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	• Electronic Dental Services signature is required. EDI packets must be ***mailed*** to Electronic Dental Services 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	**Electronic Dental Services Provider Enrollment Form** • Please complete all requested information. • Trading Partner Agreement Oregon Department of Human Services. • Please complete all requested information
SEND ENROLLMENT FORMS TO:	Electronic Dental Services 400 Vermillion Street, Suite 8 Attn: Enrollment Hastings, MN 55033
ENROLLMENT CONFIRMATION	Claims will process electronically once enrollment has been updated and approved.
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

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

PROVIDER ENROLLMENT FORM

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

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 Legacy Number as assigned by the payer:_____
(if applicable)

Group Type 2 NPI: _____
(if applicable)

Rendering Provider Information

Name	Legacy Number	NPI – Type 1
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Oregon Health Authority
HEALTH SYSTEMS DIVISION
EDI Support Services

***Trading Partner's National Provider Identifier (NPI):**
***List all taxonomy code(s) registered to this NPI:**
***List the Oregon Medicaid ID(s) associated with this NPI:**

Trading Partner Agreement for Electronic Health Care Transactions

When to complete this form: Trading partners must complete and submit this form to:

- Sign up to exchange transactions with the Oregon Health Authority (OHA).
- Authorize who will exchange these transactions for you.
- Make any changes to trading partner or submitter information on file with OHA.

How to complete this form:

- **If you need to exchange transactions for more than one NPI**, complete a TPA for each NPI.
- **If you need to exchange transactions for multiple Oregon Medicaid ID numbers**, you can use one TPA but only if all locations need the same transactions.
- **If you need to authorize more than one clearinghouse/submitter,** complete a TPA for each one.
- **Please type or print clearly. Fill in all required fields designated with an asterisk (*).** Incomplete forms will NOT be processed.
- Please maintain a copy for your records.
- **Mail the completed form to:** EDI Support Services, 500 Summer St NE, E44, Salem, OR 97301.

Questions? Email DHS.EDISupport@state.or.us.

This TPA *(select one)*:
- ☐ Fully replaces the current TPA on file. This TPA will end all previous provider/submitter combinations registered under your Oregon Medicaid ID.
- ☐ Adds information to the current TPA(s).

ONE

Trading partner information –. This cannot be a billing service.

*Type *(select one)*: ☐ Provider ☐ Clinic ☐ Coordinated Care or Managed Care Organization

*Business name *(as enrolled with OHA)*:

*****Physical address:

*****City, state and ZIP:

*****Phone number/extension:

TWO

Trading partner authorized signer information – The primary signer signs Part 7 of this form.

*Primary signer's name:

*Phone number/extension: *Title:

*Email address (*direct, not group, email)*:

Secondary signer's name:

Phone number/extension: Title:

Email address (*direct, not group, email)*:

THREE

Claims contact information – This contact must be a person, not a group.

*Primary contact's name:

*Phone number/extension: *Email address:

Secondary contact's name:

Phone number/extension: *Email address:

FOUR

EDI submitter information – If your company intends to exchange transactions directly with OHA, enter "Self" as the submitter name, and enter your company's EDI contact information. If your company intends to use a submitter/clearinghouse, complete this section for the submitter/clearinghouse.

*****Submitter name: Claims Processing Service dba Change Healthcare

*****Address: 10 Schophoester Rd # 4237

*****City, state and ZIP: Windsor Locks, CT 06096

Submitter mailbox # : MB000262

FIVE

EDI submitter's contact information – The Business Contact signs Part 8 of this form. OHA will email the Technical Contact when transaction testing is needed. Do not enter a billing service contact as the Technical Contact.

*****Business contact's name: Larry Coleman

*****Phone number/extension: (877) 394-0027 ext 60533

*Email address (*direct, not group, email)*: Larry.Coleman@changehealthcare.com

*****Technical contact's name: Eric Carley

*****Phone number/extension: (877) 394-0027 ext 60611 ☐ Third contact on reverse *(if needed)*

*****Email address (*direct, not group, email)*: ecarley@changehealthcare.com

SIX

Authorized transactions – Check all transactions that OHA should authorize for your EDI submitter.

HIPAA 5010A1 transactions for: ☐ FFS provider or ☐ CCO/MCO

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

SEVEN

Trading Partner signature – By signing below, the Trading Partner certifies the following:

- I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html, and understand my responsibilities as stated in these rules.
- I authorize OHA to transmit to the *EDI Submitter* listed in Part 4 of this form the return computer file electronic vouchers of all transactions I have marked in Part 6 of this form.

*Provider, clinic, CCO or MCO name *(from Part 1 of this form):*

*Email address:

*Authorized trading partner signature:

*Phone number/extension:

*Date:

Original signature only, of the Primary Signer listed in Part 2

EIGHT

EDI Submitter signature – By signing below, the EDI Submitter certifies the following:

- I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html, and understand my responsibilities as stated in these rules.
- I agree to protect the confidentiality of the data as required by law.

*Business contact name *(from Part 5 of this form):*
Larry Coleman

*Email address:
Larry.Coleman@changehealthcare.com

Authorized EDI submitter signature:*

*Phone number/extension:
(877) 394-0027 ext 60533

*Date:

Original signature only, of the Business Contact listed in Part 5