VAPCCC REGION 5B (VAP5B) PRE-ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- US Department of Veterans Affairs EDI Claims Agreement

WHERE SHOULD I SEND THE FORM(S)?

- Send the completed form using one of the below methods:
  - Fax the form to: 608-223-3824
  - Email a scanned copy to: edi@wpsic.com
  - Mail the form to:

    WPS Electronic Data Services
    PO Box 8128
    Madison, WI 53708-8128

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- WPS no longer sends EDI approvals to providers. WPS asked that approvals be entered after the above form is sent.
- After the enrollment form is sent to WPS, send an email to info@officeally.com. In the subject line, include "EDI Approval for VAPCCC Region 5B (VAP5B)". You can attach a scanned copy of the enrollment form or you can send us the following information:
  - Provider Name
  - Provider Phone Number
  - Provider Email Address
  - Provider Billing NPI Number
  - Provider Tax ID Number
- For questions relating to your EDI enrollment, contact WPS at 800-782-2680 Option 4.

• Please allow 24 hours for Office ally to add the approval.

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**

Revised 10/1/2012

US Department of Veterans Affairs EDI Claims Agreement

VAPC3

WPS
1717 W. Broadway
P.O. Box 8128
Madison, WI 53708

Dear US Department of Veterans Affairs (VA) Provider:

Thank you for choosing electronic submission for your healthcare claims. Wisconsin Physicians Service Insurance Corporation ("WPS") requires that all new electronic providers/groups sign, and have on file, a US Department of Veterans Affairs EDI Claims Agreement ("Agreement") prior to claims submission. We request that you complete and return the Agreement, including this cover letter, to our office.

This Agreement covers TriWest Healthcare Alliance's VA Patient-Centered Community Care (VAPC3) contracts for VAPC3 Regions 3, 5, and 6, for which WPS is a subcontractor. These regions cover all or portions of 28 states broken down as follows: **Region 3:** Alabama, Arkansas, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, Texas, Virginia and West Virginia; **Region 5A:** Arizona, California, Colorado, Idaho, Nevada, New Mexico, Oregon, West Texas and Washington; **Region 5B:** Hawaii, American Samoa, Guam and the Northern Mariana Islands; **Region 6:** Alaska.

An organization that has several providers can execute a single agreement on behalf of the group. Only one authorizing individual is needed to sign the Agreement for a clinic/group. However, we do need a complete list of all locations and providers for which you will be billing. Please include this as an attachment. In addition to the Agreement, the following information is needed (please print):

NPI Number:		
Billing Provider name:		
Claim type (select one or both);	☒ **Professional** ☒ **Institutional**	
Contact name:		**Phone number:**
Contact e-mail address (Required):		**Fax number:**

Please indicate your EDI submission option:

☒ **Billing service/clearinghouse** (please indicate name): Office Ally

☐ **Direct filing using a *vendor-supplied EDI software program* and transmitting from your site**

Indicate name of vendor: _____

Indicate submission media: ☐ WPS Bulletin Board System ☐ WPS-batch Internet submission

☐ **Direct filing using *PC-Ace software*** (free claim-entry/submission software supplied by WPS)

Indicate submission media: ☐ WPS Bulletin Board System ☐ WPS-batch Internet submission

If any of the **direct filing** options are selected above, please register as a submitter through the WPS Trading Partner System (WTPS) at **https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do.** If you have already registered as a submitter, please provide the submitter number assigned 98366. If you need assistance with registration, please contact WPS Electronic Data Services at 800-782-2680, option 4.

Please mail, fax or e-mail your completed Agreement, including this cover letter, to:

WPS Electronic Data Services
P.O. Box 8128
Madison, WI 53708-8128

Fax: (608) 223-3824
E-Mail: EDI@wpsic.com

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For Office Use Only

Tax ID._____ _____ _____, _____ _____, _____ _____,

Sub # _____ CH _____ Direct _____ WEPS _____ ALS _____ App Dt _____

Orig Sub # _____ New Sub # _____ Facets _____ Initials_____

TERMS AND CONDITIONS

It is hereby agreed between Wisconsin Physicians Service Insurance Corporation ("WPS"), and the undersigned health care provider ("Provider"), that Provider is appointed to submit claims via electronic media for reimbursement by WPS for services rendered under the VAPC3 program in Regions 3, 5 and 6. This appointment is conditioned upon Provider fully agreeing to and following all of the terms and conditions set forth in this Agreement and clearing WPS internal provider review standards for acceptance and payment of electronically-submitted claims.

1. In submitting electronic transactions, Provider will follow the specifications required by the most current version named under the HIPAA Transactions and Code Sets rules.

2. For claim transactions, Provider agrees that each claim submitted via electronic media, for all legal and other purposes, will be considered to be signed by Provider or Provider's authorized representative.

3. For claim transactions, Provider agrees to maintain a patient signature file. Provider understands WPS may validate through file audits those claims submitted via electronic media which are included in any quality control or sampling method requested by WPS. Provider understands that if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to electronic submission to WPS.

4. Provider acknowledges that WPS shall have no obligation with respect to the content of the information in claims to verify, check or otherwise inspect the information supplied by Provider. Provider further acknowledges that WPS is solely responsible for determining the completeness, accuracy and validity of the information and claims and that source documents for claims data are the responsibility of Provider.

5. WPS may apply edits as defined in the X12 ASC Implementation Guide or the WPS-TRICARE Companion Guide against any transaction. Provider understands that WPS will accept all valid transactions which meet such edit requirements and return errant transactions for correction.

6. This Agreement will terminate automatically upon the termination of WPS' subcontract with TriWest Healthcare Alliance. This Agreement may also be terminated at any time by either party by giving five (5) days advance written notice of such termination to the other party.

7. All notices under this Agreement and correspondence with WPS on technical systems matters shall be sent by Provider to:

   WPS
   Electronic Data Services
   P.O. Box 8128
   Madison, Wisconsin 53708-8128

   Notice by WPS to Provider will be addressed to the individual named in Provider's signature blank below, and sent to the mailing address shown below for Provider.

8. This Agreement may not be modified or changed orally. All modifications must be in writing signed by both parties and must be consistent with WPS' obligations under its subcontract with TriWest Healthcare Alliance and with applicable federal law.

9. This Agreement shall be binding upon the successors or assigns of the parties. However, it shall not be assigned by either party without the written consent of the other party; such approval shall not be withheld unreasonably.

10. It is agreed that the relationship of the parties is that of independent contractors. Neither party is acting as the as agent, partner or employee of the other party.

11. By executing this Agreement below, the parties agree to all of the terms and conditions of the Agreement. Provider further agrees to begin to transmit claims electronically to WPS only after Provider has received a written notice from WPS stating permission to do so has been granted.

US Department of Veterans Affairs EDI Claims Agreement

Name of Provider

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

Tax ID Number of Provider

NPI Number of Provider

Provider Payment Address

By
Signature and Title of Provider or Authorized Officer

By
WPS Authorized Signature

Date

Date

Please choose VA Region Below:

☐ **Region 3:** Alabama, Arkansas, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee Texas, Virginia and West Virginia

☐ **Region 5A:** Arizona, California, Colorado, Idaho, Nevada, New Mexico, Oregon, West Texas and Washington

☒ **Region 5B:** Hawaii, American Samoa, Guam and the Northern Mariana Islands

☐ **Region 6:** Alaska