

# MEDICAID OREGON (ORDHS) PRE-ENROLLMENT INSTRUCTIONS



## WHAT 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** to:

Office Ally  
Attn: Anita  
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 FOR ENROLLMENT?

- 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](mailto: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've been approved.
- Once you receive confirmation that you've been linked to Office Ally, you must email [support@officeally.com](mailto: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><b>*Trading Partner's National Provider Identifier (NPI):</b></p> <hr/> <p><b>List all taxonomy code(s) registered to this NPI:</b></p> <hr/> <p><b>List the Oregon Medicaid ID(s) associated with this NPI:</b></p> <hr/>
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## 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](mailto: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	<b>Trading partner information –</b> 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	<b>Trading partner authorized signer information –</b> 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	<b>Claims contact information –</b> 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	<b>EDI submitter information –</b> 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

<b>FIVE</b>	<b>EDI submitter's contact information</b> – 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	

<b>SIX</b>	<b>Authorized transactions</b> – 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)	

<b>SEVEN</b>	<b>Trading Partner signature</b> – By signing below, the Trading Partner certifies the following:	
	<ul style="list-style-type: none"> <li>I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at <a href="http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html">http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html</a>, and understand my responsibilities as stated in these rules.</li> <li>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.</li> </ul>	
	*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>	

<b>EIGHT</b>	<b>EDI Submitter signature</b> – By signing below, the EDI Submitter certifies the following:	
	<ul style="list-style-type: none"> <li>I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at <a href="http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html">http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html</a>, and understand my responsibilities as stated in these rules.</li> <li>I agree to protect the confidentiality of the data as required by law.</li> </ul>	
	*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>	