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

ALASKA MEDICAID
DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKAK1
SPECIAL NOTES	If you are a provider who practices individually and as a member of a group, you should fill out an agreement for your individual practice. A group practice authorized representative must fill out a separate agreement for the group. If you have more than one location, you will need to fill out an agreement for each location. Enrollment must be completed with Alaska Medicaid's Clearinghouse: Emdeon. Please follow the steps below to associate your office correctly: To associate your office to Emdeon Dental within the new MMIS please use the below information. Billing Agent/Clearinghouse Name: Claims Processing Service, Inc Street Address: 220 Burnham Street City: South Windsor State: CT Zip: 06074 Contact first name: Alyssa Contact Last name: Rosa Contact Phone number: 888-255-7293 Contact main number: 888-255-7293 Contact Email: dentalsupport@emdeon.com
ELECTRONIC REGISTRATIONS Agreements Required	**EDS Provider Enrollment Form:** Please complete all requested information. **PROVIDER INFORMATION SUBMISSION AGREEMENT** Pg. 1 of 4: Please enter the Group or Provider's name. Pg. 3 of 4: Sec. 22: Please complete all requested contact information. Pg 3 of 4: Sec. 23: Please complete all requested information.
SEND ENROLLMENT FORMS TO:	Enrollment forms must be mailed back to EDS: EDS 400 Vermillion St. Hastings, MN 55033 Attn: Provider Enrollment
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 submits claims through another Billing Agent other than EDS, each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	Alaska Medicaid In-State Providers 800-770-5650 Alaska Medicaid Out-of-State Providers 907-644-6800 Electronic Dental Services 800-482-3518

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PROVIDER ENROLLMENT FORM

Insurance Carrier: **Alaska Medicaid - payer ID CKAK1**

Print/Type the following:
Provider/Organization Name: _____

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

Software Vendor: _____

Group Type 2 NPI: _____
(if applicable)

Rendering Provider Information

Name	NPI – Type 1
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

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 (*To be completed by the "Provider"*)
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)).

Section I. Terms of Agreement, continued (*To be completed by the "Provider"*)

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.

11. I agree that I will not submit claims that may be payable by another resource, unless specifically waived by federal or state rules, or for claims that have already been paid.

12. I agree to comply with state and federal records retention laws that govern records maintained by my Billing Agent or me and to provide access to my records and the records maintained on my behalf by my Billing Agent for reviews and audits as required by state and federal laws.

13. I agree to protect my assigned State identification numbers (including submitter numbers) and State passwords against unauthorized use.

14. I agree that any changes in my business ownership and/or with my Billing Agent will not change my responsibility or liability under this agreement, until such time as I make written notification to the State or its designee of any such change.

15. (a) I agree to notify the State, by the close of business on the next working day for the State of Alaska, if for any reason I revoke or terminate any agreement with the above Billing Agent.
(b) I agree to notify the State of any change to my or my Billing Agent's address, telephone, or other required information within 3 working days.
(c) I agree to execute a new Department of Health and Social Services Information Submission Agreement prior to allowing any Billing Agent to submit information to the State on my behalf.

16. I plan to submit the following: (Check only one)

☐ Non-HIPAA-Compliant Information ☑ HIPAA-Compliant Information

17. (a) I will be sending *claims* in the following format: (Check all that apply)

☑ Paper ☑ Electronic

(b) I will be sending *other information* in the following format: (Check all that apply)

☑ Paper ☐ Electronic

18. I, or my billing agent on my behalf, intend to submit the following types of transactions:

☐ Eligibility Request/Response (270/271)
☐ Claims Status Request/Response (276/277)
☐ Prior Authorization Request/Response (278/278)
☐ Remittance Advice (835)
☑ Dental (837 D)
☐ Institutional (837 I)
☐ Professional (837 P)
☐ Pharmacy (NCPDP- batch)
☐ N/A (Not Applicable)

19. I will be sending claims and other information: (Check only one box)

a. ☐ Directly from my *office system* to the State

b. ☐ Through *Payerpath*^{SM} to the State (if so, skip to #21)

c. ☐ Through *Point of Sale* to the State (if so, skip to #21)

d. ☑ Through a *Billing Agent or Clearinghouse* to the State (if so, skip to #21)

20. Software Vendor Information: (Complete this item only if box 19a is checked)

Vendor Name | Telephone number | Fax Number

Vendor Address | City | State | Zip

NOT USED

Vendor Contact Name | Contact Telephone Number | 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)*:

Claims Processing Service / WebMD | 888-255-7293 | 860-289-0055

Billing Agent's Business Name | Billing Agent's Telephone Number | Billing Agent's Fax Number

220 Burnham Street | South Windsor | CT | 06074

Billing Agent's Mailing Address | City | State | Zip

220 Burnham Street | South Windsor | CT | 06074

Billing Agent's Physical Address | City | State | Zip

Dawn L Vaughan | 888-255-7293 | dentalsupport@emdeon.com

Billing Agent's Contact Name | Contact's Telephone Number | 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 ☐ if you want all questions directed to you.

Contact Name | Contact Telephone number | Contact Fax Number

Contact Address | City | State | Zip

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.**

Provider Business Name (print) | Alaska Medicaid Provider ID # (Only one ID# per Agreement. See instructions)

Provider's Name * or Authorized Representative's Name** | Title as applicable (print)

SIGN HERE

Signature of Provider* or Authorized Representative** | Date of Signature

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.***

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: _____ _____ _____