MEDICAID MARYLAND PART A (MCDMD) PRE-ENROLLMENT INSTRUCTIONS

WHICH 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 provider's

WHERE SHOULD I SEND THE FORM(S)?

- Mail form to:

    Office Ally
    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?

- Standard processing time is 2 weeks

HOW DO I CHECK STATUS?

- Send an email to dhmh.hipaaeditest@maryland.gov and 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 have 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 ID

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
   - [ ] New Application
   - [X] Change of Submitter Agent
   - [ ] Submitter Identification Form Update

Select Media if New Application:
- [ ] Electronic Transfer & Paper Voucher
- [ ] Paper Voucher Only

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** 330897513 (**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**
_____	Brian Oneill President & CEO
Print Name of Signature	**Print Name of Signature**
_____ _____	360-975-7000 _____
Telephone Number Date	**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. PO Box 872020
SUBMITTER AGENT NAME 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 date 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.

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