# State of Oklahoma

# Department of Corrections

# Laboratory

# Contract

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# Oklahoma Department of Corrections
# Laboratory Contract

It is hereby agreed between the Oklahoma Department of Corrections and the Laboratory named on the signature page, that the Laboratory shall be a provider in the Oklahoma Department of Corrections' Network of Providers.

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

## I. RECITALS

1.1 The Oklahoma Department of Corrections (hereinafter, the DOC) is a statutory body created by 57 O.S., § 505 et seq., as amended, to administer and manage the incarceration of persons who have committed criminal offences or are otherwise subjected to criminal sanctions within the State of Oklahoma.

1.2 The Laboratory shall be qualified and duly certified by the Clinical Laboratory Improvement Act of 1988 (CLIA) and 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 a laboratory providing clinical laboratory health services and satisfies additional credentialing criteria as established by the DOC.

1.3 The intent of this Contract is to provide access to enhanced quality health care, utilizing managed care components at an affordable, competitive cost to the DOC.

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 Laboratory for a specific procedure in accordance with the provisions in Article VI of this Contract.

2.2 "Emergency" means a sudden onset of a medical or mental condition displaying acute symptoms that are so severe that the absence of immediate medical attention could reasonably result in:

a) permanently placing the patient's health in jeopardy; or
b) causing other serious medical consequences; or
c) causing serious impairment to bodily functions; or
d) causing serious and permanent dysfunction of any body organ or part.

2.3 "Laboratory Services" means those laboratory services that are covered by the DOC.

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 Inmate, the Inmates's Laboratory 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. In the event of an inpatient stay, acute care is necessary due to the types of services the Inmate is receiving or the severity of the inmate's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

2.6 "Medical Services" means the professional services provided by a Network Laboratory and covered by the DOC's Plan.

2.7 "Inmates" means all persons within the DOC's custody for whom the DOC is required to furnish medical care and services.

2.8 "Network Laboratory" means a certified Laboratory that has entered into this Contract with the DOC to accept scheduled reimbursement for covered medical services provided to Inmates.

2.9 "Network Physician" means a licensed practitioner of the healing arts who has entered into a Contract with the DOC to accept scheduled reimbursement for covered medical services provided to Inmates.

2.10 "Prior Authorization" means a function performed by the DOC, or its designee, to review for medical necessity in identified areas of practice as defined at 7.11 of this Contract, prior to services being rendered.

2.11 "Referral Process" means a process by which the DOC handles the authorization, scheduling, tracking and monitoring of all medical service appointments outside the DOC. The process begins with the appropriate DOC provider diagnosing the patient with a condition that requires treatment not available within the DOC's Medical Services Division. The DOC's provider forwards the referral to the DOC's regional physician to obtain approval for the patient to access a Laboratory outside of the prison and/or county jail. The regional physician approves or denies the outside referral by checking the appropriate box on the referral form. The DOC's provider contacts the outside provider and the appointment is scheduled. In some cases, a telephone conference between the referring DOC provider and the outside provider may be warranted. In the event a procedure needs to be performed that is not indicated on the Referral Record as approved by the DOC's regional physician, a telephone conference between the outside provider and the referring provider shall be necessary.

2.12 "Consultation Documentation Process" means a process by which a two-page document called a "Referral Record" is completed with the necessary attachments. The "Referral Record" shall be delivered by the DOC's Corrections Officer that accompanies the inmate to the outside

provider's location. The form provides information to the receiving outside provider and if more information is needed, it shall be obtained via the telephone. The second page of the "Referral Record" shall be completed by the outside provider and shall document significant findings, tests and recommendations. In the event of an emergency room visit or inpatient stay, the discharge summary shall be attached to the "Referral Record" or it shall be forwarded to the DOC's medical facility when completed. In the event any follow-up appointments are deemed necessary, it shall be documented on page two of the "Referral Record" before it is sent back to the DOC's referring provider via the DOC's Correctional Officer that accompanies the inmate.

2.13 "Follow-Up Appointments" means any additional visits deemed necessary by the outside provider and documented on page two of the "Referral Record". In some cases, this information may also be correlated with the DOC's referring provider via the telephone. The DOC's regional physician shall approve all follow-up appointments. The outside provider will be notified in the event approval is denied. The outside provider shall not inform the inmate regarding potential follow-up visits.

## III. RELATIONSHIP BETWEEN THE DOC AND THE LABORATORY

3.1 The Laboratory is an independent contractor that has entered into this Contract to become a Network Laboratory and is not, nor is intended to be, the employee, agent or other legal representative of the DOC 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 The DOC and the Laboratory agree that all of the parties hereto shall respect and observe the Laboratory/patient relationship which will be established and maintained by the Laboratory. The Laboratory may choose not to establish a Laboratory/patient relationship if the Laboratory would have otherwise made the decision not to establish a Laboratory/patient relationship had the patient not been an Inmate. The Laboratory reserves the right to refuse to furnish services to an Inmate in the same manner as they would any other patient.

3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies of any third party, including but not limited to, an Inmate or a Network Provider other than the Laboratory named in this Contract.

## IV. LABORATORY SERVICES AND RESPONSIBILITIES

4.1 The Laboratory shall provide quality, medically necessary Laboratory services to Inmates, in a cost efficient manner, when such services are ordered by a licensed practitioner of the healing arts, who is a member of the Laboratory's medical staff and has been awarded the prerequisite clinical privileges to order and/or perform such services. Nothing in this Contract shall be construed to require the Laboratory to perform any procedure which is deemed professionally unacceptable or is contrary to Laboratory policy.

4.2 The Laboratory shall provide Laboratory services to Inmates in the same manner and quality as those services are provided to all other patients of the Laboratory.

4.3 The Laboratory has, and shall maintain, in good standing while this Contract is in effect, all licenses required by law, and if applicable, certification to participate in the Medicare program under Title XVIII of the Social Security Act and/or Joint Commission certification and certification by the Clinical Laboratory Improvement Amendment.

4.4 The Laboratory agrees to make reasonable efforts to refer covered Inmates to other Network Facilities with which the DOC contracts, for medically necessary services that the Laboratory cannot or chooses not to provide. Failure of the Laboratory to use Network Providers will result in a review pursuant to the credentialing plan.

4.5 The Laboratory shall furnish, at no cost to the DOC or the Inmate, any medical and billing records covering any Laboratory services, for any Inmate for which the DOC has statutory responsibility for medical care.

4.6 The Laboratory shall accurately complete the Network Laboratory Application which is attached to and made part of this Contract. The Laboratory shall notify the DOC 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 Laboratory shall reimburse the DOC for any overpayments made to the Laboratory within 30 days of the Laboratory's receipt of the overpayment notification.

4.8 The Laboratory shall submit to a patient record audit upon 48 hours advance notice.

## V. INSURANCE BOARD SERVICES AND RESPONSIBILITIES

5.1 The DOC agrees to pay the Laboratory compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.

5.2 The DOC agrees to grant the Laboratory the status of "Network Laboratory" and to identify the Laboratory as a Network Laboratory on information disseminated to DOC facilities.

5.3 The DOC agrees to continue listing the Laboratory as a Network Laboratory until this Contract terminates.

5.4 The DOC agrees to periodically provide the Laboratory with access to a listing of all Network Facilities.

5.5 The DOC agrees to provide appropriate identification cards for Inmates.

5.6 The DOC agrees to acknowledge the confidentiality of patient's records and to only release pertinent clinical information in accordance with state and federal guidelines.

5.7 The DOC shall give a 48 hour notice prior to an audit.

## VI. COMPENSATION AND BILLING

6.1 The Laboratory shall seek payment only from the DOC for the provision of medical services except as provided in paragraphs 6.3 and 6.4. The payment from the DOC shall be limited to the amounts referred to in paragraph 6.2.

6.2 The DOC agrees to pay the Laboratory's billed charges for each procedure or the fee set by the DOC for that procedure, whichever is less. Payment is allowed when the Inmate has received medically necessary covered services subject to the following policy limitations and conditions.

a) The DOC shall have the right to categorize what shall constitute a procedure. The DOC's and the Inmate's financial liability shall be limited to the procedure's allowable as determined by the DOC, paid by applying appropriate coding methodology, whether the Laboratory has billed appropriately or not.

b) The Laboratory agrees not to charge more for medical services to Inmates than the amount normally charged (excluding Medicare) by the Laboratory to other patients for similar services. The Laboratory may, however, contract with other third party payors for services. The Laboratory's usual and customary charges may be requested by the DOC and verified through an audit.

6.3 The Laboratory shall refund within 30 days of discovery to the Inmate any overpayment made by the DOC.

6.4 The Laboratory shall bill the DOC on form CMS-1500, in accordance with CMS guidelines, within 60 days of providing the laboratory services. The Laboratory shall use the current CPT codes with appropriate modifiers and ICD-9 diagnostic codes, when applicable. The Laboratory shall furnish, upon request at no cost, all information, including medical records, reasonably required by the DOC to verify and substantiate the provision of medical services and the charges for such services.

6.5 The DOC shall reimburse the Laboratory within 30 days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. The DOC will not be responsible for the delay of reimbursement due to circumstances beyond the DOC's control.

6.6 The DOC 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 Inmates at no cost to the DOC or the Inmate.

## VII. REFERRAL PROCESS

7.1 The Laboratory shall adhere to and cooperate with the DOC's Referral Process as defined in Section 2.11 of this contract.

## VIII. CONSULTATION DOCUMENTATION PROCESS

8.1 The Laboratory shall adhere to and cooperate with the DOC's Consultation Documentation Process as defined in Section 2.12 including follow-up appointments as defined in Section 2.13.

## IX. LIABILITY AND INSURANCE

9.1 Neither party to this Contract, the DOC nor the Laboratory, or any agent, employee or other representative of a party, shall be liable to third parties for any act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.

9.2 The Laboratory shall be required to obtain general and medical liability coverage~~s~~ for claims of acts and omissions of the Laboratory and its employees and agents. Such coverage shall be maintained at a level of not less than that which is mandated by state statute or less than $1,000,000 per incident, when the Laboratory is not regulated by statute. The DOC shall be notified 30 days prior to cancellation. If coverage is lost or reduced below specified limits, this Contract may be canceled by the DOC.

## X. DISPUTE RESOLUTION

10.1 The DOC and the Laboratory 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 It is agreed by the parties that no changes to the Contract, which include coverage~~s~~ or fee reimbursements, shall be made with less than 60 days notice to all affected parties.

11.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 12.2 at any time during the term of this Contract.

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 Following termination of this Contract, the DOC shall continue to have access, at no cost to the DOC, to the Laboratory's records of care and services provided to Inmates for five years from the date of provision of the services to which the records refer as set forth in paragraph 6.6.

11.5 This Contract shall terminate with respect to a Laboratory upon:

a) the loss or suspension of the Laboratory's license to operate in the state of residence, CLIA certification, Joint Commission/Medicare certification; or
b) the Laboratory does not maintain the Laboratory's professional and general liability coverage in accordance with this Contract.

## 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.

12.3 Notwithstanding the provisions in Section 12.1, the DOC may designate an Administrator to administer any of the terms of this Contract.

12.4 This Contract, together with exhibits, contains the entire agreement between the DOC and the Laboratory relating to the rights granted and the obligations assumed by the parties concerning the provision of Laboratory services to Inmates. 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 or section of it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the DOC and the Laboratory.

12.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract, which is not in conformity with existing or future legislation, shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.

12.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Contract, or any one provision, in accordance with the intent and purpose of the parties hereto.

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.

# Department of Corrections

## FACILITY CREDENTIALING INFORMATION

## CONTRACT/APPLICATIONS

- The Department of Corrections (DOC) 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..

2. **Mailing Address**-This address is used for all correspondence (not related to claims) and credentialing information.

3. **Billing Address**-This address is used for submitting all claims to DOC 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, 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.**

Claim and eligibility information is available through the DOC Provider Web Site at https://gateway.sib.ok.gov/DOC. Go to the appropriate area at the top of the website and click on the link for ClaimLink. Register for a user ID and password. Information regarding claim edits is also available at this site.

# Department of Corrections
# Facility
# Application Requirements

Thank you for your interest in the Department of Corrections Provider Network.

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

Type or print your responses and complete all sections of this 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 of the Facility listed as the insured. The insurance limits must be at the levels required in the Contract and must indicate clearly that it is general and medical liability coverage.
- ☐ **W-9 form for each Federal Tax ID number**
  W-9 forms must be signed and list only the Federal Tax ID Number listed on the Application which will be used on claim forms submitted to Department of Corrections.
- ☐ **Copy of Joint Commission Accreditation Certificate (if applicable)**
- ☐ **Contract Signature Page**
- ☐ **Electronic Funds Transfer (EFT) Form**
- ☐ **Copy of voided check for Electronic Funds Transfers**

**Incomplete Applications will be returned**

**State of Oklahoma**

# Department of Corrections

# Laboratory Application

The completed Network Provider Laboratory Application should be returned to the Department of Corrections in its entirety, along with any applicable attachments.

Please type or print your responses and complete all applicable sections of this Application. If an area of inquiry is not applicable to the Facility, so state. If you need additional space to provide COMPLETE answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

You can mail or fax the Application to:

Oklahoma Department of Corrections
ATTN: Network Management
P.O. Box 12878
Oklahoma City, OK 73157-2878
Phone: 405-717-8750 or 1-866-573-8462
Fax: 405-717-8977

## GENERAL INFORMATION

Legal Name of Owner: _____

Trade Name/dba: _____

Medicare Facility Classification: _____ Medicare Number: _____

## LICENSE INFORMATION

State: _____ License Number: _____ Expiration Date: _____

***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_____

## 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:_____

Contracting/Managed Care: _____

Telephone Number: (___)_____

Fax Number: (___) _____

Email Address:_____

## ADDRESS INFORMATION

Federal Tax ID Number: _____ National Provider Identifier Number _____

***Attach a completed W-9 form for each Federal Tax ID number***

## *PHYSICAL ADDRESS – physical location of the Facility*

**THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE**

**Physical Address:** _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____

E-mail: _____ Phone: (_____) _____

## *MAILING ADDRESS – for correspondence/credentialing*

**Mailing Address:** _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____

E-mail: _____ Phone: (_____) _____

## *BILLING/REMIT ADDRESS – for claim payments and remittance statements*

**ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS**

**Name Submitted on Claims**: _____

**Billing Office Name** (if applicable): _____

**Billing Address:** _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____

E-mail: _____ Phone: (_____) _____

## ADDITIONAL LOCATION

Federal Tax ID Number: _____ National Provider Identifier Number _____

***Attach a completed W-9 form for each Federal Tax ID number***

## *PHYSICAL ADDRESS – physical location of the Facility*

**THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE**

**Physical Address:** _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____

E-mail: _____ Phone: (_____) _____

## *MAILING ADDRESS – for correspondence/credentialing*

**Mailing Address:** _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____

E-mail: _____ Phone: (_____) _____

## *BILLING/REMIT ADDRESS – for claim payments and remittance statements*

**ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS**

**Name Submitted on Claims**: _____

**Billing Office Name** (if applicable): _____

**Billing Address:** _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____

E-mail: _____ Phone: (_____) _____

**∗Please use a copy of this page to report any additional locations.**

## HOSPITAL AND NON-HOSPITAL BASED SERVICES; if applicable

**Does the Hospital provide the following specialty services?**

☐ Yes ☐ No Ambulance

☐ Yes ☐ No Ambulatory Surgery Center

☐ Yes ☐ No Dialysis

☐ Yes ☐ No Durable Medical Equipment

☐ Yes ☐ No Home Health Care

☐ Yes ☐ No Hospice

☐ Yes ☐ No Independent Diagnostic Testing Facility

☐ Yes ☐ No Infusion Therapy

☐ Yes ☐ No Laboratory

☐ Yes ☐ No Long Term Acute Care

☐ Yes ☐ No Rehabilitation

☐ Yes ☐ No Psych/Substance Abuse

☐ Yes ☐ No Skilled Nursing Facility

☐ Yes ☐ No Sleep Study

**Does the Hospital provide the following services by a group of specialists? If the answer is yes, please list the provider group name below.**

☐ Yes ☐ No Anesthesiology Group:_____

☐ Yes ☐ No Emergency Physician Group:_____

☐ Yes ☐ No Pathology Group: _____

☐ Yes ☐ No Radiology Group: _____

HealthChoice

Oklahoma Department
Of Rehabilitation Services

# 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 Division (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:
Employees Group Insurance Division (EGID) Office of Management and Enterprise Services (OMES)
3545 NW 58 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 12/11/13

# 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 |

State of Oklahoma

# Department of Corrections Laboratory Contract Signature Page

When signed by both parties below, this constitutes agreement and acceptance of all terms and conditions contained in the Laboratory Contract. The DOC 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 the Department. By signing, both parties agree that this document shall become part of the Contract.

**FOR THE LABORATORY:**

Signature Date:_____

Name of Facility (typed or printed):

_____

Name (typed or printed):

_____

Signature:

_____

Title:

Federal Tax ID Number: _____

Primary Service Address:

_____

_____

_____

**FOR THE DOC:**

_____

Director or Chief Medical Officer
Department of Corrections
3400 M. L. King Avenue
Oklahoma City, OK 73111

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

**Oklahoma Department of Corrections**
**Attn: Network Management/Provider Relations**
**P.O. Box 12878**
**Oklahoma City, OK 73157-2878**
**Phone: 405-717-8750 or 1-866-573-8462**
**Fax: 405-717-8977**

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