MEDICAID LOUISIANA (MCDLA) PRE-ENROLLMENT INSTRUCTIONS

WHAT FORM(S) SHOULD I DO?

- **Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract for Business/Entity) and Power of Attorney**
  - **NOTE:** Original signature is required and the form must be notarized.
- **2021 Annual Certification For**m

WHERE SHOULD I SEND THE FORM(S)?

- Mail the form to:

  DXC – EDI Department
  PO Box 91025
  Baton Rouge, LA 70821-9025

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 3 weeks.

HOW DO I CHECK STATUS?

- You will receive a letter from Medicaid LA informing you of your approval.
- You may also call Medicaid LA at (225) 216-6303 and ask if you have been linked to Office Ally's Submitter ID **4507197**.
- Once you receive confirmation that you've been linked to Office Ally, you must email support@officeally.com with the below information prior to submitting claims electronically.

  Email Subject: Medicaid Louisiana (MCDLA) – EDI Approval

  Body of Email:

  Please log my EDI approval for Medicaid Louisiana
  - Provider Name
  - NPI
  - Tax ID

PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR BUSINESS/ENTITY)

INSTRUCTIONS

Prior to submitting electronic claims to Louisiana Medicaid, a seven-digit Submitter number (450XXXX) must be obtained from the Molina Medicaid Solutions Provider Enrollment Unit. The Submitter number must be linked to all provider numbers for whom claims will be submitted.

The following form(s) is (are) to be completed if the Entity/Business enrolling at this time plans to submit claims electronically to Louisiana Medicaid.

Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract for Business/Entity)

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for new Provider Number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

DBA Name of Enrolling Business/Entity – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

Billing Agent/Submitter Name/Business Name – enter the business name of the billing / submitting agent.

Name of Contact Person – enter the name of the person designated as the point of contact for questions regarding this request.

Contact Phone Number – enter the phone number of Contact Person.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Printed Name of Authorized Representative – print the name of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Title/Position – enter the title/position of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Signature of Authorized Representative – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Date of Signature – enter the date the authorized representative signed the form.

Entity/Business Medicaid Electronic Media Limited Power of Attorney (EDI Power of Attorney)

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for a new Provider Number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

DBA Name of Enrolling Business/Entity – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

Service Address of Business/Entity – enter the service address of the provider name entered.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Billing Agent/Submitter Business Name – enter the business name of the Billing Agent/Submitter.

Billing Agent/Submitter Contact Person – enter the name of the person designated as the point of contact for the Billing Agent/Submitter business.

Billing Agent/Submitter Phone Number – enter the phone number of the Billing Agent/Submitter contact person.

Enter the Parish (or County) Name where the Notary Public is located

Enter City, State and Date of Notarization

Signature of Authorized Representative – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Printed Name of Authorized Representative – print the name of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Notary Public Signature – the Notary Public should sign the form and affix his/her seal.

If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed Limited Power of Attorney in its entirety to be mailed with your completed EDI Contract.

PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR BUSINESS/ENTITY)

Louisiana Medicaid Provider Number (7 digits)

4	**5**	**0**	7	1	9	7

Submitter Number (7 digits)
(leave blank if applying for new number)

National Provider Identifier (NPI) (10 digits)

DBA Name of Enrolling Business/Entity: _____

Billing Agent/Submitter Name/Name of Business that will be submitting claims (provider name or third party biller's name): Office Ally, Inc

Name of Contact Person: _____

Contact Phone Number: _____

The Medicaid File can hold a maximum of three Submitter Numbers per Medicaid Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise requested by the provider. It is also vital to identify which Submitter Number will be designated to download the Electronic Remittance Advices (ERA).

In order for Lousiana Medicaid to gather this information, complete the following, if applicable:

When a new Submitter Number is issued, it will be set up to retrieve ERAs. If a previously assigned Submitter Number is to be used to retrieve ERAs as well, then place it in the spaces provided below.

4	5	0	7	1	9	7

☒ By checking this box you are giving authorization to have 835s produced and made available for download by either this new submitter number or the previously assigned submitter number.

List other Submitter Number(s) that are currently on file which will NOT be used for 835 ERA, but which need to remain open in the spaces below:

4	5	0				
4	5	0				7

☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.

☒ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter, etc.) to submit my claims electronically to Louisiana Medicaid. **(Power of Attorney form is required.)**

PROVIDER ACKNOWLEDEGEMENT

1. The providers attest that all information supplied with this Agreement is true, accurate and complete.

2. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 17 below. This is done in consideration for the Louisiana Department of Health (LDH), Bureau of Health Services Financing's (BHSF) processing of provider claims, as well as other valuable considerations.

3. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for EDI submission will be set by Provider Enrollment once the contract has processed.

4. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to LDH.
5. The Provider shall provide upon request of LDH or any authorized agent of LDH any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, data submissions, flow charts, file descriptions, accounting procedures, etc.
6. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims and the Annual Certification form . A copy of the certification statement is attached and is hereby incorporated by reference into this paragraph.
7. It is expressly understood that LDH or its Fiscal Intermediary (Molina Medicaid Solutions) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
8. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to their provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
9. LDH and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
10. The Provider agrees to submit to LDH, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
11. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
12. The Provider and LDH agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
13. Further, for a period of five years, during the course of a Federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying at no cost.
14. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify LDH's limited obligations as set in a certain Provider Agreement between LDH and the Provider.
15. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
16. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from Federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
17. **Applicable to those receiving 835s:** I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in **E**lectronic **F**unds **T**ransfer, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request.

Printed Name of Authorized Representative	Title/Position
Signature of Authorized Representative	Date of Signature

Revised 03/2017

ENTITY / BUSINESS
MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY
(EDI POWER OF ATTORNEY)

This form is required by all providers who will have electronic claims submitted by a third party.

Louisiana Medicaid Provider Number (7 digits)

National Provider Identifier (NPI) (10 digits)

4	**5**	**0**	7	1	9	7

Submitter Number (7 digits)
(leave blank if applying for new number)

DBA Name of Enrolling Business/Entity (Provider Name):

Service Address of Business/Entity:

Billing Agent /Submitter Business Name: Office Ally, Inc

Billing Agent /Submitter Contact Person: Customer Service

Billing Agent /Submitter Phone Number: 360-975-7000 Option 1

BE IT KNOWN that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of _____, State of Louisiana, therein residing:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing / Submitter Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program's applicable claims, by provider type, for electronic submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____ ___, State

of _____on the _____ day of _____, 20___.

Signature of Authorized Representative

Notary Public Signature

Printed Name of Authorized Representative

Notary Seal or Notary Identification Number (required)

2021

EDI ANNUAL CERTIFICATION OF ELECTRONIC FILES
Certification Period: January 1 to December 31, 2021

Provider Number (7-Digits)

4	5	0	7	1	9	7

Submitter Number

National Provider Identifier (10 Digits)

Submitter Name: Office Ally, Inc

Primary Contact Name: Payer Support Email Address: payersupport@officeally.com

Secondary Contact Name: Office Ally Support Email Address: support@officeally.com

o **Submissions by Provider Rendering Services Using their own Submitter ID:**

I certify that all services rendered during the above identified Certification Period were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claims information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistance Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

Attach a list of all Providers Names, Medicaid ID#s and NPI Numbers associated with this Submitter Number

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

o **Submissions by Third Party Biller (Billing Agents/Clearinghouses) Using their Submitter ID:**

I certify that the claim information submitted to Louisiana Medicaid is an exact duplicate of detailed claim line information received from the provider and has not been materially altered or revised except for translation to the current 837 transaction format or insertion of minor data. I certify that the information submitted in electronic format is true, accurate and complete as received from the provider. Additionally, I understand that payment of these claims will be Federal and State funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

I also certify that provider(s) with whom I have a direct relationship have furnished me with an EDI Annual Certification of Medicaid Claims Submitted Electronically Form on which the provider has attested to the truth, accuracy and completeness of the claim information. If I do not have a direct relationship with submitting providers (for instance, if the relationship is with a vendor), Louisiana Medicaid understands that I will not have an EDI Annual Certification Form from the individual(s) or entity(ies) with whom I do not maintain a contractual relationship. I agree to maintain all forms I am required to collect for a period of five (5) years.

Identify all claim types that will be submitted during this Certification Period:

CLAIM TYPE

☑ 837P 1500 Claim Form ☐ 837I UB4 Claim Form

☐ 837D Dental Claim Form ☐ Other

DATE SUBMITTER SIGNATURE (ORIGINAL)

NOTE: Updated certification forms MUST be submitted annually. Failure to maintain a completed Certification Form on file will result in the closure of the submitter number without notice to submitter. All files submitted with closed submitter numbers will be dropped from the system without being processed.

This Certification Form can only be mailed to either address located below. The form can't be faxed or scanned and emailed.

Submit to: Gainwell – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025 Phone #: 225/216-6303 Or: 8591 United Plaza Blvd., Bldg. V, Suite 270, Baton Rouge, LA 70809