



1304 Vermillion Street • Hastings, MN 55033  
 Ph 800-482-3518 • Fax 651-389-9152

**DELAWARE MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKDE1</b>				
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<p><b>Electronic Dental Services Provider Enrollment Form</b></p> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> <p><b>Delaware Title XIX Electronic Claim Submission Trading Partner Agreement</b></p> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul>				
<b>SPECIAL NOTES</b>	<ul style="list-style-type: none"> <li>▪ Medicaid will only allow original signatures on the Trading Partner Agreement. Copies or facsimiles of the form will not be accepted by Delaware Medicaid.</li> </ul>				
<b>SEND REGISTRATION FORMS TO:</b>	<p>Please mail completed ORIGINALS to:</p> <p>Electronic Dental Services          Attn: Provider Registration          1304 Vermillion Street          Hastings, MN 55033</p>				
<b>ENROLLMENT CONFIRMATION</b>	Once Medicaid approves electronic claims submission, Electronic Dental Services will notify the provider or their software vendor.				
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	If the Provider currently submits claims through another Billing Agent other than Electronic Dental Services. each Provider must re-enroll following the procedures listed above.				
<b>CONTACT PHONE NUMBERS</b>	<table> <tr> <td>Delaware Medicaid</td> <td align="right">302-454-7154</td> </tr> <tr> <td>Electronic Dental Services</td> <td align="right">800-482-3518</td> </tr> </table>	Delaware Medicaid	302-454-7154	Electronic Dental Services	800-482-3518
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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Delaware Medicaid – payer ID CKDE1**

Provider/Organization Name: \_\_\_\_\_

Tax Identification or Social Security Number: \_\_\_\_\_  
*(Number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group NPI Number: \_\_\_\_\_  
*(if applicable)*

Group Taxonomy Code: \_\_\_\_\_  
*(if applicable)*

Name	NPI	Rendering	Taxonomy Code
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

Date: \_\_\_\_\_

**DELAWARE TITLE XIX  
ELECTRONIC CLAIM SUBMISSION  
TRADING PARTNER AGREEMENT**

TYPE OF  
AUTHORIZATION:

Please specify:	New <input type="checkbox"/>	Change <input type="checkbox"/>	Cancel <input type="checkbox"/>
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Electronic Data Systems has developed, under authority granted by the State of Delaware Medicaid Program, a claim processing system to facilitate business transactions by electronically transmitting and receiving data in lieu of conventional paper-based documents.

This Agreement is made by and between the State of Delaware's Department of Health and Social Services, its fiscal agent, Electronic Data Systems (hereinafter referred to as EDS), and the undersigned provider (hereinafter referred to as Provider and/or Trading Partner):

Provider:	_____
NPI:	_____
Provider's Address:	_____ _____
Contact Person:	_____
Contact Phone:	_____
Email Address:	_____

1. EDS operates and maintains, under the authority of the Department of Health and Social Services, a paperless transaction system that allows providers to submit electronic transactions through the use of designated electronic media in compliance with current EDS electronic claim specifications and any revisions that may occur from time to time.
2. The Trading Partner agrees that it will complete, to the specifications and satisfaction of EDS, adequate testing appropriate to the electronic transactions it intends to submit, and further agrees that it will correct transaction errors or deficiencies as identified by EDS.
3. The Trading Partner attests that all services for which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the Delaware Medical Assistance Program, and that all charges submitted shall not exceed the Provider's usual and customary charges for the same services and items provided to persons not entitled to receive benefits under the Delaware Medical Assistance Program.
4. The Trading Partner agrees that any payments made in satisfaction of claims submitted electronically will be delivered from federal and state funds and that any false claims, statements or documents, or concealments of a material fact may be subject to prosecution under federal and state law.

5. The Trading Partner shall allow EDS access to its claims data. Further, the Trading Partner shall take reasonable steps to insure that the claims data will be submitted only by authorized personnel.
6. The Trading Partner will institute and adhere to security procedures to prevent unauthorized access to data, data transmissions, security access codes, and any and all other private or protected data or records. Further, the Trading Partner will promptly notify EDS of any unlawful use or unintended disclosure of Protected Health Information or any unauthorized attempt to obtain access to or otherwise tamper with any protected data. In the event that any litigation arises concerning the unlawful or unauthorized disclosure or use of Protected Health Information, the Trading Partner will comply with requests for cooperation from EDS and the Department of Health and Social Services.
7. The Trading Partner agrees that electronic transmission of all data shall be in strict accordance with the standards set forth in this agreement; Electronic Claim Submission guidelines as put forth by EDS; and as defined by the Health Insurance Portability and Accountability Act. In the event that electronic transmission of data fails to comply with the above stated specifications, EDS may, with the approval of the Department of Health and Social Services, terminate this agreement upon written notice to the Trading Partner.
8. The Provider may modify its election to use, not use, or change a third-party service provider such as a billing agent or authorized vendor but understands that in the event that any such modification is made, it is incumbent upon the Provider to give written notice to EDS by submitting a new Trading Partner Agreement specifying that said change is being authorized. Regardless of any such change to a third-party service provider, all elements of this Trading Partner Agreement shall remain in effect and apply to all electronic transactions.
9. The Trading Partner understands and agrees that all other terms and conditions of participation in the Delaware Medical Assistance Program remain in effect and are unchanged by this Trading Partner Agreement.
10. Please specify if a billing agent or an authorized vendor will be used to submit claims:

BILLING AGENT	
Name of Agent:	_____
Address:	_____
Contact:	_____
Telephone:	_____

VOID

AUTHORIZED VENDOR	
Name of Vendor:	<u>Emdeon</u>
Address:	<u>220 Burnham Street, South Windsor, CT 06078</u>
Contact:	<u>Provider Enrollment</u>
Telephone:	<u>888-255-7293 option 1</u>
Submitter ID:	<u>345463160</u>



**AUTHORIZATION TO SUBMIT ELECTRONIC CLAIMS**

**PROVIDER:**

I hereby certify that I have examined this agreement and that the representations that are contained herein are true and correct. I hereby authorize the below stated individuals to submit electronic claims on my behalf to the State of Delaware Medicaid Program. I agree to notify EDS, in writing, of any changes to this agreement.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**PERSONS AUTHORIZED TO SUBMIT CLAIMS ELECTRONICALLY:**

I accept responsibility for the accuracy of electronic claims submitted to Medicaid and understand that any and all identification numbers used to submit electronic transactions are to remain confidential. I understand that failure to maintain confidentiality may result in falsified claims and may lead to criminal prosecution.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**DEPARTMENT OF HEALTH AND SOCIAL SERVICES:**

Approved by: \_\_\_\_\_

Date: \_\_\_\_\_