**STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division**

**Electronic Data Interchange (EDI)
Manual**

March 15, 2004

Introduction/Table of Contents

Thank you for participating in the Hawaii Medicaid program. Med-QUEST, a division of the Hawaii Department of Human Services (DHS), is responsible for administering the Title XIX (Medicaid) program for the State of Hawaii.

This Electronic Data Interchange (EDI) manual is intended to provide instructions for transmitting and receiving electronic transactions with Med-QUEST and its fiscal agent, ACS State Healthcare. Previously referred to as the Electronic Claims Submission (ECS) manual, it has been expanded to accommodate changes mandated by the Health Insurance Portability and Accountability Act (HIPAA). It now contains information about all HIPAA-compliant transactions implemented by Med-QUEST for the fee for service provider population.

Note
The manual does not cover transactions used by QUEST health plans. QUEST health plan providers should contact the plans directly for EDI requirements. Health plans should refer to the Health Plan Manual for EDI requirements.

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1 Change Log and Summary

Change Log

This section is updated as each version is released. Comments are included where applicable.

Version	Release Date	Comments (if applicable)
1.0	12/12/03	This version of the EDI manual replaces the existing ECS manual. The manual was produced in conjunction with the October 2003 HIPAA Transactions and Code Sets implementation.

Summary of Changes by version

This section provides a summary of all changes to the manual. They are listed in descending version order, then by page and/or section number. A brief description of each change is also included. Where document-wide are indicated, the Page/Section # column will designate 'global change'.

There is no change summary for version 1.0.

Version	Page/Section #	Description of change

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Hawaii Department of Human Services, Med-QUEST Division

2 Before You Begin

This section provides important information for those interested in exchanging electronic transactions with Med-QUEST and ACS. It includes the following sections:

- Intended Audience
- Contact Information
- Prerequisites

2.1 Intended Audience

The DHS Medicaid EDI Manual intended for individuals or companies that intend to exchange electronic transactions with the State of Hawaii, Department of Human Services, Med-QUEST Division (MQD). Its purpose is to provide the reader with information covering all aspects of fee for service EDI, including electronic claims submission, electronic remittance advice, electronic eligibility verification/response, and other HIPAA-mandated electronic transactions. This manual provides the following:

- Registration requirements, including signup procedures
- Transaction descriptions, technical requirements, and transmission requirements
- Testing information, including tips, thresholds, and an overview of the testing process
- Contact information and links to the Med-QUEST HIPAA/EDI Web site

2.2 Contact Information

ACS, the Med-QUEST fiscal agent, is responsible for assisting providers and vendors with EDI-related issues. The ACS Provider Call Center is staffed from 7:30 a.m. until 5:00 p.m. (Hawaii Standard Time), Monday through Friday. They can be reached at the following numbers:

(808) 952-5570   **Oahu and Mainland**

(800) 235-4378   **Neighbor Islands**

The ACS EDI Team can also be reached via e-mail at **hi.ecstest@acs-inc.com**

Issue Resolution

Although ACS and Med-QUEST work hard to make the EDI process as smooth as possible, submitters may encounter difficulty or require assistance during sign-up, testing, or with production transmissions. Any problems encountered in the electronic submission of claims to MQD and/or the electronic receipt of remittance advices should be directed to the ACS Provider Call Center at the number(s) listed above. Alternatively, the submitter may contact the ACS EDI Team directly by e-mail.

The submitter should be prepared to supply the following information:

- Topic of call (for instance, the transaction ID)

- Name

- Organization and submitter ID, if applicable

- Phone number

- Nature of problem or question (FTP server connection, receipt status, etc.)

This information will be logged, assigned a Ticket Number, and the Call Center will transfer the caller to the appropriate staff member. If a staff member is not immediately available, the call will be returned as soon as possible. Callers are encouraged to reference the Ticket Number assigned to the original call on any subsequent call that deals with the same issue.

Note
It is recommended that submitters contact the ACS EDI team via e-mail during the testing process. This enables the submitter to attach examples of errors (for instance, response transactions and/or messages) with the e-mail, which can expedite resolution of the issue.

2.3 Prerequisites

Since the October 16, 2003 implementation of HIPAA Transactions and Code Sets (TCS), Med-QUEST accepts and receives only ANSI X12 transactions as mandated by HIPAA. Exceptions to this include contingency participants, which will convert to HIPAA transactions as soon as their testing has completed, and electronic transactions that Med-QUEST determines to be outside the scope of HIPAA.

Submitters (providers and/or vendors) must obtain copies of the Implementation Guides (IG) and develop transactions according to the IG specifications. Where applicable, Med-QUEST has developed an accompanying Companion Document, which is used in conjunction with the IG to provide specifications for transmitting HIPAA-compliant transactions that can be processed by the Med-QUEST system. The IGs can be downloaded from the Washington Publishing Company Web site at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Submitters are required to submit certified HIPAA transactions to Med-QUEST. Chapter 6, Testing, describes how to demonstrate certification to ACS prior to beginning the testing process.

Chapter 7, Transaction Overview, provides basic information about each transaction and, where applicable, a link to the Med-QUEST Companion Document.

3 Registration Requirements

This chapter describes how to sign up to exchange EDI with Med-QUEST and ACS. It includes the following sections:

- Access codes and passwords

- Sign-up procedures

- EDI forms

3.1 Access Codes and Passwords

To submit and receive electronic transactions with Med-QUEST and ACS, submitters must be set up with a series of IDs and passwords. It is the responsibility of the State to assign the IDs and communicate this to ACS. Types of IDs include:

- ID/password granting access to the submitter's folder on the File Transfer Protocol (FTP) server

- ID/password for the Virtual Private Network (VPN) protecting the FTP server

It is important to understand these access codes relate to the submitter, who may or may not be the provider. A provider may contract with a clearinghouse to transmit electronic transactions. If that clearinghouse bundles transactions from one or more providers and submits them to Med-QUEST, the clearinghouse is assigned a set of IDs/passwords. By contrast, a provider using software to submit/receive transactions directly with Med-QUEST will be assigned his or her own set of IDs/passwords. Providers are encouraged to communicate with their software developers, billing agents, and/or clearinghouses to understand the relationship as it relates to assignment of access codes and passwords.

To access the DHS Medicaid Online web application, log onto the DHS Medicaid Online website at: https://hiweb.statemedicaid.us. Users will need to establish a user account prior to using the system. For more information regarding the account creation process,

Note
Testing cannot begin until submitters have applied for and received the appropriate IDs and passwords. To apply, please refer to Section 3.2, Sign-up Procedures.
Med-QUEST will not assign IDs/passwords to anyone who is not a current Med-QUEST provider or an authorized representative (e.g., contracted billing agent, software developer, or clearinghouse) of a current Med-QUEST provider. ACS must understand the relationship between a provider and a billing service/software vendor/clearinghouse before IDs and passwords can be issued.

3.2 Sign-up Procedures

Submitters must sign up, which includes filling out the appropriate form(s), documenting relationship(s) between providers and their billing service/software developer/clearinghouse, and receiving the necessary access codes and passwords, prior to beginning the testing process. This section covers the following topics:

- Process overview

- Determining which forms to complete

- Submitting forms and receiving responses

Note
A **submitter** is defined as a provider or vendor who will be directly connecting to the Med-QUEST FTP server to transmit or receive EDI. A submitter can be a billing service, clearinghouse, or provider. Submitters are also referred to as **trading partners** throughout this manual. Trading partner is a HIPAA term.

3.2.1 Process Overview

Med-QUEST requires basic information about the submitter (provider and/or software developer/billing service/clearinghouse) and a signed agreement prior to beginning the testing process. In many cases, the information passed between the Submitter and the State contains Protected Health Information (PHI) and other confidential data. The State has authorized ACS to prohibit any submitter who does not complete the appropriate paperwork from participating in the EDI process. Accurate completion of this paperwork provides the following benefits:

- Provides an agreement, specific to Med-QUEST and the provider/vendor, for the submission, acceptance, and processing of electronic transactions, including electronic claims and remittance advices

- Assists in monitoring the relationship between a provider and vendor, billing service, or clearinghouse, and provides ACS with contact information

- Signifies the submitter verifies the information transmitted to the State is accurate and complete. This electronic agreement correlates to a signature on a paper claim, which attests to the accuracy of the data provided

The table below outlines the process for EDI sign-up with Med-QUEST and ACS.

Step	Action	Result
1	Contact ACS	The ACS Provider Inquiry Unit (PIU) can be reached at (808) 952-5570 ((800) 235-4378 for Neighbor Islands). PIU Associate will collect basic information from the caller and forward request to the ACS EDI Team. The ACS EDI Team will then send the EDI and VPN manuals to the requestor.
2	Access Web site	The Med-QUEST Web site at www.med-quest.us/hipaa provides detailed information about EDI and HIPAA. At this site, interested parties can download the EDI manual, learn about transaction, use helpful links, and find out more about the testing process. The site also features numerous 'Contact us' links, which go directly to ACS.
3	Complete and mail form(s)	Please see Section 3.2.2, Determining Which Forms to Complete, and Section 3.3, Completing the EDI Forms, for complete instructions. Please note ACS must receive original signed copies of these forms. A mailing address is provided in Section 3.2.3, Submitting Forms and Receiving Responses.
4	Be available to answer questions/ provide additional information	The ACS EDI Team can be reached at (808) 955-4900 or via e-mail at hi.ecstest@acs-inc.com.
5	Receive Access codes and Client software for VPN	The MQD Systems Office will provide FTP folder(s) Access code(s) to the appropriate Contact Person on the forms. The ACS EDI Team will provide the VPN Manual, which includes the VPN Access code.
6	Install Client software for VPN and verify accessibility	The VPN Manual will include instructions on how submitters can install the VPN software. The ACS EDI Team can be reached at 808-955-4900 if submitters encounter any problems when installing the VPN software.

Note
Failure to comply with the steps above, including providing complete and accurate information upon request, may result in a delay of the registration process.

3.2.2 Determining Which Forms to Complete

Med-QUEST uses four forms to authorize EDI and assign access codes and passwords. These forms are:

- Provider/Vendor Electronic Claims Submission Notification

- Electronic Provider Agreement

- Electronic Remittance Advice Registration

- Electronic Claim Data Authorized Signature

The purpose of the first form is to document the relationship between provider and vendor, to identify the submitter, and to capture all necessary contact information. The second form serves as an agreement between the provider and Med-QUEST to accept claims electronically. This form will also be used for other electronic transactions mandated by HIPAA, such as prior authorizations and claim attachments. The third form relates specifically to Electronic Remittance Advices (835) and enables the provider to receive Automated Clearinghouse (ACH) payments. The fourth form is used when provider/vendor signatory personnel changes occur.

Use the chart below to determine which forms to complete and mail:

These Submitters...	Complete these Forms
Submitter that transmits electronic claims and other related transactions and receives an electronic remittance advice	• Provider/Vendor Electronic Claims Submission Notification • Electronic Provider Agreement • Electronic Remittance Advice Registration
Submitter that transmits electronic claims and other related transactions but does NOT receive an electronic remittance	• Provider/Vendor Electronic Claims Submission Notification • Electronic Provider Agreement
Submitter that receives an electronic remittance but does not transmit electronic claims and other related transactions	• Provider/Vendor Electronic Claims Submission Notification • Electronic Remittance Advice Registration
Submitter currently exchanging EDI (submitting and/or receiving) that incurs changes in personnel that are authorized to sign documents related to electronic claims, related inbound transactions, and electronic remittance advices	• Electronic Claim Data Authorized Signature

3.2.3 Submitting Forms and Receiving Responses

Med-QUEST requires original signatures on the forms. Completed forms can be mailed to the following address:

ACS Fiscal Agent
P.O. Box 1220
Honolulu, HI 96807-1220

Receipt of the form(s) will be acknowledged by email if a valid email address is provided on the Provider/Vendor Electronic Claims Submission Notification. ACS will review the forms for completeness and accuracy and contact the sender if additions/corrections are required.

Once ACS reviews the forms and validates the data, they request access codes and passwords from the State, as described in Section 3.1, Access Codes and Passwords. The State will notify ACS when the process is complete, and ACS will in turn notify the provider/vendor as applicable. The provider/vendor will receive the following:

- ID and password to access the FTP server, where EDI transactions may be picked up and dropped off

- ID and password to access the VPN, which provides secure access to the FTP server

- Client software for the VPN, which the provider/vendor downloads and installs

Note
Providers and vendors can expect the process of reviewing the forms and assigning access codes/passwords to take approximately two (2) weeks. Providers/vendors can contact ACS by return email if they have not received a response within 2 weeks of receiving an email acknowledging receipt of the original forms.

3.3 Completing the EDI Forms

This section contains the instructions for completing the required forms. Chapter 8, EDI Forms, contains the actual forms.

3.3.1 Provider/Vendor Electronic Claims Submission Notification

This document notifies MQD of the intent to exchange electronic transactions such as claims and remittance advices. It designates those persons authorized to sign electronic claim documents. It also furnishes an estimate of the volume of claims to be submitted and lists those providers that will be included in the submissions. The Provider/Vendor must complete this notification form before testing and submitting electronic claims data to MQD or retrieving ERAs from MQD. Where a provider is utilizing a billing service or clearinghouse for claims transmission or other inbound transactions, this form is to be completed by the billing service or clearinghouse. Where a provider is retrieving ERAs directly, this form is to be completed by the provider.

Field No.	Instructions
1.	Enter the name of the Provider or Vendor.
2.	If applicable, enter the Provider ID number assigned by MQD.

Field No.	Instructions
3.	Enter the date the Provider/Vendor will begin submitting electronic claims to MQD or retrieving ERAs from MQD. Note that it will require up to 10 business days from receipt of this form for the Provider/Vendor to obtain a submitter ID, user ID and password.
4.	Check one of the following: 837 Only – if the Provider/Vendor will be submitting 837 claims and not retrieving 835s. Form 2 must also be completed. 837 and 835 – if the Provider/Vendor will be submitting 837 claims and retrieving 835s. Forms 2 and 3 must also be completed. 835 Only – if the Provider/Vendor will be retrieving 835s and not submitting 837 claims. Form 3 must also be completed.
5.	Enter the Provider/Vendor street address.
6.	Enter the Provider/Vendor city, state and zip code.
7.	Enter the Provider/Vendor telephone and fax numbers.
8.	Enter the name of the Provider/Vendor contact person.
9.	Enter the Provider/Vendor contact's telephone number.
10.	Enter the Provider/Vendor contact's e-mail address
11.	Enter the name of the Provider/Vendor technical support representative.
12.	Enter the Provider/Vendor technical support rep's telephone number.
13.	Enter the Provider/Vendor technical support rep's e-mail address.
14.	Enter the position title of the persons authorized to act as signatory.
15.	Enter the name of the persons authorized to act as signatory.
16.	The authorized signatories sign their name.
17.	Monthly estimate of average and maximum volume of HCFA-1500 claims that will be submitted electronically to MQD.
18.	Monthly estimate of average and maximum volume of UB-92 claims that will be submitted electronically to MQD.
19.	Monthly estimate of average and maximum volume of Dental claims that will be submitted electronically to MQD.
20. -29.	If the Provider/Vendor is a billing service or clearinghouse, enter the names and ID numbers (assigned by MQD) of the providers for which the submitter will be submitting claims. If the Provider/Vendor is retrieving 835s on behalf of other providers, enter the names and ID numbers (assigned by MQD) of the providers for which the Provider/Vendor will be retrieving 835s. Attach additional sheets of paper if necessary.
30.	Enter the name and title of the Provider/Vendor authorized representative.
31.	Enter the date the form was signed.
32.	Authorized signature.

3.3.2 Electronic Provider Agreement

The *Electronic Provider Agreement* is an agreement between the Provider/Vendor and MQD, which authorizes MQD to accept claims data electronically. The agreement also includes the Provider/Vendor responsibility for submitting this data in accordance with applicable rules and regulations, and within Electronic Claim Submission specifications.

Field No.	Instructions
1.	Enter the name of the Provider/Vendor.
2.	Enter the date the form was signed.
3.	Enter the name and title of the Provider/Vendor authorized representative.
4.	If applicable, enter the Provider ID number assigned by MQD.
5.	Signature of the Provider/Vendor authorized representative.

3.3.3 Electronic Remittance Advice Registration

This form should be completed and mailed to the Fiscal Agent to register to receive the 835 Electronic Remittance Advice (ERA) and automated clearing house (ACH) payments. The Provider/Vendor must complete this notification form before testing and receiving 835s from MQD.

Field No.	Instructions
1.	Enter the name of the Provider/Vendor.
2.	If applicable, enter the Provider ID number assigned by MQD.
3.	Enter the Provider/Vendor Tax ID.
4.	Enter the Provider/Vendor street address.
5.	Enter the Provider/Vendor city, state and zip code.
6.	Enter the Provider/Vendor telephone and fax numbers.
7.	Enter the name of the Provider/Vendor contact person.
8.	Enter the Provider/Vendor contact's telephone number.
9.	Enter the Provider/Vendor contact's e-mail address.
10.	Enter the name of the bank and account number where ACH payments should be deposited.
11.	Enter the bank street address, city, state and zip code.
12.	Enter the bank phone number.
13	Enter the business name attached to the bank account.
14.	Enter the routing number of the bank account.
15.	Enter the name and title of the Provider/Vendor authorized representative.
16.	Enter the date the form was signed.

Field No.	Instructions
17.	Authorized signature.

3.3.4 Electronic Claim Data Authorized Signature

This form should be completed and mailed to the Fiscal Agent whenever Provider/Vendor signatory personnel changes occur. This form will serve as notification to MQD of those individuals who become authorized or are no longer authorized to sign Electronic Claims Submission (ECS) documents on behalf of the Provider/Vendor.

Under no circumstances will MQD accept ECS documents from anyone other than the Provider / Vendor authorized signatories.

Field No.	Instructions
1.	Enter the name of the Provider/Vendor.
2.	If applicable, enter the Provider ID number assigned by MQD.
3.	Enter the position title of the persons authorized to sign ECS documents.
4.	Enter the name of the persons authorized to sign ECS documents.
5.	The authorized signatories sign their name.
6.	Enter the position titles of the persons to be removed from authorization.
7.	Enter the names of the persons to be removed from authorization.
8.	Enter the dates the contact persons should no longer be authorized to sign ECS documents.
9.	Enter the name and title of the Provider/Vendor authorized representative.
10.	Enter the date the form was signed.
11.	Authorized signature.

4 Technical Requirements

This chapter describes hardware and software requirements for EDI. It contains the following sections:

- Internet connectivity

- Virtual Private Network (VPN) standards

- File Transfer Protocol (FTP) standards

- Communications software

4.1 Internet Connectivity

Internet connectivity is secured through use of a VPN. Users must establish an Internet connection and connect to a secured VPN. After establishing a secured connection, users will be able to run FTP to initiate file transfers with Med-QUEST.

Usernames and passwords are required for FTP access and for the VPN. They are maintained by the State and communicated to submitters by ACS. Please refer to Chapter 2, Sign-up Procedures, for more information.

The DHS Medicaid Online web application requires that you use Microsoft Internet Explorer 5.5 or higher to access data through the Internet. This requirement helps ensure the Med-QUEST standards for privacy, reliability and flexibility.

If you encounter difficulties when attempting to connect to the web site, be sure that you have met these minimum browser requirements. Consult your own technical support resources for more information, if necessary; or use the link, pictured below, on the homepage to download and install Microsoft Internet Explorer 6.0.

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4.2 Virtual Private Network (VPN) Standards

Submitters must install VPN Client software on the computer used to submit or receive the transmissions. Submitters that reply for and receive a VPN ID and password are also given a Uniform Resource Locator (URL), which can be used to download the client software from a Med-QUEST server. Please refer to Chapter 2, Sign-up Procedures, for instructions. ACS may be able to provide submitters with assistance installing the VPN Client.

The following are hardware and software requirements for installing and using the VPN Client:

Hardware/Software Category	Requirement
Operating System	• Windows 95 B&C (may require dial-up networking upgrade 1.3) • Windows 98 • Windows 98 SE • Windows NT Workstation (SP3 or higher) • Windows XP • Windows 2000 Professional It is not known whether the VPN Client is compatible with Windows ME
Hardware	Hardware requirements are modest and some submitters submit successfully using 486-class workstations with 32 MB of RAM; however, Cisco recommends the following: • PC-compatible computer with Pentium processor • 18 MB of free drive space • 16 MB of RAM for Win95/98; 32 MB for NT 4.0; 64 MB for Win2000/XP • Ethernet network interface card or modem
Internet/firewall	The submitter must have a working Internet connection and any intervening firewalls must be configured to permit passage of the VPN traffic on TCP port 10000. Some Internet Service Providers (ISP) will not comply with this requirement; in such cases, submitters must obtain a separate dialup account for VPN purposes. The only known ISP issues encountered with AOL are with the free services that provide dialup Internet access.

4.3 File Transfer Protocol (FTP) Standards

After establishing a secure VPN connection, submitters should configure FTP software to point to the Med-QUEST FTP server IP address 170.68.41.129.

Med-QUEST does not provide FTP software for submitters. Most software vendors/clearinghouses bundle FTP software with their EDI software packages. Please refer to Section 4.4, Communications Software, for information about an FTP package available through a third party vendor.

Med-QUEST recommends the use of WS_FTP (see Section 4.4, Communications Software) and will provide the URL from which it can be downloaded. While the FTP

Client is not supported by Med-QUEST, ACS may be able to assist submitters with difficulties encountered installing or using the WS_FTP Client.

Note
Med-QUEST does not support anonymous FTP. Submitters must supply a valid Username and password to connect to the FTP server. Please refer to Chapter 2, Sign-up Procedures, for information on obtaining the appropriate user IDs and passwords.

4.4 Communications Software

Med-QUEST has evaluated the following software packages and provides vendor contact information for them:

Cisco VPN Dialer – Cisco Systems, Inc.

170 West Tasman Drive
San Jose, CA USA
800-553-NETS (6387) within the U.S. and Canada
http://www.cisco.com

Cisco provides the VPN Client software free of charge because the Med-QUEST VPN Concentrator is a Cisco product. It is important to note the Cisco VPN Client software may be used **only** for communicating with the Med-QUEST communications server. Med-QUEST will provide copies of the software upon request, with the understanding that it is to be sued only for communicating with the Med-QUEST communications server.

WS_FTP – Ipswitch, Inc.

333 North Avenue
Wakefield, MA 01880
617-246-1150
E-mail: info@ipswitch.com
http://www.ipswitch.com

Note
The Cisco VPN Dialer does **not** include FTP capability. This must be obtained with a separate product. There are many FTP products available on the market, and Med-QUEST does not mandate use of a particular product. WS_FTP, by Ipswitch, Inc., has been evaluated and deemed satisfactory by Med-QUEST.

5 Transmission Requirements

This chapter describes the FTP directory structure and transaction standards. It also describes transmission windows and thresholds.

5.1 File Transfer Protocol (FTP) Directory Structure

Med-QUEST provides submitters that have successfully completed the sign-up process with two sets of directories – test and production. Each mirrors the other and is distinguished by PROD (production) and TEST (test). The structure is outlined below, where **XXXXX** refers to the Submitter ID (FTP User ID) assigned by Med-QUEST:

Directory Structure	Use
FTP**XXXXX**\\CLAIMS\\ECSIN\\PROD	Submitters place production claims in this folder
FTP**XXXXX**\\CLAIMS\\ECSOUT\\PROD	Submitters receive test file acknowledgements in this folder
FTP**XXXXX**\\CLAIMS\\REMITSOUT\\PROD	Submitters pick up production remittance advice (RA) from this folder
FTP**XXXXX**\\CLAIMS\\ECSIN\\TEST	Submitters place test claims in this folder
FTP**XXXXX**\\CLAIMS\\ECSOUT\\TEST	Submitters receive test file acknowledgements in this folder
FTP**XXXXX**\\CLAIMS\\REMITSOUT\\TEST	Submitters pick up test RAs from this folder

ACS and Med-QUEST work together to control access to the production and test directories. Submitters can submit and receive only those transactions for which they are testing (test directories) or have completed testing (production directories).

Note
270/271 and 276/277 batch transactions are transmitted via the Internet at DHS Medicaid Online. Trading partners should contact ACS for more information. ACS will direct all questions related to the 270/271 and 276/277 batch transactions to the appropriate technical resource.

5.2 Transaction Naming Standards

This section describes naming standards by transaction.

Note
Trading partners should use the most current Companion Document as the official source for file naming and layout standards. This EDI manual is intended only as a general reference: the Companion Document contains the most up-to-date specifications for a particular transaction. To access Companion Documents, please refer to Chapter 7, Transaction Overview.

Med-QUEST recognizes the following naming standards:

Transaction	Naming Standard
837 fee for service claim	CLM.MMDDYY.HHMMSS.837
835 remittance advice	HI-835-01-YYYYMMDD-Full Provider ID-location code w/o leading zeros.txt Supplemental file: HI-835-02-YYYYMMDD-Full Provider ID-location code w/o leading zeros.txt
270/271 Eligibility Verification	HI-276-CCYYMMDD-01-PROVID-WEBID.txt HI-277-CCYYMMDD-01-PROVID-WEBID.txt Segment 1 – State Segment 2 – Date Segment 3 – File type: 01 = HIPAA format; 02=Unformatted; 03=Error file Segment 4 – 6-digit Provider Number Segment 5 - Web User ID created from the online account creation process.
276/277 Claim Status	HI-276-CCYYMMDD-01-PROVID-WEBID.txt HI-277-CCYYMMDD-01-PROVID-WEBID.txt Segment 1 – State Segment 2 – Date Segment 3 – File type: 01 = HIPAA format; 02=Unformatted; 03=Error file Segment 4 – 6-digit Provider Number Segment 5 - Web User ID created from the online account creation process.
TA1 Interchange Acknowledgement	MMDDYY.000000000.TA1 MMDDYY – process date 000000000 – unique 9 character Interchange Control Number

Transaction	Naming Standard
997 Functional Acknowledgement	MMDDYY.000000000.997
	MMDDYY – process date
	000000000 – unique 9 character Interchange Control Number
824 Implementation Guide Reporting	MMDDYY.000000000.824
	MMDDYY – process date
	000000000 – unique 9 character Interchange Control Number

5.3 Transmission Window

5.3.1 Inbound Transactions

Electronic claims (837) must be submitted midnight — 6:00 p.m. Hawaii Standard Time (HST) Monday through Thursday, and midnight — 4:00 p.m. HST on Friday. Transmissions received in their entirety by 6:00 p.m. Monday — Thursday and by 4:00 p.m. on Friday will be loaded to the Med-QUEST system on the day of receipt.

270 and 276 batch requests must be submitted by 6:00 p.m. HST for processing that night.

5.3.2 Outbound Transactions

Financial cycles resulting in production of either the 835 or paper Remittance Advice are run weekly.

271 and 277 bath responses will be available to the submitter by 8:00 a.m. HST the following calendar day.

5.4 Transmission Thresholds

This section describes transmission thresholds for inbound transactions.

5.4.1 Minimum/Maximum Submission

Med-QUEST and ACS set a minimum number of five (5) claims per transaction file for system efficiency. For the Maximum number of claims, the recommendation from the 837 Implementation Guide is there should be no more than 5,000 claims per transaction. Submitters with more than 5,000 claims should send multiple 837 transactions.

The 270 and 276 transactions are limited each to 1 batch request submission per day. The latest file uploaded prior to the cutoff time will be processed. The maximum file size limitation is 10 megabytes.

5.4.2 Transmission Frequency

Due to the new file naming standards implemented as part of the October 16, 2003 Transactions and Code Sets (TCS) Implementation, trading partners can submit multiple batches (837 transactions) per day. Trading partners are reminded to note the file naming conventions documented in Section 5.2, Transaction Naming and Transmission Standards. Med-QUEST has not yet determined the maximum number of daily transactions accepted by a single submitter (based on submitter ID).

6 Testing

This chapter outlines testing strategy and provides useful information for trading partners testing the following transactions:

- 837 fee for service claims (professional, institutional, dental)

- 835 remittance advice

- 270/271 Batch eligibility request and response

- 276/277 Batch claim status request and response

- Acknowledgement transactions

As new transactions are mandated the EDI manual will be updated accordingly.

The chapter includes the following sections:

- Notifying ACS of the intent to begin testing

- Preparing test data

- Exchanging test transactions

6.1 Notifying ACS of the Intent to Begin Testing

Communication is the most important part of the testing process. The ACS EDI Team works closely with Med-QUEST and submitters to achieve positive testing results.

6.1.1 Securing User IDs and Passwords

Submitters must secure IDs and passwords prior to beginning the testing process. Please refer to Chapter 3, Registration Requirements, for more information.

270/271 and the 276/277 testing will be done on the following DHS Medicaid Online test website: https://170.68.1.49

Testers will need to establish user accounts for this test site prior to testing. For assistance with creating new accounts, please refer to the DHS Medicaid Online user manual found on the Med-QUEST website. When creating a Master account on the test

site, please notify ACS. An authentication code will be issued to the Master account holder.

Note
As stated throughout the manual, ACS will not conduct testing with any submitter that is not a current Med-QUEST provider or an authorized representative (e.g., contracted billing agent, software developer, or clearinghouse) of a current Med-QUEST provider.

6.1.2 Demonstrating X12 Certification

Med-QUEST requires demonstration of certification to Level 4 for all inbound transactions. Below are some frequently asked questions regarding certification:

Why must I certify? TCS testing can be very complicated. Certifying your transactions prior to testing with ACS dramatically shortens the time it takes to complete testing.

What does Level IV mean? Med-QUEST requires demonstration of certification to Level 4 for all inbound transactions, where T1 = syntactical integrity; T2 = Implementation Guide; T3 = Balancing; and T4 = Inter-segment Data Relationships.

How can I get certified? Your software developer will send test transactions to a qualified certification entity. Below is a partial list of certifying agencies. Please be aware that Med-QUEST and ACS not recommend one agency over another, nor do we require trading partners to use a particular certification entity.
www.hipaatesting.com
www.edifecs.com
www.claredi.com

How can I demonstrate certification? Trading partners can use any of the following methods to demonstrate certification.·

- Response from certification entity indicating an 837 transaction has successfully passed Level IV certification·

- Verification the trading partner is currently in production with at least one other payer·

- Other – please contact the ACS EDI team at hi.ecstest@acs-inc.com

Note
Trading partner is synonymous with submitter for testing purposes.

6.1.3 Securing a Testing Window

To the extent possible, ACS will allow submitters to select their own testing windows. However, it is extremely important to understand that successful testing typically involves frequent interaction between the submitter and the ACS EDI Team. For this reason, ACS may be required to schedule testing during peak times.

Submitters are encouraged to contact ACS early during the testing process to discuss testing windows and establish effective communications.

6.2 Preparing Test Data

It is critical to understand that testing relates not only to validating the compliance of a HIPAA transaction, but also to validating the correctness of the data submitted as part of the transaction. For instance, ACS and Med-QUEST want to be sure a submitter can submit claims that *process and pay correctly*, not just pass HIPAA validation edits.

Outbound transactions, such as the 835 Electronic Remittance Advice, are subject to the same testing criteria. This section describes preparing test data for inbound and outbound transactions and offers testing tips and guidelines.

Chapter 7, Transaction Overview, describes each transaction accepted or produced by Med-QUEST and provides a link for the Companion Document, where applicable.

6.2.1 Preparing for Inbound Transactions

Submitters/trading partners are encouraged to prepare inbound transactions that contain valid test data. The simplest way to accomplish this is to use production data to build the test transactions, such as test claims. At a minimum, submitters should use valid recipient IDs, procedure/diagnosis codes, provider IDs, and other vital data to submit an inbound transaction such as an 837 Fee for Service Claims, 270 Eligibility Verification Request, or 276 Claim Status Request (batch).

Use of valid test data provides the following benefits:

- ACS can validate the HIPAA compliant transaction meet HPMMIS processing standards

- The submitter/trading partner can demonstrate to the provider that the electronic transactions (such as claims) process the same as a paper claim

ACS may deny access to the production environment to any submitter that declines to participate in this level of testing.

For the purposes of the 270/271 Transaction, an asterisk (*) cannot be used as a delimiter. As a standard practice, if the first name of the recipient is more than 10-characters, HPMMIS truncates the remaining letters and replaces the 10th character with an asterisk.

This asterisk is then passed through all transactions indicating that the name was longer than appears. Use of an asterisk as a delimiter causes translation issues.

Note
It cannot be stressed strongly enough that inbound transactions must be compliant and must contain the data necessary to process correctly in the Medicaid system. In particular, the 837 fee for service claim transaction is extremely complicated and offers submitters multiple ways of submitting the same data. The Med-QUEST Companion Document for the 837 identifies file layout requirements specific to HPMMIS. The only way to fully test this functionality is to provide test claims that contain valid test data, and, if possible, compare them to production claims that contain the same or similar data.

6.2.2 Preparing for Outbound Transactions

Outbound transactions, such as the 835 Electronic Remittance Advice, 271 Eligibility Verification Response (batch), and the 277 Claim Status Response (batch), are predicated upon submission of valid inbound transactions.

Med-QUEST and ACS understand that some providers may use a different vendor for claims and electronic remittance advices; this complicates but does not prohibit the testing process. 835 trading partners should perform one of the following to prepare for testing:

- Submit a sufficient number of 837 transactions to generate an 835 that can be tested and validated; **or**

- Prepare a set of test claims and work with ACS to generate transactions that can be used to produce an 835

Med-QUEST has produced a sample 835 transaction that can be downloaded and reviewed by any interested party. Please note the sample transaction is useful only to test transaction formatting; to complete 835 testing, trading partners must submit 837 transactions or work with ACS to develop test claims, which can be used to produce the 835.

Note
Med-QUEST and ACS have no control over the extent to which trading partners test outbound transactions. For this reason, providers and their vendors are strongly encouraged to test beyond mere transaction compliance (format and layout) and attempt to validate the data provided on the transaction.

6.2.3 Testing Tips and Guidelines

The Med-QUEST HIPAA/EDI Web site contains a page devoted to testing the 837 and 835 transactions. The URL is http://med-quest.us/HIPAA/testing/index.html. Of particular note are the following documents:

- Med-QUEST Approach to Group 2 Testing, found under the "Getting Started" link (http://med-quest.us/HIPAA/testing/index.html)

- **Helpful Hints for TPs**, found under the "Asking Questions" link (http://med-quest.us/HIPAA/testing/questions.html)

The ACS EDI Team will also be able to provide submitters/trading partners with helpful information.

6.3 Exchanging Test Transactions

This section describes testing cycles, transmission schedules, and file naming standards. It also describes the process for reviewing results.

6.3.1 Testing Cycles and Transmission Schedules

The HPMMIS will run according to normal production schedules. This means all scheduled daily processes will be executed daily; all weekly processes will run weekly; and so forth.

The 837, 270, and 276 test files will be accepted and processed through all adjudication and/or validation processes on a daily basis.

270 and 276 batch requests must be submitted by 6:00 p.m. HST for processing that night. The 270 and 276 transactions are limited each to 1 batch submission per day. The latest file uploaded prior to the cutoff time will be processed.

271 and 277 batch responses will be available to the submitter by 8:00 a.m. HST the following day.

Financial cycles resulting in production of either the 835 Remittance Advice or paper Remittance Advice will be run weekly.

Transmission Window for the 837

Electronic claims submissions will be accepted for the current day's test processing between 6:00 a.m. and 4:00 p.m. Arizona Standard Time (AST). Please note this is three (3) hours ahead of Hawaii Standard Time (HST).

Trading partners may submit multiple batches per day.

6.3.2 File Naming Standards

837 transactions will use the following naming standard: CLM.MMDDYY.HHMMSS.837

The file should be placed in **170.68.41.129** – FTP/XXXXX/CLAIMS/ECSIN or ECSOUT/TEST, where xxxxxx = the trading partner's 5-digit submitter-ID. ECSIN is used

for inbound transactions, such as the 837. ECSOUT is used for outbound transactions, such as the 835. This process mirrors production processes.

The file naming standards used for the 270/271 and 276/277 is the same for both production and test. Please refer to section 5.2.

Outbound transactions will be named according to standards published in the respective Companion Documents. Please see Chapter 7, Transaction Overview, for more information.

For outbound transactions, the following transaction delimiters apply:

- Element delimiter = "{" (changed from the "^")

- Composite delimiter = "|" (the pipe, no change)

- Segment delimiter = "~" (a tilde, no change)

For incoming transactions, any character from the Basic and/or Extended Character Set can be used, providing it is not used in a data element value following the interchange header.

6.3.3 Transmitting Transactions and Reviewing Results

After the test file is placed in the test folder, please email the ACS EDI Team via hi.ecstest@acs-inc.com. Include the file name and the date and time that the file was submitted. In addition, include the original claim / batch submission date when the original file was sent to production. This information will allow ACS to identify selected claims in the Med-QUEST production region and compare it to the test results.

The daily processing cycles begin at 4:00 p.m. AST. Results from the current day's run will be available the next business day. Please note the HIPAA testing team, located in Hawaii, operates three hours behind AST.

The ACS EDI Team will describe how to review and discuss testing results as trading partners contacts them to announce their intentions to begin testing.

6.3.4 Testing Thresholds by Transaction

At a minimum, trading partners must adhere to the testing thresholds described in the table below:

Transaction	# Transmissions Required	Testing Requirements
837 P, I, D	Minimum of 2 batch submissions	Minimum of 25 claims/ batch
		Maximum of 500 claims/ batch
		At least one exchange should include replacements/voids
835	Minimum of 2	In conjunction with 837 exchanges **

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** Trading partners responsible for 835 transactions only should contact ACS via email to discuss testing options. Trading partners that share responsibility across functional teams for 837 and 835 development are required to coordinate their communication to facilitate the testing validation process. Please ensure ACS has appropriate contact information.

Joint 837 and 835 Testing

Concurrent testing will be conducted for entities participating in 837 and 835 testing. The process mirrors production in that an 835 transaction is produced weekly and contains information related to all 837 test claims processed during that week. Please note claims that do not pass through translator edits will not be processed in HPMMIS, and will therefore not display on that week's 835.

835 Testing Only

Trading partners may elect to complete testing for the 835. For these providers/vendors, a maximum of two weekly production remittance advices will be placed in the test folder of the FTP server. During the test period, providers will continue to receive a hard copy remittance advice. At the end of the two-week period, the hard copy remittance advice will be discontinued and only the ERA will be produced.

6.3.5 Completing the Testing Process

Trading partners that have successfully completed applicable test cycles (see Testing Thresholds, below) should submit an email to the ACS EDI Team at <ins>hi.ecstest@acs-inc.com</ins>.

The contents of the email should indicate successful completion of the testing phase by transaction. ACS will respond with questions or with confirmation, as applicable. Providers will be advised of test completions upon notification to the submitter/trading partner.

6.4 Acknowledgements and Error Handling

Please refer to Chapter 7, Transaction Overview, for descriptions of acknowledgement transactions.

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7 Transaction Overview

Note
Trading partners should be aware that any transaction might require a version update as mandated by federal law. Med-QUEST is required to support mandated HIPAA transactions.

7.1 Inbound Transactions

This section provides a summary of inbound transactions currently supported by Med-QUEST and ACS.

7.1.1 837 Fee for Service Claim

The 837 originates with a health care provider or the health care provider's designated agent and provides all necessary information to allow the destination payer to begin adjudication of the claim.

Med-QUEST currently recognizes the following X12 versions of the 837:

Txn	Name	Version
837D	Health Care Claim: Dental	ASC X12N 837 004010X97A1
837I	Health Care Claim: Institutional	ASC X12N 837 004010X96A1
837P	Health Care Claim: Professional	ASC X12N 837 004010X98A1

Trading partners should download the appropriate Implementation Guides (IG) from the Washington Publishing Company at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Med-QUEST has developed an 837 Companion Document, which can be downloaded from the Med-QUEST HIPAA/EDI page at http://med-quest.us/HIPAA/documentsanddeliverables/technical.html.

7.1.2 Claim Attachments

Because the electronic submission specifications contained in this manual do not allow for the submission of claim attachments, the claims for the following services/claim types/situations must be submitted in hard copy with the appropriate attachments:

Service/Claim Type/Situation	Required Attachment
Sterilization	Sterilization Consent form

Service/Claim Type/Situation	Required Attachment
Hysterectomy	Hysterectomy Consent form
Claims with eligibility coupons	Coupon
Hospital outpatient claims	Itemized statement if charges exceed $2,000
Miscellaneous DME and supplies	Invoice for E1399 and 99070 procedure codes
Timely Filing Exceptions	Exception letter

7.1.3 Future Inbound Transactions

The following transactions are proposed or currently under development:

277/275 The Health Care Claim Status Notification (277) transaction set will be used as an unsolicited Health Care Claim Request for Additional Information. In this scenario this would be a 275 transaction.

The 275 transaction - Additional Information to Support a Health Care Claim or Encounter (Attachments) - is intended to send additional information about a claim or encounter when a) responding to a payer's request for additional information or b) accompanying the submission of an original claim for payment.

In this scenario, the 277 is the outbound transaction and the 275 is the inbound transaction.

7.2 Outbound Transactions

This section provides a summary of outbound transactions currently supported by Med-QUEST and ACS.

7.2.1 835 Electronic Remittance Advice

The 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice from a health care payer to a health care provider, either directly or through a Depository Financial Institution.

Med-QUEST currently recognizes the **ASC X12N 835 004010X91A1** version of the 835.

Trading partners should download the appropriate Implementation Guides (IG) from the Washington Publishing Company at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Med-QUEST has developed an 837 Companion Document, which can be downloaded from the Med-QUEST HIPAA/EDI page at http://med-quest.us/HIPAA/documentsanddeliverables/technical.html.

7.2.2 Future Outbound Transactions

The following transactions are proposed or currently under development:

277/275 The Health Care Claim Status Notification (277) transaction set will be used as an unsolicited Health Care Claim Request for Additional Information. In this scenario this would be a 275 transaction.

The 275 transaction - Additional Information to Support a Health Care Claim or Encounter (Attachments) - is intended to send additional information about a claim or encounter when a) responding to a payer's request for additional information or b) accompanying the submission of an original claim for payment.

In this scenario, the 277 is the outbound transaction and the 275 is the inbound transaction.

7.3 Inbound/Outbound Transactions

This section provides a summary of inbound/outbound transactions currently supported by Med-QUEST and ACS. Inbound/outbound transactions refer to those transactions that occur in pairs (e.g., request and response).

7.3.1 270/271 Eligibility Verification Request and Response and 276/277 Claim Status Request and Response

Interactive 270/271 and 276/277 – Testers will be able to inquire on a recipient's eligibility information by using any one of the following search options: HAWI ID, SSN, or by using the recipient's Name, DOB and Gender. In response to an eligibility request, the web application will return eligibility, enrollment, and other Medicaid information for a recipient. In response to a claims status request, the web application will return information on the claim's status and its accounting details. The response to the user is returned in real-time. It is not a HIPAA requirement for the interactive 270/271 transaction to be format compliant; however, the data content returned is HIPAA compliant.

Batch 270/271 and 276/277 - Once implemented, providers will be able to submit their 270 and 276 batch request in the HIPAA compliant format via DHS Medicaid Online. The submitter will have the ability to view the uploaded and unprocessed batch request online in the format submitted.   The request file can only be viewed up until the end of day processing. In the nightly process, a mainframe program will process the request and the response will be available for download in a HIPAA compliant format the following morning.   The response will also be available to view online, however, data viewed online requires data compliance, not format compliance.   Therefore, the batch response returned the following day to the submitter would not be in the same format as the file available online. The ability to view and/or download a response file is restricted to the submitter of the request.

7.3.2 278 Prior Authorization Request and Response

The 278 Health Care Services Review Notification handles the transmission of unsolicited health care service review information to trading partners. This information can take the form of copies of health service review outcomes or notification of the beginning or end of treatment. The following events can be handled by this transaction, Patient arrival notice, Patient discharge notice, Certification change notice, Notification of certification to primary provider(s), other provider(s), and UMOs.

The 278 transaction is intended to serve as both an inbound and outbound transaction (request and notification of receipt). In the Medicaid arena, the 278 is analogous to the prior authorization, a process currently handled through hard copy receipt a response via letter.

Med-QUEST conducted an extensive review of the 278 and determined it did not contain data necessary to processing prior authorizations in the Medicaid system. For this reason, trading partners were discouraged from submitting 278 transactions to Med-QUEST.

Future versions of the 278 are proposed that will contain the data Med-QUEST requires. When the specifications are published, Med-QUEST will begin work on 278 compliance. Until then, trading partners are urged to submit hard copy prior authorization requests.

7.3.3 Future Inbound/Outbound Transactions

Med-QUEST expects the updated 278 to be published some time in 2004.

7.4 Acknowledgement Transactions

Acknowledgement transactions can relate to inbound or outbound transactions. This section describes the acknowledgement transactions used by Med-QUEST.

7.4.1 TA1 Interchange Acknowledgement

The TA1 is used to report the status of processing a received interchange header and trailer, or non-delivery by a network provider.

For the TA1, Med-QUEST complies with the instructions provided in the 837 Implementation Guide (see appendix). The IG can be downloaded from the Washington Publishing Group Web site at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Med-QUEST did not develop a corresponding Companion Document.

7.4.2 997 Functional Acknowledgement

This transaction is used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents, such as the 837.

For the 997, Med-QUEST complies with the instructions provided in the 837 Implementation Guide (see appendix). The IG can be downloaded from the Washington Publishing Group Web site at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Med-QUEST did not develop a corresponding Companion Document.

7.4.3 824 Implementation Guide Reporting

The 824 is used to notify the submitter that the transaction contained errors, what the errors are and, if applicable, what action the submitter should take.

The 824 IG can be downloaded from the Washington Publishing Group Web site at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Med-QUEST did not develop a corresponding Companion Document.

8 EDI Forms

The Med-QUEST EDI forms are provided with this chapter. For instruction, please see Section 3.2, Sign-up procedures.

Provider/Vendor Electronic
Claim Submission Notification

1.   **Provider/Vendor Name:**   **2.**   **ID Number:**

_____   _____

As representing the Provider/Vendor with above name, I hereby notify MQD that the Provider/Vendor electronic claim submissions will start on or about **3.** _____/_____/_____.

4.   **Check one:** ____ **ECS Only**   ____ **ECS and ERA**   ____**ERA Only**

5.   **Provider/Vendor Street Address:** _____

6.   **City, State & Zip Code:** _____

7.   **Telephone & Fax Number:** _____   _____

8.   **Contact Person Name:** _____

9.   **Contact Person Phone No:** _____

10.   **Contact Person E-mail:** _____

11.   **Technical Support Name:** _____

12.   **Technical Support Phone No:** _____

13.   **Technical Support E-mail:** _____

The following individuals are authorized to sign Electronic Claim Submission documents for the above mentioned Provider/Vendor:

14. Position	15. Name	16. Signature

The Provider/Vendor named above estimates that the monthly average/maximum electronic claim submission volume will be:

	Average	*Maximum*
17. HCFA-1500 Claims:	_____	_____
18. UB-92 Claims:	_____	_____
19. Dental Claims:	_____	_____

The Provider/Vendor named above will be submitting electronic claims or retrieving electronic remittance advices on behalf of the following providers: (Attach additional sheets if necessary.)

Provider Name	**ID Number**
20. _____	_____
21. _____	_____
22. _____	_____
23. _____	_____
24. _____	_____
25. _____	_____
26. _____	_____
27. _____	_____
28. _____	_____
29. _____	_____

The Provider/Vendor named above agrees to submit only clean electronic data and correct any submission errors identified by MQD or its representatives.

30.   Authorized Representative Name/Title:

_____   _____

31.   Date: **32.   Signature:**

_____   _____

Electronic Provider Agreement

1. _____ (Provider / Vendor Organization, hereafter called "Provider") hereby is authorized to submit claims data to the State of Hawaii, Department of Human Services, Med-QUEST Division (hereafter called the "Agency") for services rendered by the undersigned Provider, in machine readable form, as specified by the Agency. The Provider certifies that the claims data so recorded and submitted as input data are in accordance with all procedures, rules, regulations or statutes now in effect. If any of those procedures, rules, regulations or statutes are hereafter amended, the Provider agrees to conform to those amendments of which the Provider has been notified. Provider further certifies that it will retain and preserve all original documents as required by law, submit all or any part of same, or permit access to same for audit purposes, as required by the State of Hawaii, or any agency of the federal government, or their representatives.

In consideration of the Agency acceptance of the Provider input data, the Provider agrees to be responsible for any incorrect or delayed payments made to the Provider as a result of any error, omission, deletion, or erroneous insert caused by the Provider in the submitted data. In the event of any inconsistencies between the input data contained and underlying source documents, whether set forth in claim forms or otherwise, the Agency shall rely on the input data only.

The Provider further agrees to hold the Agency harmless from any and all claims of liability (including but not limited to consequential damages, reimbursement of erroneous billings and reimbursement of attorney fees) incurred as a consequence of any such error, omission, deletion, or erroneous input data. The Agency shall not be responsible for any incorrect or delayed payments to the Provider resulting from any error, omission, deletion or erroneous input that does not meet the standard prescribed by the Agency. Erroneous input data shall be returned to the Provider for correction and resubmission, within limited time frame prescribed by the Agency, at the Provider's cost.

The Provider herewith authorizes the Agency to (1) make administrative corrections on submitted claims data to enable the automated processing of the same: and (2) accept as original evidence of services rendered, claim data in a form appropriate for automated data processing.

The Provider agrees and certifies that the Provider's certification appearing on all claim forms in use as of a given submission date are incorporated by reference in this agreement, shall remain valid and applicable to all claim data submitted, and herewith are adopted by the Provider as though individually executed.

2. Date: _____

3. Authorized Provider Representative Name/Title: _____

4. Provider Number (if applicable): _____

5. Authorized Provider Representative Signature: _____

Electronic Remittance Advice and Automated Clearing House Registration Form

1.   **Provider/Vendor Name:**   2.   **ID Number:**

_____   _____

☐   I am interested in receiving the MQD Fee-For-Service Remittance Advice in an electronic format while having reimbursement check(s) delivered by the U.S. Postal Service to the pay-to address(es) on file with the MQD Provider Registration Unit.

☐   I am interested in having my MQD Fee-For-Service reimbursement check(s) deposited electronically to my designated bank account via an Automated Clearing House (ACH). I understand that if I elect to receive ACH deposits, I am required to accept electronic Remittance Advices.

3.   **Tax ID (Required):**   _____

4.   **Provider/Vendor Street Address:**   _____

5.   **City, State & Zip Code:**   _____

6.   **Telephone & Fax Number:**   _____   _____

7.   **Contact Person Name:**   _____

8.   **Contact Person Phone No:**   _____

9.   **Contact Person E-mail:**   _____

FOR ACH PROVIDERS ONLY

10.   **Bank Name and Account Number:**   _____

                                               _____

11.   **Bank Address:**   _____

                                               _____

12.   Bank Phone Number: _____

13.   Business Name on Bank Account: _____

14.   Bank Federal Reserve Routing Number: _____

15.   Authorized Representative Name/Title:

_____   _____

16.   Date: **17.   Signature:**

_____   _____

Electronic Claim Data
Authorized Signature Form

1.   Provider/Vendor Name: **2.   ID Number:**

_____   _____

The following individuals are authorized to sign Electronic Claim Submission documents for the above mentioned Provider/Vendor:

3. Position	4. Name	5. Signature

The following individuals are no longer authorized to sign Electronic Claim Submission documents on behalf of the above mentioned Provider/Vendor:

6. Position	7. Name	8. Termination Date
		/ /
		/ /
		/ /

9.   Authorized Representative Name/Title:

_____   _____

10.   Date: **11.   Signature:**

_____   _____