

State of Oklahoma

Department of Rehabilitation Services

Dental Contract

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APPENDIX:

ELECTRONIC FUNDS TRANSFER FORM
SIGNATURE PAGE

Department Of Rehabilitation Services

Dental Contract

It is hereby agreed between the State Department of Rehabilitation Services and the Dentist named on the signature page, that the Dentist shall be a provider in the State Department of Rehabilitation Services' network of providers.

This contract is entered into for the purpose of defining the conditions for reimbursement by the State Department of Rehabilitation Services to the Dentist. It in no way is meant to impact on the Dentist's decision as to what he or she considers appropriate dental treatment.

I. RECITALS

- 1.1 The Department of Rehabilitation Services, hereinafter DRS, is a statutory body created by 74 O.S. 2004, § 166.1, as amended, to administer and manage a certain program of Dental care for persons eligible for public assistance.
- 1.2 The Dentist is duly licensed by the State of Practice as a practitioner of dentistry or recognized dental specialty and satisfies additional criteria as established by DRS.
- 1.3 The intent of this Contract is to provide access to quality dental health care at an affordable, competitive cost to DRS and its beneficiaries.
- 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 Dentist for a specific procedure in accordance with the provisions in Article VI of this Contract. The Dentist shall charge the usual and customary fee unless the fee schedule limits otherwise.
- 2.2 "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.
- 2.3 "Hospital Services" means those acute care inpatient and outpatient hospital services that are pre-authorized by DRS.
- 2.4 "Dental" means belonging to the study and practice of dentistry or a dental specialty for the prevention, alleviation or management of an adverse medical/dental condition.
- 2.5 "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/dental condition, and
 - b) provided for the diagnosis and treatment of the medical/dental condition, and
 - c) within standards of acceptable, prudent dentistry practice within the community, and
 - d) not primarily for the convenience of the beneficiary, the beneficiary's Dentist or another provider, and

- e) any condition which, if left untreated, could reasonably result in serious medical or dental consequences, or cause loss or irreversible damage of the affected part(s), and
 - f) the most appropriate supply or level of service that can safely be provided.
- 2.6 "Dental Services" means the professional services provided by a Network Dentist and pre-authorized by DRS.
- 2.7 "Beneficiaries" means all persons eligible for benefits provided by DRS as determined by established criteria.
- 2.8 "Network Dentist" means a licensed practitioner of the healing arts who has entered into this Contract with DRS to accept scheduled reimbursement for pre-authorized Dental services provided to its beneficiaries.
- 2.9 "Prior Authorization" means a function performed by DRS to assess the health care services available to the beneficiary and authorize appropriate services prior to services being rendered.
- 2.10 "Third Party Payer" means an insurance company or other entity making payment directly to the Dentist on behalf of DRS.

III. RELATIONSHIP BETWEEN DRS AND THE DENTIST

- 3.1 DRS has negotiated and entered into this Contract with the Dentist on behalf of the individuals who are beneficiaries of DRS. The Dentist 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 DRS 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 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 beneficiary or a network dentist other than the Dentist named in this contract.

IV. DENTIST SERVICES AND RESPONSIBILITIES

- 4.1 The Dentist agrees to provide quality dental care in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the Dentist shall provide services to beneficiaries that are deemed appropriate and pre-authorized under the established benefits of DRS.
- 4.3 The Dentist agrees to submit billing data and records of treatment in the manner and form prescribed by DRS. The individual's Dental case records will be available during regular working hours to authorized representatives of DRS and copies thereof will be furnished by the Dentist when requested by an authorized representative of DRS. The Dentist agrees to retain one copy of the billing data and records of treatment and all other records upon which a claim is based, in its file for a period of six (6) years.
- 4.4 It is understood that any person seeking Dental services has the right to make application for payment on his behalf by DRS for compensable services provided by the Dentist. The Dentist and/or Dentist's office staff agrees to assist the patient in making application for such care and services.
- 4.5 Authorized representatives of DRS shall have the right to make physical inspections of the Dentist's office and to examine such records as they relate to financial statements submitted under this Contract or to payments claimed by the Dentist under this Contract; and to conduct audits of the financial records of the Dentist, at any time, as provided by the Code of Federal Regulations, Title 34, § 74.53.

- 4.6 The Dentist agrees that all information provided is true, accurate and complete. The Dentist understands that payment and satisfaction of all claims will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may subject the Dentist to prosecution under applicable Federal and State laws. The Dentist further agrees that work, services or materials shown by any invoice or claim have been completed or supplied in accordance with the plans, specifications, order or requests furnished. The Dentist further agrees that he/she has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly to any elected official, officer or employee of DRS of money or any other thing of value to obtain payment.
- 4.7 The Dentist agrees to disclose to DRS, prior to approval or renewal of this Contract, the name of any person who has an ownership or controls an interest in, or is an agent or managing employee of the Dentist who has been convicted of a criminal offense related to such person's involvement in any program under Titles V, XVIII, XIX, or XX of the Social Security Act since inception of these programs.
- 4.8 The provider shall submit a current, complete and accurate Oklahoma Uniform Credentialing Application (ODH Form 606) and EGID OUCA Supplement as allowed under OK §63-1-106.2 and Laws 1998, c. 210, § 1 which are incorporated herein by reference. The Dentist shall notify the Network Manager of any change in the information contained in the application within fifteen (15) days of such change, including resolved litigation listed as "pending" on the original Application.
- 4.9 The Dentist shall disclose ownership and control interests at the time of entering into this Contract on the required Federal reporting form and at other times that DRS or the Secretary of Health and Human Services may require and in a form designated by DRS.
- 4.10 The Dentist agrees to submit, within thirty-five (35) days of the date on a request by DRS full and complete information about:
- a) The ownership of any subcontractor with whom the Dentist has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request;
 - b) Any significant business transactions between the Dentist and any wholly owned supplier, or between the Dentist and subcontractor, during the five (5) years period ending on the date of the request.
- 4.11 The Dentist agrees and understands that payment cannot be made by DRS to vendors providing care and/or services under Federally-assisted programs unless care and/or service is provided without discrimination on the grounds of race, color, national origin, handicap or unless program enabling legislation permits on the basis of age. This assures DRS is in compliance with the Department of Education, Regulations, Title 34, Code of Federal Regulations, 76.500 (which implements Title VI and Title VII of the 1964 Civil Rights Act, Title IX of the Education Amendments of 1972, the Rehabilitation Act of 1973 as amended, the Age Discrimination Act of 1975 and the Americans with Disabilities Act. These laws and regulations prohibit excluding from participation in, denying the benefits of, or subjecting to discrimination, under any program or activity receiving Federal Financial Assistance, any person on the grounds of race, color, national origin, any qualified person on the basis of handicap or without distinctions made on the basis of age except as legislatively permitted or required. Written complaints of non-compliance with either law should be made to the Director of Rehabilitation Services, 3545 N.W. 58th, Ste. 500, Oklahoma City, Oklahoma 73112.

V. DRS SERVICES AND RESPONSIBILITIES

- 5.1 DRS agrees to pay the Dentist compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.

- 5.2 DRS agrees to grant the Dentist the status of “Network Provider” and to identify the Dentist as a network provider on informational materials disseminated to beneficiaries.
- 5.3 DRS agrees to continue listing the Dentist as a network provider until this Contract terminates.
- 5.4 DRS agrees to provide the Dentist access to a list of all network providers.
- 5.5 DRS agrees to adhere to confidentiality of patient's records and to only release pertinent clinical information in accordance with State and Federal guidelines.
- 5.6 DRS shall give a forty-eight-hour (48) notice prior to an audit.
- 5.7 DRS agrees to provide appropriate documentation to beneficiaries for the verification of prior authorization procedures and to establish the provision of appropriate health care.
- 5.8 DRS shall maintain prior authorization programs for all Dental services.

VI. COMPENSATION AND BILLING

- 6.1 The Dentist shall seek payment only from DRS for the provision of Dental services except as provided in paragraphs 6.3. The payment from DRS shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 DRS agrees to pay the Dentist's billed charge for each procedure or the fee set by DRS for that procedure, whichever is less. DRS shall have the right to categorize what shall constitute a procedure. DRS and the beneficiary's financial liability shall be limited to the procedures allowable as determined by the DRS, paid by applying appropriate coding methodology, whether the Dentist has billed appropriately or not.
- 6.3 The Dentist agrees to accept the payment from DRS as full and complete payment for services for recipients of public assistance. If the patient is a recipient of Dental Assistance, Rehabilitation Services only, payment from the Department shall represent payment in full except the Dentist may collect an amount not to exceed that shown on DRS Form DRS-C-100, Medical services Authorization.
- 6.4 The Dentist shall bill DRS on forms acceptable to the DRS within fifteen (15) working days of providing the Dental services. The Dentist shall use the current ADA codes or CPT codes. The Dentist shall furnish, upon request at no cost, all information, including Dental records and x-rays, reasonably required by the DRS to verify and substantiate the provision of Dental services and the charges for such services if the beneficiary and the Dentist are seeking reimbursement through DRS.
- 6.5 DRS shall reimburse the Dentist within thirty (30) days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. DRS will not be responsible for delay of reimbursement due to circumstances beyond DRS' control.
- 6.6 The Dentist agrees to release all Dentist liens for which payment has been made for Title XIX by DRS and notify DRS. However, this provision does not affect the Dentist's entitlement to file a lien or liens for non-pre-authorized services.
- 6.7 DRS shall have the right at all reasonable times and, to the extent permitted by law, to inspect and duplicate all Dental and billing records relating to Dental services rendered to beneficiaries at no cost to DRS or the beneficiary.
- 6.8 The dentists shall refund within 30 days of discovery to the beneficiary any overpayments made by the beneficiary.

VII. UTILIZATION MANAGEMENT

7.1 The Dentist shall adhere to and cooperate with DRS' established prior authorization procedures.

VIII. LIABILITY AND INSURANCE

8.1 Neither party to this Contract, DRS nor the Dentist, 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 Dentist, at his/her sole expense, shall maintain a minimum of five hundred thousand dollars (\$500,000) per occurrence and five hundred thousand dollars (\$500,000) aggregate of insurance coverage for professional liability.

IX. DISPUTE RESOLUTION

9.1 DRS and the Dentist 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 X.

X. TERM AND TERMINATION

10.1 The term of this Contract shall be for one year commencing on the prescribed date, or the effective date on the signature page, whichever is later, 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 11.2.

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 This Contract shall terminate with respect to a Dentist upon:

- a) the loss or suspension of the Dentist's license to practice medicine in the State of Practice; or
- b) failure to maintain Dentist's professional liability insurance in accordance with this Contract.

10.5 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.

10.6 Following termination of this Contract, DRS shall continue to have access to the Dentist records of care and services provided to beneficiaries for six (6) years from the date of provision of the services to which the records refer as set forth in Paragraph 6.7.

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 Any notice required to be given pursuant to the terms and provisions of this Contract shall be in writing, postage prepaid, and shall be sent by certified mail, return receipt requested, to DRS at the mailing address below or the Provider at the mailing address listed on the Application. The notice shall be effective on the date indicated on the return receipt:

Department of Rehabilitation Services
ATTN: Network Management
P.O. Box 57630
Oklahoma City, Oklahoma 73157-7630

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 of Paragraph 11.1 of this Contract, the DRS 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 DRS under this Contract and to receive any notices required by this Contract.
- 11.4 This Contract, together with its exhibits, contains the entire agreement between DRS and the Dentist relating to the rights granted and the obligations assumed by the parties concerning the provision of Dental services to beneficiaries. 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, 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 DRS and the Dentist.
- 11.6 This Contract is subject to all applicable federal laws, 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 federal laws and State of Oklahoma statutes.
- 11.7 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.
- 11.8 In accordance with Presidential Executive Order 12549, all providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible for participation in federal assistance programs.
- 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.

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

**Department Of Rehabilitation Services
Dental Contract
Signature Page**

When signed by both parties below, this constitutes agreement and acceptance of all terms and conditions contained in the Dental Contract. DRS and the dentist 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 dentist. The original of the signed document will remain on file in the office of the Department of Rehabilitation. By signing, both parties agree that this document shall become a part of the Contract.

FOR THE DENTIST:

Name (Typed or Printed)

Signature

NPI

Federal Tax ID Number

Primary Service Address:

FOR DRS:

Joe D. Cordova, Director
Department of Rehabilitation Services
3545 N.W. 58th St., Ste. 500
Oklahoma City, OK 73112

Please return completed application, signature page and attachments to:

**Department of Rehabilitation Services
Attn: DRS Network Management
P.O. Box 57630
Oklahoma City, OK 73157
Phone: 1-405-717-8921 or toll-free 1-888-835-6919
Fax: 1-405-717-8977**

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