State of Oklahoma

Department of Corrections

Facility

Contract

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Oklahoma Department of Corrections
Facility Contract

This Network Facility Contract, hereinafter "Contract", is between the Oklahoma Department of Corrections, hereinafter "DOC," and the Network Facility, hereinafter "Facility," identified on the Signature Page.

I. RECITALS

1.1 The DOC is a statutory body created by 57 O.S. (2001), § 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 Facility is duly licensed by the state of residence and is certified to participate in the Medicare program under Title XVIII of the Social Security Act, and/or certified by The Joint Commission or Accreditation Association for Ambulatory Health Care (AAAHC), if applicable, and shall comply with all applicable federal, state, and local laws regulating such a Facility.

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

In consideration of the mutual covenants, promises and other good and valuable consideration, DOC and the Facility agree as follows:

II. DEFINITIONS

2.1 "Allowable Fee" means the maximum amount payable to a Facility by DOC for a referred service furnished pursuant to this Contract.

2.2 "Base Rate" means a dollar amount by which the Medicare MS DRG Relative Weight is multiplied to obtain the MS DRG Allowable Fee.

2.3 "CMS" means the Centers for Medicare and Medicaid Services.

2.4 "Covered Services" means the Medically Necessary services delivered by a Facility pursuant to this Contract.

2.5 "Emergency" means a sudden and unexpected symptom that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual or others in serious jeopardy.

2.6 "Facility Services" means those acute care inpatient and outpatient Facility services that are covered by the DOC.

2.7 "Geometric Mean Length of Stay" (GMLOS) means the current version of the Geometric Mean Length of Stay published by CMS for each MS DRG.

2.8 "Inmates" means all persons within the DOC's custody for whom the DOC is required to furnish Medical Services.

2.9 "Marginal Cost Factor" means a factor used in the Outlier Allowable Fee calculation.

2.10 "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.

2.11 "Medical Services" means the professional services provided by a Network Provider and referred by the DOC.

2.12 "Medically Necessary" means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health/substance abuse condition and complies with criteria adopted by the DOC. Direct care and treatment are within standards of good medical practice within the community and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. The services or supplies must be the most appropriate supply or level of service which can safely be provided. For hospital stays, this means that inpatient acute care is necessary due to the intensity 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. The services or supplies cannot be primarily for the convenience of the Inmate, the Inmates' prison or jail or the provider. The fact that services and supplies are Medically Necessary does not, in itself, assure that the services or supplies are covered by the DOC.

2.13 "MS DRG" means Diagnosis Related Groups and is an inpatient Facility classification, as published by the CMS. The current version of the CMS MS DRG grouper will be used to determine the MS DRG. For the purposes of this Contract, the MS DRG value, as established by the DOC, shall serve as the payment rate due hereunder unless the reimbursement is to be on a per diem basis.

2.14 "MS DRG Allowable Fee" means the MS DRG Relative Weight multiplied by the Base Rate for non-transfer cases. For the purposes of this Contract, the MS DRG Allowable Fee, as published by the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB), shall serve as the payment rate due hereunder unless the reimbursement is to be on a per diem basis.

2.15 "MS DRG Relative Weight" means the current version of the Relative Weight published by CMS for each MS DRG.

2.16 "Network Facility" means a certified facility that has entered into this Contract with the DOC to accept scheduled reimbursement for covered Medical Services provided to Inmates.

2.17 “Non-covered Services” are those services a) excluded from coverage by the DOC; or b) covered by the DOC, but inappropriately billed and therefore excluded for reimbursement based on the clinical editing software.

2.18 “OSEEGIB” means Oklahoma State and Education Employees Group Insurance Board that is contracted by the DOC to administer the claims processing in accordance with this contract.

2.19 “Outlier” means a discharge which has unique characteristics and is considered to be outside established parameters for each MS DRG. A discharge is considered an Outlier if the billed charges exceed the sum of the Outlier Threshold plus the MS DRG Allowable Fee.

2.20 “Outlier Allowable Fee” means [Billed Charges – (MS DRG Allowable Fee + Outlier Threshold)] multiplied by the Marginal Cost Factor.

2.21 “Outlier Threshold” means a dollar amount by which the total billed charges on the claim must exceed the MS DRG Allowable Fee in order to qualify for an additional Outlier amount.

2.22 “Outpatient Services” means Medically Necessary Facility Services for treatment rendered by a Facility to an Inmate, including, but not limited to, Emergency room care, clinic care, ambulatory surgery, radiology, pathology and other services which are provided without the admission of the Inmate.

2.23 “Psychiatric Day Treatment” means an approved treatment that provides a therapeutic environment consisting of appropriate mental health therapy, supportive care, case management, and reintegration into the home and community.

2.24 “Rehabilitation” means an approved treatment that leads to the restoration of an ill or injured person to self-sufficiency at their highest attainable skill.

2.25 “Referral Process” means a process by which the DOC manages the authorization, scheduling, tracking and monitoring of all Medical Service appointments outside the DOC.

2.26 “Residential” means an approved treatment Facility which provides temporary accommodations. It is a structured, safe, and therapeutic environment in which residents receive psychotherapy appropriate to an individualized treatment plan.

2.27 “Skilled Nursing Facility” means an approved treatment Facility rendering services prescribed by a physician that could not be given safely or reasonably by a person who is not medically skilled and would need continuous supervision of the effectiveness of the treatment and progress of the condition of the Inmate. These services are not custodial in nature.

2.28 “Transfer Allowable Fee” means (MS DRG Allowable Fee/Geometric Mean Length of Stay) multiplied by (Length of Stay plus 1 day).

III. RELATIONSHIP BETWEEN THE DOC AND THE FACILITY

3.1 The DOC has negotiated and entered into this Contract with the Facility. The Facility is an independent contractor that has entered into this Contract to become a Network Facility and is not, nor is intended to be the 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 Facility agree that all of the parties hereto shall respect and observe the facility/patient relationship which will be established and maintained by the Facility. The Facility may choose not to establish a facility/patient relationship if the Facility would have otherwise made the decision not to establish a facility/patient relationship had the patient not been an Inmate. The Facility 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 Facility named in this Contract.

IV. FACILITY SERVICES AND RESPONSIBILITIES

4.1 The Facility shall provide quality, Medically Necessary Facility 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 Facility'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 medical staff of the Facility to perform any procedure or course of treatment which the staff deems professionally unacceptable or is contrary to Facility policy.

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

4.3 The Facility 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 The Joint Commission and AAAHC certification.

4.4 The Facility agrees to make reasonable efforts to refer Inmates to other Network Facilities with which the DOC contracts for Medical Services that the Facility cannot or chooses not to provide.

4.5 The Facility shall participate in the Referral Process procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from that process subject to the Dispute Resolution Process provided in Article IX.

4.6 The Facility shall furnish, at no cost to the DOC, any medical and billing records covering any Facility Services, for any Inmate for which the DOC has statutory responsibility for medical care.

4.7 The Facility shall accurately complete the Network Facility Application which is attached to and made part of this Contract. The Facility shall notify the DOC of any change in the information contained in the Network Facility Application within fifteen (15) days of such change, including resolved litigation listed as "pending" on the original Network Facility Application.

4.8 The Facility shall reimburse the DOC for any overpayments made to the Facility within sixty (60) days of the Facility's receipt of the written overpayment notification or shall respond with detail within said time if Facility disputes the request for additional payment. DOC shall provide the Facility individual letters of retraction for each patient sixty (60) days prior to the retraction being made.

As an exception, the DOC will immediately deduct overpayments due to resubmission of a corrected claim, or if information is received for a claim pending additional information that subsequently impacts a paid claim or a mutually agreed to audit adjustment.

The DOC shall be entitled to additional payment if, within two years from the date of payment, DOC notifies Facility, in writing of the overpayment.

If Facility disputes the request for additional payment, the Parties shall work cooperatively and in good faith to resolve the payment issue on an informal basis within sixty (60) days of the first notification of the overpayment. If the Parties' attempt to resolve the issue is unsuccessful, then the dispute concerning the incorrect payment shall be resolved in accordance with the Dispute Resolution Process provided in Article IX.

4.9 The Facility shall submit to an Inmate record audit upon fourteen (14) business days advance notice.

4.10 The Facility shall comply with the national standards for the electronic exchange of administrative and financial health care transactions required by the Health Insurance Portability and Accountability Act of 1996, hereinafter "HIPAA".

V. DOC SERVICES AND RESPONSIBILITIES

5.1 The DOC agrees to pay the Facility compensation pursuant to the provisions of Article VI.

5.2 The DOC agrees to grant the Facility the status of "Network Facility" and to identify the Facility as a Network Facility on informational materials disseminated to prisons and county jails.

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

5.4 The DOC agrees to provide the Facility with access to a listing of all Network Facilities via the Internet.

5.5 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.

5.6 The DOC shall give fourteen (14) business days notice prior to an audit. Under no circumstances shall an audit of medical records by the DOC delay payment to Facility under Article VI.

5.7 DOC shall reimburse the Facility for any underpayments made to the Facility within thirty (30) days of DOC's receipt of the underpayment notification, or shall respond with detail within said time if DOC disputes the request for additional payment. Facility shall be entitled to additional payment if, within two years from the date of payment, Facility notifies DOC in writing of the underpayment. If DOC disputes the request for additional payment, the Parties shall work cooperatively and in good faith to resolve the payment issue on an informal basis within sixty (60) days of the first notification of underpayment. If the Parties' attempt to resolve the issue is unsuccessful, then the dispute concerning the payment shall be resolved in accordance with the Dispute Resolution Rights provided in Article IX.

5.8 DOC shall comply with the national standards for the electronic exchange of administrative and financial health care transactions required by HIPAA.

VI. COMPENSATION AND BILLING

6.1 The Facility shall seek payment only from the DOC for the provision of Covered Services. The payment shall be calculated and limited to the methodologies defined by this Contract. A list of the CPT/HCPCS codes and the Allowable Fee for each code can be found at the DOC website at https://gateway.sib.ok.gov/DOC/Login.aspx. It is DOC's intent to review and update the fee schedule annually in accordance with current methodologies. It is DOC's further intent to update the list when new CPT/HCPCS codes are identified by the American Medical Association or CMS.

6.2 When processing Inpatient claims, DOC shall determine the MS DRG Allowable Fee for non-transfer cases according to the following formula:

MS DRG Allowable Fee = MS DRG Relative Weight x Base Rate

Skilled Nursing Facility Services, Day Treatment and Residential treatment will be reimbursed utilizing the per diem methodology. In no event shall a per diem qualify as an Outlier. These benefits shall be allowed when the Inmate has received Medically Necessary Covered Services subject to the following policy limitations and conditions:

a) DOC shall pay the MS DRG Allowable Fee even when Allowable Fee exceeds billed charges.

b) The MS DRG shall be controlling, subject to DOC's approval and Article IX of the Contract.

c) The MS DRG Allowable Fee does not include any physician professional component fees, which are considered for payment according to separately billed Current Procedural Terminology code Allowable Fees.

d) DOC shall include the day of admission but not the day of discharge when computing the number of facility days provided to an Inmate. Observation Facility confinements for which a room and board charge is incurred shall be paid based on inpatient benefits.

e) In the case of a transfer, the Transfer Allowable Fee for the transferring Facility shall be calculated as follows:

Transfer Allowable Fee = (MS DRG Allowable Fee/Geometric Mean Length of Stay) x (Length of Stay + 1 day)

The total Transfer Allowable Fee paid to the transferring Facility shall be capped at the amount of the MS DRG Allowable Fee for a non-transfer case. DOC shall allow payment to the receiving Facility, if it is also the final discharging Facility, at the MS DRG Allowable Fee as if it were an original admission.

f) DOC shall use the current version of the CMS MS DRG grouper to categorize what shall constitute a procedure. DOC's financial liability shall be limited to the Allowable Fee as determined by DOC.

g) The Facility agrees not to charge more for Medical Services to Inmates than the amount normally charged by the Facility to other patients for similar services.

h) For Outlier cases, DOC shall base its payment to the Facility using an Outlier Allowable Fee plus the MS DRG Allowable Fee. The following formula shall be utilized to calculate the Outlier Allowable Fee:

Outlier Allowable Fee = [Billed Charges - (MS DRG Allowable Fee + Outlier Threshold)] x Marginal Cost Factor

6.3 When processing Outpatient claims, DOC agrees to pay the Facility the Allowable Fee based on appropriate billing according to the following:

a) DOC shall pay the Allowable Fee. If a procedure does not have an Allowable Fee, DOC will allow a percentage of the billed charges for Covered Services.

b) The Facility agrees not to charge more for Medical Services to Inmates than the amount normally charged by the Facility to other patients for similar services.

c) The Facility agrees that DOC utilizes a comprehensive claims editing system to assist in determining which charges for Covered Services to allow for payment and to assist in determining inappropriate billing and coding. Said system shall rely on Medicare and other industry standards in the development of its mutually exclusive, incidental, bundling, age conflict, gender conflict, cosmetic, experimental and procedure editing. DOC shall provide the Facility, upon request from Facility, detailed information about the processes employed in the claims editing system adopted by DOC.

6.4 A Facility's urban/rural status is determined by the county in which the Facility operates. Counties which are designated by the U.S. Census Bureau as a part of a Metropolitan Core Based Statistical Area (CBSA) are considered urban.

6.5 In a case in which the DOC is primary under applicable coordination of benefit rules, the DOC shall pay the amounts due under this Contract. In a case in which the DOC is other than primary under the coordination of benefit rules, the DOC shall pay only those amounts not payable from other sources pursuant to the applicable coordination of benefit rules, up to the DOC's maximum liability under the terms of this Contract.

6.6 The Facility may not bill an Inmate for Non-covered Services or the difference between the paid amount and the billed charge.

6.7 The Facility shall bill DOC on standard and customary forms acceptable to DOC within 120 days of providing the Facility Services, or receipt of primary payors explanation of benefits, or from discovery that OSEEGIB is responsible for payment. The Facility shall use the current CPT/HCPCS codes with appropriate modifiers and ICD diagnostic codes, when applicable. The Facility shall furnish, upon request at no cost, all appropriate medical and billing records, reasonably required by DOC to verify and substantiate the provision of Medical Services and the charges for such services if the Inmate and the Facility are requesting reimbursement through DOC. This provision shall not apply in cases involving litigation, multiple payers, or where the Inmate has failed to notify the Facility that they were an Inmate.

6.8 The DOC shall reimburse the Facility within 45 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.

VII. REFERRAL PROCESS

7.1 The Referral 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 Inmate to access a Network Facility 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.

7.2 The DOC's provider contacts the Network Facility 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.

VIII. LIABILITY AND INSURANCE

8.1 Neither party to this Contract, the DOC nor the Facility, 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.

8.2 Effective November 1, 2007, licensed medical professionals under contract with DOC who provide medical care to Inmates in DOC custody or control are employees of the State of Oklahoma for purposes of the Oklahoma Governmental Tort Claims Act (OGTCA). A licensed professional who, in good faith, provides services pursuant to this contract, and is performing the duties of his or her employment or tasks lawfully assigned, shall be treated as a state employee under the OGTCA. Coverage under the OGTCA ***only*** extends to acts under this contract. Covered professionals shall provide a history of prior claims for a period

of five (5) years. In the event a demand, claim, or legal action is filed for covered acts, the covered professional shall immediately notify:

Division of Risk Management
2401 North Lincoln Blvd. Suite 202
Oklahoma City, OK 73152
(405) 521-4999
FAX: (405) 522-4442
www.dcs.state.ok.us

Failure to notify shall be deemed failure to cooperate in the defense of the claim and may result in denial of coverage. Covered professionals should consult with their insurance carrier to determine the impact, if any, of coverage as an employee of the state of Oklahoma under the OGTCA.

IX. DISPUTE RESOLUTION

9.1 The Facility may participate in the Dispute Resolution Process as established by DOC and OSEEGIB and detailed in the OSEEGIB provider manual. Permitted Facility disputes include: clean claims, untimely claim submission, disagreements in regard to the amount paid on a claim, clinical editing, medical necessity, certification, and other disagreements relating to contractual provisions and issues. Issues not subject to the Dispute Resolution Process include, but are not limited to: Rights beyond the Plan's obligation to Inmates' Allowable Fee, coordination of benefits, and plan coverage and exclusions. In order to initiate the Dispute Resolution Process, Facilities shall contact OSEEGIB. Nothing in this Article shall interfere with either party's rights under Article X.

X. TERM AND TERMINATION

10.1 It is agreed by the parties that no changes to the Contract which include coverage, fee schedule, or reimbursement methodologies, shall be made with less than sixty (60) days notice, except revisions to injectable medications, in which case DOC shall implement the revisions as soon as possible with proper and timely notification to the Facility.

10.2 Either party may terminate this Contract with or without cause, upon giving thirty (30) days written notice pursuant to 11.2 at any time during the term of this Contract.

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

10.4 Following termination of this Contract, the DOC shall continue to have access, at no cost to the DOC, to the Facility'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.

10.5 This Contract shall terminate with respect to a Facility upon the loss or suspension of the Facility's license to operate in the state of residence, The Joint Commission's or Medicare certification or failure to maintain Facility's professional and general liability coverage in accordance with this Contract.

XI. GENERAL PROVISIONS

11.1 This Contract, including 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 The termination notice required by the terms of this Contract, shall be provided in writing and (1) mailed by the United States Postal Service (USPS), postage prepaid, certified mail, return receipt requested; or, (2) delivered by an overnight delivery company with written delivery confirmation; or, (3) hand delivered with written delivery confirmation. Notice to DOC shall be to the attention of DOC Network Manager, P.O. Box 12878, Oklahoma City, Oklahoma 73157-2878. Notice to the Facility shall be to the address listed on the DOC Facility Contract Signature Page. The notice shall be effective on the date indicated on the return receipt or written delivery confirmation.

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

11.4 This Contract is the entire agreement between the DOC and the Facility relating to the rights granted and the obligations assumed by the parties concerning the provision of Facility 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.

11.5 This Contract, or any part or section of it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the DOC and the Facility.

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

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

11.8 DOC and the Facility agree that this Contract may be formed according to the Oklahoma Uniform Electronic Transaction Act, 12A O.S. § 15-101 et seq. (Act). The Facility acknowledges that the Contract terms are located in Contract DOCPFCv1.3 at https://gateway.sib.ok.gov/DOC/Contracts.aspx and after downloading the Contract, and submitting the completed Application, signed and returned the Signature Page to DOC, DOC will note its approval on the Signature Page and return to the Facility. The Contract terms, Application, Signature page and any required information submitted by the Facility are records that may be stored as DOC electronic records under the Act.

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.

State of Oklahoma

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)**
- ☐ **Copy of AAAHC 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 Facility Application

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

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 _____

ACCREDITATION

Is this Facility accredited by the AAAHC? Yes ☐ No ☐

AAAHC 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 Facility Contract Signature Page

The Oklahoma Department of Corrections and the Facility incorporate by reference the terms and conditions of the Oklahoma Department of Corrections Facility Contract (Contract), located in Contract DOCPFCv1.3 at ***https://gateway.sib.ok.gov/DOC***, into this Signature Page and acknowledge the Contract is an electronic record created according to 12A O.S. § 15-101 et seq. The Oklahoma Department of Corrections 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 Oklahoma Department of Corrections.

FOR THE FACILITY:

Legal Name of Owner (typed or printed):

_____

Trade Name/dba (typed or printed):

_____

Authorized Officer or Representative (typed or printed):

_____

Title: _____

Signature: _____

Signature Date: _____

FOR THE DOC:

_____

Director or Chief Medical Officer
Department of Corrections
3400 M. L. King
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