim submission)

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Health Care Services, hereinafter referred to as the "Department," and:

PROVIDER INFORMATION

Provider name (full legal)		Provider number	
DBA (if applicable)		Last 4 digits of Tax Id Number or Social Security Number:	
Provider service address (number, street)	City	State	ZIP code
Contact person		E-mail address	
Contact person address (number, street)	City	State	ZIP code
Contact telephone number ( )	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		

BILLER INFORMATION (If other than the provider of service)

Biller name (full legal) Office Ally, LLC		Biller telephone number (360) 975-7000 Option 1	
DBA (if applicable)		E-mail address support@officeally.com	
Business address (number, street) 1300 SE Cardinal Court, Suite 190	City Vancouver	State WA	Zip code 98683
Contact person Customer Service	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number) JQR		

Full legal name(s) required as well as any assumed (DBA) name(s), address(es), and Medi-Cal provider number(s). The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."

1.1 CMC Batch Submission Type:

- ☐ Dial-up
- ☐ Magnetic tape
- ☒ Internet*

Real Time Submission Type:

- ☐ Point of Service (POS)
- ☒ Internet*

☐ Leased Line *or* ☐ Dial-up

* Note: Requires a completed network agreement on file.

INDICATE CLAIM TYPES WHICH WILL BE SUBMITTED ELECTRONICALLY

NCPDP Version (indicate version): _____

☐ Pharmacy (01)

ANSI X 12 837 Version (indicate version): 005010X222A1 837P / 005010X223A2 837I

- ☐ Long-Term Care (02)
- ☐ Inpatient (03)
- ☐ Outpatient (04)
- ☐ Medical/Allied Health (05)
- ☐ Vision (05)
- ☐ CHDP (11)
- ☐ Medicare Crossover Part A
- ☐ Medicare Crossover Part B

ANSI X 12 276/277 Version (indicate version): _____

☐ Claim Status Inquiry/Response

ANSI X 12 278 Version (indicate version): _____

☐ Health Care Services and Review

1.2 BACKGROUND INFORMATION

The Provider/Biller agrees to provide the Department with the above information requested in order to verify qualifications to act as a Medi-Cal electronic Biller.

2.0 DEFINITIONS

The terms used in this agreement shall have their ordinary meaning, except those terms defined in regulations, Title 22, California Code of Regulations, Section 51502.1, shall have the meaning ascribed to them by that regulation as from time to time amended. The term “electronic” or “electronically,” when used to describe a form of claims submission, shall mean any claim submitted through any electronic means such as: magnetic tape or modem communications.

3.0 CLAIMS ACCEPTANCE AND PROCESSING

The Department agrees to accept from the enrolled Provider/Biller, electronic claims submitted to the Medi-Cal fiscal intermediary in accordance with the Medi-Cal provider manuals. The Provider hereby acknowledges that he has received, read, and understands the provider manual and its contents, and agrees to read and comply with all provider manual updates and provider bulletins relating to electronic billing.

3.1 CLAIMS CERTIFICATION

The Provider agrees and shall certify under penalty of perjury that all claims for services submitted electronically have been personally provided to the patient by the Provider or under his direction by another person eligible under the Medi-Cal Program to provide to such services, and such person(s) are designated on the claim. The services were, to the best of the Provider's knowledge, medically indicated and necessary to the health of the patient. The Provider shall also certify that all information submitted electronically is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider/Biller agrees to keep for a minimum period of three years from the date of service an electronic archive of all records necessary to fully disclose the extent of services furnished to the patient. A printed representation of those records shall be produced upon request of the Department during that period of time. The Provider/Biller agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California to the California Department of HealthCare Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. The Provider also agrees that medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability. The Provider/Biller agrees that using his Medi-Cal Submitter ID plus DHCS-issued password when submitting an electronic claim will identify the submitter and shall serve as acceptance to the terms and conditions of the Department’s Telecommunications Provider and Biller Application/Agreement (DHCS 6153), paragraph 3.0. The Provider/Biller further acknowledges the necessity of maintaining the privacy of the DHCS-issued password and agrees to bear full responsibility for use or misuse of the Medi-Cal Submitter ID and password should privacy not be maintained.

3.2 VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

Regardless of whether the Provider employs a Biller, the Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all claim information for payment. This includes usual and customary charges for services rendered. The Provider shall also assume personal responsibility for verification of submitted claims with source documents. The Provider/Biller agrees that no claim shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failure to make, maintain, or produce source documents shall be cause for immediate suspension of electronic billing privileges.

3.3 ACCURACY AND CORRECTION OF CLAIMS OR PAYMENTS

The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its fiscal intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015 and, as from time to time amended. The Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information relating to that claim may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, administrative action to recover the funds, and decertification of the Provider/Biller from participation in the Medi-Cal program and/or electronic billing.

4.0 CHANGE IN ELECTRONIC BILLING STATUS

The Provider/Biller and the Department agree that any changes in Provider/Biller status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5.0 PROVIDER/BILLER REVIEWS

The Provider/Biller agrees that agents of the Department of Health Care Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider/Biller agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of claims submitted electronically.

5.1 NONEXCLUSIVE REVIEWS

The Provider/Biller agrees that the review set out in paragraph 5.0 above is not exclusive but supplements any other form of audit or review the Provider/Biller may be subject to due to its status as a certified Provider/Biller of services under the Medi-Cal or Medicare programs.

6.0 EFFECTIVE DATE

This agreement shall become effective upon approval of the Department.

6.1 TERMINATION

The Department or Provider may terminate this agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department. The Department may, however, terminate this agreement immediately, pursuant to paragraph 6.2 upon determination that the Provider/Biller has failed or refused to produce or retain source documents in accordance with federal and state law or this agreement.

6.2 TERMINATION FOR CAUSE

If the Provider/Biller is unable to produce source documents on request pursuant to paragraph 5.0, the Department may terminate this agreement immediately by directing its fiscal intermediary to cease payment of any and all electronic claims submitted by the Provider/Biller, including any claims in process on the date of such termination. The Provider/Biller has no right to appeal termination for cause pursuant to this subpart prior to the effective date of such termination. The Provider/Biller may appeal any grievance resulting from the termination in accordance with the procedure established by Title 22, California Code of Regulations, Section 51015, as from time to time amended. The Department may demand repayment of claims for which no source documents are produced, and the Provider/Biller shall have a right to appeal of such an overpayment finding to the extent provided by Section 14171 of the Welfare and Institutions Code and regulations promulgated pursuant thereto, and as from time to time amended.

6.3 EFFECT OF TERMINATION AND APPEAL

On termination pursuant to paragraph 6.1 or 6.2, the Provider/Biller may submit hard copy claims.

7.0 AGREEMENT BETWEEN PROVIDER AND BILLER (IF OTHER THAN THE PROVIDER OF SERVICE)

The Provider stipulates that any agreements with Billers to submit Medi-Cal electronic billings shall be in conformance with state law governing electronic claims submission, and shall contain provisions including, but not limited to, the following:

a. The Provider shall specifically designate the Biller as the agent to the Provider for the purpose of preparation and submission of Medi-Cal claims by the Biller. As the Provider's agent, the Biller agrees to comply with all Medi-Cal requirements on recordmaking and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Sections 14124.1 and 14124 and Title 22, California Code of Regulations, Section 51476.

b. Electronic billing for services rendered to Medi-Cal beneficiaries shall be prepared by the Biller solely from information supplied by the Provider. This information includes usual and customary charges for services rendered. A printed representation of source documents as defined in Title 22, California Code of Regulations, Section 51502.1 shall be kept, including all information transmitted as a claim by the Provider to the Biller electronically, or a period of at least three years from the date of claims submission.

c. If a department audit is initiated, the Billing Service shall retain all original records described in paragraphs 3.2, 5.0, and 7.0(b) above until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond three years from the date of the service of termination of financial relationship or longer period required by federal or state law.

d. The parties shall agree that the Department may accept electronic billings prepared, certified, and submitted by the Biller on behalf of the Provider only as long as the agreement between the Provider and the Biller remains in existence and in effect.

e. Both parties have a duty to notify the Department in writing immediately upon any change in or termination of their agreement.

8.0 DECLARATION OF INTENT

This agreement is not intended as a limitation on the duties of the parties under the Medi-Cal Act, but rather as a means of clarifying those duties as they relate to the Provider/Biller in its capacity as an authorized Provider/Biller for electronic billing.

8.1 PROVIDER TO HOLD STATE OF CALIFORNIA HARMLESS

The Provider agrees to hold the State of California harmless for any and all failures to perform by billing services, billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The Provider explicitly agrees that the Provider is assuming any and all risks that accompany electronic billing and that the Provider is not relying upon the evaluation, if any, that the State has made of the electronic billing system, software, or Biller the Provider is using. Furthermore, the Provider acknowledges that if the electronic billing system, software, or Biller contracted with, is or has been listed as available in Medi-Cal bulletins, that such listing was not an endorsement by the State of California nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

9.0 CONFIDENTIALITY OF RECORD

The Provider/Biller agrees to provide adequate precautions to protect the confidentiality of Medi-Cal beneficiary record and claims submission methods in accordance with statute or regulations Title 17, CCR, Section 6800, et seq. and/or 42 CFR, Part 400 and 440, Subpart B.

PROVIDER SIGNATURE INFORMATION

Full printed name	Title

Provider signature (original signature required; *DO NOT use black ink*)	Date
✍	

BILLING SERVICE SIGNATURE INFORMATION (complete only if "Biller Information" is completed on page 1 of 4)

Full printed name	Title
Brian Oneill	CEO/President

Owner or Corporate Officer signature (original signature required; *DO NOT use black ink*)	Date
✍	

Return Application/Agreement to: Xerox State Healthcare Services, LLC.
CMC Unit
P.O. Box 15508
Sacramento, CA 95852-1508

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.