P.O. Box 7011 Northridge, Ca 91327-7011 * (818) 368-5501 * www.signatureclaims.net

Provider Sign-up Form Information

South Carolina Medicaid

Follow instructions on how to fill out this form.

You MUST email your Medicaid Information to Signature Claims because there is a separate form that must be filled out by the clearinghouse.

MAIL all pages of TPA to:
SC Medicaid TPA
P.O. Box 17
Columbia, S.C. 29202
Call 1-888-289-0709 for assistance with questions

Read before completing TPA - Incorrect or incomple TPAs will be returned

Name: Provider or organization name. The name must match the provider ID in 2. For instance if you have an organization name you must have a group ID, if you have an individual name you must have an individual ID. Some providers have both. In this case you will complete 2 separate TPAs, one for each ID.

SC Medicaid Provider ID: This is the 6 digit provider ID. If you do not have your provider ID, you must contact enrollment and apply for one first before submitting the TPA to the EDI division. You can contact Enrollment at 803-788-7622 ext: 41650 for an enrollment packet and to sign up for Electronic Funds Transfer.

Address: This should be the providers address. (billing or street)

Contact Name: The Provider's enrollment officer or anyone who can speak about the TPA should we have questions.

Contact Phone, Email and Fax: If we cannot reach you by phone we will try via email and fax. Please complete.

Page 5. Signing for EDI Partner: Original Signature is required, no stamps, no copies, no faxes. Signature should be that of provider, or authorized representative. **Signing for SCDHHS:** is for internal SC Medicaid representative upon receipt.

Page 6. Provider Name, Medicaid#, address, and phone These should be the same as information on page 1.

NPI# This is the National Provider ID for the provider ID listed. Do not leave blank. We will not process the TPA without the NPI.

Name and Title This should be the person who signed page 5 and page 8.

The Provider will submit claims… If you would like a Webtool ID indicate the number of user Ids needed. It is one user ID per person.

Other company or software: List your clearinghouse or software vendor if you are using a third party to submit your claims. If you have your own SC Medicaid Submitter ID you can list it here.

Page 8 Signature: Should be same as signature on page 5. and name on page 6.

Appendix B Sharing Your NPI: If the TPA is for an individual provider, complete the Individual Provider section only. If the TPA is for a group ID, complete the Group section only. It is very important that the NPI that you provide is for the provider ID listed. Note that the TPA will not be processed without the NPI information. Refer to page 1. for information on applying for an NPI.

I. General

This Agreement, effective upon execution by both parties (the "Effective Date"), is between the South Carolina Department of Health and Human Services (SCDHHS) and the Electronic Data Interchange (EDI) Partner identified in paragraph A. below:

A. Provider/ EDI Partner Information:

1. Name: _____

2. S.C. Medicaid Provider Number, if Applicable (Note: A separate completed TPA is required for each provider number.):
   _____

3. Address: _____

   _____

4. Contact Name: _____

5. Contact Telephone Number: _____

6. Contact E-Mail Address: _____

7. Contact Fax Number: _____

8. National Provider Identifier (NPI) Number. If you qualify and have registered your NPI with SCDHHS, it must be included in Appendix A. If you qualify and have not registered your NPI with SCDHHS, please complete the Trading Partner Agreement, and Appendices A & B. **This agreement will not be processed without your NPI information**.

   If you qualify and have not yet applied for an NPI, you can apply to the National Plan and Provider Enumeration System (NPPES) used by CMS to assign NPIs in any of the following ways:
   1) Apply through the Web address: https://nppes.cms.hhs.gov
   2) Call (800) 465-3203 or (800) 692-2326 (TTY) for a paper application.

3) E-mail customerservice@npienumerator.com to obtain a paper application.
4) Write to the NPI Enumerator, P.O. Box 6059, Fargo, N.D. 58108-6059.

If you **DO NOT** qualify for an NPI, complete the Trading Partner Agreement and Appendix A.

II. Purpose

A. This Agreement outlines the requirements for the electronic transfer of protected health information (PHI) between the EDI Partner named in paragraph I. A. (above) and SCDHHS.

B. The EDI Partner is in the business of submitting said electronic transactions on behalf of itself or provider(s).

C. The exchange of information is for the purpose of allowing providers to conduct electronic transactions through the EDI Partner for health care services provided to Medicaid beneficiaries of the SCDHHS. This Agreement provides for the exchange of information between these parties necessary for the processing of such transactions. These transactions must be in accordance with the American National Standards Institute (ANSI) accredited standards and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, CFR 45 Parts 160 and 162, Standards for Electronic Transactions, published in the Federal Register August 17, 2000.

D. The EDI Partner is prohibited from transferring PHI received from SCDHHS for any purpose not expressly permitted by and related to paragraphs II A, B, and C above.

III. Provisions of the Agreement

A. The EDI Partner agrees to follow the SCDHHS billing guidelines as provided to providers for the submission of Health Care Claim transactions.

B. All Medicaid providers must enter into an "Electronic Media Billing Agreement" with SCDHHS (see Appendix A).

C. All transactions must be formatted in accordance with the HIPAA Implementation Guides available at http://www.wpc-edi.com/hipaa. SCDHHS Medicaid Companion Guides, which specify certain situational data elements necessary for SCDHHS, are available at http://www.dhhs.state.sc.us. HIPAA transactions to be exchanged

between the EDI Partner and SCDHHS are identified in the SC Medicaid Technical Communications User's Manual.

D. The EDI Partner must complete testing for each of the transactions it will implement and shall not be allowed to exchange data with SCDHHS in production mode until testing is satisfactorily passed as determined by SCDHHS. Successful testing means the ability to successfully pass HIPAA compliance checking and to process PHI transmitted by EDI Partner to SCDHHS. SCDHHS will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of an EDI Partner being tested by SCDHHS. Such certification must be at least level 4 as defined by WEDI.

E. The EDI Partner warrants and represents that it has a legally binding contract between itself and all providers for whom it is submitting data or that the EDI Partner is itself a provider authorized to submit claims and receive health care information for beneficiaries who have coverage for services by the SCDHHS.

F. SCDHHS and the EDI Partner will protect the PHI contained in the exchange of information by means of both physical and electronic security measures.

1. Each entity will control access to its physical locations so that only authorized personnel have access to the information.
2. Each entity will utilize passwords in accordance with established procedures so that only authorized personnel have knowledge of those passwords. Upon departure of personnel from employment, the EDI Partner will promptly or immediately notify SCDHHS so that a new password can be established. SCDHHS will establish a similar system for departure of its own employees.
3. Each Party to this Agreement will report to the other any violation of security and/or the release of PHI that is not in accordance with this Agreement.
4. Technical rules for the electronic transfer of PHI between the Parties can be found in the SC Medicaid Technical Communications User's Manual.

IV. Modification and Termination

A. Except as otherwise provided herein, this Agreement may be modified or amended only by agreement of the parties, in writing, and executed with

the same formality as this Agreement. The failure of either Party to insist upon strict performance of any provision of this Agreement shall not constitute a waiver of any subsequent default of the same or similar nature.

B. The Parties agree to modify this Agreement to comply with changes to applicable federal and state regulations.

C. Either party may terminate this Agreement at any time upon written notification of the other party.

D. Binding Effect and Entire Agreement

1. This Agreement contains the entire understanding of the parties, and there are no representations, warranties, covenants, or undertakings other than those expressed and set forth herein. Except as otherwise stated herein, all the provisions of this Agreement shall be binding upon the respective successors in interest to the parties.
2. Termination or expiration of this Agreement for any reason shall not release either Party from any liabilities or obligations set forth in this Agreement.

E. Governing Law: this Agreement shall be construed in accordance with and governed by the laws of the state of South Carolina regardless of the forum where it may come up for construction.

V. Confidentiality

A. Each Party agrees that during the term of this Agreement, and for a period of six (6) years thereafter, such Party shall use the same means it uses to protect confidential proprietary information (including PHI), but in any event not less than reasonable means to prevent the disclosure and to protect the confidentiality both when:

1. Written information received from the other Party is marked or identified as confidential.
2. Oral or visual information identified as confidential at the time of disclosure is summarized in writing and provided to the other Party in such written form promptly after such oral or visual disclosure.

B. The foregoing shall not prevent either Party from disclosing PHI that belongs to such Party or is:

1. Already known by the recipient Party without an obligation of confidentiality other than under this Letter Agreement.

2. Publicly known or becomes publicly known through no unauthorized act of the recipient Party.
3. Rightfully received from a third party.
4. Independently developed by such Party without use of the other Party's PHI.
5. Disclosed without similar restrictions to a third party by the Party owning PHI.
6. Approved by the other Party for disclosure.
7. Required to be disclosed pursuant to a requirement of a governmental agency or law so long as the disclosing Party provides the other Party with notice of such requirement prior to any such disclosure. Each Party represents that it has the right to disclose information that it has made and will make available to the other hereunder.

VI. Definitions:

(a) Covered Entity. "Covered Entity" shall mean SCDHHS and the EDI Partner.

(b) Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

(c) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164.501.

(d) Required to be disclosed. "Required to be disclosed" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

VII. Term

The term of this Agreement shall commence on the Effective Date and continue in effect until terminated in accordance with Section IV of this Agreement.

Signing for EDI Partner:

_____ _____

Name **Date of Signature**

Signing for SCDHHS:

_____ _____

Name **Date of Signature**

Appendix A

MEDICAID PROVIDER
ELECTRONIC MEDIA BILLING AGREEMENT

The South Carolina Department of Health and Human Services (DHHS) and

Provider Name: _____ Provider Medicaid # _____
NPI #_____

recognize the mutual advantage of submitting claims electronically. This agreement sets forth the necessary procedures for submitting claims electronically.

-Address Of Medicaid Provider: _____

-Phone Number of Medicaid Provider: _____

-Name and title of individual practitioner, administrator, proprietor, corporate officer or individual within the Medicaid Provider's organization who has authority to enter into a contract and sign this agreement: (Signature of authorized representative required on last page)

-Name: _____ Title:_____

The Provider will submit claims using the following software or company:
_____ South Carolina Medicaid Web-based Claims Submission Tool
Number of IDs requested: _____
_X___ Other Company or Software: Signature Claims (M00473CA2)

The Provider agrees:

A. To submit claims only through a business agent as defined in 42 CFR 447.10(f) which states:
Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for the service is (1) Related to the cost of processing the billing; (2) Not related on a percentage or other basis to the amount that is billed or collected; and (3) Not dependent upon the collection of the payment." The Provider understands that, in accordance with 42 CFR 447.10(h) "Payment for any service furnished to a recipient by a provider may not be made to or through a factor, either directly or by power of attorney." "Factor means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the

provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable." (42 CFR 447.10 (b)). Further "payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by a court order." (42 CFR 447.10 (e)).

B. That if the Provider decides to utilize a business agent to submit claims, Provider must authorize the business agent by written contract to submit Medicaid claims in his behalf.

C. To furnish a copy of the aforementioned contract to DHHS or its designee upon request.

D. To assure that claims are submitted in the format specified by DHHS and to submit test claims for approval by DHHS prior to submitting claims for payment.

E. To assure that a transmittal letter is submitted as specified by DHHS along with each cartridge/tape/diskette.

F. To correct any and all discrepant claims submitted.

G. To maintain and ensure ready association of electronic claims with source documents, including but not limited to: (1) a signed statement from the patient consenting to the release of information necessary to process claims; (2) justification for rendering services; (3) identification of practitioner rendering services; (4) records corroborating that the services furnished were the same services contained in the claim; and (5) documentation proving that a claim was submitted electronically, by whom it was submitted and when it was submitted.

H. To retain all records for a period of seventy-two (72) months after the close of the federal fiscal year in which the services were rendered.

I. That DHHS, the United States Department of Health and Human Services, General Accounting Office, the State Auditor, the Attorney General, or their designees, have the right to audit and confirm information submitted and to access and/or photograph source documents and medical records during regular business hours.

J. That any incorrect payments ascertained as a result of such an audit will be adjusted according to applicable provisions of Title XIX of the Social Security Act as amended, the S.C. State Plan for Medical Assistance, other applicable State and Federal laws and regulations, and DHHS Medicaid guidelines.

K. That the submission of an electronic media claim is a claim for Medicaid payment

and that "payment of this claim 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." (42 CFR 455.18(a)(2)).

L. That either party may terminate this agreement at any time upon written notification of the other party.

M. That certain claims may not be submitted electronically and that DHHS has the sole authority to determine which claims may or may not be submitted electronically.

N. That under certain circumstances, DHHS may require prepayment review of claims and that the Provider will be notified in writing of the DHHS's intent to conduct prepayment review during which time electronic claims will not be accepted.

O. That this agreement in no way exempts the Provider from being subject to all other Medicaid regulations in effect at the time the Provider submits a claim.

P. To safeguard and require, in the Provider's written contract with its business agent, that its business agent shall safeguard the use and disclosure of information concerning Medicaid recipients in accordance with all applicable Federal and State laws and regulations. The Provider understands that, in accordance with 42 CFR 431.305(b), "this information must include at least (1) name and address; (2) medical services provided; (3) social and economic conditions or circumstances; (4) agency evaluation of personal information; and (5) medical data, including diagnosis and past history of disease or disability."

Q. To be responsible for all services rendered, charges billed, and reimbursement received.

I have read, understand and agree with the conditions set forth in this agreement.

_____ _____

Signature (must be authorized representative designated on page 6) Date of Signature

Appendix B

SHARING YOUR NATIONAL PROVIDER IDENTIFIER WITH THE SOUTH CAROLINA MEDICAID PROGRAM

To participate in electronic claims and related transactions, you must register your NPI with South Carolina Medicaid. To register your NPI with South Carolina Medicaid, complete the following:

INDIVIDUAL PROVIDER

SC Medicaid Provider Number:		
NPI Number:		
Date NPI Issued:		
Individual Provider's Name:		
SSN/EIN:		
Mailing Address:		
City, State, Zip:		
Primary Practice Address:		
City, State, Zip:		
Provider Taxonomy Code	Provider License Number	State License Board
Contact Name, Title & Phone #:		

GROUP/ORGANIZATION PROVIDER

SC Medicaid Provider Number:		
NPI Number:		
Date NPI Issued:		
Group/Organization Provider's Name:		
EIN:		
Mailing Address:		
City, State, Zip:		
Primary Practice Address:		
City, State, Zip:		
Provider Taxonomy Code	Provider License Number	State License Board
Contact Name, Title & Phone #:		