Medicaid of Kentucky

Attention Providers:

To start sending your claims electronically to Medicaid of Kentucky through EDS, you will need to print and review the enrollment form. Please sign the form and submit to EDS using one of the methods below.

Payer:	Medicaid of Kentucky
Payer ID:	CKKY1
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482-3518 or Enrollment@edsedi.com
Payer Enrollment Applications:	**Agreement Between the Kentucky Department for Medicaid Services and Electronic Billing Agency**
Upload, Email or Fax Applications to :	Enrollment@edsedi.com.com Fax (651)389-9152
Processing Time:	Payer estimates 5-7 business days from date of submission to payer. EDS will notify you of approval.

MAP-246
(Rev 09/10)

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 DentalXChange 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. 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.

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

SIGNATURE, AUTHORIZED AGENT OF BILLING AGENCY	**DATE**
(Contact Person) (First and Last Name)	**(Telephone Number)**

5010 Contact information

To ensure the dissemination of 5010 information is communicated to the appropriate contact, please complete the section below.

9900001797 DentalXChange
(10 digit Trading Partner ID, begins with 99) (Clearinghouse, Software and/or Billing Agent Contact)

17701 Cowan, Suite 250 Irvine, Ca 92614
(Mailing Address)

enrollment@dentalxchange.com (800) 576-6412
(Email Address) (Telephone Number)

Please return form to:
Electronic Claims Submission
P.O. Box 2016
Frankfort, KY 40602-2016
Phone: (800) 205-4696
Fax: (502) 209-3242
Email: ky_edi_helpdesk@hp.com

MAP-380
(Rev 09/10)

Agreement Between the Kentucky Department for Medicaid Services And the Kentucky Medicaid Provider

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

This addendum to the Provider Agreement is made and entered into as of the _____ (Day) day of _____ (Month) _____ (Year) by and between the Commonwealth of Kentucky, Cabinet for Health and 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 for Health and Family Services, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medicaid Program (KMP).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 Medicaid Program (KMP). as

_____ (Type of Provider) _____ (Provider Number) _____ (National Provider Identifier (NPI))

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 members of the Kentucky Medicaid Program (KMP) via electronic media rather than via paper forms prescribed by the KMP.

   B. Agrees to assume the 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 KMP. 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 Electronic Data Interchange (EDI) 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.

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

(Provider)

(Provider Signature)

(Contact Person) (First and Last Name)

(Title)

(Date)

(Telephone Number)

(Software Vendor and/or Billing Agency)

(Media)

5010 Contact information
To ensure the dissemination of 5010 information is communicated to the appropriate contact, please complete the section below.

9900001797
(10 digit Trading Partner ID, begins with 99)

DentalXChange
(Clearinghouse, Software and/or Billing Agent Contact)

17701 Cowan, Suite 250 Irvine, Ca 92614
(Mailing Address)

enrollment@dentalxchange.com
(Email Address)

(800) 576-6412
(Telephone Number)

Please return form to:
Electronic Claims Submission
P.O. Box 2016
Frankfort, KY 40602-2016
Phone: (800) 205-4696
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