Network Provider

Wig/Scalp Prosthesis

Contract

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Network Provider Wigs/Scalp Prosthesis Contract

It is hereby agreed between the Office of Management and Enterprise Services Employees Group Insurance Department (EGID), and the Wig/Scalp Prosthesis Vendor named on the signature page, that the Wig/Scalp Prosthesis Vendor shall be a Provider in the EGID's network of providers.

This Contract is entered into for the purpose of defining the conditions for reimbursement by EGID to the Wig/Scalp Prosthesis Vendor. It in no way is meant to impact on the Wig/Scalp Prosthesis Vendor's decision as to what is considered appropriate in the delivery of services.

I. RECITALS

1.1 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 Network Provider is a Wig/Scalp Prosthesis Vendor that is duly licensed by the Board of Cosmetology in the state in which the Wig/Scalp Prosthesis Vendor operates and satisfies additional credentialing criteria as established by EGID.

1.3 The intent of this Contract is to provide access to enhanced quality wig/scalp prosthesis services for those members who have received chemotherapy/radiation treatment, 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 a Wig/Scalp Prosthesis Vendor for a specific product in accordance with the provisions in Article VI of this Contract.

2.2 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating Network Providers and other health care providers.

2.3 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.

2.4 "Wig/Scalp Prosthesis" means those services provided by a Network Wig/Scalp Prosthesis Vendor that are covered by the Employees Health Insurance Plan for members who have received chemotherapy/radiation treatment.

2.5 "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.

2.6 “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 condition, and
c) within standards of acceptable, prudent practice within the community, and
d) not primarily for the convenience of the member, the member's Wig/Scalp Prosthesis Vendor 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.

2.7 "Members" means all persons covered by the Group Insurance 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.

2.8 "Network Provider" means a Wig/Scalp Prosthesis Vendor who has entered into this Contract with EGID to accept scheduled reimbursement for covered wig/scalp prosthesis services provided to members.

2.9 "Prior Authorization" means a function performed by EGID, or its designee, to review for the necessity of a wig/scalp prosthesis prior to services being rendered.

2.10 "Employees Health Insurance Plan" means the HealthChoice benefit plan designed to enhance the quality of care, and to financially incentivize members to use Network Providers.

2.11 "Third Party Payor" means an insurance company or other entity making payment directly to the Network Provider on behalf of EGID.

III. RELATIONSHIP BETWEEN EGID AND THE WIG/SCALP PROSTHESIS VENDOR

3.1 EGID has negotiated and entered into this Contract with the Network Provider Wig/Scalp Prosthesis Vendor on behalf of the individuals who are members of the Employees Health Insurance Plan. The Network Provider Wig/Scalp Prosthesis Vendor is an independent contractor who has entered into this Contract to become a Network Provider 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 Wig/Scalp Prosthesis Vendor agree that all of the parties Hereto shall respect and observe the provider/patient relationship that will be established and maintained by the Wig/Scalp Prosthesis Vendor. The Wig/Scalp Prosthesis Vendor may choose not to establish a provider/patient relationship if the Wig/Scalp Prosthesis Vendor would have otherwise made the decision not to establish a provider/patient relationship had the patient not been a member. The Wig/Scalp Prosthesis Vendor reserves the right to refuse to furnish services to a member in the same manner as

3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies in any third party, including but not limited to, a member or a Network Provider other than the Wig/Scalp Prosthesis Vendor named in this Contract.

IV. WIG/SCALP PROSTHESIS VENDOR SERVICES AND RESPONSIBILITIES

4.1 The Wig/Scalp Prosthesis Vendor agrees to provide quality wig/scalp prosthesis services in a cost efficient manner.

4.2 For the purpose of reimbursement, the Wig/Scalp Prosthesis Vendor shall provide wig/scalp prosthesis services to members that are necessary and covered under the Health Insurance Plan.

4.3 The Wig/Scalp Prosthesis Vendor agrees to make reasonable effort to refer covered members to other Network Providers. Failure of the Wig/Scalp Prosthesis Vendor to use Network Providers will result in a review pursuant to the credentialing plan.

4.4 The Network Provider Wig/Scalp Prosthesis Vendor shall request prior authorization from EGID before providing wig/scalp prosthesis services. The Network Provider shall be prepared to give the following information:

a) patient's name
b) member's name
c) member's social security number
d) patient's age and sex
e) physician's prescription including the diagnosis and type of chemotherapy and/or radiation being utilized in the patient's treatment
f) patient status (i.e., employee, dependent)

4.5 The Wig/Scalp Prosthesis Vendor shall participate in the prior authorization procedures provided in Articles IV and VII and for purposes of reimbursement and abide by decisions resulting from those reviews subject to rights of reconsideration, review and appeal.

4.6 The Wig/Scalp Prosthesis Vendor shall accurately complete the Network Provider Application that is attached to and made part of this Contract. The Wig/Scalp Prosthesis Vendor shall notify EGID's Network Manager 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 Wig/Scalp Prosthesis Vendor shall reimburse EGID for any overpayments made to the Wig/Scalp Prosthesis Vendor within 30 days of the Provider's receipt of the overpayment notification.

4.8 The Wig/Scalp Prosthesis Vendor shall submit to a patient record audit upon 48 hours advance notice.

4.9 The Wig/Scalp Prosthesis Vendor shall participate in HELP/Wellness promotions sponsored by EGID under the terms of the promotion.

V. EGID SERVICES AND RESPONSIBILITIES

5.1 EGID agrees to pay the Wig/Scalp Prosthesis Vendor compensation pursuant to the provisions of Article VI.

5.2 EGID agrees to grant the Wig/Scalp Prosthesis Vendor the status of "Network Provider" and to identify the Wig/Scalp Prosthesis Vendor as a Network Provider on informational materials disseminated to members.

5.3 EGID agrees to continue listing the Wig/Scalp Prosthesis Vendor as a Network Provider until this Contract terminates.

5.4 EGID agrees to periodically provide the Wig/Scalp Prosthesis Vendor access to a list of all Network Providers.

5.5 EGID agrees to provide appropriate identification cards for members.

5.6 EGID agrees to adhere to 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.

5.8 EGID shall maintain a prior authorization program in order to aid its members in making decisions that will maximize medical benefits and reduce their financial risk.

VI. COMPENSATION AND BILLING

6.1 The Wig/Scalp Prosthesis Vendor shall seek payment only from EGID for the provision of wig/scalp prosthesis services except as provided in paragraphs 6.3, and 6.9. The payment from the Employees Health Insurance Plan shall be limited to the amounts referred to in paragraph 6.2.

6.2 EGID agrees to pay the Wig/Scalp Prosthesis Vendor’s billed charges for wig/scalp prosthesis services or the fee set by EGID for those services, whichever is less.

a) EGID may reduce the payment by any deductibles, coinsurance and copayments.
b) EGID shall have the right to categorize what shall constitute a procedure. EGID’s financial liability shall be paid by applying appropriate coding methodology, whether the Wig/Scalp Prosthesis Vendor has billed appropriately or not.
c) The Wig/Scalp Prosthesis Vendor agrees not to charge more for wig/scalp prosthesis services to members than the amount normally charged (excluding Medicare) by the Wig/Scalp Prosthesis Vendor to other patients for similar services. The Wig/Scalp Prosthesis Vendor may, however, contract with other third party payors for services. The Wig/Scalp Prosthesis Vendor’s usual and customary charges may be requested by the EGID and verified through an audit.

6.3 The Wig/Scalp Prosthesis Vendor agrees that the only charges for which a member may be liable and be billed are as provided in paragraphs 6.2, and 6.8. The Wig/Scalp Prosthesis Vendor shall not waive any deductibles, copayments and coinsurance required by the EGID, except during times of HELP/Wellness promotions, when the copayment/coinsurance is waived by EGID.

6.4 The Wig/Scalp Prosthesis Vendor shall refund within 30 days of discovery to the member any overpayments made by the member.

6.5 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 the EGID's maximum liability under the terms of this Contract.

6.6 The Wig/Scalp Prosthesis Vendor shall bill EGID on forms acceptable to EGID within 60 days of providing the wig/scalp prosthesis services. The Wig/Scalp Prosthesis Vendor shall bill using the most appropriate codes based on industry guidelines, including the current HCFA Common Procedure Coding System (HCPCS) with appropriate modifiers and ICD codes. Wig/Scalp Prosthesis Vendor shall furnish, upon request at no cost, all information, including medical records, reasonably required by EGID to verify and substantiate the provision of services and the charges for such services if the member and the Wig/Scalp Prosthesis Vendor are seeking reimbursement through EGID.

6.7 EGID shall reimburse the Wig/Scalp Prosthesis Vendor 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 delay of reimbursement due to circumstances beyond EGID's control.

6.8 The Wig/Scalp Prosthesis Vendor shall not charge the member for services denied during prior authorization procedures described in Article VII, unless the Wig/Scalp Prosthesis Vendor has obtained a written waiver from that member. Such a waiver shall be obtained only upon the denial of prior authorization and prior to the provision of those services. The waiver shall clearly state that the member shall be responsible for payment of services denied by EGID.

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. UTILIZATION REVIEW

7.1 The Wig/Scalp Prosthesis Vendor shall adhere to and cooperate with EGID's prior authorization procedures. These procedures do not guarantee a member’s eligibility or that benefits are payable, but assure the Wig/Scalp Prosthesis Vendor that the services to be provided are covered under the Plan.

7.2 Upon the member’s request, EGID shall reconsider any non-approved services. The Wig/Scalp Prosthesis Vendor may submit a formal written appeal to EGID.

7.3 The Wig/Scalp Prosthesis Vendor shall request prior authorization from EGID or its designee for all wig/scalp prosthesis products.

7.4 Prior authorization requirements are intended to maximize insurance benefits assuring that services are provided to the member at the appropriate level. In no event is it intended that the prior authorization procedures interfere with the Wig/Scalp Prosthesis Vendor's decision regarding the appropriate wig/scalp prosthesis products to be provided to the patient.

7.5 EGID shall maintain review procedures and screening criteria that take into account professionally acceptable standards for quality services in the community. EGID or its designee shall consider all relevant information concerning the member before necessity is approved or denied.

VIII. LIABILITY AND INSURANCE

8.1 Neither party to this Contract, EGID nor the Wig/Scalp Prosthesis Vendor, nor any agent, employee or other representative of a party, shall be liable to third parties for any negligent act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.

8.2 The Wig/Scalp Prosthesis Vendor, at its sole expense, shall maintain a minimum of $100,000 per occurrence of insurance coverage for professional liability.

IX. MARKETING, ADVERTISING AND PUBLICITY

9.1 EGID shall encourage its members to use the services of the Network Provider Wig/Scalp Prosthesis Vendor.

9.2 EGID shall have the right to use the name, office address, telephone number and specialty of the Wig/Scalp Prosthesis Vendor for purposes of informing its members and prospective members of the identity of the Network Providers.

9.3 The Wig/Scalp Prosthesis Vendor, upon prior approval of EGID, shall have the right to publicize the Network Provider status in EGID's Network of Providers.

X. DISPUTE RESOLUTION

10.1 EGID and the Wig/Scalp Prosthesis Vendor 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.

XI. TERM AND TERMINATION

11.1 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 11.2.

11.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 12.2.

11.3 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.

11.4 This Contract shall terminate with respect to a Wig/Scalp Prosthesis Vendor upon failure to maintain Wig/Scalp Prosthesis Vendor's professional liability insurance in accordance with this Contract.

11.5 Following the effective date of termination, this Contract shall be of no further force or effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this Contract.

11.6 Following termination of this Contract, EGID shall continue to have access to the Wig/Scalp Prosthesis Vendor's records of services and products 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.

XII. GENERAL PROVISIONS

12.1 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.

12.2 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.

12.3 Notwithstanding the provisions of Paragraph 12.1 of this Contract, EGID may appoint an Administrator to administer any of the terms of the Network Contract referenced herein, and any and all duties or acts required of EGID under this Contract and to receive any notices required by this Contract.

12.4 This Contract, together with its exhibits, contains the entire agreement between EGID and the Wig/Scalp Prosthesis Vendor relating to the rights granted and the obligations assumed by the parties concerning the provision of medical 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.

12.5 This Contract, or any part, section or exhibit of, or attached to it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the EGID and the Wig/Scalp Prosthesis Vendor.

12.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract that 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.

12.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and the determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this entire Contract, or any one of them, in accordance with the intent and purpose of the parties hereto.

12.8 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.

12.9 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.

HealthChoice

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.

HealthChoice

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.

HealthChoice

IDRS Oklahoma Department of Rehabilitation Services

DOC Department of Corrections Oklahoma

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: _____

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: 1-405-717-8790 or 1-800-543-6044 or Fax: 1-405-717-8977 or 1-405-717-8702
EGID.EFTEnroll@omes.ok.gov or EGID.NetworkManagement@omes.ok.gov

Revised 02/18/2016

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

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

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	Required
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	Optional
Submission Date	The date on which the enrollment is submitted	Optional

Network Provider Wig/Scalp Prosthesis Contract
Signature Page

The Office of Management and Enterprise Services Employees Group Insurance Department (EGID), and the Facility incorporated by reference the terms and conditions of the HealthChoice Network Facility Contract (Contract) located in HCWSPv1.7 at www.ok.gov/sib/Providers/Contracts_and_Applications into this Signature Page and acknowledge the Contract is an electronic record created according to 12A O.S. § 15-011 et seq. EGID and the Facility 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 Facility. The original of the signed document will remain on file in the office of EGID

FOR THE FACILITY:

_____
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

HealthChoice | DRS Oklahoma Department of Rehabilitation Services | DOC Department of Corrections Oklahoma

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

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

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