



Medicaid ALASKA Enrollment Instructions – Professional Claims and ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI customer account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to make sure provider ID #s are valid. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the submitted paperwork, in case you need to follow up on your request.

MAIL COMPLETED FORMS TO-

Affiliated Computer Services, Inc.
HIPAA Provider Support Team
P. O. Box 240808
Anchorage, AK 99524-0808

(Forms can also be faxed to 907-644-8126 to help in expediting the enrollment process. However, the original signed documents must also be mailed.)

837- CLAIMS Provider Enrollment (New) or (Change of Service)

For first time request, or to change billing agent/clearinghouse for submitting electronic claims, **this form must be completed for EACH Medicaid Alaska provider group and/or individual.**

1. Provider Information Submission Agreement (4 Pages)

- Page 1- I, _____ - Enter Provider's Name
- Page 3- Box 22 – Enter contact information for technical person or billing person in provider's office who can answer questions about electronic claim submissions.
Box 23 – Enter billing provider's name, billing provider's Medicaid Alaska ID #, name of authorized signer, signature, title, and date.
- Page 4- Do NOT complete Sections III or IV.

835 - ERAs Electronic Remittance Request (New) or (Change of Service)

For first time request, or to change the billing provider's ERA service, authorizing Practice Insight to retrieve 835 ERA files, complete this form:

1. Provider Electronic Remittance Authorization (2 Pages)

List ALL Medicaid Alaska Provider ID Numbers and NPI #'s -- group and individual.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller or software support vendor for assistance or call Medicaid Alaska EDI at 907-644-6800 Option #3.



STATE OF ALASKA
Department of Health and Social Services
PROVIDER INFORMATION SUBMISSION AGREEMENT

The following constitutes an Information Submission Agreement between a provider enrolled in the Alaska Department of Health and Social Services Medical Assistance Program (“*Provider*”), and the State of Alaska, Department of Health and Social Services (“*State*”). The terms of this agreement govern the submission of clinical and financial information sent to the State in support of services performed by the Provider.

I, _____, as Provider, enter into this Provider Information Submission Agreement with the State as authorization to submit clinical and financial information directly to the State either: (1) electronically by me; or (2) in an electronic or paper format through a Billing Agent on my behalf. All information submitted under the terms of this agreement is in support of services performed by me.

Section I. Terms of Agreement (<i>To be completed by the “Provider”</i>)	
1.	I am the Provider named above
2.	I agree to comply with all state and federal laws as they apply to the State of Alaska, Department of Health and Social Services programs in which I participate.
3.	I agree that payment and satisfaction of claims that I submit or that are submitted by my Billing Agent, including electronic transactions, will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.
4.	I agree that I am fully responsible for all information and claims submitted by my Billing Agent or me and that all overpayments made to me by the State will be repaid by me.
5.	I agree to comply with the current and future Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) for all services, information, and transactions, including electronic transactions, privacy, and security regulations.
6.	I agree that any transactions completed under this agreement will be compliant with all state and federal laws, including Title VII of the Civil Rights Act of 1964, which prohibits exclusion or discrimination on the basis of race, color, religion, sex, or national origin.
7.	I agree to test any changes or modifications to my electronic file or file layout or my Billing Agent’s electronic file or file layout and seek approval of my test submission by the State. I understand that failure to do so may result in claim processing delays.
8.	I agree to provide the State 30 days notice to set up or change electronic file or file layout specifications for information submissions. I agree to cooperate by transmitting test transactions to the State during a set-up period prior to any transmission to the State. I understand that the duration of testing may be 30 days or more.
9.	I agree, as applicable, to submit Alaska-specific data elements in accordance with State of Alaska Medical Assistance Provider Billing Manuals, Companion Guides, and other State Program Guides to the extent that Alaska-specific data elements do not change the meaning or intent of any of the Health and Human Services (HHS) Transaction Standard’s implementation specifications (45 CFR Part 162.915(d)) and/or do not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915(a)).
10.	I agree that I have the responsibility to ensure that all information submitted is complete and accurate, and that all electronic transactions meet the standards for HIPAA compliance, regardless of whether I use a Billing Agent, a clearinghouse, a billing service, or other third party submitter, or whether I directly submit transactions or information.

20. Software Vendor Information: (Complete this item only if box 19a is checked)		
<hr/> Vendor Name	<hr/> Telephone number	<hr/> Fax Number
<hr/> Vendor Address	<hr/> City	<hr/> State Zip+4
<hr/> Vendor Contact Name	<hr/> Contact Telephone Number	<hr/> Contact E-Mail Address (if available)
21. Billing Agent Information: I authorize the following Billing Agent to submit information, including claims, on my behalf (Complete this item ONLY if you will be billing indirectly through a Billing Agent, Clearinghouse, contractor, or other entity):		
<hr/> Billing Agent's Business Name	<hr/> Billing Agent's Telephone Number	<hr/> Billing Agent's Fax Number
<hr/> Billing Agent's Mailing Address	<hr/> City	<hr/> State Zip+4
<hr/> Billing Agent's Physical Address	<hr/> City	<hr/> State Zip+4
<hr/> Billing Agent's Contact Name	<hr/> Contact's Telephone Number	<hr/> Contact's E-Mail Address (if applicable)
22. Contact Person's Information: This section is to be completed with the name(s) and telephone number(s) of the individual(s), other than yourself or the billing agent listed above, who can answer questions about the information furnished in this Information Submission Agreement. You do not need to furnish any names if you want all questions directed to you. Check here <input type="checkbox"/> if you want all questions directed to you.		
<hr/> Contact Name	<hr/> Contact Telephone number	<hr/> Contact Fax Number
<hr/> Contact Address	<hr/> City	<hr/> State Zip+4
<hr/> Contact E-Mail Address		
23. I understand and agree to comply with all items numbered 1-22 listed above. By my signature below, I acknowledge my responsibility for compliance with this agreement and my authority to enter into this agreement on behalf of the Provider. Additionally, by my signature below, I, the Provider, authorize the Billing Agent named above to submit information, including claims, on my behalf. No photocopies or facsimile signatures will be accepted.		
<hr/> Provider Business Name (print)	<hr/> State Provider Identification Number (Only one ID per Agreement see instructions)	
<hr/> Provider's Name* or Authorized Representative's Name**	<hr/> Title as applicable (print)	
<hr/> Signature of Provider* or Authorized Representative**	<hr/> Date of Signature	

**Individuals and sole proprietors must sign their own enrollment agreement form.*

***An authorized representative is the duly appointed official of any business organized under the laws of the state of Alaska or other state, to operate as a corporation, partnership, LLC, joint venture, or similar organization ("entity"), who has the legal authority to enroll the entity in the Alaska Medical Assistance program, to make changes and/or updates to the enrollment status of the entity, and to commit the entity to the terms and conditions set forth in this enrollment application. The authorized representative must be a general partner, chairman of the board, chief financial officer, chief executive officer, president, or direct owner of at least 5% or more of the entity seeking enrollment, or must hold a position of similar status.*

Section II. Definitions

“Billing Agent” used in this agreement means: Any Billing Agent, Clearinghouse, billing service, other third party submitter, contractors, or other entity submitting information directly to the Alaska Medical Assistance Program, State of Alaska, Department of Health and Social Services, on behalf of an enrolled Provider.

“Provider” used in this agreement means: A party who is properly enrolled in the State of Alaska Department of Health and Social Services program(s) including, as applicable, the Alaska Medical Assistance Program, and authorized to provide and be reimbursed for covered services.

“State” used in this agreement means: The State of Alaska, Department of Health and Social Services, or its designee.

Section III. To Be Completed by the State or its Designee

The State agrees to continue to mail checks, remittance advices, resubmission turnaround documents etc., directly to the Provider, Provider’s Billing Agent, or other entity as recorded on the State’s Medicaid Management Information System (MMIS) provider and submitter files. The State agrees to comply with all HIPAA laws.

- This agreement is effective and begins on the _____ day of _____, 20____. The above Provider is authorized to submit information, which may include claims, to the State.
- This agreement is effective and begins on the _____ day of _____, 20____. The above Provider has authorized the Billing Agent identified above to submit information, which may include claims, to the State on the Provider’s behalf.

Signed this _____ day of _____, 20____.

 State Representative or designee Name, Title, and (if applicable, designee’s Company or Agency Name)

 State or State’s designee Signature

 Date of Signature

Section IV. To Be Completed by the State or its Designee

	Begin date	End date
Test Submitter # assigned to this Provider	_____	_____
Production Submitter # assigned to this Provider	_____	_____
Termination effective date: _____ Date termination notification received: _____		
Hard copy file updated: _____	MMIS file updated: _____	
_____	_____	
_____	_____	
Electronic submitter file updated: _____	_____	_____

Provider Electronic Remittance (835) Authorization

Alaska Medical Assistance is capable of sending an 835 transaction to a single entity/organization only. The purpose of this form is to allow providers to designate who should receive their 835. Please complete the following form for this designation and indicate all State Provider Identification Number(s) and corresponding National Provider Identifier (NPI) number(s) that are applicable.

Send My 835 To:

Self (practice management software able to receive)

Billing Agent

Clearinghouse

Other

Organization Name: _____

Contact Name: _____

Phone Number: _____

Provider Name: _____

State Provider Identification Number _____	Corresponding NPI# _____
State Provider Identification Number _____	Corresponding NPI# _____
State Provider Identification Number _____	Corresponding NPI# _____
State Provider Identification Number _____	Corresponding NPI# _____
State Provider Identification Number _____	Corresponding NPI# _____
State Provider Identification Number _____	Corresponding NPI# _____
State Provider Identification Number _____	Corresponding NPI# _____
State Provider Identification Number _____	Corresponding NPI# _____

Telephone #: _____

Attach additional pages if necessary

I authorize the above named entity to receive and process my electronic remittances (835) from Alaska Medical Assistance Programs. I may have multiple entities submitting claims for me and understand that only one entity can be designated by me to accept and process my electronic remittance. I also understand that the entity I have authorized above must have prior approval from Affiliated Computer Services, Inc. to receive electronic remittances.

Print Authorized Representative Name

Title Authorized Representative

Signature of Provider* or Authorized Representative**

Date

* *Individuals and sole proprietors must sign their own enrollment agreement form.*

** *An authorized representative is an appointed official to whom the provider has granted the legal authority to enroll the provider in the Medicaid program, to make changes and/or updates to the provider's status in the Medicaid program (e.g., new practice locations, changes of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider's organization, or must hold a position of similar status and authority within the provider's organization.*

If you fax this document, please be sure to mail the original.

Mail original or fax to: **Affiliated Computer Services, Inc.**
HIPAA Provider Support Team
P.O. Box 240808
Anchorage, AK 99524-0808

Fax number: (907) 644-8126