220 Burnham Street ● South Windsor CT 06074
Vox 888-255-7293 ● Fax 860-289-0055

LOUISIANA MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

<table>
<tr><td>PAYER ID NUMBER</td><td>EPSDT - CKLA1
ADULT - CKLA2</td></tr>
<tr><td>ELECTRONIC REGISTRATIONS

Agreements Required</td><td>Emdeon Business Services Provider Enrollment Form
• Please complete all requested information.

Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract)

Pg 1: Fill in 7 digit billing provider number.
Fill in billing provider name
Fill in effective date of change in Billing Agent
Please leave all other information blank as it does not apply.

Pg 2: Print name of person completing the form
Fill in phone number of person completing form
Complete with original Provider or authorized agents signature
Date

Medicaid Electronic Media Limited Power of Attorney

Please complete this in the presence of a Notary Public.
Your original signature will be required.

• Please fill in the billing provider number, billing provider name and rendering address.</td></tr>
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emdeon™
business services

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SPECIAL NOTES	• Effective May 1, 2007 letters are mailed to providers confirming enrollment, linkages to groups, linkages to submitter numbers, and confirming changes to effective dates of enrollment. Third parties are to obtain and verify all provider information directly with the provider. ▪ Medicaid *Electronic Media Limited Power of Attorney* **must be notarized**. ▪ Group practices should complete the **Provider's Election to Employ Electronic Media Submission of Claims for Processing in the Louisiana Medical Assistance Program** and **Medicaid Electronic Media Limited Power of Attorney** using the **billing** provider name and number. The Emdeon Business Services Provider Enrollment Form should include the **billing and rendering** provider names and numbers. ▪ **An EDI Annual Certification of Electronically-Submitted Medicaid Claims in required to be filed with the Louisiana Medical Assistance Program. Failure to submit the certification may result in the denial of electronic claims.**
SEND REGISTRATION FORMS TO:	**Please mail completed original forms to:** **Emdeon Business Services** **220 Burnham Street** **South Windsor, CT 06074** **Attn: Provider Enrollment**
ENROLLMENT CONFIRMATION	Effective May 1, 2007 providers are responsible for notifying Emdeon Business Services when they receive their letter of approval from Unisys. Emdeon is no longer able to confirm enrollment status with Unisys and will need to be faxed the approval letter which Unisys has mailed to the provider. The provider may fax their approval letter to 860-289-0055. Once the approval letter is received by Emdeon and recorded in our systems Emdeon will notify the provider or their software vendor.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	Louisiana Medicaid Provider Relations 800-473-2783 or 225-924-5040 Emdeon Business Services 888-255-7293

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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Louisiana Medicaid – payer IDs CKLA1 AND CKLA2**

Provider/Organization Name: ____

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

Software Vendor: ____

Group Number: ___________________________
(If applicable)

Group NPI Number: ________________________
(if applicable)

Name	Rendering Number	NPI

Address: ____

City, State, Zip Code: ____

Office Contact Name: ____

Telephone Number: __________________ Fax Number: ________________

Date: ______________________________

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

Provider Number (7 digits)

4	5	0	2	9	7	5

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

Provider Name: ________________

Billing Agent/Submitter Name: CPS - Louisiana

Contact Name of Person Completing the Form: ________________ Contact Phone #

Will this **new** Submitter Number be used to retrieve 835 Electronic Remittance Advices (ERA)? ☐ Yes ☐ No

If you checked the **No** box, please provide the Submitter Number that will be used to retrieve 835 ERA in the spaces below. If spaces below are left blank, no electronic 835 ERA will be provided.

4	5	0				

☐ I am an enrolled Louisiana Medicaid provider and wish to submit my own claims electronically to Louisiana Medicaid.

☐ I am an enrolled Louisiana Medicaid provider and wish to use a Third Party to submit my claims electronically to Louisiana Medicaid.

1. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 13 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.

2. 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.

3. 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 the State Agency.

4. The Provider shall provide upon request of the director of the State Agency supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.

5. 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 the Annual Certification form . A copy of the said certification statement is attached and is hereby incorporated by reference into this paragraph.

6. It is expressly understood that the State Agency or its Fiscal Intermediary (Unisys) 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.

7. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.

8. The State Agency 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.

9. The Provider agrees to submit to the State Agency, 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.
10. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
11. The Provider and the State Agency 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.
12. 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.
13. 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 the State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.
14. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
15. 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.
16. I attest that all information supplied with this Agreement is true, accurate and complete.

SIGN HERE

______________________________	______________________________
Print Name of Person Completing Form	Signature of Provider or Authorized Agent
______________________________	______________________________
Phone Number of Person Completing Form	Date of Signature

Issuance of submitter number or linkage of third-party billing number denotes acceptance of this agreement by the Louisiana Department of Health and Hospitals

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.

POWER OF ATTORNEY OR PROCURATION | UNITED STATES OF AMERICA

Provider Number (7 digits)

4	5	0	2	9	7	5

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

Provider Name: ______________________

Provider Address: ______________________

____

Billing Agent Name: CPS - Louisiana

Billing Agent Address: 220 Burnham Street

South Windsor, CT 06074

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 and in the presence of the witness hereinafter named and undersigned:

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 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 for the provider type for magnetic tape, diskette, or telecommunication 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, and the undersigned competent witnesses, in the City of ____________, State of ______________on the ____ day of ____________, 20___.

______________________ Signature of Provider or Authorized Agent

______________________ Notary Public Signature

Notary Seal (required)