# 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?

- Standard processing time is approximately 6-8 weeks.

## HOW DO I CHECK STATUS?

- Approximately 6-8 weeks after Medicaid receives your form, they will email/mail you an approval letter.
- If you have not received a letter within 6-8 weeks, 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.

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## 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

***Trading Partner's National Provider Identifier (NPI):**

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

**List the Oregon Medicaid ID(s) associated with this NPI:**

# Trading Partner Agreement for Electronic Health Care Transactions

**When to complete this form:** Trading partners must complete and submit this form to:

- Sign up to exchange transactions with the Oregon Health Authority (OHA).
- Authorize who will exchange these transactions for you.
- Make any changes to trading partner or submitter information on file with OHA.

**How to complete this form:**

- **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 ID numbers**, 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 (*).** 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 *(select one)*:
- ☐ Fully replaces the current TPA on file. This TPA will end all previous provider/submitter combinations registered under your Oregon Medicaid ID.
- ☐ Adds information to the current TPA(s).

**ONE**

**Trading partner information –.** This cannot be a billing service.

*Type *(select one)*: ☐ Provider ☐ Clinic ☐ Coordinated Care or Managed Care Organization

*Business name *(as enrolled with OHA)*:

*****Physical address:

*****City, state and ZIP:

*****Phone number/extension:

**TWO**

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

*Primary signer's name:

*Phone number/extension: *Title:

*Email address (*direct, not group, email)*:

Secondary signer's name:

Phone number/extension: Title:

Email address (*direct, not group, email)*:

**THREE**

**Claims contact information –** This contact must be a person, not a group.

*Primary contact's name:

*Phone number/extension: *Email address:

Secondary contact's name:

Phone number/extension: *Email address:

**FOUR**

**EDI submitter information –** If your company intends to exchange transactions directly with OHA, enter "Self" as the submitter name, and enter your company's EDI contact information. If your company intends to use a submitter/clearinghouse, complete this section for the submitter/clearinghouse.

*****Submitter name: Office Ally

*****Address: PO Box 872020

*****City, state and ZIP: Vancouver, WA 98687

Submitter mailbox # : MB000329

**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.

*****Business contact's name: Molly Eggleston

*****Phone number/extension: (360)975-7000 x6324

*Email address (*direct, not group, email)*: molly.eggleston@officeally.com

*****Technical contact's name: Will Morrow

*****Phone number/extension: (360) 975-7000 x6284 ☐ Third contact on reverse *(if needed)*

*****Email address (*direct, not group, email)*: will.morrow@officeally.com

**SIX**

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

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

| | | |
|---|---|---|
| ■ **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 (CCO/MCO only) | |
| ☐ **NCPDP 1.2/D.0** | Request and Response (B1, B2, B3) (CCO/MCO only) | |
| ☐ **Pharmacy** | Rx Carve-Out File (CCO/MCO only) | |
| ☐ **Status file** | CCO Status File (CCO/MCO 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, clinic, CCO or MCO name *(from Part 1 of this form):*

*Email address:

*Authorized trading partner signature:

*Phone number/extension:

*Date:

*Original signature only, of the Primary Signer listed in Part 2*

**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 *(from Part 5 of this form):*

*Email address:

*Authorized EDI submitter signature:*

*Phone number/extension:

*Date:

*Original signature only, of the Business Contact listed in Part 5*