MEDICAID OREGON (ORDHS) PRE-ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- Oregon Medicaid Electronic Data Interchange Trading Partner Agreement
    - If additional assistance is needed, click here for complete enrollment instructions

WHERE SHOULD I SEND THE FORM(S)?

- Oregon DHS requires original signatures for both the Trading Partner (provider) and the EDI Submitter (Office Ally).
- Mail the forms to Office Ally with the **original signatures in blue ink to:**

Office Ally
Attn: Anita
PO Box 872020
Vancouver, WA 98687

The form must be signed in blue ink. Forms with signatures not in blue ink will be rejected.

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Processing time is approximately 6-8 weeks

HOW DO I CHECK STATUS?

- Approximately 7 business days after Medicaid receives your form, they will mail you an approval letter.
- If you have not received a letter within 7 days, please email support@officeally.com and request a status update (include your NPI/Tax ID when requesting an update).
- You may also call (888) 690-9888 and ask if your registration packet has been received and if you've been approved.
- Once you receive confirmation that you've been linked to Office Ally, 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 EDISS or Noridian Pre-Enrollments Please Also Include: Providers Submitter Number**

REVISED 9/29/16

Oregon Health Authority
HEALTH SYSTEMS DIVISION
EDI Support Services

Print

Clear Form

Trading Partner's National Provider Identifier (NPI):

List all taxonomy code(s) registered to this NPI:

List all Oregon Medicaid ID(s) associated with this NPI

Trading Partner Agreement for Electronic Health Care Transactions

Trading partners: Use this TPA to sign up to exchange electronic data interchange (EDI) transactions with Oregon Medicaid, and to authorize who will exchange these transactions for you. You will need to submit a new TPA anytime you have changes to your trading partner or submitter information.

- **If you need to exchange transactions for more than one NPI**, complete a TPA for each NPI.
- **If you need to exchange transactions for multiple Oregon Medicaid provider numbers with the same NPI**, you can use one TPA but only if all locations need the same transactions.
- **If you need to authorize more than one clearinghouse/submitter,** complete a TPA for each one.
- **Please type or print clearly. Fill in all required fields designated with an asterisk (*).** Include full names and direct contact information in parts 2 through 5. Incomplete forms will NOT be processed.
- Please maintain a copy for your records.
- **Mail the completed form to:** EDI Support Services, 500 Summer St NE, E44, Salem, OR 97301.

Questions? Email DHS.EDISupport@state.or.us.

This TPA is: ☐ New ☐ Revised. *This form replaces all previous TPAs for this Provider/Submitter combination*.

ONE

Trading partner (provider, prepaid health plan, coordinated care organization, clinic or allied agency) information

*Business name:
*Physical address:
Secondary address:
*City, state and ZIP:
*Phone number: *Fax number:

TWO

Trading partner authorized signer information – The primary signer signs Part 7 of this form.

*Primary signer's name:
*Phone number: *Title:
*Email address: *Fax number:

Secondary signer's name:
Phone number: Title:
Email address: Fax number:

THREE

Claims contact information

*Primary contact's name:
*Phone number: *Title:
*Email address: *Fax number:

Secondary contact's name:
Phone number: Title:
Email address: Fax number:

FOUR

EDI submitter information – If your company intends to submit its own transactions, mark submitter type as "Self" and enter your company's EDI contact information.

*Company name: Office Ally Submitter ID (MB#): MB000329
*Address line 1: PO Box 872020
Address line 2:
*City, state and ZIP: Vancouver, WA 98687

*Submitter type *(check **all** that apply)*: ☐ Self ☐ Prepaid Health Plan ☒ Clearinghouse
☐ Billing service ☐ Other *(please specify):*

FIVE

EDI submitter's contact information – The Business Contact signs Part 8 of this form. OHA will email the Technical Contact when transaction testing is needed. Do not enter a billing service contact as the Technical Contact. Please list individual emails (not group emails).

*Business contact's name: Molly Eggleston
*Phone number: (360) 975-7000 x6324 *Title: Client Support Coordinator
*Email address: molly.eggleston@officeally.com *Fax number: (360) 896-2151 x6284

*Technical contact's name: Will Morrow Title: Transaction Analyst
*Phone number: (360) 975-7000 x6284 Fax number: (360) 896-2151
*Email address: will.morrow@officeally.com ☐ Third contact on reverse *(if needed)*

SIX

Authorized transactions – Check all transactions that OHA should authorize for your EDI submitter.

HIPAA 5010A1 transactions for: ☒ FFS provider or ☐ PHP/CCO

☒ **005010X222A1 837P**	Professional Claim Submission
☐ **005010X224A2 837D**	Dental Claim Submission
☐ **005010X223A2 837I**	Institutional Claim Submission
☒ **005010X221A1 835**	Electronic Remittance Advice
☐ **005010X279A1 270 and 271:** ☐ **Batch** ☐ **Real-time**	Eligibility Benefits Inquiry and Response
☐ **005010X212 276 and 277:** ☐ **Batch** ☐ **Real-time**	Claims Status Request and Response
☐ **005010X218 820**	Group Premium Payments
☐ **005010X220A1 834**	Benefit Enrollment and Maintenance (PHP/CCO only)
☐ **NCPDP 1.2/D.0**	Request and Response (B1, B2, B3) (PHP/CCO only)
☐ **Pharmacy**	Rx Carve-Out File (PHP/CCO only)
☐ **Status file**	CCO Status File (PHP/CCO only)

SEVEN

Trading Partner signature – By signing below, the Trading Partner certifies the following:

- I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html, and understand my responsibilities as stated in these rules.
- I authorize OHA to transmit to the *EDI Submitter* listed in Part 4 of this form the return computer file electronic vouchers of all transactions I have marked in Part 6 of this form.

*Provider, PHP/CCO, clinic or allied agency name:

*Email address:

*Authorized trading partner signature *(original signature only):*

*Phone number:

*Date:

EIGHT

EDI Submitter signature – By signing below, the EDI Submitter certifies the following:

- I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html, and understand my responsibilities as stated in these rules.
- I agree to protect the confidentiality of the data as required by law.

*Business contact name, title:
Molly Eggleston Client Support Coordinator

*Email address:
molly.eggleston@officeally.com

*Authorized EDI submitter signature *(original signature only):*

*Phone number:
(360) 975-7000 x6324

*Date: