MEDICAID OREGON (ORDHS) PRE-ENROLLMENT INSTRUCTIONS

WHICH 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.** Use the following address:

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?

- 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 have been approved
- Once you receive confirmation that you have been linked to Office Ally, you MUST email Support@officeally.com with the below information PRIOR to submitting claims electronically

Email Subject: Medicaid Oregon (ORDHS) – EDI Approval

Body of Email:

Please log my EDI approval for Medicaid Oregon.

- Provider Name
- NPI
- Tax ID

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: _____

*****Phone number/extension: _____

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

*****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