MEDI-CAL (MC051)
ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- Electronic Healthcare Claim Payment/Advice Receiver Agreement (ANSI ASC X12N 835-Transaction)

WHERE SHOULD I SEND THE FORM(S)?

- Mail the original forms to:

  Medi-Cal Fiscal Intermediary
  ATTN: HIPAA Help Desk
  PO Box 13029
  Sacramento, CA 95813-4029

- **PLEASE NOTE:** Faxed copies are **NOT** accepted, originals must be sent to Medi-Cal.

WHO CAN SIGN THE FORM(S)?

- Medi-Cal requires the signature of the provider or President, CEO or Owner of a group in **BLUE INK**
  - Signature must be **ORIGINAL**
  - Signature must be in **BLUE INK**
  - Signature must be by provider or owner on file at Medi-Cal as authorized to sign
  - Medi-Cal will not accept signatures in black ink or signatures from office managers or billers
  - DO NOT use white out

ELECTRONIC HEALTH CARE CLAIM PAYMENT/ADVICE RECEIVER AGREEMENT (ANSI ASC X12N 835-Transaction)

TYPE OF AUTHORIZATION: ☐ NEW ☐ CHANGE ☐ CANCEL

IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Health Care Services (DHCS), hereinafter referred to as the Department, and the undersigned Provider.

PROVIDER INFORMATION

The Electronic Health Care Claim Payment/Advice Receiver Agreement (ANSI ASC X12N 835-Transaction) must be completed and submitted by an active Medi-Cal Provider. Rendering Providers will need to use the Group Provider Number. Non-providers can receive an 835-Transaction (per provider instruction); however, the authorizing Provider must submit the agreement. A letter of acknowledgement will be e-mailed to the provider when possible; otherwise, the letter will be mailed to the provider's service address.

Important Note: The following provider information must match the current information on file with DHCS Provider Enrollment, or the application will not be approved. To verify if the provider information is current, contact the Medi-Cal Fiscal Intermediary or the Department of Health Care Services, Provider Enrollment Division. If your file is not updated, submit a supplemental application form to DHCS Provider Enrollment Division.

PROVIDER NAME (full legal)		PROVIDER NUMBER	
DBA (if applicable)		Last 4 digits of Tax Identification Number or Social Security Number	
PROVIDER SERVICE ADDRESS (number, street)	CITY	STATE	ZIP CODE
CONTACT PERSON			
CONTACT PERSON ADDRESS (number, street)	CITY	STATE	ZIP CODE
CONTACT PHONE NUMBER	CONTACT EMAIL ADDRESS		

Note: Full legal name(s), assumed (DBA) name(s), and provider number(s) are required. The provider identified above will be hereinafter referred to as the "Provider."

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

RECEIVER INFORMATION

A Provider can designate up to two entities to receive an 835-Transaction. The two Receivers can be either the Provider or an outside party (such as a billing service, clearinghouse, or another provider), or up to two outside parties. A provider must have a business associate agreement with

outside parties who are designated to receive the 835-Transaction. This business associate agreement must be in compliance with 45 Code of Federal Regulations Section 164.504(e). A Provider designated as a Receiver will need an active Provider Number (Rendering Provider Numbers may not be used), and a Medi-Cal Point of Service (POS) Network/Internet Agreement Form on file or submitted with this agreement form. If a Computer Media Claims (CMC) Submitter Identification Number is used, a Medi-Cal Point of Service (POS) Network/Internet Agreement Form is not necessary. All non-providers authorized by the Provider to receive an 835-Transaction must have a DHCS-issued Computer Media Claims (CMC) Submitter Identification Number on file. If the non-provider does not have a CMC Submitter ID Number, they should contact the CMC Help Desk, (916) 636-1100 to request a CMC Application/Agreement Form. The CMC Application is also available at **www.medi-cal.ca.gov**.

The authorizing Provider must complete this section.

Receiver #1

RECEIVER NAME (full legal) Office Ally, LLC	DBA (if applicable)	RECEIVER PHONE NUMBER 360-975-7000 Option 1	
RECEIVER ADDRESS (number, street) 1300 SE Cardinal Court, Suite 190	CITY Vancouver	STATE WA	ZIP CODE 98683
CONTACT PERSON Customer Service	RECEIVER ID: (PROVIDER # or CMC SUBMITTER ID#) JQR		

Receiver #2 (optional)

RECEIVER NAME (full legal)	DBA (if applicable)	RECEIVER PHONE NUMBER	
RECEIVER ADDRESS (number, street)	CITY	STATE	ZIP CODE
CONTACT PERSON	RECEIVER ID: (PROVIDER # or CMC SUBMITTER ID#)		

BACKGROUND INFORMATION

The Provider/Receiver agrees to provide the Department with the above requested information in order to verify qualifications to act as a Receiver of the 835-Transaction.

DEFINITIONS

The terms used in this agreement shall retain ordinary meaning except those terms defined in Title 22, *California Code of Regulations*, Section 51502.1, which may, from time to time, be amended.

CHANGE IN RECEIVING ELECTRONIC 835-Transaction

The Provider/Receiver and the Department agree that any changes in Provider/Receiver status, which might affect eligibility to receive 835-Transactions pursuant to Federal and State law, shall be promptly communicated to each party. Reference the Medi-Cal Provider Manuals 835-Transaction section for current procedures on the record update process.

CONFIDENTIALITY OF RECORD

The Provider/Receiver agrees to maintain adequate administrative, technical, and physical safeguards to protect the confidentiality of protected health information in accordance with State and Federal statutes and/or regulations, in particular 45 Code of Federal Regulations Parts 160 and 164. Any breach of security or unlawful disclosure of protected health information shall be

reported to the Department within 24 hours of the Provider/Receiver learning of such breach or disclosure and may be grounds for termination of this Agreement.

SCOPE OF SERVICE

The Medi-Cal Fiscal Intermediary agrees to supply to Provider/Receiver 835-Transaction Remittance Advice Detail (RAD) data for adjudicated Medi-Cal claims for Providers who have authorized the Department to send such information. The Medi-Cal Fiscal Intermediary will:

(a) Load weekly adjudicated Health Care Payment/Advice data (835-Transaction) to the Medi-Cal Internet Web site (**www.medi-cal.ca.gov**) by the Medi-Cal warrant date.

(b) Retain weekly adjudicated Health Care Payment/Advice data (835-Transaction) on the Medi-Cal Internet Web site for six weeks. For RAD data beyond six weeks, reference the Medi-Cal Provider Manuals for instructions to order a hard copy RAD. Hard copy RADs are required for Claims Inquiry Forms/Appeals.

(c) The Provider will receive an e-mail notification when the Electronic Health Care Claim Payment/Advice Receiver Agreement application is approved.

PROVIDER OBLIGATIONS

The Provider will:

(a) Complete and submit to the Medi-Cal Fiscal Intermediary an Electronic Health Care Claim Payment/Advice Receiver Agreement form for any additional receivers of 835-Transaction data. A Provider can designate up to two entities to receive an 835-Transaction. The two Receivers can be both the provider and an outside party (such as a billing service, clearinghouse, or another provider), or two outside parties. All non-providers that have been authorized by a provider to receive an 835-Transaction must have a Computer Media Claims (CMC) Submitter Identification Number on file and must have a business associate agreement in effect between the non-provider and the provider, which complies with 45 Code of Federal Regulations, Section 164.504(e).

(b) Ensure that a current and complete Medi-Cal Point of Service (POS) Network/Internet Agreement form and Electronic Health Care Claim Payment/Advice Receiver Agreement form are on file with the Medi-Cal Fiscal Intermediary.

(c) Not provide the data supplied under this Agreement to any third party except the applicable agents for whom the Provider has authorized to provide billing collection and/or reconciliation services and which have a business associate agreement in effect with the provider, in compliance with 45 Code of Federal Regulations, section 164.504(e). The Provider acknowledges that 835-Transaction data is confidential information owned by the State, the Medi-Cal Fiscal Intermediary, and/or applicable providers. This provision shall survive the expiration of this Agreement.

(d) Regardless of whether the Provider employs a third party Receiver to access the 835-Transaction, the Provider agrees to retain personal responsibility for the receipt of all Health Care Payment/Advice (835-Transaction) information.

(e) The Provider/Receiver agrees to use their DHCS-issued CMC Submitter Identification Number and Provider Identification Number (PIN) when accessing the Medi-Cal Internet Web site. The CMC Submitter ID Number will identify the Receiver and shall serve as acceptance to the terms and conditions of the Department's Telecommunications Provider and Biller Application/Agreement (DHCS Form 6153). The Provider further acknowledges the necessity of maintaining the privacy of the DHCS-issued CMC Submitter ID Number and agrees to bear full legal responsibility for use or misuse of the CMC Submitter ID Number and PIN if privacy is not maintained.

(f) Upon review of all 835-Transaction data, if the Provider/Receiver finds the data unreadable or incorrect, they are instructed to contact the Medi-Cal Fiscal Intermediary for resolution. Failure to report any such data inaccuracies shall constitute acceptance thereof.

(g) The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its Fiscal Intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015, as, from time to time, amended.

EFFECTIVE DATE

This agreement shall become effective upon approval of the Department's authorizing agent.

TERMINATION

The Department or Provider may terminate this agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department. The Provider/Receiver has no right to appeal termination for cause pursuant to this subpart prior to the effective date of such termination. The Provider/Receiver may appeal any grievance resulting from the termination in accordance with the procedure established by Title 22, *California Code of Regulations*, Section 51015, as from time to time, amended.

PROVIDER/RECEIVER TO HOLD STATE OF CALIFORNIA HARMLESS

The Provider/Receiver agrees to hold the State of California harmless for any and all failures to perform by the Receiver services, software, or other features of 835-Transactions, which do not occur with paper (hard copy) Remittance Advice Details. The Provider/Receiver explicitly agrees that the Provider/Receiver assumes any and all risks that accompany receiving 835-Transactions, and that the Provider/Receiver is not relying upon the evaluation, if any, the State has made of the electronic receiver's system or software the Provider/Receiver is using. Provider/Receiver acknowledges that neither the Department nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by the Department. Furthermore, the Provider/Receiver acknowledges that if the electronic Receiver system, software of Receiver contracted with, is or has been listed as available in Medi-Cal bulletins, that such listing was not an endorsement by the State of California nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

LIMITATION OF LIABILITY

The Department shall not be liable to Provider or any authorized Receiver for any claim of, or damage or injury suffered by Provider or any authorized Receiver caused by the Department's delay in furnishing the data supplied hereunder. Moreover, neither party shall be liable for any damage amounts representing indirect, consequential (such as loss of business or loss of profits), or punitive damages.

Each party shall be excused from performance under this Agreement for any period and to the extent that it is prevented from performing; in whole or in part, as a result of delays caused by the other party, the State, or an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control.

AGREEMENT BETWEEN PROVIDER AND ADDITIONAL THIRD PARTY RECEIVER (IF OTHER THAN THE PROVIDER OF SERVICE)

The Provider stipulates that any agreements with a Receiver to receive Medi-Cal 835-Transactions shall be in conformance with State and/or Federal law governing electronic transactions and shall contain provisions including, but not limited to, the following:

(a) The Provider shall specifically designate the Receiver as the agent of the Provider for the purpose of receiving 835-Transactions for the Provider. As the Provider's agent, the Receiver agrees to comply with all Medi-Cal requirements on record making and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Section 14124.1 and 14124 and Title 22, *California Code of Regulations*, Section, 51476. The Receiver also agrees to comply with state and federal laws on privacy of individually identifiable health information, including 45 Code of Federal Regulations Parts 160 and 164.

(b) The parties shall agree that the Department will make available 835-Transactions to additional Receivers only as long as the agreement between the Provider and the Receiver including the business associate provisions required by 45 Code of Federal Regulations Section 164.504(e), remains in existence and in effect.

The Provider is required to notify the Department in writing immediately upon any change in or termination of their agreement.

In addition to the electronic 835-Transaction, does the <u>Provider</u> want to continue to receive the hardcopy RAD (Remittance Advice Detail Summary)?

YES ☐ **NO** ☐

<u>To be completed by Provider - CHECK APPROPRIATE BOX</u>

☐ I hereby authorize the California Medicaid Program/Title XIX to load my 835-Transactions to the Medi-Cal Internet Web site – **<u>www.medi-cal.ca.gov</u>**.

☐ I hereby authorize the California Medicaid Program/Title XIX to update the previous 835-Receiver Agreement with the information on this form.

☐ I hereby cancel my 835-Transaction authorization.

PROVIDER SIGNATURE INFORMATION

FULL PRINTED NAME	TITLE
PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED; DO NOT USE BLACK INK)	DATE

Please return to Medi-Cal Fiscal Intermediary, HIPAA Help Desk, P.O. Box 13029, Sacramento, CA 95813-4029.

This authorization remains in full force and effect until the California Medicaid Program/Title XIX receives written notification from the Provider of its termination, or until the California Medicaid Program/Title XIX or appointing authority deems it necessary to terminate the agreement.