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

OREGON MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CKOR1**
SPECIAL NOTES	EDS signature is required**. EDI packets must be mailed to EDS in their entirety to obtain this required signature.** All forms must contain original signatures in **BLUE ink**. All fields marked with an * are required. OMAP enrolled group practices need only submit **one** EDI Registration Packet listing the group as the Trading Partner.
ELECTRONIC REGISTRATIONS Agreements Required	EDS Provider Enrollment Form • Please complete all requested information. Trading Partner Agreement Oregon Department of Human Services. • Pg. 1: Enter Billing NPI number and Billing provider name. • Pg. 5: Enter Billing provider name, title, phone number, original authorized signature in BLUE ink, signer name and date. Exhibit A Application for Authorization • Pg. 1: Enter Billing Trading Partner name, phone number, Billing provider number, Tax ID number, Billing NPI number, taxonomy code, date and original Trading Partner signature in BLUE ink. • Pg. 2: Will be completed by EDS. • Pg. 3: Leave blank as it does not apply. Exhibit B EDI Registration • Complete all sections. Areas marked with an * are • Required, others are optional; signature must be original in BLUE ink. Exhibit C EDI Registration Change Form • Complete sections 1-4 and 8.
SEND ENROLLMENT FORMS TO:	Electronic Dental Services 1304 Vermillion Street, Suite 8 Attn: Enrollment Hastings, MN 55033
ENROLLMENT CONFIRMATION	EDS will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	Oregon Medicaid EDI Helpdesk 503-947-5347 Electronic Dental Services 800-482-3518

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

PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Oregon Medicaid – payer ID CKOR1**

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

Name	Number	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Print Clear Form

National Provider Identifier or
Oregon Medicaid Provider Number _____

DIVISION OF MEDICAL ASSISTANCE PROGRAMS
EDI Support Services

Health Insurance Portability and Accountability Act

TRADING PARTNER AGREEMENT
ELECTRONIC HEALTH CARE TRANSACTIONS

This Trading Partner Agreement (TPA) between the Oregon Health Authority (OHA), Division of Medical Assistance Programs (DMAP) and _____ (name of Provider, Prepaid Health Plan,Clinic or Allied Agency), hereinafter referred to as Trading Partner, provides the terms and conditions which govern the registration and conduct of Electronic Data Interchange (EDI) Health Care Transactions, in the performance of obligations under a contract with either the OHA or the Department of Human Services (DHS).

For purposes of this TPA, a Contract means a specific written agreement between OHA or DHS and said Trading Partner that provides, or manages the provision of, health care services, goods or supplies to Covered Individuals and in the provision of which OHA may exchange Data with the Trading Partner.

A Contract specifically includes, without limitation, a Provider Enrollment Agreement, a Fully Capitated Heath Plan Managed Care Contract, a Dental Care Organization Managed Care Contract, a Mental Health Organization Managed Care Contract, a Chemical Dependency Organization Managed Care Contract, a County Financial Assistance Agreement, or any other applicable written agreement, interagency agreement, intergovernmental agreement, or grant agreement between OHA or DHS and Trading Partner.

Reference in this TPA to OHA's Electronic Data Transmission (EDT) rules refers to Oregon Administrative Rules (OAR) 943-120-0100 through 943-120-0200.

Capitalized terms used but not defined herein shall have the same meaning as those terms in OAR 943-120-0100 of OHA's Electronic Data Transmission (EDT) rules.

For mutual consideration, the parties agree as follows.

A. Provider, Prepaid Health Plan, Clinic or Allied Agency Obligations as a Trading Partner. Providers, Prepaid Health Plans, Clinics or Allied Agencies that wish to register to conduct EDI Health Care Transactions with DMAP must execute this TPA. A Provider, Prepaid Health Plan, Clinic or Allied Agency that has a TPA with DMAP shall be referred to as a Trading Partner when functioning in that capacity. In addition to the obligations set forth in the Contract, the Trading Partner shall comply with OHA's EDT rules, and other state and federal rules, policies and procedures applicable to Electronic Data Interchange Transactions.

1. Valid Contract with OHA or DHS Required as a Mandatory Condition of Registration. Only Providers, Prepaid Health Plans, Clinics or Allied Agencies with a currently valid Contract may register as a Trading Partner.

2. Trading Partner as an EDI Submitter. If the Trading Partner wishes to register and conduct its own EDI Transactions directly with DMAP, the Trading Partner will be referred to as an EDI Submitter. An EDI Submitter is the entity that establishes the electronic connection with DMAP to conduct an EDI Transaction on behalf of a Trading Partner.

3. Trading Partner Agent as an EDI Submitter. A Trading Partner may use, in the performance of this TPA, one or more Agents as the Trading Partner's EDI Submitter.The Trading Partner's authorization and registration of its EDI Submitter(s) for purposes of this TPA is expressly subject to acceptance by DMAP, based on criteria established in OHA's Electronic Data Transmission (EDT) rules.

4. Application for Authorization. A Trading Partner must submit an Application for Authorization (Exhibit A) to register for EDI Transactions with DMAP, and to identify and authorize the EDI Submitter. If Trading Partner will be using an Agent as the EDI Submitter, the Application for Authorization (Exhibit A) shall include a signed EDI Submitter Certification before DMAP may accept an electronic transmission from such Agent. The Application for Authorization, when fully executed, shall be incorporated into this TPA by reference and shall be effective on the date of its execution, unless specified otherwise.

5. EDI Registration Information. Trading Partner or authorized EDI Submitter must register the name and type of EDI Transactions they are prepared to send or to receive, subject to applicable testing requirements. The Registration Form must be fully completed and signed by Trading Partner or authorized EDI Submitter as a condition of DMAP registering and accepting an electronic Data Transmission. The EDI Registration Form, when fully executed, shall be incorporated into this TPA by reference and shall be effective on the date of its execution, unless specified otherwise.

6. Changes in any Material Information. Trading Partner shall submit an updated TPA, Application for Authorization or EDI Registration Form to DMAP within ten (10) business days of any material changes in the information. Material changes include but are not limited to changes of address or e-mail address, Contract number or Contract status, identification of authorized individuals of the Trading Partner or EDI Submitter, the addition or deletion of authorized transactions, or any other change that may affect the accuracy of or authority for an EDI Transaction. Only the forms that contain the material change in information must be updated. Trading Partner's signature or the signature of an authorized EDI Submitter is required to ensure that an updated TPA, Application for Authorization or EDI Registration form is valid and authorized. DMAP is authorized to act on Data Transmissions submitted by authorized EDI Submitter(s) based on information on file until an updated form has been received and approved. Failure to submit an updated form may impact the ability of a Transaction to be processed without errors. Failure to timely submit a signed updated form may result in a rejection of a Data Transmission.

7. Accuracy and Security of Transmissions. Trading Partner and DMAP shall take reasonable care to ensure that Data and Data Transmissions are timely, complete, truthful, accurate and secure, and shall take reasonable precautions to prevent unauthorized access to the Information System, the Data Transmission itself or the contents of an Envelope which is transmitted either to or from DMAP pursuant to this TPA, and in compliance with 45 CFR Parts 160 and 162, if applicable.

8. Express Warranties Regarding Agents. Trading Partner expressly warrants that its EDI Submitter(s) will take all appropriate measures to maintain the timeliness, accuracy, truthfulness, confidentiality, security and completeness of each Data Transmission. Furthermore, Trading Partner further expressly warrants that its EDI Submitter(s) will be specifically advised of, and will be directed to comply in all respects with, the terms of this TPA.

B. Provider, Prepaid Health Plan, Clinic or Allied Agency Certification.

As a condition for receiving payment from DMAP using Medicaid funds, or for other programs for which DMAP makes health care payments, and as a condition of registration of EDI Transactions with DMAP, by my signature to this TPA, I hereby agree to and certify the following:

1. To the best of my knowledge all Data prepared, processed and submitted as claims or encounter data at my direction are true and valid claims or encounter data for healthcare goods or services provided to a Covered Individual under the applicable Contract, and the rules, regulations and policies of OHA.

2. I will maintain Data Transaction information and Source Document information for seven (7) years from the date of the service and be able to reproduce claims or encounters for resubmission or audit upon request by OHA.

3. I will only take such actions that are authorized in the Application or Registration with respect to Registered EDI Transactions, and I will provide updated information within ten (10) business days of a material change in that information.

4. I will allow, upon request and at a reasonable time and place, authorized federal or state government agents to inspect and copy any records I maintain on the services provided or billed under the Contract.

5. I am responsible for the accuracy, truthfulness and completeness of all Data submitted by my Agent(s) to the extent provided by the law.

6. I acknowledge that my Agent will sign Data Transmissions, or may submit Data Transmissions without signature, on my behalf for the purpose of reimbursement from OHA. I acknowledge that I may be liable based on such actions for my participation in Medicaid or other programs to the extent applicable federal or state criminal or civil laws so provide.

7. In conducting EDI Transactions, I will adhere to all OHA Electronic Data Transmission (EDT) rules, and other applicable OHA rules, policies and procedures in effect on the date the service or good was provided.

8. If the EDI Transaction relates to payment for Medicaid services or supplies (including Oregon Health Plan and waivered services) by OHA to a Provider, Prepaid Health Plan, Clinic or Allied Agency on a fee-for-service basis, the following rule applies to any claim for payment - 42 CFR 447.10:

   (d) *Who may receive payment*. Payment may be made only -
   (1) To the provider; or
   ***
   (3) In accordance with paragraphs (e), (f) and (g) of this section.
   ***
   (f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is -
   (1) Related to the cost of processing the billing;
   (2) Not related on a percentage or other basis to the amount that is billed or collected; and
   (3) Not dependent upon the collection of the payment.
   (g) *Individual practitioners.* Payment may be made to -
   (1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;
   (2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or

(3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

9. I understand that
   a) payments in relation to my EDI Transactions will be from federal and state funds and
   b) I may be prosecuted under applicable federal or state criminal or civil laws if I or my Agent directly engages, or conspires to engage, in fraudulent actions such as submitting false claims or documents, making misrepresentations, or concealing material facts that would affect payment.

C. General Provisions.

1. Tax Certifications. The individual signing below on behalf of Trading Partner hereby certifies and swears under penalty of perjury that s/he is authorized to act on behalf of Tradnig Partner, s/he has authority and knowledge regarding Trading Partner's payment of taxes, and to the best of her/his knowledge, Trading Partner is not in violation of any Oregon tax laws. For purposes of this certification, "Oregon tax laws" means those programs listed in ORS 305.380(4), including without limitation, the state inheritance tax, personal income tax, withholding tax, corporation income and excise taxes, amusement device tax, timber taxes, cigarette tax, other tobacco tax, 9-1-1 emergency communications tax, the elderly rental assistance program, and local taxes administered by the Department of Revenue (Lane Transit District Self-Employment Tax, Lane Transit District Employer Payroll Tax, Tri-Metropolitan Transit District Employer Payroll Tax, and Tri-Metropolitan Transit District Self-Employment Tax).

2. Compliance with Applicable Law. DMAP's performance under this Trading Partner Agreement is conditioned upon Trading Partner's compliance with the provisions of ORS 279.312, 279.314, 279.316 and 279.320 which are incorporated by reference herein. In the performance of EDI Transactions under this Agreement, Trading Partner shall use recycled and recyclable products to the maximum extent which is economically feasible in compliance with ORS 279.555.

3. Interpretations; Order of Precedence. Whenever possible, all terms and conditions in this Trading Partner Agreement and any Contract are to be harmonized. Any ambiguity in this TPA shall be resolved to permit the Parties to comply with the HIPAA Transaction Rules, if those rules apply to the EDI transaction. For EDI Transactions governed by the HIPAA Transaction Rules, this TPA should not be interpreted in any manner that would do any of the following:
   (a) Change the definition, data condition, or use of a data element or segment in a Standard Transaction;
   (b) Add any data elements or segments to the maximum defined data set;
   (c) Use any code or data elements that are either marked "not used" in the Standard Transaction, implementation specification or are not in the Standard Transaction's implementation specification(s); or
   (d) Change the meaning or intent of the Standard Transaction's implementation specification(s).

4. Term and Termination.
   (a) Effective Date; Term. This Trading Partner Agreement shall be effective on the date DMAP notifies the Trading Partner of the OHA's acceptance of the TPA. This TPA shall terminate on the earlier of (i) the date of termination of all Contracts that form the basis for Trading Partner submission of EDI Transactions to DMAP, unless said Contract is timely renewed or extended with no lapse of time between Contracts and DMAP receives a timely update of EDI Registration, or (ii) the date on which termination of the TPA is effective under section C(4)(b); except that the TPA shall remain in effect to the extent necessary for Trading Partner or DMAP to complete obligations involving EDI under the Contract for dates of service when the contract was in effect.
   (b) Termination for Cause. Upon knowledge of a material breach by Trading Partner, or any EDI Submitter or other Agent, the State shall either:

(1) Notify Trading Partner of the breach and specify a reasonable opportunity in the notice for Trading Partner to cure the breach, and terminate the TPA if Trading Partner does not cure the breach of the terms of the TPA or end the violation within the time specified by OHA; or
(2) Immediately terminate this TPA if Trading Partner has breached a material term of this TPA and cure is not possible in OHA's reasonable judgment.
(3) The rights and remedies provided in this TPA are in addition to any rights and remedies provided in a Contract.

Trading Partner and Title:

Phone number:

Authorized Signature:

Type or Print Name:

Date:

Print Clear Form

Oregon Health Authority

DIVISION OF MEDICAL ASSISTANCE PROGRAMS
EDI Support Services

Health Insurance Portability and Accountability Act
Exhibit A — Application for Authorization (Trading Partner or EDI Submitter)

☐ New application ☐ Updated application Effective date: _____

Instructions:

- **Trading partners acting as their own EDI submitter: Complete sections A and C.**
- **Trading partners using an authorized agent as their EDI submitter: Complete section A. Have each authorized EDI submitter complete and sign section B.** Failure to include section B for each EDI submitter will result in non-approval of the EDI submitter's registration.

A. Trading Partner Application for Authorization of EDI submitter:

I, the trading partner _____ signing this Application for Authorization, by identifying my EDI submitter in this section as the EDI submitter, hereby request approval to register my EDI submitter to prepare, process, submit and receive my EDI transactions with the Oregon Medicaid Management Information System (OR-MMIS). I authorize my EDI submitter to take the following actions on my behalf: (Must check those that apply or check at least one.)

- ☑ Request and participate in business-to-business testing with OR-MMIS for my registered transactions.
- ☑ Submit a request for approval to conduct my registered transactions.
- ☑ Submit updates of the EDI submitter information on this Application for Authorization form.
- ☑ Submit updates of the EDI registration form.
- ☑ Request password and log-on information for my registered transactions.
- ☑ Conduct my registered transactions.

I understand that authorization to act as an EDI submitter and to register EDI transactions will not be effective until approved by the Division of Medical Assistance Programs (DMAP).

Trading partner name (print):	Phone number:
DMAP contract or provider ID number(s):	Federal taxpayer ID number:
National Provider Identifier (NPI):	Taxonomy code(s):
Date:	Authorized trading partner signature: (original signature required) SIGN HERE

B. EDI submitter certification conditions

I, the authorized EDI submitter, agree to and certify as follows:

1. All data I submit to OR-MMIS on behalf of the trading partner is a true and correct representation of the source data I received from the trading partner.
2. I understand that I may be prosecuted under applicable federal and state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data system input, other acts of misrepresentation or conspiracy to engage therein.
3. I will maintain data transaction information for seven years from the date of the service and be able to reproduce claims for resubmission or audit upon request by DMAP.
4. I will only take such actions that are authorized in the application or by change request by the trading partner with respect to the trading partner's registered EDI transactions.
5. Before billing for any services or conducting a transaction, I will review and fully comply with the OHA Electronic Data Transmission (EDT) rules, OAR 943-120-0100 through 943-120-0200, and other federal and state laws and regulations applicable to the services and to the registered transactions.
6. I will allow, upon request and at a reasonable time and place, authorized federal or state government agents to inspect and copy any records I maintain on the services provided and billed on behalf of trading partner or otherwise related to an EDI transaction.
7. If the EDI transaction relates to payment for Medicaid services or supplies (including Oregon Health Plan and waivered services) by DMAP to a provider, prepaid health plan, clinic or allied agency on a fee-for-service basis, the following rule applies to any claim for payment – 42 CFR 447.10:

> (d) *Who may receive payment*. Payment may be made only -
> (1) To the provider; or
> ***
> (3) In accordance with paragraphs (e), (f) and (g) of this section.
> ***
> (f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is -
> (1) Related to the cost of processing the billing;
> (2) Not related on a percentage or other basis to the amount that is billed or collected; and
> (3) Not dependent upon the collection of the payment.
> (g) *Individual practitioners.* Payment may be made to -
> (1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;
> (2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or
> (3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

Authorized EDI submitter certification:

I certify that I am authorized by the trading partner identified herein to submit registered EDI transactions to OR-MMIS. Failure of the authorized EDI submitter to agree to or to comply with these certification conditions shall result in denial or termination of the authorized EDI submitter's registration by DMAP. My signature below signifies agreement to these EDI submitter certification conditions.

EDI submitter name and title (print): Claims Processing Service Inc. dba Emdeon Dental		Phone number: (888) 255-7293
OR-MMIS EDI submitter number (if available): 276147		Federal taxpayer ID number: 061267267
Date:	Authorized EDI submitter signature: (Original signature required)	

C. Trading partner Application for Authorization to submit EDI transactions: (Complete only if self-submitter)

I, the trading partner _____ signing this application, by identifying myself below as the EDI submitter, hereby request approval to register my EDI transactions with OR-MMIS.

EDI submitter legal entity name: (print):		
EDI submitter contact individual name: (print)		
Address:		
Phone number:	E-mail:	FAX number:
EDI submitter federal tax ID number:	OR-MMIS EDI submitter number: (if available)	
Date:	Authorized trading partner signature: (original signature required)	

Oregon Health Authority

DIVISION OF MEDICAL ASSISTANCE PROGRAMS
EDI Support Services

Health Insurance Portability and Accountability Act
Exhibit B — EDI Registration Form

Use this form to indicate which transactions you or your EDI submitter is requesting to exchange with DMAP.

Trading Partner (provider, prepaid health plan, clinic or allied agency): You are required to have signed a Trading Partner Agreement (TPA) before completing this form.

- If you do not have a current TPA (DMAP 2080) with DMAP under your Oregon Medicaid provider number, you must complete the TPA and Exhibit A (DMAP 2081) before completing this form.
- If you have a new EDI Submitter, you must complete a new Exhibit A before completing this form.
- If your EDI Submitter has not changed and you only want to add or delete authorized transactions, complete Exhibit C (DMAP 2083).

Please be sure to type or print clearly and fill in all required fields designated with an asterisk(*)**. Incomplete forms will NOT be processed. Please maintain a copy for your records.**

When complete, send this form with the TPA and Exhibit A, as applicable to:

EDI Support Services
500 Summer St NE, E44
Salem, OR 97301

503-945-6898 (fax)
1-888-690-9888 (phone)

This registration is: ☐ New ☐ Revised Effective date:

ONE

Trading partner information

*Name:
***Physical address:**
Secondary address:
***City, state and ZIP:**
***Phone number:** *Fax number:

TWO

Provider/Plan number

***Provider/Plan number for which the submitter has authorization (see Exhibit A):** Number:
*National Provider Identifier(s) (NPI):
*Taxonomy code(s):

THREE

Trading partner authorized signer information *(cannot be a billing service or clearinghouse)*. If the primary signer listed here is different from the one listed on your current TPA, you must complete a new TPA and Exhibit A before we can update your EDI registration.

*Primary authorized signer:
*Phone number: *Title:
*E-mail address: *Fax number:

Secondary contact:
Phone number: Title:
E-mail address: Fax number:

FOUR

Claims contact information

*Primary contact:
*Phone number: *Title:
*E-mail address: *Fax number:

Secondary contact:
Phone number: Title:
E-mail address: Fax number:

Complete Sections Five and Six with EDI submitter information. **If your company intends to submit its own transactions,** mark submitter type as "Self" and enter your company's EDI contact information.

FIVE

EDI submitter information – This must match what is listed on your current Exhibit A (DMAP 2081).

*Company name: Claims Processing Service Inc. dba Change Healthcare Submitter ID: 276147

*Address line 1: 220 Burnham Street

Address line 2:

*City, state and ZIP: South Windsor, CT 06078

*Submitter type (check **all** that apply):

☐ Self ☐ Prepaid Health Plan ☑ Clearinghouse ☐ Billing service ☐ Other *(please specify):*

SIX

EDI submitter's contact information – The EDI Testing Team will use the Technical Contact's e-mail address for communications about third-party or business-to-business testing.

*Business contact: Dawn L Vaughan

*Phone number: (888) 255-7293 *Title: Dental Vendor / Payer Liaison

*E-mail address: dentaluspport@changehealthcare.com *Fax number: (860) 289-0055

*Technical contact: Dawn Bezion Title: Analyst

*Phone number: (888) 255-7293 Fax number: (860) 289-0055

*E-mail address: dentalbatch@changehealthcare.com

☐ Third contact on reverse *(if needed)*

SEVEN

Authorized transactions – Check all transactions for which authorization should be registered.

HIPAA 5010A1 Transactions for: ☐ FFS provider or ☐ Prepaid health plan

- ☐ **005010X222A1 837P** Professional Claim Submission
- ☑ **005010X224A2 837D** Dental Claim Submission
- ☐ **005010X223A2 837I** Institutional Claim Submission
- ☐ **005010X221A1 835** Health Care Claim Payment/Advice (RA)
- ☐ **005010X279A1 270 and 271** Health Care Eligibility Benefits Inquiry and Response
- ☐ **005010X212 276 and 277** Health Care Claims Status Request and Response
- ☐ **005010X218 820** Group Premium Payments
- ☐ **005010X220A1 834** Benefit Enrollment and Maintenance
- ☐ **NCPDP 1.2/D.0** Request and Response (B1, B2, B3) (PHP/CCO only)
- ☐ **Pharmacy** Carve-Out File (PHP/CCO only)
- ☐ **Status file** Health Care Claim Status (PHP/CCO only)

EIGHT

Signature – Of the primary authorized signer named in Section Three.

*Provider, prepaid health plan, clinic or allied agency name: *Phone:

*Authorized trading partner signature *(original signature only):* *Date:

Type or print name: