

PENNSYLVANIA BLUESHIELD / UNITED CONCORDIA PAPER AND ELECTRONIC REGISTRATION REQUIREMENTS

PAPER REGISTRATIONS

Agreements Required None required.

ELECTRONIC REGISTRATIONS

Agreements Required Provider must sign and return to United Concordia an original copy of the *Dental Electronic Data Interchange Enrollment Form*.

Return the completed form to:
United Concordia Companies, Inc.
Dental Electronic Services
PO Box 898215
Camp Hill, PA 17089-8215

Claims will continue to be printed and mailed to Pennsylvania BlueShield/United Concordia until confirmation from Pennsylvania BlueShield/United Concordia is received by CPS.

SPECIAL NOTES

Three Lines of Business United Concordia handles three lines of dental insurance electronically. They are:

1. Pennsylvania Blue Shield
2. FMDP
3. UCCI

Completing the registration form qualifies the provider to submit claims electronically for all three lines of business.

In order for the CPS electronic claims system to properly recognize the claims, they should be named using the following conventions:

For the Line of Business...	Use the Carrier Name...
Pennsylvania Blue Shield	BLUE SHIELD OF PA
Tricare - Active Duty Family Member Dental Plan (FMDP)	UCCI FMDP
United Concordia Companies, Inc.	UCCI

Last Revision Date 7/3/96

CPS, Inc. 220 Burnham St., S. Windsor, CT 06074 · 860/289-6090

ELECTRONIC BILLING AGREEMENT

FOR:

(Provider Name)

(Medicaid Provider No.)

(Provider Street Address)

(City, State, Zip Code)

(Telephone)

The undersigned provider hereby elects to submit Medicaid claims by electronic means to the Office of Provider Services, Division of Medical Assistance in accordance with the provisions below.

All specifications set forth in the "DSHS, Title XIX, Electronic Billing Specifications," as from time to time amended, shall be met for every entry submitted. A copy of such procedures may be requested at any time from the Office of Provider Services. The department agrees to supply the provider with any amendments to these specifications within a reasonable time prior to the time such amendments or changes to the procedures shall go into effect.

The provider and/or his agents shall be responsible for total compliance with said electronic billing specifications. Any change in the provider's data processing agent (submitter or intermediary) shall be preceded by a thirty (30) day written notice to the Office of Provider Services.

The provider and/or intermediary shall provide, upon the request of the state, supportive documentation to ensure that all technical requirements are being met. Examples of supportive documentation include, but are not limited to program listing, tape dumps, flow charts, file descriptions, accounting procedures and the like.

The provider shall continue to be ultimately responsible for the accuracy and truthfulness of all Medicaid claims submitted for payment. Nevertheless, the provider, if he selects a data processing agent to submit Medicaid claims directly, must give legal power of attorney to that agent in order that the agent might act as a submitter of Medicaid claims in behalf of the provider.

The provider acknowledges that the following provider's certification statement, under which he endorses warrants in payment of Medicaid services, applies to all services he provides regardless of the method of submission to the Department of Social and Health Services:

"I hereby certify under penalty of perjury that all goods and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap; that the services listed were medically indicated and necessary to the health of this patient.

I understand in endorsing or depositing this warrant that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws."

It is expressly understood that the department may reject an entire submission at any time for failure to comply with the "Electronic Billing Specifications" as in effect pursuant to paragraph number one or for any other valid reason.

The provider agrees that this election does not in any way modify the requirements of the policies and procedures for services, except as to claim submission methods.

The department and the provider agree that this document may be amended by mutual consent of the contracting parties at any time. Such amendments must, however, be in writing and must be signed by the authorized representatives of the contracting parties. This agreement shall not be verbally amended.

The provider agrees to submit to the Department of Social and Health Services or its authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.

The provider shall inform the Office of Provider Services where source documents will be maintained. DOCUMENTS WILL BE MAINTAINED AT THE FOLLOWING ADDRESS:

Claims Processing Service, Inc.

220 Burnham Street

South Windsor, CT 06074-4128



Dental Electronic Data Interchange Enrollment Form

NAME OF PROVIDER, SUPPLIER, OR GROUP _____

ADDRESS _____
STREET _____
CITY _____ STATE _____ ZIP CODE _____

CONTACT PERSON _____ TELEPHONE NUMBER _____ PROVIDER NO. _____

Please check one:

- Assign this provider a new electronic billing source number
- Add this provider to existing source no. 0940670 and DTL A621

Please check the claim types for which you are applying to submit electronically:

- UCCI
- Pennsylvania Blue Shield (an independent licensee of the Blue Cross and Blue Shield Association)
- ConcordiaPLUS
- DentalPLUS

CHECK WITH VENDOR TO ENSURE SOFTWARE CAPABILITY:

Name of Software Vendor _____ Dental Claims Express

Name of Billing Service Claims Processing Service, Inc.

- Is your software capable of retrieving reports? YES NO
- Do you wish to retrieve Submission Analysis Reports Electronically? YES NO
- Do you wish to retrieve Reconciliation Electronically? YES NO

PLEASE CHECK ONE:

- National Standard Format (NSF) specify version 1.04 OR American National Standard Institute (ANSI)
- Element Separator _____
- Segment Separator _____
- Composite Separator _____

Electronic Billing Media: Dialup (Telephone Transmission)

PLEASE DESCRIBE YOUR MODEM SETUP:

1. Asynchronous:

- Specify Modem Type: MNP Hayes/Z-Modem
- Modem Speed: 1200 2400 9600 14,400 28,800
- other, specify _____

2. Synchronous:

- Modem Speed: 2400 4800 9600 14,400 28,800
- other, specify _____

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Dental claims electronically to United Concordia Companies, Inc. (UCCI):

A. THE PROVIDER AGREES:

1. That it will be responsible for all Dental claims submitted to UCCI by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Dental subscriber/sponsor to any other person or organization except UCCI without the express written permission of the Dental subscriber/sponsor or his/her parent or legal guardian, or where required for the care and treatment of a subscriber/sponsor who is unable to provide written consent, or to bill insurance primary or supplementary to Dental, or as required by State or Federal law.
3. That it will submit claims only on behalf of those Dental beneficiaries who have given their written authorization to do so, and to certify that required subscriber/sponsor signatures, or legally authorized signatures on behalf of beneficiaries, are on file.
4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
 - Subscriber/sponsor's name,
 - Subscriber/sponsor's Dental insurance claim number,
 - Date(s) of service,
 - Procedure/service performed
5. UCCI has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the subscriber/sponsor's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to UCCI guidelines.
6. That it will ensure that all claims for UCCI primary payment have been developed for other insurance involvement and that UCCI is the primary payer.
7. That it will submit claims that are accurate, complete, and truthful.
8. That it will retain all original source documentation and medical record pertaining to any such particular Dental claim for a period of at least 6 years, 3 months after the bill is paid.
9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all subscriber/sponsor-specific data from improper access.
10. That it will acknowledge that all claims will be paid from UCCI funds, that the submission of such claims is a claim for payment under one of the UCCI programs, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal, State and Local law.
11. That it will establish and maintain procedures and controls so that information concerning Dental beneficiaries, or any information obtained from UCCI shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with § 1106 (a) of the Act).
12. That it will research and correct claim discrepancies.
13. That it will notify UCCI within 2 business days if any transmitted data are received in an unintelligible or garbled form.
14. That by enrolling to submit Dental claims electronically to UCCI, it remains responsible for those claims. In accepting claims submitted electronically to UCCI from any billing service or through the use of a particular product which accomplishes this process, UCCI is not attesting to the appropriateness of the methods used by the billing service or to the accuracy of a particular vendor's product which purportedly facilitates such electronic submissions. The provider furnishing the item or service for whom payment is claimed under UCCI retains the responsibility for any claim regardless of the format in which it chooses to submit the claim.

B. UNITED CONCORDIA COMPANIES, INC. WILL:

1. Transmit to the provider an acknowledgment of claim receipt.
2. Affix the intermediary/carrier number, as its electronic signature on each remittance advice sent to the provider.
3. Ensure that payments to providers are timely in accordance with UCCI's policies.
4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to any electronic biller to obtain such services.
5. Ensure that all Dental electronic billers have equal access to any services that UCCI makes available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services UCCI sells directly, indirectly, or by arrangement.
6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE: Federal, State or Local law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by UCCI under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Dental claims are submitted to UCCI. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. SIGNATURE:

I am authorized to sign this document on behalf of the indicated party, and I have read and agree to the foregoing provisions and acknowledge same by signing below:

PROVIDER'S NAME (please print or type)		
TITLE		
ADDRESS		
CITY	STATE	ZIP CODE
SIGNATURE		
DATE		