

MEDICAID MARYLAND PART A (MCDMD) PRE-ENROLLMENT INSTRUCTIONS



WHAT FORM(S) SHOULD I DO?

- Maryland Medical Care Programs Submitter Identification Form
- Trading Partner Agreement
 - Both Forms must have **original** signature. Medicaid Maryland requires both Office Ally's signature and the providers.

WHERE SHOULD I SEND THE FORM(S)?

- Mail form to:
 - Office Ally
 - Attn: Anita
 - PO Box 872020
 - Vancouver, WA 98687
- Office Ally will sign the document(s) and mail them to Medicaid Maryland.
 - If you would like to track the mailing of your enrollment form (from OA to payer), you may include a prepaid certified envelope when sending your enrollment to Office Ally.

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard processing time is 2 weeks.

HOW DO I CHECK STATUS?

- Send an email to dhmh.hipaeditest@maryland.gov. Include your NPI and Provider number. In your email ask if your provider numbers have been linked to Office Ally's submitter number 330897513.
- 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 Maryland Part A (MCDMD) - EDI Approval

Body of Email:

Please log my EDI approval for Medicaid Maryland Part A.

- Provider Name
- NPI
- Tax

**MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM**

For Version 005010 HIPAA Transaction Set

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

- | | |
|---|--|
| 1. This is a | Select Media if New Application: |
| <input type="checkbox"/> New Application | <input type="checkbox"/> Electronic Transfer & Paper Voucher |
| <input type="checkbox"/> Change of Submitter Agent | <input type="checkbox"/> Paper Voucher Only |
| <input type="checkbox"/> Submitter Identification Form Update | |

2. Provider Information

a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	

3. Electronic Submitter Information

a) Submitter Name:	Office Ally
b) Submitter Address:	PO Box 872020, Vancouver, WA 98687
c) Submitter ID(ISA Qualifier and ISA ID):	330897513

4. EDI Information

Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	005010X279A1
	276/277 Claim Status & Response	005010X212
X	837 Health Care Claim Institutional / 277CA Claim Acknowledgment	005010X223A2 / 005010X214X
	837 Health Care Claim Professional / 277CA Claim Acknowledgment	005010X222A1 / 005010X214X
	837 Health Care Claim Dental / 277CA Claim Acknowledgment	005010X224A2 / 005010X214X
	820 Premium Payment	005010X218
	835 Health Care Claim Payment/Advice 835 GS Receiver ID <u>330897513</u> (Required, if Checked) Receiver EDI Information (Required if different from above listed Submitter ID or if you are a Pharmacy Provider or Business Associate requesting an 835): Receiver Name: Receiver Address: ISA Qualifier and ISA ID:	005010X221A1

**MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM**

For Version 005010 HIPAA Transaction Set

The provider, _____ hereby authorizes

PROVIDER NAME

Office Ally _____, hereafter

SUBMITTER AGENT

referred to as Submitter Agent, to transmit HIPAA transactions to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the Submitter Agent the return computer electronic files of all data processed. The Submitter Agent agrees to protect the confidentiality of this data as required by law.

Signature of Provider

Signature of Submitter Agent

Print Name of Signature

Brian Oneill President & CEO

Print Name of Signature

Telephone Number

Date

360-975-7000

Telephone Number

Date

Note: This form requires completion of all requested information and **original signatures** to be processed.

MAIL TO:

**SYSTEMS LIAISON SERVICES
201 W. PRESTON ST., RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK**

For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____

Trading Partner Agreement

This Agreement is by and between the Medical Care Program (Medicaid) and

PROVIDER NAME

PROVIDER ADDRESS

_____, hereafter known as the Provider.
CITY, STATE & ZIP CODE

[If applicable] the Provider and Program hereby agree that the Provider may use a certified clearinghouse (Submitter Agent),

Office Ally
SUBMITTER AGENT NAME

PO Box 872020
SUBMITTER AGENT ADDRESS

Vancouver, WA 98687, hereafter known as Submitter Agent, to
CITY, STATE & ZIP CODE

transmit HIPAA transactions arising from the Provider's participation in the Program.

1. Purpose of Agreement- This agreement is intended to facilitate communications between the Program and the Provider in the processing by the Program of electronic transactions filed by or on behalf of the Provider.
2. Provider Submission of transactions- The Provider shall submit all data transmissions pursuant to Program standards. The Provider hereby warrants that all data will be submitted in compliance with the Program's regulations, transmittals, and any provider manual(s) specific to the provider. The Program reserves the right to modify its regulations, transmittals and other manuals at any time and to notify Provider of those changes by electronic communication. The Program reserves the right to reject any transaction which does not conform to its data submission standards.
3. Program Acceptance of Electronic Transactions- The Program agrees to accept valid transactions submitted by the Provider or the Submitter Agent.
4. Cooperation with Testing- During the testing phase, as designated by the Program, both Program and Provider agree to cooperate with each other, and with entities performing business associate type functions for the contracting parties, for the purpose of striving for accuracy, timeliness, security and completeness of data transmissions.
5. Use of Standard Transactions and Code Set Format- HIPAA regulations, at 45 CFR Part 162 HIPAA Federal Electronic Transactions and Code Sets for Data Exchange, provide for certain transaction standards for transfer of data between trading partners. The Provider must submit and the Program will be prepared to accept, translate, or route HIPAA compliant transactions. As HHS modifies the standards, the trading partners agree to incorporate by reference any modifications or changes to 45 CFR Part 162.

Trading Partner Agreement

6. Prohibited Acts- 45CFR § 162.915 specifies that trading partners will not enter into an agreement that would: “change the definition, data condition or use of a data element or segment in a standard; add any data elements or segments to the maximum defined set; use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specifications(s); or change the meaning or intent of the standard’s implementations specification(s)”.
7. Expenses- Each party shall bear its own expenses in implementing this process of transmitting information via this agreement.
8. Confidentiality and Security- Each party shall comply with all HIPAA and State Security and Confidentiality requirements in the handling of protected health information and take reasonable precautions to prevent unauthorized access to any part of the transaction process. In the event that data is improperly sent or received under this agreement, such data shall be highlighted and disposed of or returned in an appropriate manner.
9. Provider Identifiers- The parties shall agree on a unique identifier to be used by Provider. Provider is responsible for disclosing the unique identifier to its agents and only as is prudent to maintain appropriate security for the identifier.
10. This Trading Partner Agreement may be terminated by the Medical Care Program at any time.

All other agreements between the Program and Provider remain in full force and effect.

AGREED:

PROVIDER NAME: _____

PROVIDER NUMBER: _____

NATIONAL PROVIDER IDENTIFIER (NPI) # _____

AUTHORIZED SIGNATURE

DATE: _____ Phone # _____

RETURN VIA MAIL:

Rita Tate
201 W. Preston St., Rm. LL3
Baltimore, MD 21201
ATTN: HIPAA Billing Agreements

Revised: 3/21/12