



Medicaid of Alaska

Attention Providers:

In order to start sending claims electronically to Medicaid of Alaska through EDS, you will need to sign and complete the attached forms.

Payer:	Medicaid of Alaska
Payer ID:	CKAK1
For Enrollment Questions:	Contact the EDS Enrollment Department at (800)482-3518 or Enrollment@edsedi.com
Enrollment Application:	Provider Electronic Remittance (835) Authorization
Mail Original Form to:	Conduent HIPAA Provider Support Team P.O. Box 240808 Anchorage, AK 99524-0808
Email or Fax a Copy of the Application to:	Enrollment@edsedi.com Fax (651)389-9152
Special Instructions:	Original signature is required Payer Values on Billing/Group NPI
Approval Process and Timeframes:	Payer estimates 4-6 weeks for processing.



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 <i>(To be completed by the "Provider")</i>	
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)).
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.

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

- 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. 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):

Billing Agent's Business Name	Billing Agent's Telephone Number	Billing Agent's Fax Number
Billing Agent's Mailing Address	City	State Zip + 4
Billing Agent's Physical Address	City	State Zip + 4
Billing Agent's Contact Name	Contact's Telephone Number	Contact's Email Address (if applicable)

17. **I understand and agree to comply with all items numbered 1-16 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. No photocopies or facsimile signatures will be accepted.**

Provider Business Name (print)	State Provider Identification Number (Only one ID per Agreement see instructions)
Provider's Name* or Authorized Representative's Name**	Title as applicable (print)
Signature of Provider* or Authorized Representative**	Date of Signature

**Individuals and sole proprietors must sign their own enrollment agreement form.*

***An authorized representative is the duly appointed official of any business organized under the laws of the state of Alaska or other state, to operate as a corporation, partnership, LLC, joint venture, or similar organization ("entity"), who has the legal authority to enroll the entity in the Alaska Medical Assistance program, to make changes and/or updates to the enrollment status of the entity, and to commit the entity to the terms and conditions set forth in this enrollment application. The authorized representative must be a general partner, chairman of the board, chief financial officer, chief executive officer, president, or direct owner of at least 5% or more of the entity seeking enrollment, or must hold a position of similar status.*

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



Claims Enrollment Instructions

To start sending your claims electronically to Medicaid of Alaska through EDS you will need to follow the instructions below. (* indicates required field)

* Payer Name	Medicaid of Alaska
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A. Provider Information

* Provider Name			
* Provider Address			
Street			
City	State/Province	Zip Code/Postal Code	

B. Provider Identifiers Information

* Provider Identifier(s)		
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)		
National Provider Identifier (NPI)		

Authorized Signature

Electronic or Printed Signature of Person Submitting Enrollment

Printed Name & Title of Person Submitting Enrollment



Claims Enrollment Instructions

Provider Instructions

Provider Information:

Provider Name - Complete legal name of institution, corporate entity, practice or individual provider

Provider Address

- **Street** - The number and street name where a person or organization can be found
- **City** - City associated with provider address field
- **State/Province** - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
- **Zip Code/Postal Code** - System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
- **Country Code** - ISO-3166-1 Country Code

Provider Identifiers Information:

Provider Identifiers

- **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)** - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
- **National Provider Identifier (NPI)** - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

Electronic Remittance Advice Information:

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) - Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment

- **Provider Tax Identification Number (TIN)**
- **National Provider Identifier (NPI)**

Submission Information:

Reason for Submission:

- **New Enrollment**
- **Change Enrollment**
- **Cancel Enrollment**

Authorized Signature

The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

- **Electronic Signature of Person Submitting Enrollment**
- **Written Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
- **Printed Name of Person Submitting Enrollment** - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
- **Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment

800.482.3518

400 Vermillion St. Hastings. MN 55033