

**State of Oklahoma**  
**Department of Correction**  
**Provider**  
**Contract**

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SIGNATURE PAGE

# **Oklahoma Department of Corrections**

## **Provider Contract**

It is hereby agreed between the Oklahoma Department of Corrections, and the Provider named on the signature page, that the provider shall be a Provider in the Oklahoma Department of Correction's network of providers.

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

### **I. RECITALS**

- 1.1 The Oklahoma Department of Corrections (hereinafter, Department) is a statutory body created by 57 O.S. 1989, § 505 et seq., as amended, to administer and manage the incarceration of persons who have committed felony crimes or are otherwise subjected to criminal sanctions within the State of Oklahoma.
- 1.2 The Provider is duly licensed or certified by the State of Oklahoma as a practitioner of the healing arts and satisfies additional credentialing criteria as established by the Department.
- 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 Department for the benefit of the inmates under its care, custody and control.
- 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 Provider for a specific procedure 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 "Concurrent Review" means a function performed by the Department or its designee that determines and updates medical necessity for continued inpatient hospitalization.
- 2.3 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating Providers and other health care professionals.
- 2.4 "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.

- 2.5 "Inmate" means a person who has been sentenced to a term of incarceration with the Department or an offender that Oklahoma law requires the Department provide medical care for.
- 2.6 "Hospital Services" means those acute care inpatient and outpatient hospital services that are medically necessary for the well-being and health of an inmate.
- 2.7 "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.
- 2.8 "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 Inmate's health care 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 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.
- 2.9 "Medical Services" means the professional services provided by a Network Provider and are medically necessary for the well-being and health of an inmate.
- 2.10 "Network Provider" means a licensed practitioner of the healing arts who has entered into this Contract with the Department to accept scheduled reimbursement for covered health services provided to inmates.
- 2.11 "Prior Authorization" means a function performed by the Department to review for Medical Necessity in identified areas of practice as defined at Article VII of this contract, prior to services being rendered.
- 2.12 "Third Party Payer" means an insurance company or other entity making payment directly to the Provider on behalf of the Department.
- 2.13 "Certification" means a function performed by the Department or its designee to review and certify medical necessity for emergency, holiday or weekend surgeries and observation stays with duration of more than twenty-four (24) hours within one (1) working day after services are incurred.

### **III. RELATIONSHIP BETWEEN THE DEPARTMENT AND THE PROVIDER**

- 3.1 The Department has negotiated and entered into this Contract with the Provider on behalf of the individuals who are Inmates under the care, custody and control of the Department. 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 the Department 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 Department and the Provider agree that all of the parties hereto shall respect and observe the Provider/patient relationship that will be established and maintained by the Provider. The Provider may choose not to establish a Provider/patient relationship if the Provider would have otherwise made the decision not to establish a Provider/patient relationship had the patient not been an inmate. The Provider reserves the right to refuse to furnish services to an inmate in the same manner as he/she would any other patient.
- 3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies in any third party, including but not limited to, an inmate or a Network Provider other than the Provider named in this contract.

#### **IV. PROVIDER SERVICES AND RESPONSIBILITIES**

- 4.1 The Provider agrees to provide quality health care in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the Provider shall provide services to inmates that are medically necessary.
- 4.3 The Provider agrees to make reasonable effort to refer covered inmates to those Network Providers, with which the Department contracts, for medically necessary services that the Provider cannot or chooses not to provide. Failure of the Provider to use Network Providers will result in a review pursuant to the credentialing plan.
- 4.4 The Provider shall prescribe for the Department's inmates medications identified on the adopted formulary or explain, in writing, on behalf of the inmate to the Department why it is medically inappropriate to do so.
- 4.5 The Provider shall participate in the Prior Authorization procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from those reviews subject to rights of reconsideration, review and appeal.
- 4.6 The Provider shall submit a current, complete and accurate Oklahoma Uniform Credentialing Application (ODH Form 606) and EGID OUCA Supplement as allowed under OK §63-1-106.2 and Laws 1998, c. 210, § 1 which are incorporated herein by reference. The Provider shall notify the Department's Network Manager of any change in the information contained in the application within fifteen (15) days of such change, including resolved litigation listed as "pending" on the original application.
- 4.7 The Provider shall reimburse the Department for any overpayments made to the Provider within 30 days of the Provider's receipt of the overpayment notification.
- 4.8 The Provider shall submit to a patient record audit upon 48 hours advance notice.

#### **V. DEPARTMENT'S SERVICES AND RESPONSIBILITIES**

- 5.1 The Department agrees to pay the Provider compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.
- 5.2 The Department agrees to periodically provide the Provider with a list of all Network Providers
- 5.3 The Department agrees to adhere to confidentiality of patient's records and to only release pertinent clinical information in accordance with State and Federal guidelines.

- 5.4 The Department shall give a forty-eight-hour (48) notice prior to an audit.
- 5.5 The Department shall maintain a prior authorization program to aid in making decisions that will maximize medical benefits and reduce financial risk.

## **VI. COMPENSATION AND BILLING**

- 6.1 The Provider shall seek payment only from the Department for the provision of medical services except as provided in paragraphs 6.3 and 6.4. The payment from the Department shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 The Department agrees to pay the Provider's billed charge for each procedure or the Schedule set by the Department for that procedure, whichever is less.
  - a) The Department shall have the right to categorize what shall constitute a procedure. The Department's financial liability shall be limited to the procedures allowable as determined by the Department, paid by applying appropriate coding methodology, whether the Provider has billed appropriately or not.
  - b) The Provider agrees not to charge more for medical services to inmates than the amount normally charged (excluding Medicare) by the Provider to other patients for similar services. The Provider may, however, contract with other Third Party Payers for services. The Provider's usual and customary charges may be requested by the Department and verified through an audit.
- 6.3 The Provider shall bill the Department on forms acceptable to the Department within sixty (60) days of providing the medical services. The Provider shall use the current CPT codes with appropriate modifiers and ICD or DSM-3 diagnostic codes, when applicable. The Provider shall furnish, upon request at no cost, all information, including medical records, reasonably required by the Department to verify and substantiate the provision of medical services and the charges for such services if the Provider is seeking reimbursement through the Department.
- 6.4 The Department shall reimburse the Provider within thirty (30) days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. The Department will not be responsible for delay of reimbursement due to circumstances beyond the Department's control.
- 6.5 The Department 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 Department.

## **VII. UTILIZATION REVIEW**

- 7.1 The Provider shall adhere to and cooperate with the Department's Prior Authorization procedures.
- 7.2 A request for authorization shall be made within one (1) working day after an emergency admission or observation stay with duration greater than twenty-four (24) hours. Such notification shall be at no charge to the Department. Failure to comply with the prior authorization requirements shall result in the Provider's reimbursement being penalized by ten percent (10%) if medical necessity is confirmed retrospectively and, if not confirmed, there shall be no reimbursement.
- 7.3 The Provider or his/her representative shall notify the Department or its designee of any outpatient surgical procedure, which is to be accomplished outside the Provider's office.

- 7.4 The Prior Authorization Review requirements are intended to maximize benefits, assuring that hospital and medical services are provided to the inmate at the appropriate level of care. In no event is it intended that the procedures interfere with the Provider's decision to order admission or discharge of the inmate to or from the hospital.
- 7.5 The Department shall maintain review procedures and screening criteria that take into account professionally acceptable standards for quality medical care in the community. The Department or its designee shall consider all relevant information concerning the inmate before medical necessity is approved or denied.
- 7.6 At the time of the authorization request the Provider should be prepared to give the following information:
- a) Inmate's name and DOC number,
  - b) Age and sex,
  - c) Diagnosis,
  - d) Reason for admission,
  - e) Scheduled date of admission,
  - f) Planned procedure or surgery,
  - g) Scheduled date of surgery,
  - h) Name of hospital,
  - i) Name of Provider, and
  - j) Inmate facility (i.e.: LARC, Mabel Bassett).
- 7.7 The Department shall not retrospectively deny any previously approved care. The Provider and/or his/her designee shall update the Department, or its designee, as the inmate's condition or diagnosis changes. Updated information may result in a change of the originally approved length of stay.
- 7.8 The Provider shall request prior authorization before the admission or referral of inmates to non-network hospitals except in cases of emergencies. The Department shall review emergency referrals to non-network hospitals to determine whether the admission was medically necessary and an emergency as defined in this Contract.
- 7.9 The Provider shall request prior authorization from the Department or its designee for the following:
- a) Solid organ transplantation, including ABMT/HDCT/Peripheral stem cell recovery,
  - b) Durable medical equipment,
  - c) Mental health/substance abuse (day and residential treatment),
  - d) Bone growth stimulators, and
  - e) Breast surgeries, implants, reductions and reconstruction.
  - f) Any other procedure not included in the authorization.

## **VIII. LIABILITY AND INSURANCE**

- 8.1 Neither party to this Contract, the Department 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 his/her sole expense, shall maintain a minimum of one million dollars (\$1,000,000) per occurrence and one million (\$1,000,000) aggregate of insurance coverage for professional liability. If the hospital at which the Provider has admitting

privileges has a lower liability limit, the Provider is required to maintain liability pursuant to this Contract.

## **IX. MARKETING, ADVERTISING AND PUBLICITY**

- 9.1 The Department shall have the right to use the name, office address, telephone number and specialty of the Provider for purposes of informing Department liaisons at each inmate facility of the identity of the Network Provider.
- 9.2 The Provider, upon prior approval of the Department, shall have the right to publicize the Provider's status in the Department's network of providers.

## **X. DISPUTE RESOLUTION**

- 10.1 The Department 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 XI.

## **XI. TERM AND TERMINATION**

- 11.1 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 12.2.
- 11.2 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.
- 11.3 This Contract shall immediately terminate, without notice, with respect to a Provider upon:
  - a) the loss or suspension of the Provider's license to practice medicine in the State of Practice; or
  - b) failure to maintain Provider's professional liability insurance in accordance with this Contract.
- 11.4 Following the effective date of termination, this Contract shall be of no further force or effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this Contract.
- 11.5 Following termination of this Contract, the Department shall continue to have access to the Provider records of care and services provided to inmates for five (5) years from the date of provision of the services to which the records refer as set forth in Paragraph 6.5.

## **XII. GENERAL PROVISIONS**

- 12.1 This Contract or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.
- 12.2 At any place within this Contract that notice is required, it is the intention of the parties that only those with regard to termination by either party of participation in the Contract must be sent by certified mail, a return receipt requested, at no other time when notice is required by this Contract is there an obligation by either party to use certified mail. The Network Newsletter serves as the primary method by which providers receive all other

notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.

- 12.3 Notwithstanding the provisions of Paragraph 12.1 of this Contract, the Department 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 Department under this Contract and to receive any notices required by this Contract.
- 12.4 This Contract, together with any exhibits, contains the entire agreement between the Department and the Provider relating to the rights granted and the obligations assumed by the parties concerning the provision of medical 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, section or exhibit of, or attached to it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the Department and the Provider.
- 12.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules. Any provision of this Contract that is not in conformity with existing or future legislation shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.
- 12.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and the determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this entire Contract, or any one of them, in accordance with the intent and purpose of the parties hereto.
- 12.8 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.
- 12.9 As mandated by HB1086, the Transparency, Accountability, and Innovation in Oklahoma State Government 2.0 Act of 2011, all payments disbursed by the Office of the State Treasurer must be made solely through electronic funds transfer (EFT). Provider/facility hereby agrees to accept EFT payments by July 1, 2013. Provider acknowledges that all health and dental claims received after July 1, 2013, regardless of the date of service, will be denied pending receipt of additional information if EFT payment information is not on file as of July 1, 2013.

## 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

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**State of Oklahoma**  
**Department of Corrections**  
**Provider Contract**  
**Signature Page**

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When signed by both parties below, this constitutes agreement and acceptance of all terms and conditions contained in the Provider Contract. The DOC and the Provider 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 Provider. 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 a part of the Contract.

**FOR THE PROVIDER:**

**FOR DOC:**

\_\_\_\_\_  
Name (Typed or Printed)

\_\_\_\_\_  
Director or Chief Medical Officer  
Department of Corrections  
3400 Martin Luther King Avenue  
Oklahoma City, OK 73111

\_\_\_\_\_  
Signature

\_\_\_\_\_  
NPI

\_\_\_\_\_  
Federal Tax ID Number

Primary Service Address:  
  
\_\_\_\_\_  
  
\_\_\_\_\_

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

**Oklahoma Department of Corrections**  
**ATTN: Network Management**  
**P.O. Box 57630**  
**Oklahoma City, OK 73157-7630**  
**Phone: 1-405-717-8750 or 1-866-573-8462**  
**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](mailto: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](http://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