Submitter/Provider Relationship EDI Agreement (Form EDI-201)

All New Jersey Medicaid and Charity Care Providers desiring to submit HIPAA formatted electronic claims must complete a New Jersey Medicaid HIPAA 837 Claims EDI Agreement. The various EDI agreements used by New Jersey Medicaid and the corresponding instructions for their completion are provided later in this section. The EDI Agreement and HIPAA certification received for the specified HIPAA transaction sets must be prior approved and on file with Molina Medicaid Solutions before HIPAA formatted claims may be submitted electronically. Molina Medicaid Solutions will notify the EDI Submitter of New Jersey Medicaid's approval for the submission of HIPAA formatted electronic claims.

Submitters who are currently enrolled with Molina Medicaid Solutions for the submission of HIPAA 4010A1 formatted electronic claims and have completed and returned the Addendum to the existing EDI Agreement along with a 5010 HIPAA Certification do NOT have to complete the EDI Agreements included in this Companion Guide. The Addendum Agreement replaces the previously executed EDI Agreement on file with Molina Medicaid Solutions.

All other providers/submitters who have not been approved to submit claims electronically with Molina Medicaid Solutions must complete one of the following New Jersey Medicaid EDI Agreements.

- If the provider/submitter intends on submitting the claims directly to New Jersey Medicaid, then the **HIPAA 837 Claims EDI Agreement (Form EDI-101)** must be completed and returned to the Molina EDI Unit. In addition, a copy of the HIPAA certification form certifying their capability to produce HIPAA compliant transactions must be included as an attachment to the EDI agreement. Only after the agreement and certification have been received and accepted by the Molina EDI unit will a Submitter ID be assigned.

- A new agreement must be completed when a provider or billing service changes ownership or name of the company and a new HIPAA Certification is also required to be provided.

- It is the responsibility of each submitter to notify the EDI UNIT if there is a change in address, contact information or email address. Please use the EDI SUBMITTER UPDATE form.

- In addition, a completed **Submitter/Provider Relationship EDI Agreement (Form EDI–201)** for each New Jersey Medicaid Provider Number under which claims will be submitted needs to be completed and returned with the **HIPAA 837 Claims EDI Agreement (Form EDI-101).**

- New Jersey Medicaid and Charity Care providers who are submitting claims directly to Molina Medicaid Solutions that have already been assigned a Submitter ID must complete a **Submitter/Provider Relationship EDI Agreement (Form EDI–201)** for each Billing/Pay-to New Jersey Medicaid provider number they will be billing for.

- New Jersey Medicaid and Charity Care providers who are submitting claims through a Clearing House/Billing Service are required, along with the Clearing House/Billing Service, to complete a **Submitter/Provider Relationship EDI Agreement (Form EDI–201).** A separate agreement is required for each Billing/Pay-to New Jersey Medicaid provider number.

- New Jersey Medicaid and Charity Care providers wishing to receive their remittance advice information electronically must complete the **Submitter Electronic Remittance EDI Agreement (Form EDI–801).**

Providers using a billing service to submit HIPAA formatted electronic claims must complete the **Submitter/Provider Relationship EDI Agreement (Form EDI–201**) along with the billing service. The billing service is responsible for ensuring that each provider properly completes and submits these agreements to Molina Medicaid Solutions. If the agreement is not properly completed, it will be returned to the submitter/billing service for proper completion.

Providers must notify Molina Medicaid Solutions in writing when the use of a billing service for the submission of electronic claims has been terminated. When a provider changes billing services, the new billing service must ensure that the provider completes a new EDI Agreement form and submits it to Molina Medicaid Solutions along with a copy of the HIPAA certification form. Molina Medicaid Solutions will notify the billing service when approval to submit claims electronically has been granted.

Providers must notify Molina Medicaid Solutions in writing when their use of a software developer's application for the direct submission of electronic claims to Molina Medicaid Solutions has been terminated. When a provider changes to a new software product, the provider must complete a new **Submitter/Provider Relationship EDI Agreement (Form EDI–201**) and submit it to Molina Medicaid Solutions along with a copy of the HIPAA certification form. Molina Medicaid Solutions will notify the provider when approval to submit claims electronically has been granted.

All New Jersey Medicaid HIPAA EDI Agreements **MUST** be submitted to Molina Medicaid Solutions with **ORIGINAL** signatures. Facsimile copies of agreements will **NOT** be accepted. If the agreement is not properly completed, Molina Medicaid Solutions will return it for proper completion.

Submitter/Provider Relationship EDI Agreement (Form EDI–201) – Instructions

WHO SHOULD COMPLETE THIS AGREEMENT?

WHAT IF I AM THE PROVIDER AND SUBMIT MY CLAIMS DIRECTLY TO NEW JERSEY MEDICAID?

Providers who are submitting their claims directly to New Jersey Medicaid will need to complete an agreement for each of their New Jersey Medicaid billing/pay-to provider numbers. In this case, the provider is considered to serve as both the submitter and the provider. In most cases a provider submitting their claims directly to New Jersey Medicaid will be submitting claims under a single New Jersey Medicaid billing/pay-to provider number. However, there are cases where the provider may have been issued multiple New Jersey Medicaid billing/pay-to provider numbers. When this occurs, a separate agreement is required for each provider number.

WHAT IF I USE A CLEARINGHOUSE/BILLING SERVICE TO SUBMIT THE CLAIMS TO NEW JERSEY MEDICAID ON MY BEHALF?

Providers who are submitting their claims to New Jersey Medicaid through a Clearing House/Billing Service must also execute a **Submitter/Provider Relationship EDI Agreement (Form EDI–201**) with the Clearing House/Billing Service and the completed agreement must be returned to the Molina EDI Unit for processing. A separate agreement is required for each New Jersey Medicaid billing/pay-to provider number.

In this case, the Submitter (or the Clearing House who owns the NJ Submitter ID completes Section 1 of the agreement and the provider completes Section 2 of the agreement.

Section 3 is to be completed by the provider to identify the software that is being used within the provider's office to capture the claims data and to then send that claims data to the Clearing House/Billing Service.

SECTION 1: SUBMITTER INFORMATION

For the ☐**MEDICAID**, or ☐**CHARITY CARE** check boxes located at the top of the form, indicate the type of claims for which you will be submitting electronic claims. Check **one** box only. A separate New Jersey Medicaid HIPAA EDI Agreement is required for each provider number you will be electronically submitting claims for unless the provider is a group practice and the group is responsible for the billing of the individual providers associated with the provider group.

1. **Submitter Name**: Enter the name of the Provider or Clearing House/Billing Service Name as registered with New Jersey Medicaid/Molina Medicaid Solutions.

2. **Submitter ID:** Enter the Submitter ID as assigned by Molina Medicaid Solutions.

3. **Submitter Street Address**: Enter the physical street address of the Provider or Clearing House/Billing Service. This MUST be a physical address. If a P.O. Box is entered in this area, the document will be rejected and returned for correction.

4. **City, State, Zip Code**: Enter the city, state and zip code. This MUST be part of the physical address.

5. **Submitter Representative's Signature**: This MUST be an original signature of the Provider or Clearing House/Billing Service. THIS MAY NOT BE STAMPED. This person should have liability authority of the business.

6. **Date Signed**: Date signature was placed on this form.

7. **Submitter Representative's Name**: PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 5 above).

8. **Submitter Representative Telephone Number/Ext:** Enter the phone number along with the extension of a person from your company in the event Molina Medicaid Solutions needs to contact someone in reference to their electronic file submission.

9. **FAX:** Enter the FAX number of your place of business.

10. **Submitter Representative Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your Submitter file profile. This email address will be used to contact someone from your company concerning the electronic file submission or allow you to submit HIPAA electronic claims.

11. **2nd Submitter Contact Person:** Enter the name of a person in the event Molina Medicaid Solutions needs to contact someone from your company. This person's name will be entered as part of your Submitter file profile. This person's name will be used to confirm a provider has been linked to your Submitter ID, preferably someone in the Enrollment Department who handles the EDI Agreement applications.

12. **Phone/Ext:** Enter the secondary phone number along with the extension of a person from your company in the event Molina Medicaid Solutions needs to contact someone.

13. **2nd Submitter Contact Person Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your Submitter file profile. This email address will be entered as part of your Submitter file profile. This email address will be used to confirm a provider has been linked to your Submitter ID, preferably someone in the Enrollment Department who handles the EDI Agreement applications.

SECTION 2: PROVIDER INFORMATION

NOTE: THIS INFORMATION SHOULD ONLY BE THE INFORMATION OF A NEW JERSEY MEDICAID PROVIDER. IF YOU ARE A SECONDARY BILLING SERVICE, PLEASE ADD A SUPPLEMENTARY SECTION 3 AND PLACE BILLING SERVICE INFORMATION ONLY IN SECTION 3.

14. **Action Requested:** Please check appropriate box if you are either adding a new provider number to be linked to your Submitter ID or terminating an existing provider from your Submitter ID.

15. **Provider Name:** Enter the BUSINESS name of the provider as they are registered with Molina Medicaid Solutions.

16. **New Jersey Medicaid Provider Number:** Enter the New Jersey Medicaid Provider number assigned to the provider by Molina Medicaid Solutions. In the case of a GROUP PRACTICE, the New Jersey Medicaid provider number assigned to the group practice should be used. If a provider practices as a sole practitioner, then his individual number may be used.

17. **NPI Number:** Enter the NPI number of the provider as assigned by NPPES and registered with Molina Medicaid Solutions.

18. **Provider Street Address:** Enter the physical street address of the provider's place of business or service address as it is registered with Molina Medicaid Solutions. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

19. **City, State, Zip Code:** Enter the city, state and zip code. This **MUST** be part of the physical address.

20. **Provider EDI Contact Person:** Enter the name of a person from the provider's place of business in the event Molina Medicaid Solutions needs to contact someone at the provider level. (This must be someone at the provider's place of business. If a provider chooses to use a secondary billing service, the billing service information should be place in Section 5.

21. **Phone/Ext:** Enter the phone number along with the extension of a person from the provider's or place of business in the event Molina Medicaid Solutions needs to contact someone. This phone number is used to verify a current phone number is on file for the provider.

22. **FAX:** Enter the FAX number of the provider's place of business.

23. **Email Address:** PLEASE PRINT CLEARLY. Enter the email address of a contact person from the provider's place of business in the event Molina Medicaid Solutions needs to contact someone.

24. **Provider Representative's Signature**: This MUST be an actual signature of the New Jersey provider business owner. THIS MAY NOT BE STAMPED. This person should have liability authority of the business.

25. **Date Signed**: Date signature was placed on this form.

26. **Provider Representative's Name**: PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 24 above).

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

27. **SOFTWARE VENDOR NAME:** Enter the BUSINESS name of the Software Vendor.

28. **STREET ADDRESS:** Enter the physical street address of the software vendor. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

29. **CITY, STATE, ZIP CODE:** Enter the city, state and zip code. This **MUST** be part of the physical address.

30. **SOFTWARE CONTACT PERSON:** Enter the name of a person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.

31. **PHONE/EXT:** Enter the phone number along with the extension of a person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.

32. **SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the email address of a contact person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.

33. **2nd SOFTWARE CONTACT PERSON:** Enter the name of a secondary person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.

34. **PHONE/EXT:** Enter a secondary phone number along with the extension of a person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company.

35. **2nd SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the email address of a second contact person from the software company in the event Molina Medicaid Solutions needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.

36. **FAX:** Enter the FAX number of the software company.

37. **SOFTWARE PRODUCT NAME:** If a software company has multiple products, please enter the name of the product you are installing for the submission of the HIPAA transaction sets indicated in Section 3 above.

38. **SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME:** Please enter the release number of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 3 above.

39. **SOFTWARE PRODUCT RELEASE DATE:** Please enter the release date of the software product you are installing for submission of the HIPAA transaction sets indicated in Section 3 above.

Return the completed EDI Agreement to Molina Medicaid Solutions at the following address:

Via U.S. Mail
EDI UNIT
Molina Medicaid Solutions
P.O. Box 4804
Trenton, New Jersey 08650 – 4804

Other Carriers
EDI UNIT
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619

For Internal Use Only EMCAGREE			
DOCTYPE	Submitter ID	Submitter & Provider Name	
Update Initials	Date	QA Initials/Date	Provider Group Number

☐ 837-I-D-P
☐ E-RA
☐ SIGN
☐ ADD
☐ TERM

state of new jersey

Submitter/Provider Relationship EDI Agreement

☒ MEDICAID ☐ CHARITY CARE

SECTION 1: SUBMITTER INFORMATION

Every EDI submitter assigned a Submitter ID by New Jersey Medicaid must complete, sign and submit this New Jersey Medicaid Submitter/Provider Relationship Agreement before the submitter is authorized to submit claims for a New Jersey Medicaid Provider.

In some cases the submitter may be a New Jersey Medicaid provider and in other cases the submitter may be a third party Clearing House/Billing Service. Regardless, New Jersey Medicaid cannot process claims submitted with a specific Submitter ID for a specific New Jersey Medicaid provider number unless this agreement has been properly completed and submitted to New Jersey Medicaid or their designated agent. By signing this agreement the New Jersey Medicaid provider is authorizing the submitter to submit claims electronically to New Jersey Medicaid on their behalf.

A separate agreement is required for each New Jersey Medicaid Billing Provider Number.

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims 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, or both.

1) Submitter Name: Office Ally 2) Submitter ID: 9904204

3) Submitter Street Address: 1300 SE Cardinal Court, Suite 190
(P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

4) City, State, Zip Code: Vancouver, WA 98683

5) Submitter Representative's Signature (must be original) 6) Date Signed

7) Submitter Representative's Name – Please Print Clearly: Brian O'Neill

8) Submitter Representative Telephone Number/Ext: (360) 975-7000 Option 1 9) FAX: (360)896-2151

10) Submitter Representative Email Address: support@officeally.com

11) 2nd Submitter Contact Person: Customer Service 12) Phone/Ext (360) 975-7000 Option 1

13) 2nd Submitter Contact Person Email Address: info@officeally.com

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

Provider Name: ______________________________ Provider #: ______________

SECTION 2: PROVIDER INFORMATION

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims 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, or both.

14) Action Requested: ☐ Add New Provider ☐ Terminate Existing Provider

15) Provider Name: ______________________________

16) New Jersey Medicaid Provider Number: ______________________________

17) Provider NPI Number: ______________________________

18) Provider Street Address: ______________________________

(*P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)*

19) City, State, Zip Code: ______________________________

20) Provider EDI Contact Person: ______________________________ 21) Phone/Ext:(   )   /

22) FAX: (   )   23) Email Address: ______________________________

______________________________ ______________

24) Provider Representative's Signature (must be original) 25) Date Signed

____

26) Provider Representative's Name – Please Print Clearly

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

This section is to identify the third party software vendor practice management system that the provider is using to exchange information with their third party billing service. This section may also be repeated if a secondary billing service is being used in addition to a clearing house.

27) SOFTWARE VENDOR NAME: Office Ally

28) STREET ADDRESS: 1300 SE Cardinal Court, Suite 190

(*P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the software vendor.)*

Provider Name: ______________________ Provider #: ______________

29) CITY, STATE, ZIP CODE: Vancouver, WA 98683

30) SOFTWARE CONTACT PERSON: Customer Service 31) PHONE/EXT: (360)975-7000 Option 1

32) SOFTWARE CONTACT PERSON EMAIL ADDRESS: info@officeally.com

33) 2nd SOFTWARE CONTACT PERSON: Dan Waclawsky 34) PHONE/EXT:(360) 975-7000 x7254

35) SOFTWARE CONTACT PERSON EMAIL ADDRESS: dan.waclawsky@officeally.com

36) FAX : (360) 896-2151

37) SOFTWARE PRODUCT NAME: Proprietary

38) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: N/A

39) SOFTWARE PRODUCT RELEASE DATE: N/A

*** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. ***

Return the completed EDI Amendment to Molina Medicaid Solutions at the following address:

<u>Via U.S. Mail</u>
EDI UNIT
Molina Medicaid Solutions
P.O.Box 4804
Trenton, New Jersey 08650 – 4804

<u>Other Carriers</u>
EDI UNIT
Molina Medicaid Solutions
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619