PAYER ID: SUBMITTER ID:

Emdeon Claims Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization

Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	

2 Vendor *(Emdeon certified vendor used to submit files to Emdeon)*

Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					

3 Payer

Payer ID		
Group ID	Individual Provider ID	NPI ID

4 Confirmations

Send Emdeon Claim Confirmations To:	

Special Instructions:

- All Payer Registration forms must contain original signatures, NO stamped signatures or photocopies are accepted.

- SUBMIT COMPLETED FORM TO:
  Emdeon
  Donelson Corporate Ctr Bldg 3
  3055 Lebanon Pike Ste 1000
  NASHVILLE, TN 37214-2230

EMDEON REVISION FORM DATE:

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 (*To be completed by the "Provider"*)	
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)).

Section I. Terms of Agreement, continued (*To be completed by the "Provider"*)	
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.
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.	I plan to submit the following: (Check only one) ☐ Non-HIPAA-Compliant Information ☐ HIPAA-Compliant Information
17.	(a) I will be sending *claims* in the following format: (Check all that apply) ☐ Paper ☐ Electronic (b) I will be sending *other information* in the following format: (Check all that apply) ☐ Paper ☐ Electronic
18.	I, or my billing agent on my behalf, intend to submit the following types of transactions: ☐ Eligibility Request/Response (270/271) ☐ Claims Status Request/Response (276/277) ☐ Prior Authorization Request/Response (278/278) ☐ Remittance Advice (835) ☐ Dental (837 D) ☐ Institutional (837 I) ☐ Professional (837 P) ☐ Pharmacy (NCPDP- batch) ☐ N/A (Not Applicable)
19.	I will be sending claims and other information: (Check only one box) *a.* ☐ Directly from my *office system to the State* *b* ☐ *Through PayerpathSM to the State (if so, skip to #21)* *c.* ☐ *Through Point of Sale to the State (if so, skip to #21)* d. ☐ Through a *Billing Agent or Clearinghouse* to the State (if so, skip to #21)

20. Software Vendor Information: (Complete this item only if box 19a is checked)

Vendor Name ____ Telephone number ____ Fax Number ____

Vendor Address ____ City ____ State ____ Zip+4 ____

Vendor Contact Name ____ Contact Telephone Number ____ Contact E-Mail Address (if available) ____

21. 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)*:

Emdeon — Billing Agent's Business Name
866.924.4634 — Billing Agent's Telephone Number
615-231-4843 — Billing Agent's Fax Number

3055 Lebanon Rd — Billing Agent's Mailing Address
Nashville — City
TN — State
37214- — Zip+4

SAME — Billing Agent's Physical Address
City ____ State ____ Zip+4 ____

Enrollment Help Desk — Billing Agent's Contact Name
866-924-4634 — Contact's Telephone Number
payerregistration@emdeon.com — Contact's E-Mail Address (if applicable)

22. Contact Person's Information: This section is to be completed with the name(s) and telephone number(s) of the individual(s), other than yourself or the billing agent listed above, who can answer questions about the information furnished in this Information Submission Agreement. You do not need to furnish any names if you want all questions directed to you. Check here ☐ if you want all questions directed to you.

Contact Name ____ Contact Telephone number ____ Contact Fax Number ____

Contact Address ____ City ____ State ____ Zip+4 ____

Contact E-Mail Address ____

23. **I understand and agree to comply with all items numbered 1-22 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 an appointed official to whom the provider has granted the legal authority to enroll the provider in the Medicaid program, to make changes and/or updates to the provider's status in the Medicaid program (e.g., new practice locations, changes of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider's organization, or must hold a position of similar status and authority within the provider's organization.***

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

Section IV. To Be Completed by the State or its Designee

		Begin date	End date
Test Submitter # assigned to this Provider	_______________	__________	_____________
Production Submitter # assigned to this Provider	_______________	__________	_____________

Termination effective date: ________________ Date termination notification received:___________________

Hard copy file updated______________________ MMIS file updated: _____________

______________________ _____________

______________________ _____________

Electronic submitter file updated: ______________________ __________________ _____________