MEDICAID MARYLAND PRE-ENROLLMENT INSTRUCTIONS – MCDMD

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 2 weeks.

WHAT FORM(S) SHOULD I COMPLETE?

- Maryland Medical Care Programs Submitter Identification Form
- Trading Partner Agreement

WHERE SHOULD I SEND THE FORMS?

- The form must be mailed to Office Ally for our signature. Medicaid Maryland requires an original signature from the Clearinghouse and Provider.
  Office Ally
  Attn: Anita
  PO Box 872020
  Vancouver, WA 98687
- Office Ally will sign the document(s) and send them on to Medicaid Maryland.

ORIGINAL SIGNATURES ARE REQUIRED BY THE PROVIDER AND BY OFFICE ALLY.

WHAT PROVIDER NUMBER DO I USE?

- NPI Number
- Provider Number

WHO CAN SIGN THE FORMS?

- Owner or authorized personnel

HOW DO I CHECK STATUS?

- Send an email to HIPAAEDITest@dhmh.state.md.us. Include your NPI# and Provider # and ask if those numbers are linked to Office Ally's Submitter ID 330897513.

☒ If you are linked 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

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM

For Version 005010 HIPAA Transaction Set

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

1. This is a
   [ ] New Application
   [X] Change of Submitter Agent
   [ ] Submitter Identification Form Update

Select Media if New Application:
[ ] Electronic Transfer & Paper Voucher
[ ] Paper Voucher Only

2. **Provider Information**

a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	

3. **Electronic Submitter Information**

a) Submitter Name:	Office Ally
b) Submitter Address:	PO Box 872020, Vancouver, WA 98687
c) Submitter ID(ISA Qualifier and ISA ID):	330897513

4. **EDI Information**

Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	005010X279A1
	276/277 Claim Status & Response	005010X212
X	837 Health Care Claim Institutional / 277CA Claim Acknowledgment	005010X223A2 / 005010X214X
	837 Health Care Claim Professional / 277CA Claim Acknowledgment	005010X222A1 / 005010X214X
	837 Health Care Claim Dental / 277CA Claim Acknowledgment	005010X224A2 / 005010X214X
	820 Premium Payment	005010X218
	835 Health Care Claim Payment/Advice **835 GS Receiver ID** 330897513 (**Required, if Checked**) Receiver EDI Information (Required if different from above listed Submitter ID or if you are a Pharmacy Provider or Business Associate requesting an 835): Receiver Name: Receiver Address: ISA Qualifier and ISA ID:	005010X221A1

MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM
For Version 005010 HIPAA Transaction Set

The provider, ________________________________ hereby authorizes
PROVIDER NAME

Office Ally ________________________________, hereafter
SUBMITTER AGENT

referred to as *Submitter Agent*, to transmit HIPAA transactions to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the *Submitter Agent* the return computer electronic files of all data processed. The *Submitter Agent* agrees to protect the confidentiality of this data as required by law.

______________________________	______________________________
Signature of Provider	**Signature of Submitter Agent**
______________________________	Brian Oneill President & CEO
Print Name of Signature	**Print Name of Signature**

______________	__________	360-975-7000	__________
Telephone Number	**Date**	**Telephone Number**	**Date**

Note: This form requires completion of all requested information and **original signatures** to be processed.

MAIL TO:

SYSTEMS LIAISON SERVICES
201 W. PRESTON ST., RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK

For Internal Use Only:
Systems Liaison Services Signature: ______________________________
Date Received: ______________________________

Trading Partner Agreement

This Agreement is by and between the Medical Care Program (Medicaid) and

____________________________________. _____________________________________
PROVIDER NAME PROVIDER ADDRESS

____________________________________, hereafter known as the Provider.
CITY, STATE & ZIP CODE

[If applicable] the Provider and Program hereby agree that the Provider may use a certified clearinghouse (Submitter Agent),

Office Ally . PO Box 872020
SUBMITTER AGENT NAME SUBMITTER AGENT ADDRESS

Vancouver, WA 98687, hereafter known as Submitter Agent, to
CITY, STATE & ZIP CODE
transmit HIPAA transactions arising from the Provider's participation in the Program.

1. Purpose of Agreement- This agreement is intended to facilitate communications between the Program and the Provider in the processing by the Program of electronic transactions filed by or on behalf of the Provider.

2. Provider Submission of transactions- The Provider shall submit all data transmissions pursuant to Program standards. The Provider hereby warrants that all data will be submitted in compliance with the Program's regulations, transmittals, and any provider manual(s) specific to the provider. The Program reserves the right to modify its regulations, transmittals and other manuals at any time and to notify Provider of those changes by electronic communication. The Program reserves the right to reject any transaction which does not conform to its data submission standards.

3. Program Acceptance of Electronic Transactions- The Program agrees to accept valid transactions submitted by the Provider or the Submitter Agent.

4. Cooperation with Testing- During the testing phase, as designated by the Program, both Program and Provider agree to cooperate with each other, and with entities performing business associate type functions for the contracting parties, for the purpose of striving for accuracy, timeliness, security and completeness of date transmissions.

5. Use of Standard Transactions and Code Set Format- HIPAA regulations, at 45 CFR Part 162 HIPAA Federal Electronic Transactions and Code Sets for Data Exchange, provide for certain transaction standards for transfer of data between trading partners. The Provider must submit and the Program will be prepared to accept, translate, or route HIPAA compliant transactions. As HHS modifies the standards, the trading partners agree to incorporate by reference any modifications or changes to 45 CFR Part 162.

6. Prohibited Acts- 45CFR § 162.915 specifies that trading partners will not enter into an agreement that would: "change the definition, data condition or use of a data element or segment in a standard; add any data elements or segments to the maximum defined set; use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specifications(s); or change the meaning or intent of the standard's implementations specification(s)".

7. Expenses- Each party shall bear its own expenses in implementing this process of transmitting information via this agreement.

8. Confidentiality and Security- Each party shall comply with all HIPAA and State Security and Confidentiality requirements in the handling of protected health information and take reasonable precautions to prevent unauthorized access to any part of the transaction process. In the event that data is improperly sent or received under this agreement, such data shall be highlighted and disposed of or returned in an appropriate manner.

9. Provider Identifiers- The parties shall agree on a unique identifier to be used by Provider. Provider is responsible for disclosing the unique identifier to its agents and only as is prudent to maintain appropriate security for the identifier.

10. This Trading Partner Agreement may be terminated by the Medical Care Program at any time.

All other agreements between the Program and Provider remain in full force and effect.

AGREED:

PROVIDER NAME: ___________________________________

PROVIDER NUMBER: ___________________

NATIONAL PROVIDER IDENTIFIER (NPI)# ______________________

____
AUTHORIZED SIGNATURE

DATE: _____________________ Phone # _________________________

RETURN VIA MAIL:

Rita Tate
201 W. Preston St., Rm. LL3
Baltimore, MD 21201
ATTN: HIPAA Billing Agreements