

NORTH CAROLINA MEDICAID
PAPER AND ELECTRONIC REGISTRATION REQUIREMENTS

PAPER REGISTRATIONS

Agreements Required None required.

ELECTRONIC REGISTRATIONS

Agreements Required Provider must sign and return to the Division of Medical Assistance an original copy of the *Electronic Claims Submission (ECS) Agreement* form. The *Attachment for Group Providers* is only required if the provider is requesting to file electronically for a group provider number.

Return the completed form(s) to:
Division of Medical Assistance
Provider Enrollment
1985 Ulmstead Drive
PO Box 29529
Raleigh, NC 27626-0529

The Division of Medical Assistance takes up to 10 working days to register new electronic providers. When the provider has been authorized to send electronically, DMA will send a notice in the mail. The provider should contact CPS upon receiving this notice to confirm the authorization to submit electronic claims via ECS.

Claims will continue to be printed and mailed to EDS/North Carolina Medicaid by CPS until confirmation from the provider has been received by CPS.

SPECIAL NOTES

ECS Provider
Re-Registrations

If currently submitting electronic claims through another clearinghouse, the provider must contact CPS at 860/289-6090 for further instructions.

NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

The undersigned Provider of Medical Care ("Provider") under the State's Title XIX (Medicaid) Program in consideration of the right to submit claims by paperless means rather than by or in addition to the submission of paper claims hereby agrees, certifies and stipulates that it will abide by the following terms and conditions:

1. The Provider shall abide by all rules and regulations of the Medicaid Program and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and the Division of Medical Assistance (DMA).
2. All electronic claims submissions by Provider shall be true, accurate, and complete, and Provider's signature on this agreement shall be binding as certification of such and the Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement or claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (see P.L. 95-142 and N.C.G.S. 108A-63) and fined or imprisoned as provided by law.
3. The Provider will notify DMA in writing 10 days in advance of any changes in Provider's name or address or Provider identification numbers for which electronic submission is to be canceled or added to this agreement.
4. A claim entry sought to be processed shall fully comply with the "Technical Requirements for Electronic Media Submission", as amended, and all applicable N. C. or Fiscal Agent technical specifications for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to the Provider's or its billing agent's failure to comply with the "Technical Requirements for Electronic Media Submission" or the terms of this Agreement. Provider agrees that it will not submit through electronic means sterilization, hysterectomy, abortion or other claims requiring supporting documentation.
5. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.
6. The Provider shall execute an agreement with its billing agent or intermediary, if any, which includes all of the provisions of this certification. For purposes of compliance with this agreement and the laws, rules and regulations applicable to providers of Medical Assistance, the acts and/or omissions of Provider's billing agent(s) shall be deemed those of the Provider.
7. The Provider shall have on file at the time of submission and for five years thereafter, all original source documents and medical records relating to any claim, including but not limited to the provider's signatures and can be associated and identified with source documents. Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or State Attorney General's Office a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients and that the failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.
8. The Provider and/or its billing agent shall assure confidentiality of the names and identification numbers of all Medicaid recipients for which the Provider submits claims to the Medicaid program.

9. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims in a submission. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.
10. Both the Provider and DMA have the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims.
11. No substitutions for or alterations to this agreement are permitted. This agreement may be amended by written notification only for a change in the Provider's name or address. In the event of change in Provider Identification Number, this agreement is terminated. An additional ECR agreement must be executed to bill electronically under any provider number not included on this agreement.
12. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Reattitude Advice and that the services were rendered by or under the direction of the Provider.

THE UNDERSIGNED HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ALL OF THE STIPULATIONS, CONDITIONS AND TERMS STATED HEREIN. IF THE PROVIDER CEASES TO PARTICIPATE IN THE TITLE XIX PROGRAM THIS AGREEMENT IS CANCELED. IF STATE AND FEDERAL FUNDS CEASE TO BE AVAILABLE, THIS AGREEMENT IS CANCELED.

NOTE: EXCEPT WHEN SIGNATURE IS REQUIRED, PLEASE TYPE OR PRINT THE FOLLOWING:

PROVIDER NAME: _____

COMPUTER VENDOR NAMES:

Hardware _____
Phone No. _____

BILLING/MAILING ADDRESS: _____

software _____
Phone No. _____

PROVIDER SIGNATURES:

_____ DATE _____

PROVIDER NO. _____

_____ DATE _____

PROVIDER NO. _____

_____ DATE _____

PROVIDER NO. _____

IF GROUP PROVIDER, GROUP NUMBER: _____

Office Contact Person: _____ Phone No. _____

NC DEPARTMENT OF HUMAN RESOURCES
Division of Medical Assistance

Assistant Director Recipient and Provider Services

Date Accepted _____

Copy: DMA
EDS
Provider
(Rev. 10/92)

