

State of Oklahoma

Department of Rehabilitation Services

Infusion Therapy Contract

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APPENDIX:

INFUSION THERAPY PROVIDER APPLICATION
ELECTRONIC FUNDS TRANSFER FORM
SIGNATURE PAGE

Department Of Rehabilitation Services Infusion Therapy Contract

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

This contract is entered into for the purpose of defining the conditions for reimbursement by Department of Rehabilitation Services to the Provider. It in no way is meant to impact on the Provider's decision as to what is considered appropriate Infusion Therapy services.

I. RECITALS

- 1.1 Department of Rehabilitation Services (DRS) is a statutory body created by 74 O.S. § 166.1, as amended, to administer and manage a certain program of medical care for persons eligible for public assistance.
- 1.2 The Infusion Therapy provider shall be qualified and duly certified to participate in the Medicare program under Title XVII of the Social Security Act, and shall comply with all applicable federal, state, and local laws, regulating such services and satisfies additional credentialing criteria as established by DRS.
- 1.3 The intent of this Contract is to provide access to enhanced quality Infusion Therapy services 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 an Infusion Therapy Provider for a specific product in accordance with the provisions in Article VI of this Contract. The Provider 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 "Infusion Therapy" means those services provided by a Network Infusion Therapy Provider that are pre-authorized by DRS.
- 2.4 "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.
- 2.5 "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 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 beneficiary, the beneficiary's Provider 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. For hospital stays, this means that the acute care as an inpatient is necessary due to the kind of services the Beneficiary is receiving or the severity of the Beneficiary's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- 2.6 "Beneficiaries" means all persons eligible for benefits provided by DRS as determined by established criterion.
- 2.7 "Network Provider" means an Infusion Therapy Provider who has entered into this Contract with DRS to accept scheduled reimbursement for pre-authorized Infusion Therapy services provided to beneficiaries.
- 2.8 "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.
- 2.9 "Third Party Payor" means an insurance company or other entity making payment directly to the Provider on behalf of DRS.

III. RELATIONSHIP BETWEEN DRS AND THE INFUSION THERAPY PROVIDER

- 3.1 DRS has negotiated and entered into this Contract with the Provider on behalf of the individuals who are Beneficiaries of DRS. The Provider 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 Provider other than the Provider named in this contract.

IV. INFUSION THERAPY PROVIDER SERVICES AND RESPONSIBILITIES

- 4.1 The Provider agrees to provide quality Infusion Therapy services in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the Provider shall provide Infusion Therapy services to beneficiaries that are medically necessary and pre-authorized under the established benefits of DRS.
- 4.3 The Provider agrees to submit billing data and records of treatment in the manner and form prescribed by DRS. The individual's medical case records will be available during regular working hours to authorized representatives of DRS. The Provider 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 6 years.
- 4.4 It is understood that any person seeking medical services has the right to make application for payment on his behalf by DRS for compensable services provided by the Provider. The Provider and/or Provider's office staff agrees to assist the patient in making application for such care and services.
- 4.5 The Provider shall participate in the Prior Authorization procedures as established by DRS.
- 4.6 The Provider shall accurately complete the Network Provider application that is attached to and made part of this Contract. The Provider shall notify DRS' 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 Provider shall submit to a patient record audit upon 48 hours advance notice.
- 4.8 Authorized representatives of DRS shall have the right to make physical inspections of the Provider's office and to examine such records as they relate to financial statements submitted under this Contract or to payments claimed by the Provider under this Contract; and to conduct audits of the financial records of the Provider at any time, as provided by the Code of Federal Regulations, Title 34 § 74.53.
- 4.9 The Provider agrees that all information provided is true, accurate and complete. The Provider 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 Provider to prosecution under applicable Federal and State laws. The Provider 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 Provider further agrees that no payment has been made, given or donated or agreed to pay, give or donate, either directly or indirectly to any elected official,

officer or employee of the State of Oklahoma of money or any other thing of value to obtain payment.

- 4.10 The Provider 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 Provider 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.
- 4.11 The Provider 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 may require and in a form designated by DRS.
- 4.12 The Provider agrees to submit, within 35 days of the date on a request by DRS full and complete information about:
 - a) The ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the twelve month period ending on the date of the request;
 - b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and subcontractor, during the 5 years period ending on the date of the request.
- 4.13 The Provider agrees and understands that payment cannot be made by DRS to Providers 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 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, 3535 N.W. 58th, Suite 500, Oklahoma City, Oklahoma 73112.

V. DRS SERVICES AND RESPONSIBILITIES

- 5.1 DRS agrees to pay the Provider compensation pursuant to the provisions of Article VI.
- 5.2 DRS agrees to grant the Provider the status of "Network Provider" and to identify the Provider as a Network Provider on informational materials disseminated to beneficiaries.

- 5.3 DRS agrees to continue listing the Provider as a Network Provider until this Contract terminates.
- 5.4 DRS agrees to provide the Provider access to a list of all Network Providers.
- 5.5 DRS agrees to provide appropriate documentation to beneficiaries for the verification of prior authorization procedures and to establish the provision of appropriate health care.
- 5.6 DRS agrees to adhere to confidentiality of patient's records and to only release pertinent clinical information in accordance with State and Federal guidelines.
- 5.7 DRS shall give a forty-eight hour (48) notice prior to an audit.
- 5.8 DRS shall establish and maintain prior authorization procedures.

VI. COMPENSATION AND BILLING

- 6.1 The Provider shall seek payment only from DRS for the provision of Infusion Therapy services except as provided in paragraph 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 Provider'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 procedure's allowable as determined by DRS, paid by applying appropriate coding methodology, whether the Provider has billed appropriately or not.
- 6.3 The Provider 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 Medical Assistance, Rehabilitation Services only, payment from the Department shall represent payment in full except the Provider may collect an amount not to exceed that shown on DRS form, DRS-C-100, Medical Services Authorization.
- 6.4 The Provider shall refund within 30 days of discovery to DRS any overpayments made by DRS.
- 6.5 The Provider shall bill DRS on forms acceptable to DRS within 15 working days of providing the medical services. The Provider shall use the current HCPCS codes, CPT codes and ICD codes, when applicable. The Provider shall furnish, upon request at no cost, all information, including medical records, reasonable required by DRS to verify and substantiate the provision of medical services and the charges for such services if the beneficiary and the Provider are seeking reimbursement through DRS.

- 6.6 DRS shall reimburse the Provider within 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.
- 6.7 The Provider agrees to release all Provider liens for which payment has been made for Title XIX by DRS and notify DRS. However, this provision does not affect the Provider's entitlement to file a lien or liens for non-pre-authorized services.
- 6.8 DRS 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 beneficiaries at no cost to DRS or the beneficiary.

VII. UTILIZATION MANAGEMENT

- 7.1 The Provider shall adhere to and cooperate with DRS's established Prior Authorization procedures. These procedures do not guarantee a beneficiary's eligibility or that benefits are payable, but assure the Provider that the medical services to be provided are pre-authorized under the plan.
- 7.2 The Infusion Therapy Provider shall request prior authorization from DRS or its designee for all Infusion Therapy services.
- 7.3 Prior Authorization procedures are intended to enable DRS to ensure that services are provided at the appropriate level of care. In no event is it intended that the procedures interfere with the Provider's decision regarding the patient's care.

VIII. LIABILITY AND INSURANCE

- 8.1 Neither party to this Contract, DRS nor the Provider, 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 Provider, at Provider's sole expense, shall maintain a minimum of \$1,000,000 per occurrence of insurance coverage for professional liability.

IX. DISPUTE RESOLUTION

- 9.1 DRS and the Provider 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 Provider upon failure to maintain Provider'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 Provider records of equipment provided to beneficiaries for 6 years from the date of provision of the services to which the records refer as set forth in Paragraph 6.8.

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, OK 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, 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 the 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 Provider relating to the rights granted and the obligations assumed by the parties concerning the provision of medical 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 Provider.
- 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.

Department Of Rehabilitation Services
Network Infusion Therapy Vendor Credentialing Information
Contract Applications

The Department of Rehabilitation (DRS) 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.

Department Of Rehabilitation Services
Infusion Therapy
Vendor Application Requirements

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.

Department Of Rehabilitation Services Network Facility Application

The completed Network Facility Application should be returned to the Department of Rehabilitation Services in its entirety, along with any applicable attachments. You can mail, fax or email the Application to:

DRS Network Management
Attn: Network Management
P.O. Box 57630
Oklahoma City, Oklahoma 73157-7630
FAX: 1-405-717-8977
Email: EGID.DRSNetworkManagement@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

**Department Of Rehabilitation Services Network
Infusion Therapy Contract
Signature Page**

When signed by both parties below, this constitutes agreement and acceptance of all terms and conditions contained in the Infusion Therapy Contract to be effective the date denoted on the copy of the executed Signature Page returned to the facility. The original of this 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 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 DRS:

Joe D. Cordova, Director
Department of Rehabilitation Services
3535 N.W. 58th St., Ste. 500
Oklahoma City, OK 73112

Please return completed application, signature page and required attachments to:

**Department of Rehabilitation Services
Attn: Network Management
P.O. Box 57630
Oklahoma City, OK 73157-7630
Email: EGID.DRSNetworkManagement@omes.ok.gov
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