220 Burnham Street ● South Windsor, CT 06074
Vox 888-255-7293 ● Fax 860-289-6090

ALABAMA MEDICAID
ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKAL1
ELECTRONIC REGISTRATIONS Agreements Required	**Please be aware that this form is headed MEDICAL, but it is used for DENTAL Registration as well.** **Electronic Media Claim Submission Agreement** • No information needs to be filled in. Already provided. **Electronic Claims Submission Agreement** • Fill in Provider's name, original signature, date, Provider number and Software Company name. **WebMD Dental Provider Enrollment Form** • Please complete all requested information
SEND REGISTRATION FORMS TO:	Please mail completed forms to: WebMD Dental 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment
ENROLLMENT CONFIRMATION	▪ Medicaid requires the Provider to follow up on the status of their registration forms. ▪ Enrollment status may be verified by calling Provider Relations: In-state Providers (800) 688-7989 Out-of-state Providers (334) 215-0111 ▪ Once Medicaid approves electronic claims submission, **WebMD Dental must be notified before claims can be transmitted**. ▪ Contact WebMD Dental Provider Enrollment at (888) 255-7293.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than WebMD Dental each Provider must re-enroll following the procedures listed above.

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CONTACT PHONE NUMBERS	Medicaid In-State Providers 800-688-7989 Medicaid Out-of-State Providers 334-215-0111 WebMD Dental Provider Enrollment 888-255-7293

WebMD Dental
A service of WebMD Business Services

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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **ALABAMA MEDICAID**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(This is the number that will be used to submit electronic claims)

Software Vendor: _____

Group Number: _____

Rendering Name and Number:

_____ _____

_____ _____

_____ _____

_____ _____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

MEDICAL
ELECTRONIC MEDIA CLAIM SUBMISSION
AGREEMENT (REV. 03/89)

WHEREAS, the Alabama Medicaid Agency, (hereinafter referred to as Medicaid), has been designated as the Agency to administer the Medicaid Program in the State of Alabama under Title XIX of the Social Security Act, and

WHEREAS, the undersigned Provider is currently enrolled as a Provider with the Alabama Medicaid Program, and

WHEREAS, the undersigned Provider desires to submit claims for services rendered under the Medicaid program by use of electronic media, including, but not limited to, magnetic tape, diskette, or on-line computers.

NOW, THEREFORE, the parties hereby agree that the Provider shall submit electronic media claims consistent with the provisions of Title XIX of the Social Security Act, as amended, and under the terms and conditions set forth herein.

1. Medicaid agrees that Provider may submit claims for covered services rendered under the Medicaid program by use of electronic media, including, but not limited to magnetic tape, diskette, or on-line computer.

2. Provider hereby agrees to establish and maintain a file containing the signature of each recipient of services furnished by the Provider, or when applicable, the signature of a responsible person made on behalf of said recipient. Said signature shall be established and maintained for each claim submitted consistent with Alabama Medicaid Administrative Code Rule 560-X-1.8. as amended herein incorporated by reference.

3. Provider hereby agrees to keep such records, including original source documents, as are necessary to disclose fully the nature and extent of services provided to recipients under the Alabama Title XIX Plan and to furnish information regarding any payment of claims for providing such services as Medicaid may request. Said records, including original source documents, shall be maintained for the period of time prescribed in Alabama Medicaid Administrative Code Rule 560-X-1-21, as amended, and the Medicaid Billing Manual, both of which are herein incorporated by reference.

4. Provider hereby agrees that the method of electronic media claims submission shall be governed by the submitted under the existing rules, regulations, and policy directives of Medicaid, herein incorporated by reference. Provider further agrees that said method of electronic media claims submission shall be governed by and submitted under the provisions of DENTAL (Submittal Procedure Manual), as amended, herein incorporated by reference.

5. Provider hereby agrees to and shall be solely responsible for the accuracy and authenticity of said electronic media claims submitted. Provider shall retain and maintain detailed records, including original source documents which shall fully disclose the nature and extent of the service as reflected in the electronic media claim submitted. Said records shall

be maintained at Provider's site. Provider shall make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, Alabama Medicaid Agency, and other agencies of the State of Alabama. Provider shall, upon either verbal or written request from any agency listed above, furnish free of charge a copy of any requested record. If the Provider has no copier, the Provider shall allow the person requesting the copy to remove the original for copying. Said agencies shall have the right to inspect and audit said records and confirm for any purpose information contained therein. Provider or this agent shall insure that every electronic claim entry can be readily associated and identified with an original source document.

6. Medicaid shall have the right to recoup, adjust, or recover an incorrect payment made to Provider through existing procedures, as amended, or through independent action pursuant to the laws of the State of Alabama.

7. Provider hereby agrees that services described on the electronic media claim are true, accurate, and complete.

8. Provider hereby certifies that services described on the electronic media claim was personally rendered by him or under his personal direction. The Provider further agrees that said service was medically necessary for the treatment of the condition as indicated by the diagnosis and shall maintain records, including source documents, to verify such.

9. Provider agrees to accept as payment in full, the amount paid by Medicaid for the electronic media claims submitted for payment.

10. Provider agrees that Claims Processing Service, Inc. (name of billing agency) is empowered and authorized to submit electronic media claims on his behalf. Medicaid shall have the right to verify the existence of said authorization. Medicaid shall have the right to audit and confirm, for any purpose, information submitted by Provider to said billing agent.

11. PROVIDER UNDERSTANDS THAT SUBMISSION OF AN ELECTRONIC MEDIA CLAIM IS A CLAIM FOR MEDICAID PAYMENT AND THAT ANY PERSON WHO, WITH INTENT TO DEFRAUD OR DECEIVE, MAKE, CAUSES TO BE MADE, OR ASSISTS IN THE PREPARATION OF ANY FALSE STATEMENT, MISREPRESENTATION OR OMISSION OF A MATERIAL FACT IN ANY CLAIM OR APPLICATION FOR ANY PAYMENT. REGARDLESS OF AMOUNT, KNOWING THE SAME TO BE FALSE, IS SUBJECT TO CIVIL AND/OR CRIMINAL SANCTIONS UNDER THE APPLICABLE STATE AND FEDERAL STATURES.

12. Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C., 2000d. et seg), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. – 70b) the Age Discrimination Act of 1975 (42 U.S.C. – 6101. et. seg), and the Regulations issued thereunder by the Department of Health and Human Services (45 C.F.R. Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program of services by this facility.

Electronic Claims Submission Agreement

MEDICAL

13. This agreement shall become effective on the date of its execution by Medicaid and shall continue for an indefinite period unless it is amended, revised, or terminated by either party upon thirty (30) days written notice. This agreement shall immediately terminate upon termination of the separate Provider Contract authorizing participation in the Medicaid Program.

The undersigned certify and agree that they have read and understand the above and freely and voluntarily enter into the same, on the date(s) entered below.

Provider's Name

Physician's Signature - if Power of Attorney is held to sign for the provider, the provider's name must be signed.

Date Signed

Provider Number

Software Company Name

FOR FISCAL AGENT USE ONLY:

EMC _____

OPS _____

PE _____ _____
T-DATE Y-DATE

TSO _____

LETTER _____

TYPE _____

SEC/CODE _____

AG/ID _____

PROVADDR _____

Complete this section ONLY if your company actually submits provider's claims to EDS.

Claims Processing Service, Inc.
Billing Agent Name

John Dydyn, Jr.
Authorized Representative

Mar 22, 1998
Date Signed

EDS Authorized Representative

Date Signed

MAIL COMPLETED CONTRACT TO:

EDS Federal
P.O. Box 244035
Montgomery, AL 36124

Attention: Misty Smith
Provider Relations Representative