PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR INDIVIDUALS)

1	2	3	4	5	6	7

Louisiana Medicaid Provider Number (7 digits)

4	5	0	3	8	2	1

Submitter Number (7 digits)
(leave blank if applying for a new number)

1	2	3	4	5	6	7	8	9	0

National Provider Identifier (NPI) (10 digits)

Name of Individual Enrolling: THERAPIST NAME

Billing Agent/Submitter Name/Name of Business that will be submitting claims (provider name or Third Party Biller's name): Trizetto Provider Solutions, LLC

Name of Contact Person: Provider Enrollment Department

Contact Phone Number: 800-969-3666

The Medicaid File can hold a maximum of three Submitter Numbers per Medicaid Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise requested by the provider. It is also vital to identify which Submitter Number will be designated to download the Electronic Remittance Advices (ERA).

In order for Louisiana Medicaid to gather this information, complete the following, if applicable:

When a new Submitter Number is issued, it will be set up to retrieve ERAs. If a previously assigned Submitter Number is to be used to retrieve ERAs as well, then place it in the spaces provided below.

4	5	0	3	8	2	1

☑ By checking this box you are giving authorization to have 835s produced for the Individual listed above and available for download by either this new submitter number or the previously assigned submitter number.

List other Submitter Number(s) that are currently on file which will NOT be used for 835 ERA, but which need to remain open in the spaces below:

4	5	0				
4	5	0				

☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.

☑ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter, etc.) to submit my claims electronically to Louisiana Medicaid. **(Power of Attorney form is required.)**

PROVIDER ACKNOWLEDGMENT

1. I attest that all information supplied with this Agreement is true, accurate, and complete.
2. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims bhy means of the electronic media claims processing method in accordance with Paragraphs 1 through 16 below. This is done in consideration for the Louisiana Department of Health, Bureau of Health Services Financing's (hereinafter referred to as "LDH") processing of provider claims, as well as other valuable considerations.
3. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for my EDI submission will be set by Provider Enrollment once the contract has processed.

Provider Name: THERAPIST NAME

4. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to LDH.
5. The Provider shall provide upon request of LDH any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, data submissions, flow charts, file descriptions, accounting procedures, etc.
6. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims.
7. It is expressly understood that LDH or its Fiscal Intermediary (Molina Medicaid Solutions) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
8. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to their provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
9. LDH and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
10. The Provider agrees to submit to LDH, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
11. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
12. The Provider and LDH agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
13. Further, for a period of five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying at no cost.
14. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify LDH's limited obligations as set in a certain Provider Agreement between LDH and the Provider.
15. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
16. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
17. **Applicable to those receiving 835s:** I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in Electronic Funds Transfer, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request.

Printed Name of the Individual Provider

Signature of the Individual Provider

Date of Signature

INDIVIDUAL
MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY
(EDI POWER OF ATTORNEY)

This form is required by all providers who will have electronic claims submitted by a third party.

1	2	3	4	5	6	7

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(leave blank if applying for a new number)

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National Provider Identifier (NPI) (10 digits)

Name of Individual Enrolling: THERAPIST NAME

Practice Street Address: Therapist's Street Address

Billing Agent /Submitter Business Name: Trizetto Provider Solutions, LLC

Billing Agent /Submitter Contact Person: Provider Enrollment Department

Billing Agent /Submitter Phone Number: 800-969-3666

BE IT KNOWN that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of _____ , State of Louisiana, therein residing:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing / Submitter Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program the applicable claims, by provider type, for electronic submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____ ,
State of _____ on the _____ day of _____, 20___.

_____
Signature of the Individual Provider

_____
Notary Public Signature

_____
Printed Name of the Individual Provider

Notary Seal or Notary Identification Number (required)

Revised 11.2017

INDIVIDUAL EDI ENROLLMENT AGREEMENT

Welcome to *EasySteps* Billing. We want to make each step of joining our team as easy as possible, so we have completed the forms required by Medicaid for you. The attached form will add TriZetto, our clearinghouse, to your Louisiana Medicaid account allowing you to bill through them electronically. You will have to sign and date, get one notarized, and mail them to the address below. After receiving the forms, Medicaid will process your documents and mail a confirmation letter of your enrollment to you. According to LA Medicaid, this should take approximately 18 business days; however it may take longer. You can call LA Medicaid at 225-216-6370 to check on the status of your enrollment which usually speeds the process. Once you have received confirmation from Medicaid and send us a copy of the confirmation letter, we will run a few test claims and activate your electronic billing.

Please review the contract to make sure all information is accurate. Please update your provider page if your information needs to be updated and print new forms.

The first 2 pages are the EDI Enrollment agreement that we have filled out for you. An original signature and date in blue ink are required at the bottom of page 2. The second page is the Medicaid Electronic Media Limited Power of Attorney, which must be notarized.

Please mail completed forms to:

EDI - Gainwell

P.O. Box 80159

Baton Rouge, LA 70898-0159

Please Note:

Our clearinghouse requires a copy of the acceptance letter before we can submit claims electronically. EasySteps Billing cannot be activated until you email/text us a copy of your EDI approval letter.

If you do not receive the EDI approval letter by mail, you can contact Louisiana Medicaid at 225-216-6370 and request they to send you the letter again (confirm they have your correct mailing address). If you call Medicaid, ask for the date your electronic claim submission request was accepted and let us know. *This will speed up the process!*