



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
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

<p>*Trading Partner's National Provider Identifier (NPI):</p> <hr/> <p>List all taxonomy code(s) registered to this NPI:</p> <hr/> <p>List the Oregon Medicaid ID(s) associated with this NPI:</p> <hr/>

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 (<i>select one</i>): <input type="checkbox"/> Fully replaces the current TPA on file. This TPA will end all previous provider/submitter combinations registered under your Oregon Medicaid ID. <input type="checkbox"/> Adds information to the current TPA(s).	
ONE	Trading partner information – This cannot be a billing service.
	*Type (<i>select one</i>): <input type="checkbox"/> Provider <input type="checkbox"/> Clinic <input type="checkbox"/> Coordinated Care or Managed Care Organization
	*Business name (<i>as enrolled with OHA</i>): _____
	*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 (<i>direct, not group, email</i>): _____
	Secondary signer's name: _____
Phone number/extension: _____ Title: _____	
Email address (<i>direct, not group, email</i>): _____	
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 (<i>direct, not group, email</i>): _____	
	*Technical contact's name: Will Morrow	
	*Phone number/extension: (360) 975-7000 x6284 <input type="checkbox"/> Third contact on reverse (<i>if needed</i>)	
	*Email address (<i>direct, not group, email</i>): will.morrow@officeally.com	

SIX	Authorized transactions – Check all transactions that OHA should authorize for your EDI submitter.	
	HIPAA 5010A1 transactions for: <input type="checkbox"/> FFS provider or <input type="checkbox"/> CCO/MCO	
	<input type="checkbox"/> 005010X222A1 837P	Professional Claim Submission
	<input type="checkbox"/> 005010X224A2 837D	Dental Claim Submission
	<input type="checkbox"/> 005010X223A2 837I	Institutional Claim Submission
	<input type="checkbox"/> 005010X221A1 835	Electronic Remittance Advice
	<input type="checkbox"/> 005010X279A1 270 and 271:	<input type="checkbox"/> Batch <input type="checkbox"/> Real-time Eligibility Benefits Inquiry and Response
	<input type="checkbox"/> 005010X212 276 and 277:	<input type="checkbox"/> Batch <input type="checkbox"/> Real-time Claims Status Request and Response
	<input type="checkbox"/> 005010X218 820	Group Premium Payments
	<input type="checkbox"/> 005010X220A1 834	Benefit Enrollment and Maintenance (CCO/MCO only)
	<input type="checkbox"/> NCPDP 1.2/D.0	Request and Response (B1, B2, B3) (CCO/MCO only)
	<input type="checkbox"/> Pharmacy	Rx Carve-Out File (CCO/MCO only)
<input type="checkbox"/> Status file	CCO Status File (CCO/MCO only)	

SEVEN	Trading Partner signature – By signing below, the Trading Partner certifies the following:	
	<ul style="list-style-type: none"> 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 <i>EDI Submitter</i> 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 (<i>from Part 1 of this form</i>): _____	*Email address: _____
	*Authorized trading partner signature: _____	*Phone number/extension: _____
		*Date: _____
	<i>Original signature only, of the Primary Signer listed in Part 2</i>	

EIGHT	EDI Submitter signature – By signing below, the EDI Submitter certifies the following:	
	<ul style="list-style-type: none"> 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 (<i>from Part 5 of this form</i>): _____	*Email address: _____
	*Authorized EDI submitter signature: _____	*Phone number/extension: _____
		*Date: _____
	<i>Original signature only, of the Business Contact listed in Part 5</i>	