



**Network Provider
Independent Diagnostic
Testing Facility
Contract**

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APPENDIX:

FACILITY CREDENTIALING INFORMATION APPLICATION
NETWORK FACILITY APPLICATION REQUIREMENTS ELECTRONIC
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SIGNATURE PAGE



Network Provider Independent Diagnostic Testing Facility Contract

It is hereby agreed between the Office of Management and Enterprise Services Employees Group Insurance Department (EGID), and the Independent Diagnostic Testing Facility, (hereinafter, IDTF) named on the signature page, that the IDTF shall be a Provider in EGID's Network of Providers.

This Contract is entered into for the purpose of defining the conditions for reimbursement by EGID to the IDTF. It in no way is meant to impact on the IDTF's decision as to what is considered appropriate medical treatment.

I. RECITALS

- 1.1 EGID (hereinafter, EGID) is a statutory body created by 74 O.S.2012, § 1301 et seq. as amended, to administer and manage certain insurance benefits for employees of the State of Oklahoma.
- 1.2 The IDTF shall be qualified and duly certified to participate in the Medicare program under Title XVIII of the Social Security Act, and shall comply with all applicable federal, state, and local laws regulating such a IDTF providing clinical IDTF health services and satisfies additional credentialing criteria as established by EGID.
- 1.3 The intent of this Contract is to provide access to enhanced quality health care, utilizing managed care components at an affordable, competitive cost to EGID and its members.
- 1.4 Failure to abide by any of the following provisions may result in non-renewal of the Contract or may be cause for termination.

II. DEFINITIONS

- 2.1 "Allowable Fee" means the maximum charge payable to an IDTF for a specific procedure in accordance with the provisions in Article VI of this Contract. The IDTF shall charge the usual and customary fee unless the fee schedule limits otherwise.
- 2.2 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating facilities and other health care providers.
- 2.3 "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

- 2.4 HELP/Wellness (Health Education Lifestyle Planning) means the program established to actively promote responsible behavior and the adoption of lifestyles that are in the best interest of the Plan member's good health.
- 2.5 "IDTF Services" means those IDTF services that are covered by the State Health Insurance Plan.
- 2.6 "Medical" means belonging to the study and practice of medicine for the prevention, alleviation or management of a physical or mental defect, illness, or condition.
- 2.7 "Medically Necessary" means services or supplies that, under the provisions of this Contract, are determined to be:
- a) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
 - b) provided for the diagnosis and treatment of the medical condition, and
 - c) within standards of acceptable, prudent medical practice within the community, and
 - d) not primarily for the convenience of the member, the member's IDTF or another provider, and
 - e) any condition which, if left untreated, could deteriorate into a life threatening situation, and
 - f) the most appropriate supply or level of service that can safely be provided.
- 2.8 "Medical Services" means the professional services provided by a Network IDTF and covered by EGID's Plan.
- 2.9 "Members" means all persons covered by EGID's Plans, including active, retired, or vested employees, survivors and others on approved leave or disability and their covered dependents eligible at the time of service.
- 2.10 "Network IDTF" means a provider of IDTF services who has entered into this Contract with EGID to accept scheduled reimbursement for covered IDTF services provided to members.
- 2.11 "State Employees Health Insurance Plan" means the HealthChoice benefit plan designed to enhance the quality of care and to financially incentivize members to use Network Facilities.
- 2.12 "Third Party Payor" means an insurance company or other entity making payment directly to the IDTF on behalf of EGID.

III. RELATIONSHIP BETWEEN EGID AND THE IDTF

- 3.1 EGID has negotiated and entered into this Contract with the IDTF on behalf of the members of the State Employees Health Insurance Plan. The IDTF is an independent contractor who has entered into this Contract to become a Network IDTF and is not, nor is intended to be, the employee, agent or other legal representative of EGID in the performance of the provisions of this Contract. Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of independent contractor for the purposes of this Contract.

- 3.2 EGID and the IDTF agree that all of the parties hereto shall respect and observe the IDTF/patient relationship which will be established and maintained by the IDTF. The IDTF may choose not to establish an IDTF/patient relationship if the IDTF would have otherwise made the decision not to establish an IDTF/patient relationship had the patient not been a member. The IDTF reserves the right to refuse to furnish services to a member in the same manner as they would any other patient.
- 3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies of any third party, including but not limited to, a member or a Network Provider other than the IDTF named in this Contract.

IV. IDTF SERVICES AND RESPONSIBILITIES

- 4.1 The IDTF shall provide quality, medically necessary IDTF services to members, in a cost efficient manner, when such services are ordered by a licensed practitioner of the healing arts, and has been awarded the prerequisite clinical privileges to order and/or perform such services. Nothing in this Contract shall be construed to require medical staff of the IDTF to perform any procedure or course of treatment which the staff deems professionally unacceptable or is contrary to IDTF policy.
- 4.2 The IDTF shall provide IDTF services to members in the same manner and quality as those services are provided to all other patients of the IDTF.
- 4.3 The IDTF has, and shall maintain, in good standing while this Contract is in effect, all licenses required by law, and certification to participate in the Medicare program under Title XVIII of the Social Security Act and/or Joint Commission certification.
- 4.4 The IDTF agrees to make reasonable efforts to refer covered members to other Network Providers with which EGID contracts, for medically necessary services that the IDTF cannot or chooses not to provide.
- 4.5 The IDTF shall furnish, at no cost to EGID, any medical and billing records covering any IDTF services, for any member, with the understanding that each member, as a condition of enrollment in the Employees Group Insurance Department Insurance Plan, has authorized such disclosure.
- 4.6 The IDTF shall accurately complete the Network IDTF Application which is attached to and made part of this Contract. The IDTF shall notify EGID of any change in the information contained in the Application within 15 days of such change, including resolved litigation listed as “pending” on the original Application.
- 4.7 The IDTF shall reimburse EGID for any overpayments made to the IDTF within 30 days of the IDTF's receipt of the overpayment notification.
- 4.8 The IDTF shall submit to a patient record audit upon 48 hours advance notice.
- 4.9 The IDTF shall participate in HELP/Wellness promotions sponsored by EGID, at EGID's allowable under the terms of the promotion.

V. EGID SERVICES AND RESPONSIBILITIES

- 5.1 EGID agrees to pay the IDTF compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.
- 5.2 EGID agrees to grant the IDTF the status of "Network IDTF" and to identify the IDTF as a Network IDTF on informational materials disseminated to members.
- 5.3 EGID agrees to continue listing the IDTF as a Network IDTF until this Contract terminates.
- 5.4 EGID agrees to periodically provide the IDTF access to a listing of all Network Facilities.
- 5.5 EGID agrees to provide appropriate identification cards for members.
- 5.6 EGID agrees to acknowledge the confidentiality of patient's records and to only release pertinent clinical information in accordance with state and federal guidelines.
- 5.7 EGID shall give a 48 notice prior to an audit.

VI. COMPENSATION AND BILLING

- 6.1 The IDTF shall seek payment only from EGID for the provision of medical services except as provided in paragraphs 6.3, 6.4 and 6.9. The payment from EGID shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 EGID agrees to pay the IDTF's billed charges for each procedure or the fee set by EGID for that procedure, whichever is less. This shall be allowed when the member has received medically necessary covered services subject to the following policy limitation and conditions:
 - a) EGID and the member will pay the allowed charges according to the terms of the member's HealthChoice Plan in effect on the date charges are incurred by the member.
 - b) EGID may reduce the payment by any deductibles, coinsurance and co-payments according to the member's HealthChoice Plan in effect at the time charges are incurred.
 - c) EGID shall have the right to categorize what shall constitute a procedure. EGID's and the member's financial liability shall be limited to the procedure's allowable as determined by EGID, paid by applying appropriate coding methodology, whether the IDTF has billed appropriately or not.
 - d) The IDTF shall provide, at no additional charge, all supplies necessary for the collection, preparation and preservation of all specimens to be submitted to the IDTF for testing.
- 6.3 The IDTF agrees that the only charges which a member may be liable and be billed by the IDTF shall be for deductibles, coinsurance, copayments or services not covered by the Oklahoma State Employees Health Insurance Plan, or as provided in paragraph 6.4 and the member's HealthChoice Plan in effect at the time charges are incurred. The IDTF shall not waive any deductibles, copayments and coinsurance required by EGID, except during times of HELP/Wellness promotions, when the copayment/coinsurance is waived by EGID.
- 6.4 The IDTF shall not collect amounts in excess of the Plan limits unless the member has exceeded his/her annual or lifetime maximum.

- 6.5 The IDTF shall refund within 30 days of discovery to the member any overpayment made by the member.
- 6.6 In a case in which EGID is primary under applicable coordination of benefit rules, EGID shall pay the amounts due under this Contract. In a case in which EGID is other than primary under the coordination of benefit rules, EGID shall pay only those amounts not payable from other sources pursuant to the applicable coordination of benefit rules, up to EGID's maximum liability under the terms of this Contract.
- 6.7 The IDTF shall bill EGID on forms acceptable to EGID within 60 days of providing the IDTF services. The IDTF shall use the current CPT codes with appropriate modifiers, HCPCS codes and ICD diagnostic codes, when applicable. The IDTF shall furnish, upon request at no cost, all information, including medical records, reasonably required by EGID to verify and substantiate the provision of medical services and the charges for such services if the member and the IDTF are seeking reimbursement through EGID. This provision shall not apply in cases involving litigation, multiple payors, or where the patient has failed to notify the IDTF that they were a member.
- 6.8 EGID shall reimburse the IDTF within 30 days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. EGID will not be responsible for the delay of reimbursement due to circumstances beyond EGID's control.
- 6.9 EGID shall have the right at all reasonable times and to the extent permitted by law, to inspect and duplicate all medical and billing records relating to medical services rendered to covered members at no cost to EGID or the member.

VII. LIABILITY AND INSURANCE

- 7.1 Neither party to this Contract, EGID nor the IDTF, or any agent, employee or other representative of a party, shall be liable to third parties for any act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.
- 7.2 The IDTF shall be required to obtain general and medical liability coverages for claims of acts and omissions of the IDTF and its employees and agents. Such coverage shall be maintained at a level of not less than that which is mandated by state statute or less than \$1,000,000 per incident and \$1,000,000 aggregate, when the IDTF is not regulated by statute. EGID shall be notified 30 days prior to cancellation. If coverage is lost or reduced below specified limits, this Contract may be canceled by EGID.

VIII. MARKETING, ADVERTISING AND PUBLICITY

- 8.1 EGID shall encourage its members to use the services of the Network IDTF.
- 8.2 EGID shall have the right to use the name, address and phone number of the IDTF in a provider listing for purposes of informing members and prospective members of the identity of the IDTF, and otherwise carrying out the terms of this Contract.
- 8.3 The IDTF, upon prior approval of EGID, shall have the right to publicize its status as a Network Facility.

IX. DISPUTE RESOLUTION

9.1 EGID and the IDTF agree that their authorized representatives will meet in a timely manner, and negotiate in good faith, to resolve any problems or disputes that may arise in performance of the terms and provisions of this Contract. Nothing in this Article shall interfere with either party's rights under Article XI.

X. TERM AND TERMINATION

10.1 The term of this Contract shall commence on the effective date on the signature page, and shall remain in effect until terminated by either party subject to 10.2.

10.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 10.1 at any time during the term of this Contract.

10.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.

10.4 Following termination of this Contract, EGID shall continue to have access, at no cost to EGID, to the IDTF's records of care and services provided to members for five years from the date of provision of the services to which the records refer as set forth in paragraph 6.9.

10.5 This Contract shall terminate with respect to an IDTF upon:

- a) the loss or suspension of the IDTF's Medicare certification; or
- b) failure to maintain IDTF's professional and general liability coverage in accordance with this Contract.

XI. GENERAL PROVISIONS

11.1 This Contract, or any of the rights, duties, or obligations of the parties, hereunder, shall not be assigned by either party without the express written consent and approval of the other party.

11.2 At any place within this Contract that notice is required, it is the intention of the parties that only those with regard to termination by either party of participation in the Contract must be sent by certified mail, a return receipt requested, at no other time when notice is required by this Contract is there an obligation by either party to use certified mail. The Network Newsletter serves as the primary method by which providers receive all other notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.

11.3 Notwithstanding the provisions in Section 11.1, EGID may designate an Administrator to administer any of the terms of this Contract.

11.4 This Contract contains the entire agreement between EGID and the IDTF relating to the rights granted and the obligations assumed by the parties concerning the provision of IDTF services to

members. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract, not expressly set forth in this Contract, are of no force or effect.

- 11.5 This Contract, or any part or section of it, may be amended at any time during the term of the contract by mutual written consent of duly authorized representatives of EGID and the IDTF.
- 11.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract, which is not in conformity with existing or future legislation, shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.
- 11.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Contract, or any one provision, in accordance with the intent and purpose of the parties hereto.
- 11.8 Nothing in this contract shall imply that the IDTF is obligated to perform any medical procedure which would be contradicted by the Directives for Catholic Health Care Facilities.
- 11.9 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.
- 11.10 As mandated by HB1086, the Transparency, Accountability, and Innovation in Oklahoma State Government 2.0 Act of 2011, all payments disbursed by the Office of the State Treasurer must be made solely through electronic funds transfer (EFT). Provider/facility hereby agrees to accept EFT payments by July 1, 2013. Provider acknowledges that all health and dental claims received after July 1, 2013, regardless of the date of service, will be denied pending receipt of additional information if EFT payment information is not on file as of July 1, 2013.



**Network Provider Facility Credentialing Information
Contract Applications**

HealthChoice requires all three addresses on the respective pages of the application.

1. **Service Address** – This address is used for the location where health care services are performed and/or the physical location of the provider. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all HealthChoice Network Providers.
2. **Mailing Address** – Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.
3. **Billing Address** – This address is used for submitting all claims to HealthChoice for processing and appears in box 33 of the CMS-1500 claim form or box 2 on the UB-04. If box 2 is not used by the facility, the billing address appears in Box 1 of the UB-04. Claims will be paid exclusively to the billing address.

Each address must have a corresponding phone number, email address, fax number and contact person.

Insurance Certificate/Face Sheet must have name of the applicant listed as the insured. The insurance limits must be at the levels required in the contract and must indicate clearly the coverage type(s) stated in the contract. Product liability coverage in lieu of professional/medical liability is acceptable for DME only.

W-9 forms must be signed and list only the Tax ID number for each location listed on the application which will be used on claim forms

Please return entire application packet with the new information.



**Network Facility
Application Requirements**

Thank you for your interest in the HealthChoice Provider Network.

Please complete the attached Application and submit with the required attachments listed below.

Complete all sections of the application. If an area of inquiry is not applicable to the facility, please indicate. If you need additional space to provide complete answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

Retain the Contract for your records.

REQUIRED ATTACHMENTS

Please attach a copy of each of the following documents to your completed Application:

- Current state(s) license(s)**
- Face Sheet of current general and medical liability insurance policy**
Insurance Certificate/Face Sheet must have the name or the Facility listed as the insured. The insurance limits must be at the levels in the Contract and must indicate clearly that it is general and medical liability coverage.
- W-9 form for each Federal Tax Identification Number**
W-9 forms must be signed and list only the Federal Tax Identification Number listed on the Application which will be used on claim forms submitted to HealthChoice.
- Contract Signature Page**
- Electronic Funds Transfer (EFT) Form**
- Copy of voided check or bank letter for Electronic Funds Transfers**
- Copy of Medicare Certification Letter**
- Copy of Joint Commission Accreditation Certificate (if applicable)**
- Copy of AAAHC Accreditation Certificate (if applicable)**

Incomplete applications will be returned.



Network Facility Application

The completed Network Facility Application should be returned to the Office of Management and Enterprise Services Employees Group Insurance Department in its entirety, accompanied by the applicable attachments. You may mail, fax or email the completed application to:

Office of Management and Enterprise Services
Employees Group Insurance Department
ATTN: Network Management
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-844-804-2642
Fax: 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

General Information

Legal Name of Owner: _____
Trade Name/DBA: _____
Medicare Facility Classification: _____ Medicare Number: _____

License Information

State: _____
License Number: _____
Expiration Date: _____

A copy of facility license is required for each state of practice.

Accreditation

Is this Facility accredited by the Joint Commission: Yes No
Joint Commission Program ID Number: _____
Date of most current accreditation: _____ Expiration Date: _____
Is this Facility accredited by the AAAHC? Yes No
Date of most current accreditation: _____ Expiration Date: _____

Insurance Information

Copy of Insurance Certificate/face sheet is required.

Please provide the following information about the Facility's current general and medical liability insurance coverage.

Name of Carrier: _____

Limits of General and Medical Liability Per Occurrence: _____ Expiration Date: _____

Important Facility Contacts

CEO/Administrator: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

CFO: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Credentialing Contact: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Address Information

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 form for each Federal Tax ID number.

Physical Address – physical location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing Address

Mailing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.

Billing/Remit Address – for claims payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Additional Location

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 form for each Federal Tax ID number.

Physical Address – physical location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing Address- for correspondence/credentialing

Mailing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Billing/Remit Address – for claims payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Please use copies of these pages to report any additional locations.

Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information

Provider Name: _____
Doing Business As Name (DBA): _____

Provider Address

Street: _____
City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or
Employer Identification Number (EIN): _____
National Provider Identifier (NPI): _____ Provider Type: _____

Financial Institution Information

A VOIDED CHECK OR A BANK LETTER VERIFYING THE ACCOUNT AND ROUTING NUMBERS IS REQUIRED.

Financial Institution Name: _____
Financial Institution Routing Number: _____
Type of Account at Financial Institution: _____
Provider's Account Number with Financial Institution: _____
Account Number Linkage to Provider Identifier: _____
 Provider Tax Identification Number (TIN) or National Provider Identifier (NPI)

You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. Online instructions on how you can determine the status of your EFT enrollment is available at <http://www.ok.gov/sib/Providers/EFT/index.html>

Submission Information

Reason for Submission
 New Enrollment Change Enrollment

Authorized Signature

I hereby authorize the Employees Group Insurance Department (EGID) to initiate credit entries in accordance with HB 1086 Transparency, Accountability and Innovation in Oklahoma State Government 2.0 Act of 2011 to the account indicated above. I hereby authorize the financial institution/bank named above to credit the same to such account.

Written Signature of Person Submitting Enrollment: _____
Printed Name of Person Submitting Enrollment: _____
Printed Title of Person Submitting Enrollment: _____
Submission Date: _____

EFT INSTRUCTIONS

Please complete this EFT form in its entirety. Leaving required fields blank or failing to attach a voided check or bank letter will result in an incomplete application and/or denied claims. If you have any questions regarding the use of this form or any of the information requirements, please contact us using the information listed at the bottom of page 1 of this form. To ensure the security of your information when submitting this form via email, please submit your form and any attachments in an encrypted WinZip file, then submit the password for the WinZip file in a separate email.

THE EFT FORM IS A **MANDATORY** PART OF YOUR ENROLLMENT APPLICATION

Provider Information

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

Provider Address

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (ZIP stands for zone improvement plan) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for EFT with specific provider type description included by the health plan in its instruction and guidance for EFT enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

Financial Institution Information

Financial Institution Name	Official name of the provider's financial institution	Required
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Required
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited	Required
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required

Submission Information

Reason For Submission	Check appropriate box. Please note that EFT cannot be cancelled.	Optional
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Authorized Signature

Written Signature of Person Submitting Enrollment	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment	Required
Printed Name of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Title of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Submission Date	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
	The date on which the enrollment is submitted	Optional



**Network Provider Independent Diagnostic Testing Facility Contract
Signature Page**

The Office of Management and Enterprise Services Employees Group Insurance Department (EGID), and the IDTF Provider, incorporate by reference the terms and conditions of the Network Provider IDTF Contract (Contract) into this Signature Page. EGID and IDTF Provider further agree that the effective date of the Contract is the effective date denoted on the copy of the executed Signature Page returned to the IDTF Provider. The original of the signed document will remain on file in the office of EGID.

FOR THE IDTF PROVIDER:

Legal Name of Owner (Typed or Printed)

Trade Name/DBA (Typed or Printed)

Federal Tax ID Number

Address of the Facility:

Authorized Officer or Representative (Typed or Printed)

Title

Signature

Signature Date

FOR EGID:

Diana O'Neal
Deputy Administrator
Employees Group Insurance Department

Please return the completed Application, Signature Page, and required attachments to:

Office of Management Enterprise Services
Employees Group Insurance Department
ATTN: Network Management
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-844-804-2642
Fax: 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name: _____

Doing Business As Name (DBA): _____

Provider Address

Street: _____

City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _____

National Provider Identifier (NPI) _____ Provider Type: _____

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)

Provider Tax Identification Number (TIN): _____

National Provider Identifier (NPI): _____

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: _____

Clearinghouse Contact Name: _____ Telephone Number: _____

Submission Information

Reason for Submission

New Enrollment

Change Enrollment

Cancel Enrollment

Authorized Signature

I hereby authorize the Office of Management and Enterprise Services Employees Group Insurance Department to send electronic remittance advice (ERA/835) as designated herein. I am authorized to elect Electronic Remittance Advice (ERA) transactions on behalf of the indicated party and I acknowledge the same by signing below.

Written Signature of Person Submitting Enrollment: _____

Printed Name of Person Submitting Enrollment: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____

Please mail, fax or email the completed form or questions to:
Office of Management and Enterprise Services Employees Group Insurance Department
3545 N.W. 58th St, Ste., 110, Oklahoma City, OK 73112
Phone: 405-717-8790 or 800-543-6044 or Fax: 405-717-8977 or 405-717-8702
EGID.EFTEnroll@omes.ok.gov or EGID.NetworkManagement@omes.ok.gov

ERA INSTRUCTIONS

Please complete this ERA Form in its entirety. Leaving any required fields blank will result in an incomplete process. If you have any questions regarding the use of this form, or any of the field requirements, please see our contact information listed at the bottom of page 1 of this form. Information about how to check the status of your ERA is available at www.ok.gov/sib/Providers/Provider_EFT/index.html

Provider Information

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

Provider Address

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for ERA with specific provider type description included by the health plan in its instruction and guidance for ERA enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment	Required
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Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name	Official name of the provider's clearinghouse	Required; i.e., Emdeon This should be the clearinghouse who is currently handling your electronic claims for HealthChoice, Oklahoma Department of Corrections and/or Oklahoma Department of Rehabilitation Services Any request for routing of ERAs to another destination will require additional setup and testing.
Clearinghouse Contact Name	Name of a contact in clearinghouse office for handling ERA issues	Optional
Telephone Number	Telephone number of contact	Optional

Submission Information

Reason For Submission	Check appropriate box.	Required
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Authorized Signature

The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

Required

Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	
Submission Date	The date on which the enrollment is submitted	Optional