

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:	
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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

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EMDEON REVISION FORM DATE:

Annual Certification Information

All claims submitted to Louisiana Medicaid electronically via a 450XXXX number must be certified using the EDI Annual Certification of Electronically-Submitted Medicaid Claims form.

- An Annual Certification form is required prior to submission into production.
- The form must be submitted annually in order to update provider / submitter data.
- The purpose of the annual certification is to ensure that submitters understand that claims they submit for the year must meet LA Medicaid guidelines.
- Failure to maintain annual certification will result in the deactivation of the submitter number.

If the 450XXXX number belongs to a third party biller, clearinghouse, or billing agent, then it is the third party's responsibility to maintain the annual certification via the form. It is NOT the provider's responsibility to certify annual—it is the submitters.

If the 450XXXX and the 7-digit Louisiana Medicaid number belong to the same provider or provider group, then it is the provider's responsibility to complete this form when requesting a new submitter number and to maintain it annually thereafter.



State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

November 6, 2009

Dear Submitter:

All submitters must have a 2010 Annual Certification Form on file with Louisiana Medicaid. This form must be on file to allow ongoing submission of electronic claims. **The deadline for the completed Annual Certification form is December 31, 2009.**

Enclosed is the following form:

- Annual Certification Form for calendar year 2010

ACTION NEEDED:

The enclosed form **MUST** be completed and returned to the address below on or before December 31, 2009. **Failure to submit a completed Certification form will result in closure of the submitter number and all electronic files will be dropped from the system without being processed.**

Please return to this address

Unisys – EDI Department
P O Box 91025
Baton Rouge, LA 70821-9025

PROVIDER RESPONSIBILITY: If the provider is submitting directly to Medicaid with their own submitter ID the provider must ensure that all rules and regulations are followed. If the provider is using a billing agent/clearinghouse for claims submission they must ensure a similar certification form is sent to their submitter for their records. The provider should also ensure that all claims are true, accurate and complete.

THIRD PARTY BILLERS:

It is the responsibility of each third-party biller to ensure that similar certification forms are received from each provider for whom they submit electronic claims to Louisiana Medicaid. These forms must include language where the provider attests to the truth, accuracy and completeness of all claim information and that the provider understands that all claims are paid using Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These provider Certification forms must be kept on file for a minimum of five (5) years.

FUTURE CERTIFICATION FORMS:

During the 4th Quarter of each year, correspondence will be mailed to all open submitters requesting an updated Annual Certification Form. This form must be submitted by December 31 of each year. Failure to submit the updated Certification Form timely will result in termination of the submitter number thus preventing the ability to transmit electronic claims to Louisiana Medicaid.

Please contact the EDI Department at 225/216-6303 regarding all questions.

Sincerely,

Handwritten signature of Jerry Phillips in cursive.

Jerry Phillips
Medicaid Director

EDI ANNUAL CERTIFICATION OF ELECTRONICALLY-SUBMITTED MEDICAID CLAIMS

2010

Certification Period: January 1, to December 31, 2010

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4	5	0	0	7	4	4
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Provider Number (7 digits) – If submission contains files for more than 1 provider, list ALL provider numbers and attach to this Certification.

National Provider Identifier (10 Digits)

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Submitter Name: EMDEON

Primary Contact Name: ENROLLMENT HELP DESK Email address: PAYERREGISTRATION@EMDEON.COM

Secondary Contact Name: _____ Email address: _____

o Submissions by Provider Rendering Services Using their own Submitter ID:

I certify that all services rendered during the above identified Certification Period were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claims information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistance Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

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

o Submissions by Third Party Biller (Billing Agents/Clearinghouses) Using their Submitter ID:

I certify that the claim information submitted to Louisiana Medicaid is an exact duplicate of detailed claim line information received from the provider and has not been materially altered or revised except for translation to the current 837 transaction format or insertion of minor data such as provider number or recipient number. I certify that the information submitted in electronic format is true, accurate and complete as received from the provider. Additionally, I understand that payment of these 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.

I also certify that provider(s) with whom I have a direct relationship have furnished me with an EDI Annual Certification of Medicaid Claims Submitted Electronically Form on which the provider has attested to the truth, accuracy and completeness of the claim information. If I do not have a direct relationship with submitting providers (for instance, if the relationship is with a vendor), Louisiana Medicaid understands that I will not have an EDI Annual Certification Form from the individual(s) or entity(ies) with whom I do not maintain a contractual relationship. I agree to maintain all forms I am required to collect for a period of five (5) years.

Attach a list of provider(s) name(s) and identification numbers.

Identify all claim types that will be submitted during this Certification Period:

CLAIM TYPE 837P 837 I 837 D Non-Ambulatory Transportation Case Management Other:

DATE

SUBMITTER SIGNATURE (ORIGINAL)

NOTE: Updated certification forms MUST be submitted annually. Failure to maintain a completed Certification Form on file will result in the closure of the submitter number without notice to submitter. All files submitted with closed submitter numbers will be dropped from the system without being processed.

Submit to: Unisys – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025 Phone #: 225/216-6303
Or: 8591 United Plaza Blvd., Bldg. V, Suite 300, Baton Rouge, LA 70809

Entity / Business
Louisiana's Medicaid Program
INSTRUCTIONS FOR PROVIDER'S ELECTION TO EMPLOY
ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING
IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

Prior to submitting electronic claims to Louisiana Medicaid, a seven-digit submit number (450XXXX) must be obtained from the Unisys Provider Enrollment Unit. The submitter number must be linked to all provider numbers for whom claims will be submitted.

The following form(s) is (are) to be completed if the Entity / Business enrolling at this time plans to submit claims electronically to Louisiana Medicaid.

EDI Contract

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Unisys. (Leave blank if applying for new Provider Number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted.

Note: Atypical providers leave this blank.

Doing Business As Name of Enrolling Entity – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

Name of Contact Person – enter the name of the person designated as the point of contact for questions regarding this request.

Contact Phone Number – enter the phone number of Contact Person.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Billing Agent / Submitter Business Name – enter the business name of the billing / submitting agent.

Signature of Authorized Representative – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Date of Signature – enter the date the authorized representative signed the form.

EDI Power of Attorney

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Unisys. (Leave blank if applying for a new Provider Number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted.

Note: Atypical providers leave this blank.

Doing Business As Name of Enrolling Entity – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

Business/Practice Address – enter the address of the provider name entered.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Billing / Submitter Agent Business Name – enter the business name of the billing / submitter agent.

Billing / Submitter Agent Contact Person – enter the name of the person designated as the point of contact for the Billing / Submitter Agent business.

Billing / Submitter Agent Phone Number – enter the phone number of the Billing / Submitter Agent contact person.

Enter the Parish (or County) Name where the Notary Public is located

Enter City, State and Date of Notarization

Signature of Authorized Representative – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Notary Public Signature – the Notary Public should sign the form and affix his/her seal

**If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed Limited Power of Attorney in its entirety to be mailed with your completed EDI Contract.

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

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Louisiana Medicaid Provider Number (7 digits)

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National Provider Identifier (NPI) (10 digits)

DBA Name of Enrolling Business / Entity:

Name of Contact Person: _____

Contact Phone Number: _____

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

Billing Agent/ Submitter Name / Name of Business that will be submitting claims
(provider name or third party biller's name):

EMDEON

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				
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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				

<input type="checkbox"/>	I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.
<input checked="" type="checkbox"/>	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.)

- 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 16 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.
- 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: _____

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 any 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 electronic claims and 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.
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

Print the Name of the Authorized Representative

Title / Position of Authorized Representative

Signature of Authorized Representative

Date of Signature

**ENTITY / BUSINESS
 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.

	4	5	0	0	7	4	4
Louisiana Medicaid Provider Number (7 digits)	Submitter Number (7 digits) (leave blank if applying for new number)						
	Billing / Submitter Agent Business Name: EMDEON						
National Provider Identifier (NPI) (10 digits)	Billing / Submitter Agent Contact Person: ENROLLMENT HELP DESK						
Doing Business As Name of Enrolling Entity (Provider Name):	Billing / Submitter Agent Phone Number: 866.924.4634						
Business/Practice Address:							

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 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, in the City of _____, State of _____ on the _____ day of _____, 20____.

 Signature of Authorized Representative

 Notary Public Signature

 Print Name of Authorized Representative

*Notary Seal or Notary Identification Number
 (required)*