

ALAMEDA ALLIANCE FOR HEALTH (95327) PRE-ENROLLMENT INSTRUCTIONS



WHAT FORM(S) SHOULD I DO?

- Electronic Data Interchange (EDI) Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Mail, fax or email form to:
Alameda Alliance for Health
Attn: EDI Enrollment – IT Dept
1240 South Loop Road
Alameda, CA 94502

Fax: (510) 747-4290

Email: edisupport@alamedaalliance.org

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard processing time is 1 business day after the receipt of the enrollment form.

HOW DO I CHECK STATUS?

- To check the status of your enrollment, send and email to edisupport@alamedaalliance.org to verify if you have been linked to Office Ally to receive your 835s.



1240 South Loop Road
Alameda, CA 94502

Tel: 510-373-5757
edisupport@alamedaalliance.org

ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

Thank you for your interest in transmitting information electronically to **Alameda Alliance for Health**. The first step in the EDI process is completion of the EDI Enrollment Form and Trading Partner Agreement below. Please complete these forms and mail, email or fax the forms to:

Alameda Alliance for Health

Attn: EDI Enrollment-IT Dept

1240 South Loop Road

Alameda, CA 94502

FAX: 510-747-4290

Email: edisupport@alamedaalliance.org

NOTE: EDI testing cannot be initiated until Alameda Alliance for Health has received your completed EDI Enrollment Form and Trading Partner Agreement.

EDI ENROLLMENT INFORMATION

Today's Date: _____

Desired Production Date: _____

Anticipated Frequency of Transmission (circle one):

Daily / Weekly / Monthly/ Other _____

SUBMITTER INFORMATION (Note: exact provider name below should appear on inbound EDI claims)

Company/Provider Name: _____

Submitter's Tax ID # or UPIN (if applicable): _____

Group NPI (if applicable): _____

Individual NPI: _____

NPI Eff. Date: _____

Address: _____

Phone #: _____

Fax #: _____

CONTACT INFORMATION

Contact Person: _____ E-mail Address: _____

Telephone #: _____ Fax #: _____

Information Systems Contact Person: _____ E-mail Address: _____

Telephone #: _____ Fax #: _____

TRANSMISSION/FORMAT INFORMATION

Submitter plans to transmit/receive the following transactions (check one or more):

- Professional Health Claims (ASC X12N 837-005010X222A1)
- Institutional Health Claims (ASC X12N 837-005010X0223A2)
- Health Care Claim Payment Advice (ASC X12N 835-005010X0221A1)
- Health Care Eligibility Status Request and Response Transaction (ASC X12N 270/271-005010X279A1)

CLEARINGHOUSE INFORMATION

Alameda Alliance for Health will receive files directly from a submitter or via the submitter's clearinghouse. All clearinghouse fees are the submitter's responsibility.

It is also the submitter's responsibility to secure a Business Associate Agreement with its clearinghouse. If you indicate below that a Business Associate Agreement is not in place, Alameda Alliance for Health will not send any PHI to the clearinghouse on the submitter's behalf. The submitter must provide Alameda Alliance for Health written notice 30 days prior to terminating an active Business Associate Agreement with its clearinghouse.

Do you currently use a clearinghouse for electronic transmissions (circle one)?

No Yes Clearinghouse name _____

If yes, do you plan to use this clearinghouse for transmissions involving Alameda Alliance for Health (circle one)?

Yes No

Do you have a Business Associate Agreement in place with your clearinghouse (circle one)?

Yes No

TRADING PARTNER AGREEMENT

This agreement is made between Alameda Alliance for Health ("Plan") and _____

("Trading Partner") as of _____ day of _____, 20____. This agreement provides the terms and conditions governing electronic transfers of data between Plan and Trading Partner (collectively "Parties"). Both Parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Both Plan and Trading Partner agree to take steps reasonably necessary to ensure that electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan's Electronic Data Interchange (EDI) Enrollment Form, and the then current version of the Plan companion guides. This agreement will remain in effect until terminated according to the terms listed in this agreement. This agreement cannot be altered or amended without a written statement signed by both Parties.

I. Term and Termination

This agreement will remain effective indefinitely beginning on the effective date of this agreement. Either Party may voluntarily terminate this agreement by providing written notice to the other Party thirty (30) days in advance of the termination date. If a Party breaches any material obligation of this agreement, the other Party may terminate this agreement immediately upon providing written notice to the other Party.

II. Obligations of the Parties

1. Each Party will be responsible for and take reasonable care to ensure that the information submitted in each electronic transaction by itself, its employees, or its agents is accurate, complete and truthful.
2. Each Party will take reasonable precautions to limit the disclosure of the electronic data to authorized personnel on a need-to-know basis. Company and Trading Partner will notify the other Party of a termination of its relationship with a previously authorized employee

or vendor (i.e., clearinghouse), that may require action to foreclose submission and receipt of transactions by person or vendor no longer authorized to act on its behalf.

3. Parties will not disclose the electronic data to any other person or organization without the express written permission of the subject of the data (i.e., the Plan's member or the Trading Partner's patient/customer) unless such disclosure is permissible by State or Federal law. Plan and Trading Partner will notify the other Party if it becomes aware of any use or disclosure that is not expressly permitted by this agreement.

4. Each Party will treat the information sent and received electronically as proprietary and will not use the information for any purpose or in a manner that would violate any privacy, security, or confidentiality laws or regulations including, but not limited to, the HIPAA law. Each party will put appropriate safeguards in place to protect patient specific data from improper access and will maintain the confidentiality of any security access codes.

5. Both Parties must agree that adequate testing has been completed before "live," production submissions will be transmitted or accepted to or from the other Party.

6. Plan and Trading Partner will not consider the other Party's electronic submission "received" (and will not "date stamp" the transaction) until the file has passed the Plan's initial edits.

7. Each Party will pay its own costs, charges, or fees it may incur as a result of transmitting electronic transactions to, or receiving electronic transactions from, the other Party.

8. Each Party will retain all original source documentation that supports the electronic data submission for at least six years and as required by applicable state and federal laws. Plan and Trading Partner shall have access to the other Party's original source documentation for auditing and verification purposes. Both Parties will research and correct any data discrepancies at its own expense. If a discrepancy is identified in either Party's original source documentation, both Parties agree to implement corrective action that will ensure an accurate and prompt resolution which may include adjusting any incorrect payments identified as a result of such audit. Anyone who misrepresents or falsifies information relating to a claim may, upon conviction, be subject to fines and/or imprisonment under Federal law.

9. Plan and Trading Partner will notify the other Party promptly if any transmitted data is received in an unintelligible or garbled form. Both Parties agree to retransmit the original transmission if a data transmission is lost or indecipherable.

10. Plan agrees to provide an acknowledgement of receipt of the Trading Partner's electronic data submission.

III. Indemnification

Plan and Trading Partner shall hold harmless and indemnify the other Party from any and all claims, liabilities, judgments, damages or judgments asserted against, imposed upon or incurred due to its own negligence, intentional wrongdoing, or violation of this agreement.

IV. Authorized Signature

I am authorized to sign this agreement on behalf of said Trading Partner. I have read and agree to the foregoing provisions and acknowledge the same by signing below.

Alameda Alliance for Health Trading Partner

By: _____

Title: _____

Date: _____