MEDICAID KENTUCKY (MCDKY) EDI-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

If you are only enrolling for 837 Claims Enrollment, complete both below forms:

- **Agreement between the KY Medicaid Program and Electronic Billing Agency (MAP 246)** (page 2)
- **Cabinet for Health & Family Services Dept for Medicaid Services KY Medical Assistance Program (MAP 380)** (page 3-4)

If you would like to enroll for 835 ERA Transaction, you must also complete the following form:

- **835/U277 Request for Electronic Remittance Advice (ERA)** (page 5)

WHERE SHOULD I SEND THE FORM(S)?

- Email the forms to ky_edi_helpdesk@gainwelltechnologies.com
- Or Fax the forms to (502) 209-3242

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is 1-2 weeks.

HOW DO I CHECK STATUS?

- Call Medicaid Kentucky's EDI Help Desk at (800) 205-4696 and ask if you have been linked to Office Ally's Submitter Number **9900004139.**

- **Once you receive confirmation that you've been linked to Office Ally, you may begin submitting your 837 claims electronically.**

MAP-246
(Rev 09/10)

Agreement Between the Kentucky Department for Medicaid Services And Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The Office Ally has entered into a contract with
(Name of Billing Agency)

_____, _____,
(Name of Provider) (Provider Number)

_____ to submit claims via electronic media for service provided to KMP recipients.
(National Provider Identifier [NPI])

The billing agency agrees:

1. Billing Agency also agrees to maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with the HIPAA Security Standards once finalized.
2. To maintain or have access to a record of all claims submitted for payment for a period of at least six (6) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider and in compliance with the HIPAA transaction and code set regulations by the appropriate due date, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to commit fraud or deceive, makes or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.
5. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations with their provider's business associate agreement. Billing agency agrees to take "reasonable steps" to cure the breach or to end any uncovered violations of confidentiality or security of data under their control.

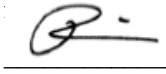
The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.
3. To maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with HIPAA Security Standards once finalized.
4. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations.

This agreement may be terminated upon written notice by either party without cause.

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material


Brian O'Neill, President and CEO , 11/30/2015
Signature, Authorized agent of Billing Agency Date

Payer Enrollment Department , (360) 975-7000
Contact Person (First and Last Name) Phone number

5010 Contact information

To ensure the dissemination of 5010 information is communicated to the appropriate contact, please complete the section below.

9900004139 , Office Ally
(10 digit trading partner id, begins with 99) (Clearinghouse, Software and/or Billing agent contact)

PO Box 872020, Vancouver, WA 98687
(mailing address)

payerenrollment@officeally.com , (360) 975-7000
(email address) (phone #)

Please return form to:
Electronic Claims Submission,
P.O. Box 2016
Frankfort, KY 40602-2016

Clear Form

MAP-380
(Rev 09/10)

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

This addendum to the Provider Agreement is made and entered into as of the _____day of
(Day)
_____, _____, by and between the Commonwealth of Kentucky, Cabinet for Health and
(Month) (Year)
Family Services, Department for Medicaid Services, hereinafter referred to as the Cabinet, and

_____, _____
(Provider Name) (Provider Address)

_____, _____, _____
(City) (State) (Zip Code)

hereinafter referred to as the provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Health and Family Services, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as

_____, _____, _____
(Type of provider) (Provider Number) NPI (National Provider Identifier)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP

B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent

C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media"

"This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may by prosecuted under applicable Federal and State Law."

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

Either party shall have the right to terminate this Addendum upon written notice without cause.

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

_____
(Provider)

_____
(Provider Signature)

_____, _____
(Contact Person) (First and Last Name) (Title)

_____, _____
(Date) (Telephone Number)

_____, _____
(Software Vendor and/or Billing Agency) (Media)

5010 Contact information

To ensure the dissemination of 5010 information is communicated to the appropriate contact completes the portion below.

9900004139, Office Ally
(10 digit trading partner id, begins with 99) (Clearinghouse, Software and/or Billing agent contact)

PO Box 872020, Vancouver, WA 98687
(mailing address)

payerenrollment@officeally.com, 360-975-7000
(email address) (phone #)

Please return form to:
Electronic Claims Submission
P.O. Box 2016
Frankfort, KY 40602-2016

gainwell

835/U277 Request for Electronic Remittance Advice (ERA)

Enter the Trading Partner number to be used to retrieve ERA: (10 digits beginning with 99)

9900004139

Company Information:

Company Name:

Address:

City: State: Zip:

Contact:

Phone:

E-Mail Address:

- The 835 and U277 are generated weekly after a Friday claim processing cycle.
- List the NPI, taxonomy and KY Medicaid provider numbers for all providers you wish to be linked to the Trading Partner number listed above.

NPI Number	Taxonomy Number	KY Medicaid Provider Number

☐ Check this box to remove the NPI from the Trading Partner id.

Please submit this form by one of the methods listed below:

Email: KY_EDI_Helpdesk@gainwelltechnologies.com (Please note there is an underscore after KY And EDI in this e-mail address)
Fax: (502) 209-3200
Mail: Gainwell Technologies, EDI Helpdesk, 656 Chamberlin Ave., Frankfort, KY 40601