MEDICAID AK PRE-ENROLLMENT INSTRUCTIONS – MCDAK

HOW LONG DOES PRE-ENROLLMENT TAKE?

- 5-10 business days

WHERE SHOULD I SEND THE FORMS?

- Mail the original forms to:

  ACS
  HIPPA Provider Support Team
  PO Box 240808
  Anchorage, AK 99524-0808

WHAT FORM SHOULD I DO?

- Provider Information Submission Agreement (must be mailed with the original signature)
- 835 Authorization Form (can be faxed to 907-644-8126 but original needs to be mailed)

HOW DO I CHECK STATUS?

- You will be notified via email by ACS that your enrollment has been completed; however, you can also contact the EDI department at 907-644-6800 option 3. Ask if you have been linked to Office Ally's submitter ID AK03373.

☒ To complete your enrollment follow 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 Noridian Pre-Enrollments Please Also Include: Submitter number**
- **For Tufts Health Plan Pre-Enrollments, please also include the billing address that was setup with the payer and if it is for a professional or institutional claim.**

Revised 10/1/2012

ENTER YOUR APPLICATION TRACKING NUMBER: _____

STATE OF ALASKA
Department of Health and Social Services
PROVIDER INFORMATION SUBMISSION AGREEMENT

The following constitutes an Information Submission Agreement between a provider enrolled in the Alaska Department of Health and Social Services Medical Assistance Program ("*Provider"*), and the State of Alaska, Department of Health and Social Services ("*State"*). The terms of this agreement govern the submission of clinical and financial information sent to the State in support of services performed by the Provider.

I,_____ , as Provider, enter into this Provider Information Submission Agreement with the State as authorization to submit clinical and financial information directly to the State either: (1) electronically by me; or (2) in an electronic or paper format through a Billing Agent on my behalf. All information submitted under the terms of this agreement is in support of services performed by me.

Section I. Terms of Agreement (*To be completed by the "Provider"*)	
1.	I am the Provider named above.
2.	I agree to comply with all state and federal laws as they apply to the State of Alaska, Department of Health and Social Services programs in which I participate.
3.	I agree that payment and satisfaction of claims that I submit or that are submitted by my Billing Agent, including electronic transactions, will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.
4.	I agree that I am fully responsible for all information and claims submitted by my Billing Agent or me and that all overpayments made to me by the State will be repaid by me.
5.	I agree to comply with the current and future Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) for all services, information, and transactions, including electronic transactions, privacy, and security regulations.
6.	I agree that any transactions completed under this agreement will be compliant with all state and federal laws, including Title VII of the Civil Rights Act of 1964, which prohibits exclusion or discrimination on the basis of race, color, religion, sex, or national origin.
7.	I agree to test any changes or modifications to my electronic file or file layout or my Billing Agent's electronic file or file layout and seek approval of my test submission by the State. I understand that failure to do so may result in claim processing delays.
8.	I agree to provide the State 30 days notice to set up or change electronic file or file layout specifications for information submissions. I agree to cooperate by transmitting test transactions to the State during a set-up period prior to any transmission to the State. I understand that the duration of testing may be 30 days or more.
9.	I agree, as applicable, to submit Alaska-specific data elements in accordance with State of Alaska Medical Assistance Provider Billing Manuals, Companion Guides, and other State Program Guides to the extent that Alaska-specific data elements do not change the meaning or intent of any of the Health and Human Services (HHS) Transaction Standard's implementation specifications (45 CFR Part 162.915(d)) and/or do not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915(a)).
10.	I agree that I have the responsibility to ensure that all information submitted is complete and accurate, and that all electronic transactions meet the standards for HIPAA compliance, regardless of whether I use a Billing Agent, a clearinghouse, a billing service, or other third party submitter, or whether I directly submit transactions or information.

Section I. Terms of Agreement, continued (*To be completed by the "Provider"*)

11. I agree that I will not submit claims that may be payable by another resource, unless specifically waived by federal or state rules, or for claims that have already been paid.

12. I agree to comply with state and federal records retention laws that govern records maintained by my Billing Agent or me and to provide access to my records and the records maintained on my behalf by my Billing Agent for reviews and audits as required by state and federal laws.

13. I agree to protect my assigned State identification numbers (including submitter numbers) and State passwords against unauthorized use.

14. I agree that any changes in my business ownership and/or with my Billing Agent will not change my responsibility or liability under this agreement, until such time as I make written notification to the State or its designee of any such change.

15. (a) I agree to notify the State, by the close of business on the next working day for the State of Alaska, if for any reason I revoke or terminate any agreement with the above Billing Agent.
(b) I agree to notify the State of any change to my or my Billing Agent's address, telephone, or other required information within 3 working days.
(c) I agree to execute a new Department of Health and Social Services Information Submission Agreement prior to allowing any Billing Agent to submit information to the State on my behalf.

16. Billing Agent Information: I authorize the following Billing Agent to submit information, including claims, on my behalf *(Complete this item ONLY if you will be billing indirectly through a Billing Agent, Clearinghouse, contractor, or other entity)*:

Office Ally Submitter ID AK03373	360-975-7000	360-896-2151
Billing Agent's Business Name	Billing Agent's Telephone Number	Billing Agent's Fax Number
PO Box 872020	Vancouver	WA 98687
Billing Agent's Mailing Address	City	State Zip + 4
16703 SE McGillivray Blvd, ste 200	Vancouver	WA 98683
Billing Agent's Physical Address	City	State Zip + 4
Customer Service	360-975-7000 Option 1	support@officeally.com
Billing Agent's Contact Name	Contact's Telephone Number	Contact's Email Address (if applicable)

17. **I understand and agree to comply with all items numbered 1-16 listed above. By my signature below, I acknowledge my responsibility for compliance with this agreement and my authority to enter into this agreement on behalf of the Provider. Additionally, by my signature below, I, the Provider, authorize the Billing Agent named above to submit information, including claims, on my behalf. No photocopies or facsimile signatures will be accepted.**

Provider Business Name (print)	State Provider Identification Number (Only one ID per Agreement see instructions)
Provider's Name* or Authorized Representative's Name**	Title as applicable (print)
Signature of Provider* or Authorized Representative**	Date of Signature

Individuals and sole proprietors must sign their own enrollment agreement form.

****An authorized representative is the duly appointed official of any business organized under the laws of the state of Alaska or other state, to operate as a corporation, partnership, LLC, joint venture, or similar organization ("entity"), who has the legal authority to enroll the entity in the Alaska Medical Assistance program, to make changes and/or updates to the enrollment status of the entity, and to commit the entity to the terms and conditions set forth in this enrollment application. The authorized representative must be a general partner, chairman of the board, chief financial officer, chief executive officer, president, or direct owner of at least 5% or more of the entity seeking enrollment, or must hold a position of similar status.***

Section II. Definitions

"Billing Agent" used in this agreement means: Any Billing Agent, Clearinghouse, billing service, other third party submitter, contractors, or other entity submitting information directly to the Alaska Medical Assistance Program, State of Alaska, Department of Health and Social Services, on behalf of an enrolled Provider.

"Provider" used in this agreement means: A party who is properly enrolled in the State of Alaska Department of Health and Social Services program(s) including, as applicable, the Alaska Medical Assistance Program, and authorized to provide and be reimbursed for covered services.

"State" used in this agreement means: The State of Alaska, Department of Health and Social Services, or its designee.

Section III. To Be Completed by the State or its Designee

The State agrees to continue to mail checks, remittance advices, resubmission turnaround documents etc., directly to the Provider, Provider's Billing Agent, or other entity as recorded on the State's Medicaid Management Information System (MMIS) provider and submitter files. The State agrees to comply with all HIPAA laws.

☐ This agreement is effective and begins on the _____ day of _____, 20___. The above Provider is authorized to submit information, which may include claims, to the State.

☐ This agreement is effective and begins on the _____ day of _____, 20___. The above Provider has authorized the Billing Agent identified above to submit information, which may include claims, to the State on the Provider's behalf.

Signed this _____ day of _____, 20 __ .

_____

State Representative or designee Name, Title, and (if applicable, designee's Company or Agency Name)

_____ _____

State or State's designee Signature Date of Signature

Provider Electronic Remittance (835) Authorization

Alaska Medical Assistance is capable of sending an 835 transaction to a single entity/organization only. The purpose of this form is to allow providers to designate who should receive their 835. Please complete the following form for this designation and indicate all Alaska Medical Assistance ID(s) and corresponding National Provider Identifier (NPI) number(s) that are applicable.

Send My 835 To:

- ☐ Self (practice management software able to receive)
- ☐ Billing Agent
- ☑ Clearinghouse
- ☐ Other

Organization Name: Office Ally Submitter ID AK03373

Contact Name: Customer Service

Phone Number: 360-975-7000 Option 1

Provider Name: _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

Alaska Medical Assistance ID _____ **Corresponding NPI#** _____

_____

Telephone #: _____

Attach additional pages if necessary

I authorize the above named entity to receive and process my electronic remittances (835) from Alaska Medical Assistance Programs. I may have multiple entities submitting claims for me and understand that only one entity can be designated by me to accept and process my electronic remittance. I also understand that the entity I have authorized above must have prior approval from Xerox to receive electronic remittances.

_____ _____

Print Authorized Representative Name **Title Authorized Representative**

_____

Signature of Provider* or Authorized Representative**

_____

Date

* ***Individuals and sole proprietors must sign their own enrollment agreement form.***

** ***An authorized representative is an appointed official to whom the provider has granted the legal authority to enroll the provider in the Medicaid program, to make changes and/or updates to the provider's status in the Medicaid program (e.g., new practice locations, changes of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider's organization, or must hold a position of similar status and authority within the provider's organization.***

If you fax this document, please be sure to mail the original.

Mail original or fax to: **Xerox**
HIPAA Provider Support Team
P.O. Box 240808
Anchorage, AK 99524-0808

Fax number: (907) 644-8126