MEDICAID OREGON (ORDHS) EDI-ENROLLMENT INSTRUCTIONS

WHICH FORMS SHOULD I COMPLETE?

- **Oregon Heath Authority Trading Partner Agreement for Electronic Health Care Transactions**
  - Form must be signed by provider's authorized signing authority.

WHERE SHOULD I SEND THE FORM(S)?

- Email to OHA.TPAgreements@odhsoha.oregon.gov
  - Only send one TPA per email, if you have more than one enrollment request.

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is 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 your approval letter, please contact the payer at 888-690-9888 and ask if your registration has been approved.

WHEN CAN I SUBMIT MY CLAIMS ELECTRONICALLY?

- **Before you can submit your claims electronically, you must email payerenrollment@officeally.com to log the approval in Office Ally's system.**
  - **Email Subject:** Medicaid Oregon (ORDHS) – Claims EDI Approval
  - **Email Body:** Please log my 837 Enrollment Approval for Medicaid Oregon:
    - Provider Name:
    - Provider NPI:
    - Provider Tax ID:

Trading Partner Agreement (TPA) for Electronic Health Care Transactions

For form instructions, click here.

If you have further questions, email OHA.TPAgreements@odhsoha.oregon.gov.

Please make sure all sections marked with an asterisk (*) have been completed to avoid automatic denial.

☐ Check this box if you are **only updating contacts**. Please leave section 5, 7 and 8 blank and complete the rest of the form.

National provider identifier (NPI)***:** _____

Medicaid ID*: _____

Taxonomy codes*: _____

Section 1: Medicaid provider information

Business name (as enrolled with OHA)***:** _____

Physical address (as enrolled with OHA)***:** _____

City, state, and zip*: _____

Phone number with extension*: _____

Section 2: Trading partner authorized signer information

Primary authorized signer's name*: _____

Title*: _____

Individual email address (**not** group email)*****: _____

Phone number with extension*: _____

Secondary authorized signer's name: _____

Title: _____

Individual email address (**not** group email): _____

Phone number with extension: _____

Print Reset

Section 3: Trading partner claims contact information

Primary claims contact name*: _____

Individual email address (**not** group email)*: _____

Phone number with extension*: _____

Secondary claims contact name: _____

Individual email address (**not** group email): _____

Phone number with extension: _____

Section 4: Electronic data interchange (EDI) Submitter Information

- If your company intends to exchange transactions directly with OHA, enter the name (as listed in Section 1) as this will become the submitter name; or
- If you intend to use a submitter or clearinghouse, complete this part with their information.

Submitter or clearinghouse name*: Office Ally

Address*: PO BOX 872020

City, state, and zip*: Vancouver, WA 98687

Submitter EDI mailbox number*: MB000 329

Section 5: Authorized transactions

Check all transactions that OHA should authorize for your EDI submitter.

HIPAA 5010A1 transactions*:

☐ 005010X222A1 837P	Professional claim submission
☐ 005010X223A2 837I	Institutional claim submission
☐ 005010X224A2 837D	Dental claim submission
☐ 005010X221A1 835	Electronic remittance advice
☐ 005010X279A1 270 and 271	Eligibility benefits inquiry and response
☐ 005010X212 276 and 277	Claims status request and response
☐ 005010X218 820	Group premium payments (not available to all provider types)
☐ Pharmacy 340B file	Pharmacy 340B file

Section 6: Trading Partner Signature

By signing below, the Trading Partner certifies the following:

- I have read the Electric Data Transmission Oregon Administrative Rules (OAR) (Chapter 943, Division 120) at Secretary of State OAR rules website, and understand my responsibilities as stated in these rules.
- I authorize OHA to transmit to the EDI Submitter listed in Section four (4) of this form the return computer file electronic vouchers of all transactions I have marked in Section five (5) of this form.

Primary authorized signer's printed name*: _____

Authorized signer's signature*: _____

Date*: _____

Section 7: EDI submitter information

Sections 7 and 8 are to be completed and signed by the submitter or Clearinghouse that is chosen by the Medicaid provider.

Submitter business contact name*: Pam Ply

Individual email address (**not** group email)**:** pam.ply@officeally.com

Phone number with extension*: 360-975-7000 X6324

Submitter technical contact name*: Cara Trahey

Individual email address (**not** group email)**:** cara.trahey@officeally.com

Phone number with extension*: 360-975-7000

Section 8: EDI submitter required signature

By signing below, the EDI submitter certifies the following:

- I have read the Electric Data Transmission Oregon Administrative Rules (OAR) (Chapter 943, Division 120) at Secretary of State OAR rules website, and understand my responsibilities as stated in these rules.
- I agree to protect the confidentiality of the data as required by law.

Primary authorized signer's printed name*: Pam Ply

Authorized signer's signature*: 

Date*: 01/23/25

Email the completed form as a PDF document to:
OHA.TPAgreements@odhsoha.oregon.gov

Fax forms to (503) 945-5972.

If you cannot submit by email or fax, you can **mail forms to**:

EDI Support Services
ATTN: TPA Requests
500 Summer St NE E44
Salem, OR 97301

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact TPA Team at OHA.TPAgreements@odhsoha.oregon.gov or 503-378-3503. We accept all relay calls.

All general questions need to be submitted via **email**. **General question calls** will not be accepted.

Medicaid Division
EDI Support Services
500 Summer St NE E44
Salem, OR 97232

OHA.TPAgreements@odhsoha.oregon.gov

OREGON HEALTH AUTHORITY

Print Reset