



ENROLLMENT PACKET

ELECTRONIC DATA INTERCHANGE (EDI) SUBMISSION

Frequently Asked Questions About Electronic Data Interchange (EDI)

In an effort to assist submitters and providers with their electronic claims, the Electronic Data Interchange (EDI) Department has compiled a list of frequently asked questions and the answers.

Submitter ID

What is a Submitter ID and how is it different from a Provider ID?

A Submitter ID is a seven-digit number beginning with "450" that is necessary to logon to the EDI system. A Provider ID is a seven-digit number beginning with "1" that is assigned to each provider who provides services to Louisiana Medicaid recipients and is used for billing purposes.

What is the difference between a provider and a Third Party Biller?

A provider is an individual or entity that provides services to Louisiana Medicaid recipients. A Third Party Biller does not provide services to recipients, but bills services to Louisiana Medicaid on behalf of the provider.

How can I obtain a Submitter ID?

Submitter IDs are issued by the Molina Provider Enrollment Department. The necessary forms may be obtained at <http://www.lmmis.com/provweb1/default.htm>. Look for the HIPAA Billing Instructions and Companion Guides link and then locate the EDI General Companion Guide.

How do I link a provider to my submitter ID or add another provider to my submitter ID?

For a provider to be linked to a submitter ID, the provider will have to submit a *Provider's Election to Employ Electronic Media Submission of Claims for Processing in the Louisiana Medical Assistance Program Form* and a *Medicaid Electronic Media Limited Power of Attorney* (if submitting through a third party). Both forms may be found in the EDI General Companion Guide. Multiple provider numbers may be linked to one submitter number.

What is my submitter ID?

The submitter ID is a seven-digit number issued by Louisiana Medicaid that begins with 450. If you do not know your number, submit a written request on letterhead showing your submitter name and address, to request a copy of the original correspondence. The request must be signed by an authorized party and submitted hardcopy to Molina - Provider Enrollment, P.O. Box 80159, Baton Rouge, LA 70898.

Is my provider number linked to my submitter ID?

When a provider number is initially linked to a submitter ID, the provider receives a letter giving them the submitter ID and the date of linkage. This letter should be forwarded to the third party biller as needed.

For a third party to ensure that all providers are linked to their submitter ID, the submitter must complete and submit a *Request for Third Party Biller Linkage Information* form. All requests are worked in order of receipt.

What is the status of my EDI Submitter ID application?

The turnaround time for issuing submitter IDs is approximately three (3) weeks. Once the number has been issued, a letter is mailed to the Provider's Pay-To Address notifying the provider of the submitter number and effective date. This letter should be forwarded to the third party biller as needed. It is unnecessary to contact Molina Provider Enrollment Department prior to three (3) weeks from submission date.

How should a provider update their address information on the Louisiana Medicaid files?

An Address/Telephone Change form must be completed and submitted to the Molina Provider Enrollment Department via fax at 225/216-6392. The form must be completed in its entirety and should include both the provider number and submitter number. This is the only form that can be submitted via fax to Provider Enrollment. All other faxed forms are rejected for original signatures.

Test Submissions

Where can I find a list of Vendors/Billing Agents/Clearinghouses (VBCs) that have been approved?

An updated VBC list may be obtained at: <http://www.lamedicaid.com> under HIPAA Information Center. See the VBC List link for the latest report. This report shows the status of VBCs in the testing phase with Louisiana Medicaid and is updated monthly.

Do I need to test before submitting into production?

All submitters of Long-Term Care claims MUST test before submission to production. For all others, if the vendor of the software has been approved for a particular claim type by Louisiana Medicaid, no further testing is required. If the vendor's software is not approved, the submitter must wait until the vendor has successfully completed all required testing before submitting claims to production.

How do I get my submitter password?

Passwords are required for submission of both test and production claims. Passwords may be obtained by sending an email to *hipaaedi@unisys.com (the * asterisk is part of the email address). The email should include the following information: Submitter ID, Submitter Name, name of software vendor, contact person name, telephone number and email address. The Molina EDI Department will send the ID and password via return email.

Production Submissions

How do I submit claims into production?

After all testing requirements have been met for your claim type, you may begin submitting to production. Send an email to *hipaaedi@unisys.com (the * asterisk is part of the email address) and include the following information: submitter ID, submitter name, claim type (physician, dental, etc.), software vendor's name, contact person and phone number. Also indicate if you have a password or not and include a request to begin to submit to production. The EDI Department will email you when the submitter is moved to production. Additional questions should be directed to your vendor.

How do I start getting a production 835?

Because a submitter cannot revert to proprietary electronic remittance advices once they transition to a production 835, a testing process is employed to ensure that the submitter is prepared to process the 835 upon receipt. To request a test, please contact the Molina EDI Department at *hipaaedi@unisys.com (the * asterisk is part of the email address).

After I submit a file, what do I need to do to make sure my file has been accepted?

A TA1 is available immediately upon transmission and a 997 functional acknowledgement is available within 24 hours. Both acknowledgements should be checked to ensure that the file was received and accepted. Both files may be obtained by calling the same bulletin board system where the files were transmitted.

What is a TA1?

The TA1 segment acknowledges the receipt of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange regardless of the validity of the contents of the data included inside the header/trailer envelope. The validity of the data contained within the actual transaction will be acknowledged in the 997.

What is a 997?

The 997 is a functional acknowledgment generated after the X12 transaction has been received. The 997 checks the file syntactically for errors and lets the submitter know if the entire file has been accepted or rejected.

Can I get a good TA1 and 997 and my file still reject?

Yes. It is possible to get a good TA1 and 997 and the file then fails a business edit. The TA1 and 997 ensures that the file is syntactically correct for a HIPAA transmission. A business edit is an edit established by the Department of Health and Hospitals to identify known problems that occur with regularity.

I sent a file and was not paid on my RA; what happened to my claims?

You should check to see that you received a good TA1 and 997. If the file was accepted for processing, it could have failed for a business edit. Check the file to ensure that it did not include any data that would cause the file to drop for a business edit. If no problems are identified, contact your third party biller or the Molina EDI Department at 225-237-3200 ext. 2 for assistance.

I submitted my claims to a Clearing House or Billing Agent and have not received payment. What should I do?

You should contact your Clearing House or Billing Agent to ensure that the claims were submitted to Louisiana Medicaid. If the files were submitted, you should see if they received a good TA1 and 997 or whether or not there were data problems that would cause the file to drop for a business edit. If the claims still cannot be located, the Clearing House or Billing Agent should contact the Molina EDI Department for help.

EDI SUBMITTER CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Provider Enrollment Unit in order to obtain a Louisiana Medicaid Program Submitter Number:

FOR LOUISIANA PROVIDER(S) (INDIVIDUAL OR ENTITIES) WISHING TO SUBMIT THEIR OWN CLAIMS – DIRECTLY TO LOUISIANA MEDICAID – NOT THROUGH A BILLING AGENT OR CLEARINGHOUSE:

Completed	Document Name
<input type="checkbox"/>	1. A completed Provider's Election To Employ Electronic Data Interchange Of Claims For Processing In The Louisiana Medical Assistance Program (EDI Contract). The name on the EDI contract must match that of the enrolled provider.*
<input type="checkbox"/>	2. A completed EDI Annual Certification Of Electronically-Submitted Medicaid Claims current year. *

FOR BILLING AGENTS / CLEARINGHOUSES WHO WILL BE SUBMITTING ELECTRONIC CLAIMS TO LOUISIANA MEDICAID ON BEHALF OF ENROLLED LOUISIANA MEDICAID PROVIDER(S):

Completed	Document Name
<input type="checkbox"/>	1. Completed Form PE-50Sub* (Read instructions carefully before completing this form).
<input type="checkbox"/>	2. A completed Provider's Election To Employ Electronic Data Interchange Of Claims For Processing In The Louisiana Medical Assistance Program* (EDI Contract) for a provider for whom you wish to submit electronic claims
<input type="checkbox"/>	3. A completed Medicaid Electronic Media Limited Power Of Attorney* (EDI Power Of Attorney). This form is required for all EDI contracts where submissions will be made by a third party.
<input type="checkbox"/>	4. A completed EDI Annual Certification Of Electronically-Submitted Medicaid Claims current year: January 1, To December 31, 200__*

FOR THOSE SUBMITTERS WISHING TO RETRIEVE 835s (ELECTRONIC REMITTANCES) ONLY:

Completed	Document Name
<input type="checkbox"/>	1. A completed Provider's Election To Employ Electronic Data Interchange Of Claims For Processing In The Louisiana Medical Assistance Program* (EDI Contract)
<input type="checkbox"/>	2. A completed Medicaid Electronic Media Limited Power Of Attorney* (EDI Power Of Attorney), if applicable. This form is required for all EDI contracts where submissions will be made by a third party.
<input type="checkbox"/>	3. A completed EDI Annual Certification Of Electronically-Submitted Medicaid Claims current year: January 1, To December 31, 200__*

- Forms are included in this packet.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. INCOMPLETE/INACCURATE FORMS WILL BE RETURNED FOR CORRECTION.

ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS).

Please submit all required documentation to:
Molina Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Instructions for Louisiana Medicaid PE-50Sub Provider Enrollment Form

The following fields **MUST** be completed:

Medicaid Submitter Number – your seven- (7) digit Medicaid submitter number, if known. Indicate if this application is for a new enrollment or an update to an existing enrollment. A new enrollment is for a submitter with no prior Louisiana Medicaid submitter number. An update to an existing enrollment is for a submitter that has had a Louisiana Medicaid submitter number in the past and that number is either closed or contains old information.

Is this a Change of Ownership (CHOW)? – indicate whether or not this entity has had a change of ownership that has not been reported to Louisiana Medicaid.

** The Department of Health and Hospitals has defined a change of ownership (CHOW) as any change in: (1) Name; (2) Ownership; (3) Management; or (4) change in Taxpayer ID.

This definition remains in effect even if the Internal Revenue Service, Secretary of State or Medicare does not recognize the change as a CHOW. Any change that meets the criteria above requires a full enrollment packet for updates to the Louisiana Medicaid submitter file.

SECTION A – SUBMITTER INFORMATION & PHYSICAL LOCATION

Submitter Name – enter the submitter name – either the “Doing Business As” (DBA) name

Area Code and Telephone # - enter the telephone number at the physical location of the business or individual named in the *Submitter Name*.

Social Security Number – enter the social security number assigned to the owner of the business identified in the *Submitter Name* field.

Physical Street Address - enter the physical location address of the business named in *Submitter Name*.

Mailing Address (if different) – enter the mailing address if mail cannot be received at the Physical Street Address. For example, if the Physical Street Address is 123 Main Street, Anywhere, LA but mail cannot be received there, enter the mailing address such as PO Box 85555, Anywhere, LA.

Physical City – enter the city in which your *Physical Street Address* is located.

Mailing Address City – enter the city in which your *Mailing Address* is located.

Physical State – enter the state in which your *Physical Street Address* is located.

Mailing Address State – enter the state in which your *Mailing Address* is located.

Physical Zip Code – enter the zip code in which your *Physical Street Address* is located.

Mailing Address Zip Code – enter the zip code in which your *Mailing Address* is located.

Parish/County – enter the parish / county in which your *Physical Street Address* is located.

Parish Code – the parish code of your physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

Acadia	01	E. Baton Rouge	17	Madison	33	St. Landry	49
Allen	02	E. Carroll	18	Morehouse	34	St. Martin	50
Ascension	03	E. Feliciana	19	Natchitoches	35	St. Mary	51
Assumption	04	Evangeline	20	Orleans	36	St. Tammany	52
Avoyelles	05	Franklin	21	Ouachita	37	Tangipahoa	53
Beauregard	06	Grant	22	Plaquemines	38	Tensas	54
Bienville	07	Iberia	23	Pointe Coupee	39	Terrebonne	55
Bossier	08	Iberville	24	Rapides	40	Union	56
Caddo	09	Jackson	25	Red River	41	Vermillion	57
Calcasieu	10	Jefferson	26	Richland	42	Vernon	58
Caldwell	11	Jefferson Davis	27	Sabine	43	Washington	59
Cameron	12	Lafayette	28	St. Bernard	44	Webster	60
Catahoula	13	Lafourche	29	St. Charles	45	W. Baton Rouge	61
Claiborne	14	LaSalle	30	St. Helena	46	W. Carroll	62
Concordia	15	Lincoln	31	St. James	47	W. Feliciana	63
DeSoto	16	Livingston	32	St. John	48	Winn	64

Out-Of-State

Texas	87	Mississippi	88	Arkansas	89	Other	99
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State Status – check “In (0)” if your *Provider Street Address* is located within Louisiana or “Out (1)” if it is located outside Louisiana.

Location Type – check “Urban (1)” if your *Provider City* is an urban location or “Rural (2)” if it is a rural location.

SECTION B – OWNERSHIP INFORMATION

Practice Type – check the appropriate box for the individual/entity entered in *Provider Name* field.

Contact Information – enter the name and phone number of the person that can be contacted should additional information be required.

SECTION C - SUBMITTER ACCEPTANCE OF INFORMATION

Read the information included in this section.

Print Name of Authorized Agent - print the name of the authorized agent that will sign this document.

Submitter’s Authorized Agent’s Signature – **signatures must be original** (stamped signatures and initials are not accepted).

Date – enter the date this agreement was signed.

**INACCURATE/INCOMPLETE FORMS WILL BE
RETURNED FOR CORRECTION**

Louisiana Medicaid Third Party Biller Form

This Form is Required for All Submitters Requesting a New Submitter Number

Submitter Provider # (if known) (Leave Blank for New Submitter Numbers)						Is this a Change of Ownership (CHOW)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>See Instructions for definition of CHOW per Louisiana Medicaid policy.</i> If yes, current LA Medicaid submitter number:
4	5	0				
This enrollment packet is for a <input type="checkbox"/> New Submitter Number <input type="checkbox"/> Update to Existing Submitter Number or <input type="checkbox"/> Other (Please specify)						

<input type="checkbox"/>	I am an enrolled Louisiana Medicaid provider and wish to submit my claims electronically directly to Louisiana Medicaid (I will submit the claims via modem from my office – not through a Billing Agent or Clearinghouse)
<input type="checkbox"/>	I am a Billing Agent / Clearinghouse and wish to submit Louisiana Medicaid claims electronically for Louisiana Medicaid providers (these claims are claims received from enrolled Louisiana Medicaid providers and not claims for services that I have provided.)
<input type="checkbox"/>	I wish to retrieve 835s (electronic remittances) only. (I will not be submitting any claims to Louisiana Medicaid.)

A	Submitter Name			Area Code & Telephone # () - - -		Social Security # (Required) - - -			
	Physical Street Address - Can Mail Be Received at this address: <input type="checkbox"/> Y <input type="checkbox"/> N					Mailing Address (if different)			
	Physical City		State	Zip Code		Mailing Address City		State	Zip Code
	Parish /County			Parish/County Code	State Status <input type="checkbox"/> In (0) <input type="checkbox"/> Out (1)		Location Type <input type="checkbox"/> Urban (1) <input type="checkbox"/> Rural (2)		IRS Reporting #

B	Practice Type (All Providers)					
	<input type="checkbox"/> Individual (01) <input type="checkbox"/> Partnership (02) <input type="checkbox"/> Corporation (03) <input type="checkbox"/> Hospital Based Physician (04) <input type="checkbox"/> Health Maintenance Organization (05) <input type="checkbox"/> Group Practice (Private) (06) <input type="checkbox"/> Teaching Provider (Physician / Dentist) (07) <input type="checkbox"/> Public Clinic or Group (08)			The following person may be contacted for additional information regarding this enrollment application:		
				Contact Person		
			Contact Phone # ()			

C	I, the undersigned, certify to the following: <ol style="list-style-type: none"> 1. 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.; 2. that the information submitted in electronic format is true, accurate and complete as received from the provider; 3. I understand that payment of these claims will be paid to the provider from Federal and State funds; 4. that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws; and 5. that I will notify the Provider Enrollment Unit whenever the above information needs to be updated. 					
	Print Name of Authorized Agent		Signature of Authorized Agent		Date	
	ALL SUBMITTERS MUST COMPLETE ENTIRE FORM- INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION					

Instructions for Completing the EDI Contract

The following must be completed by every submitter/provider who wants to submit claims electronically. The instructions are as follows:

Provider Number – enter the Louisiana Medicaid provider number for the provider that will be submitting electronic claims to Molina. Leave blank if applying for new number. Must match name on Louisiana Medicaid files, if provider is currently enrolled.

Submitter Number – enter the Louisiana Medicaid submitter number that will be submitting electronic claims to Molina. Leave blank if applying for new number.

Provider Name – enter the name of the provider associated with the provider number entered.

Effective Date of Change in Billing Agent - enter the date that the requested change is to take effect

Name of Data Processing Agent – enter the name of the submitter that is assigned with the submitter number entered

Number in First, Second, Third Bucket – if more than one submitter number is on file, enter the submitter number that should be loaded in each “bucket”. The first bucket must hold the submitter number of the submitter who will retrieve the 835. Other active/closed numbers can be placed in the subsequent buckets.

Print Name of Person Completing Form – print the name of the person completing the form

Phone Number of Person Completing Form – enter the phone number of the person completing the form in case they must be contacted for additional information

Signature of Provider or Authorized Agent – the provider (individual) or the provider’s authorized agent (entities) must sign the form for it to be processed

Date of Signature – enter the date the provider or the provider’s authorized agent signed the form

Instructions for Completing the EDI Power of Attorney

Provider Number – enter the Louisiana Medicaid provider number for the provider that will be submitting electronic claims to Molina. Leave blank if applying for new number.

Submitter Number – enter the Louisiana Medicaid submitter number that will be submitting electronic claims to Molina. Leave blank if applying for new number.

Provider Name – enter the name of the provider associated with the provider number entered.

Provider Address – enter the address associated with the provider name entered

Billing Agent Name – enter the name of the Billing Agent (or submitter)

Billing Agent Address – enter the address associated with the Billing Agent submitter name entered

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

Enter City, State and Date of Notarization

Signature of Provider or Authorized Agent – the provider or the provider’s authorized agent MUST sign the form for it to be processed

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

Instructions for Completing the EDI Annual Certification

Provider Number – enter the Louisiana Medicaid provider number that will be submitting electronic claims to Molina. Leave blank if applying for new number. Leave blank if this is for a Third Party Biller.

Submitter Number – enter the Louisiana Medicaid submitter number that will be submitting electronic claims to Molina. Leave blank if applying for new number.

Submitter Name – enter the name associated with the “450” submitter number. If the provider will submit their own claims, this would be the provider name. If claims are submitted through a third party, this would be the name of the third party who actually transmits claims to Louisiana Medicaid.

Claim Type – enter the type of claims this submitter number will submit to Louisiana Medicaid.

Date of Signature – enter the date the provider or the provider’s authorized agent signed the form

Signature of Provider or Authorized Agent – the provider or the provider’s authorized agent must sign the form for it to be processed

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

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Provider Number (7 digits)

4	5	0				
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Submitter Number (7 digits)
(leave blank if applying for new number)

Provider Name: _____

Effective Date of Change
in Billing Agent: _____

Name of Data
Processing Agent: _____

Number in First
Bucket (see
instructions) _____

Second Bucket _____

Third Bucket _____

- I am an enrolled Louisiana Medicaid provider and wish to submit my claims electronically directly to Louisiana Medicaid (I will submit the claims via modem from my office – not through a Billing Agent or Clearinghouse)
- I am a Billing Agent / Clearinghouse and wish to submit Louisiana Medicaid claims electronically for other Louisiana Medicaid providers (these claims are claims received from enrolled Louisiana Medicaid providers and not claims for services that I have provided.)
- I wish to retrieve 835s (electronic remittances) only. (I will not be submitting any claims 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 or for a change in my billing agent is as stated above.
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 (Molina) 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.

Print Name of Person Completing Form

Signature of Provider or Authorized Agent

Phone Number of Person Completing Form

Date of Signature

**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

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Provider Number (7 digits)

4	5	0				
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Submitter Number (7 digits)
(leave blank if applying for new number)

Provider Name:

Billing Agent Name:

Provider Address:

Billing Agent 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 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)

**EDI ANNUAL CERTIFICATION OF
ELECTRONICALLY-SUBMITTED MEDICAID CLAIMS**
Certification Period: January 1, to December 31, 200_____

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4	5	0				
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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.

Submitter Number (7 digits)

Submitter Name: _____

○ **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.

○ **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: Molina – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025

Request for Submitter Linkage Information

Submitter Name: _____

Submitter Number: _____

Submitter FAX number: _____

The following information MUST be supplied in its entirety. Incomplete or incorrect information will not be acted upon. Once the information has been gathered, Provider Enrollment will fax this form to the number listed above.

Provider Number	Provider Name	Submit / 835*	Rejected for Correction	Linked	Pending
<i>(Completed by Molina Provider Enrollment Staff)</i>					
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Indicate if the submitter number will be used to submit claims or to retrieve 835s only.

Signature

Date

Contact Phone Number

Fax completed form to: Molina Provider Enrollment, 225/216-6392
Please be aware that it may take up to one (1) week for Provider Enrollment to respond to this request.
This form may be copied for future use.