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

KENTUCKY MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKKY1
ELECTRONIC REGISTRATIONS Agreements Required	***ONE SET OF FORMS FOR EACH PROVIDER NUMBER*** **(2 originals) MAP-380 – Provider Agreement Electronic Media Addendum** • Page 1 - Fill in the date, provider name, address, provider type, provider number and NPI number. • Page 2 – Fill in provider name, provider signature, contact name, contact title, date and phone number. **(1 original) MAP-246 – Agreement Between the Kentucky Medicaid Program and Electronic Media Billing Agency** • Fill in provider name, provider number and NPI number. **ELECTRONIC DENTAL SERVICES PROVIDER ENROLLMENT FORM** • Please fill in all requested information
SPECIAL NOTES	• Each provider number must complete a set of forms. For example: if a group of 3 providers is registering you will need to complete one set of forms for the group and one set for each of the 3 providers resulting in a total of 4 packets. • If the Provider does NOT have an assigned KY Medicaid Provider Number they must contact Kentucky Medicaid (First Health) at (877) 838-5085. • If the Provider is changing from an Individual Provider to a Group Practice, the Provider must fill out Form MAP-347. • Forms may be obtained by calling Electronic Dental Services Provider Enrollment at 800-482-3518 or KY Medicaid Provider Enrollment at (877) 838-5085.

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

SEND REGISTRATION FORMS TO:	Please mail or fax completed forms to: Electronic Dental Services Attn: Provider Enrollment 1304 Vermillion Street Hastings, MN 55033 Fax 651-389-9152
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Electronic Dental Service and EDS. Electronic Dental Services will contact the provider or their software vendor when approval is received.
CHANGING ELECTRONIC BILLING AGENTS	▪ If the provider currently submits claims through another Billing Agent other than Electronic Dental Services each Provider must submit forms MAP-380 and MAP-246. ▪ In addition, each Provider must include a letter stating the name of the previous billing agent and that they are switching over to Electronic Dental Services, the name and address of the facility and appropriate Provider. ▪ Please return these forms with the letter(s) to Electronic Dental Services at the address provided above.
CONTACT PHONE NUMBERS	Electronic Dental Services 800-482-3519 KY Medicaid Provider Enrollment 877-838-5085

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

PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **KENTUCKY MEDICAID – payer ID CKKY1**

Provider/Organization Name: ____

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

Software Vendor: ____

Group Number: ___________________________
(if applicable)

Group NPI Number: ____________________________
(if applicable)

Rendering Provider Name	Provider Number	Individual NPI Number
______________________________	_________________________	________________________
______________________________	_________________________	________________________
______________________________	_________________________	________________________
______________________________	_________________________	________________________

Address: ____

City, State, Zip Code: ____

Office Contact Name: ____

Telephone Number: _____________________________ Fax Number: ______________________________

Date: ______________________________

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

This addendum to the Provider Agreement is made and entered into as of the __________day of
(Day)
__________, __________, by and between the Commonwealth of Kentucky, Cabinet for Health and
(Month) (Year)
Family Services, Department for Medicaid Services, hereinafter referred to as the Cabinet, and

____________________________________, ____
(Provider Name) (Provider Address)

____, ___________, ________________
(City) (State) (Zip Code)

hereinafter referred to as the provider.

WITNESSETH, THAT:

Whereas, the Cabinet fro Health and Family Services, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as

____________________________, ___________________________, ____________________________
(Type of provider) (Provider Number) NPI (National Provider Identifier)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media"

      "This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may by prosecuted under applicable Federal and State Law."

   D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet

   E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

Either party shall have the right to terminate this Addendum upon written notice without cause.

____
(Provider)

____
(Provider Signature)

____________________,	____________________
(Contact Person) (First and Last Name)	(Title)
____________________,	____________________
(Date)	(Telephone Number)
CPS / WebMD dba Emdeon Business Services,	PC to PC
(Software Vendor and/or Billing Agency)	(Media)

Please return form to:
KyHealth Choices
P.O. Box 2110
Frankfort, KY 40602-2110

Agreement Between the Kentucky Department for Medicaid Services
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The CPS / WebMD dba Emdeon Business Services has entered into a contract with
(Name of Billing Agency)

____, _______________________,
(Name of Provider) (Provider Number)

_______________________ to submit claims via electronic media for service provided to KMP recipients.
(National Provider Identifier [NPI])

The billing agency agrees:

1. Billing Agency also agrees to maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with the HIPAA Security Standards once finalized.
2. To maintain or have access to a record of all claims submitted for payment for a period of at least six (6) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider and in compliance with the HIPAA transaction and code set regulations by the appropriate due date, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to commit fraud or deceive, makes or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.
5. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations with their provider's business associate agreement. Billing agency agrees to take "reasonable steps" to cure the breach or to end any uncovered violations of confidentiality or security of data under their control.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.
3. To maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with HIPAA Security Standards once finalized.
4. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations.

This agreement may be terminated upon written notice by either party without cause.

____
SIGNATURE, AUTHORIZED AGENT OF BILLING AGENCY

____
DATE

Dawn L Vaughan
CONTACT PERSON **(FIRST AND LAST NAME)**

888-255-7293
TELEPHONE NUMBER

MEDIA: [ ] POS [ ] PC to PC [ ] CD

Please return form to: KyHealth Choices, P.O. Box 2110, Frankfort, KY 40602-2110